NHS Devon ICB Board Meeting (Public)

16 November 2022 09:30 - 16 November 2022 17:00

NHS Devon

NHS Devon Integrated Care Board (ICB) meeting

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

16 November 2022

1000 to 1330 hours

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 public meeting

Introductory items	Lead	Action	1000
Welcome, introduction and apologies Chair to share private/development session themes	Sarah Wollaston, Chair	Discussion	
Declarations of Interest	Sarah Wollaston	Discussion	
Minutes of the previous meeting held on 19 October 2022	Sarah Wollaston	Approval	
Citizen's voice			**1005**
Citizen's involvement story	Experiences of 36 hours waiting in Barnstaple ED waiting room	Discussion	
Leadership	**Lead**	**Action**	**1025**
Chair's report	Sarah Wollaston	Endorse	
Chief Executive's report	Jane Milligan, Chief Executive	Endorse	
Assurance and system oversight	**Lead**	**Action**	**1035**
Performance I. Performance framework – elective care winter plan	John Finn Director Urgent & Elective Care Commissioning	Endorse	
II. Review of Findings - East Kent Maternity and Neonatal Services Report	Darryn Allcorn	Endorse	
Finance report I. NHS Devon month 6 report II. ICS month 6 report	Bill Shields Chief Finance Officer	Endorse	11.00
BREAK			11.15
Strategy			
Peninsula Acute Sustainability Programme update	Liz Davenport Chief Executive Officer, Torbay and South Devon Foundation Trust	Endorse	11.20

Integrated Care Strategy update	Simon Tapley Chief Transformation and Strategic Planning Officer	Endorse	11.50
Assurance, Governance and Risk	**Lead**	**Action**	
Integrated Quality and Performance Report (IQPR) including Urgent emergency care, elective recovery, Mental Health, learning disability and neurodiversity and Primary Care	Darryn Allcorn Chief Nursing Officer	Endorse	12.10
Board Committee Assurance updates/reports: i. Quality and Performance Committee ii. Finance Committee (verbal update) iii. Audit and Risk Committee iv. People and Culture Committee v. Primary Care Transition Committee	Committee Chairs	Endorse	12.15
Action Log	Sarah Wollaston	Approval	12.45
Public Questions - on publication of the agenda, members of the public are invited to submit any questions related to agenda items up to 2 days prior to the meeting to jodie.howland@nhs.net. Appropriate questions and responses will be shared during the meeting and published on the website following the meeting			**12.50**
Questions from members of the public	Sarah Wollaston	Discussion	
Any other business			12.55
Cornwall and the Isles of Scilly Integrated Care Board – Chief Executive Report	Jane Milligan	For information	
Close			**13.00**

Declaration of Interests Register -
Register updated and generated by the Governance Team -

Register last updated 31 October 2022

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 updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
Dr	Acheson	Nigel	Chief Medical Officer, Integrated Care Board	ICS Senior leadership team ICB Board Audit and Risk Committee (If Required) NHS Devon Finance Committee Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee Quality and Performance Committee ICS Executive Committee ICB Senior Executive Team	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 Relative consultant Dermatologist at the Royal Devon University Hospital In-law is a GP partner in the Woodbury Practice	05/10/2018		12/05/2022				NHS Devon ICB
	Allcorn	Darryn	Chief Nurse	Quality and Performance Committee System Quality and Performance Group ICB Board Audit and Risk Committee (If Required) Quality and Risk Group ICS Executive Committee ICB Senior Executive Team	Honorary Associate Professor University of Exeter Seconded to NDHT (to 18 September 2020) Strategic Chief Nurse, Nightingale Hospital Exeter System Chief Nurse, Devon STP		11/05/2020		01/02/2022	Direct	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
Prof	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	Director, Plymouth Institute of Health & Care Research (PIHR). It is likely that members of my institute will undertake funded research for NHS Devon partners Trustee of Change Grow Live (a national charity that provides substance use, CYP, domestic violence, prison etc services. Devon does not currently contract services to CGL 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	Partner runs a research consultancy specilising in the integration and analysis of large data (inc NHS)	10/03/2022		10/03/2022				NHS Devon ICB
	Brown	Steven	Director of Public Health (DCC)	STP Directors ICS Partnership Board ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group ICS Executive Committee	No interests declared		19/11/2020		19/11/2020				Devon County Council
	Clarke	Graham	Independent Non Executive Director of Audit and Risk	ICB Board Audit and Risk Committee NHS Devon Finance Committee Primary Care Commissioning Transitional Committee	Non-Executive Director of Medicine Discovery Catapult Non Execuitve 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	01/01/2020		04/08/2022				NHS Devon ICB

	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	Director of Torbay Pharmaceuticals		24/11/2016	21/06/2022				Torbay and South Devon NHS Foundation Trust
	Dowell	John	Finance Director	Senior Executive Team Meeting Senior Leadership Team (SLT) Primary Care Commissioning Transitional Committee (PCCTC) ICB Board NHS Devon Finance Committee ICS Executive Committee	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	20/10/2020	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	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	16/03/2022			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	NHS Devon ICB
OBE	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	14/07/2022	Financial / Personal	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.	NHS Devon ICB
	Howland	Jodie	Governance and Facilities Business Manager	ICB Board One Devon ICP Partnership Board Audit and Risk Committee Building Coordinators Green Team Integrated Care Partnership Committee			11/02/2020	08/08/2022		Indirect	Any shift allocation that I am supporting with will be agreed and approved by a third party	NHS Devon ICB
Prof	Khalil	Hisham	Independent Non Executive Director of Quality and Performance	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		01/09/2004	24/02/2022				NHS Devon ICB
	Lee	Tracey	Chief Executive for Plymouth City Council	ICB Board Remuneration & Internal ICB Workforce	Director of Destination Plymouth Ltd		03/09/2022	13/09/2022				Plymouth City Council

Lou Glover	Sarah	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		28/06/2022	28/06/2022				NHS Devon ICB
Milligan	Jane	CEO ICS for Devon	ICB Senior Executive Team Meeting 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	21/06/2022	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.	NHS Devon ICB
Millward	Andrew	Chief Communications and Corporate Affairs Officer	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 Committee	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	10/10/2022	Non-Financial Interest Professional	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.	NHS Devon ICB
O'Kelly	Frank	Primary Care Partner for NHS ICB	ICB Board Primary Care Commissioning Transitional Committee Remuneration & Internal ICB Workforce	GP Partner at Amicus Health Blundell's School Lead Doctor Clinical Lead for STEER Education Member of the National Armed Forces Reference Group CQC Manager for Amicus Health Attends Tiverton High School Welfare Meeting fortnightly		01/01/1999	11/07/2022	Financial			NHS Devon ICB
Orford	Kevin	Independent Non Executive Director of Finance and Remuneration	ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Committee 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	15/07/2022				NHS Devon ICB

	Renshaw	Paul	Director of Workforce Stategy	ICB Board Audit and Risk Committee (If Required) ICS Executive Committee Executive Workforce Committee People & Culture Committee ICB Senior Executive Team	Non-active Consultancy partner for Linea Consulting . No remuneration for this position. No work carried out for Linea to date. Quarterly online meetings take place out of normal business hours.i attend these occasionally		2018	10/10/2022	Partner	Direct	Any Conflicts of interest at meetings will be highlighted and would seek line manager approval for any work to be carried out prior to any taking place	NHS Devon ICB
	Tapley	Simon	Chief Transformation and Strategic Planning Officer	ICB Senior Executive Team ICB Senior Leadership Team Audit and Risk Committee (If Required) Vacancy Control Panel ICB Board NHS Devon Finance Committee Executive Strategy and Transformation Group		Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon ICB Step-son is a Receptionist at Albany Surgery	01/11/2016	04/08/2022	Non-Financial Interest Professional	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.	NHS Devon ICB
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	Spouse is president of the Royal College of Psychiatrists and a consultant forensic psychiatrist employed by Devon Partnership Trust Relative is a registrar in Obstetrics and Gynaecology on the South West training scheme (currently on maternity leave) but will be returning to RD&E in late 2022. Relative is a registrar in Anaesthetics on the south West training scheme and currently based at Derriford	26/11/2021	27/06/2022	Non-Financial Personal Interests	Indirect	Where a piece of ICB/ICSD work or an item on a Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB

INTEGRATED CARE BOARD, BOARD MEETING (Public)
MINUTES

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

Location: Via Microsoft Teams

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

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

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

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

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

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

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

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

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

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

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

Minutes approved	Date:	Signed by chair:

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

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

Report of the ICB chair

Integrated Care Board

Date of committee	Date report produced
November 16, 2022	November 7, 2022

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:**	November 7, 2022
Email:	Nick.pearson@nhs.net		

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

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Executive summary (250 words max) – high level overview of the content of the report and the reasons why it is being presented

This document includes summary updates on the Integrated Care Partnership Board, Cavell Centres, the Change Leaders Event, Cost of living summit and recent visits / speaking arrangements.

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

-

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. For information only

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

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	None - reporting only
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

Report of the NHS Devon chair

Integrated Care Board

7 November

One Devon Integrated Care Partnership (ICP) Board Chair

Councillor James McInnes and I have been acting as Joint Interim Chairs of the One Devon Partnership since July 2022. With the full membership in place, the partnership was able to agree its substantive chair earlier this month. Councillor James McInnes was nominated and unanimously confirmed by the board. I feel this is really good news and important that this role is led by one of our system partners,

James is well known as a Devon County Councillor and chair of the Health and Wellbeing board. He brings with him a wealth of local knowledge and experience of social care issues together with a highly engaging and effective approach that will underpin and strengthen our work together in future.

I know the whole board will join me in congratulating James.
I have accepted the role of vice chair and look forward to working alongside James to ensure that there is a joined-up approach and good communication between both boards

Change Leaders' Event

Partners across Devon, Plymouth and Torbay have been working together to develop long term goals for the local health and care system.

The Change Leaders Event was attended by more than 100 senior leaders from a range of sectors, including the NHS; local authorities; hospices; voluntary, community and social enterprise; public health and other local partnerships.

It aimed to align delegates around a shared understanding of the current system context and work to develop One Devon while involving leaders in co-developing system priorities, which will directly inform the development of the draft Integrated Care Strategy that the One Devon Partnership will submit in December 2022.

Cllr James McInnes and I hosted the event which included compelling presentations by chief executives and leaders from NHS Devon as well as a wide range of our partner organisations.

It was great to bring so many people together to talk about the needs of local people, our current challenges and opportunities and then use the expertise and experience in the room to inform our future goals.

The Integrated Care Strategy will set the direction for health and care across Devon, Plymouth and Torbay.

In a post-event survey, 84 per cent of respondents said the conference had helped them gain a better understanding of the wider system context in Devon, including population needs, challenges, opportunities and system development.

My thanks to everyone involved in making the online event such a success, the presenters and facilitators and also Naomi Pardington-Green and Alex Cameron who played a key role in ensuring it went quite so smoothly.

The Devon Plan Working Group, which will continue to bring together a range of system partners, will produce the first draft of the Integrated Care Strategy by the end of December with a view to it being reviewed, approved and published in its final form before April 2023.

The timescales are demanding but as all other strategies must be consistent with the Integrated Care Strategy, it is important to have this overarching guide in place.

Cost-of-Living Crisis Summit

The One Devon Partnership board also discussed work across Devon to involve communities in its work, particularly following Covid-19 and the widening health inequalities that have been exposed since the pandemic.

The cost-of-living crisis will further widen health inequalities and the One Devon Partnership summit on 7 November highlighted many examples of the great work that is happening across communities to tackle this.

The cost-of-living summit was an opportunity to share best practice around Devon as well as to identify gaps.

I am delighted that NHS Devon has been allocated £300,000 to share with the VSCE through the One Devon Partnership in order to support a wide range of community projects this winter.

The summit was also an opportunity to involve VCSE partners in deciding how grants should be rapidly assessed and distributed so that they can be put to good use as quickly as possible.

Uncertainties ahead

The current problems in the economy will not have escaped anyone’s attention.

The NHS, of course, does not exist or operate in a vacuum and I wanted to provide some context for what many commentators have predicted will be the worst winter on record for us.

There are plenty of uncertainties ahead. No one at this stage knows what the Chancellor’s statement later this month holds in store. A great many organisations

will be, like us, waiting to see how this affects our communities, the people who rely on our services and our wider local economy.

For our local authorities, the financial situation is even more challenged. Councils have faced increased demand on their services, especially within adults and children's social care, with extraordinary inflationary rises in their costs to deliver them.

Devon County Council is one of those affected. Before this summer, the council went public with its financial problems after many years of balancing the books.

This month council leader John Hart warned the Government that without further support or intervention, cuts to services were inevitable. The impact of the social care reforms will significantly add to their costs but, as yet, there are no identified sources of funding or workforce to carry out the additional assessments that will be required or to care for those who will become eligible for support.

Plymouth City and Torbay councils are facing similar problems.

This winter NHS Devon is bracing for the ongoing impact of COVID as well as a predicted harsh season for flu. We will also need to plan for potential industrial action over the coming months with Unison, the Royal College of Nursing, Royal College of Midwives, GMB and Unite, all balloting or planning to ballot members.

As always, thank you to colleagues across the NHS in Devon for their dedication and commitment to the people who rely on our services and to supporting each other in challenging times.

West End Health and Wellbeing Centre (also known as the Plymouth Cavell Centre)

I wanted to update the board on the latest developments in the West End Health and Wellbeing Centre project.

As you will be aware, Plymouth City Council and the NHS have been working together on plans for a purpose-built health and wellbeing centre in the West End of the city. Stonehouse is one of the most disadvantaged areas in the UK.

The centre would include a range of services all under one roof in a convenient location, helping to prevent illness and encourage people to lead longer, healthier lives.

We, alongside our local partners, developed the business case at pace while national colleagues sought to identify the funding needed.

However, it has recently been confirmed by Government that no national funding is currently available and that for the scheme to progress, the NHS Devon integrated care board would need to prioritise its construction via its operational capital budget or other locally sourced funding solutions.

The NHS locally receives about £80 million a year for capital works across Devon, Plymouth and Torbay.

The vast majority is needed for ‘critical’ and ‘high priority’ backlog maintenance projects in existing sites, to maintain patient and staff safety and keep buildings open for patient services.

We have always been clear that an additional confirmed funding source needed to be identified for the West End project because existing funding is already fully committed for critical and high priority projects, with works in train, and we are therefore currently unable to cover the shortfall in national funding.

These projects range from creating more capacity in hospital Emergency Departments and work on a hospital ward for patients to recover after operations to improving fire safety measures.

The Plymouth West End Health and Wellbeing Centre Board – which includes NHS, local authorities and system partners – will now review options for the future as the picture on capital funding emerges following the Chancellor’s autumn statement later this month.

We remain hopeful that as this is a desperately needed project, essential to our plans for prevention of ill-health and fully ‘shovel-ready’, it may yet be able to benefit from slippage elsewhere in other national schemes. That progress was made so quickly on the preparatory stages is a tribute to the close co-operation and involvement of community and system partners.

In the meantime, other funding avenues will continue to be explored. We understand that a request to fund the national pilot programme, of which the Plymouth centre is part, will be made centrally as part of the next Spending Review in 2024/25.

Report of the chief executive

ICB report

Date of committee	Date report produced
November 16, 2022	November 7, 2022

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:**	November 7, 2022
Email:	Nick.pearson@nhs.net		

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

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Executive summary (250 words max) – high level overview of the content of the report and the reasons why it is being presented

The document includes summary updates on Covid-19 and vaccinations, Winter planning, NHS Genomics Strategy, Black History Month and recent visits / speaking engagements.

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

-

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. The board is requested to note the report

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

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	None - reporting only
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

Report of the chief executive

Integrated Care Board

November 4

COVID-19 and vaccination update

In the months preceding November there was a steady rise in the numbers of people in our hospitals with COVID-19.

By the end of October there were around 180 people being cared for, but I am pleased to report that in recent days there has been a fall.

The level of decrease over the next few weeks is expected to be relatively modest and we may actually see an increase again this month, but obviously we are all hoping that we have passed the current wave.

COVID-related sickness among our staff remains relatively low (compared to some previous waves) in our hospitals.

We remain, of course, ever vigilant. It is clear that the vaccination programme has successfully helped us to overcome the worst of the pandemic so far. But it is equally clear that the disease is still very much with us and that it remains vitally important that people receive the latest vaccinations being offered.

So far in our county this autumn, more than 323,000 Covid boosters have been delivered. This is a superb number and takes the total of Covid jabs received by people in Devon to almost 3.9 million.

We know all too well from previous waves how COVID-19 can impact our staff and in turn our patients, residents and our services.

And with COVID staff absence numbers beginning to rise, we have urged our frontline health and care staff to act quickly so we can protect ourselves, our colleagues, and protect our patients.

Public health experts have warned that this is likely to be a bad flu season, due to lockdowns causing people to be less immune to this year's flu virus.

All frontline NHS staff have been encouraged to book a flu vaccine and this year, frontline social care workers are also being offered the free flu and COVID-19 vaccines as part of the winter vaccine programme.

Finally, in this section, a national campaign is urging people to protect themselves and their babies when pregnant

For many years, the NHS has recommended that, if pregnant, you should be vaccinated against flu to protect from serious illness. A Covid-19 booster vaccination is also recommended, if it is more than three months since the last dose.

The Joint Committee on Vaccination and Immunisation's advice is those expecting are far more likely to get severe COVID-19 infection if they contract the disease.

In the UK to date over 250,000 vaccines have been given in pregnancy.

Our thanks as ever to everyone involved in the vaccination campaign to date – whether a clinician, a staff member or one of the many volunteers that help us.

You are helping to make us all safer and we thank you very much indeed.

Winter planning

I have previously provided significant updates to the Board on Winter planning and the funding being provided to address Winter pressures, together with the current difficulties faced by Devon hospitals.

This month I will therefore keep it relatively brief.

Firstly, I wanted to report that we have received confirmation that the Devon system has been ranked number one in the SW for its number of weekend discharges.

This is no mean feat and has taken huge effort from everyone involved – from nurses and doctors on the wards, managerial and discharge staff, social services and care homes. It is indeed good progress during difficult times, but we are by no means on top of the situation during the week just yet.

A great deal of effort is going into this and while some of the issues are difficult to resolve quickly, all partners and staff are committed to doing so.

NHS Devon is continuing to work on its Winter plan and is putting in place mitigations to expand capacity over the Winter, as a result of the additional funding.

Immediate actions include ongoing system-wide communications to the public, the development of an enhanced protocol for forecourt ambulance diverts and the short-term expansion of ambulance catchment for Royal Devon University Hospital (RDUH).

The latter measures commenced on Monday 10 October and are planned to run until 7 November.

Evidence suggests that this is resulting in an average of 3 ambulances per day going to Royal Devon and Exeter Hospital – taking a little pressure off UHP.

Owing to earlier than expected winter pressures, we have also brought forward the opening of the care hotel in Plymouth. A total of 40 beds were mobilised on October 18 (was due November) with the remaining 20 beds opening on October 31.

We are working on a clear recovery plan to reflect the improvement work required for urgent and emergency care, with a view to stabilising and sustaining this work. I expect to be able to bring this to the Board in due course.

I also wish to briefly update the Board more generally on our work on virtual wards which provide additional capacity for frail patients or those who need respiratory care.

As you know, virtual wards allow patients to receive the care they need at home safely and conveniently, rather than being in hospital.

Recruitment to virtual ward roles is now underway at all providers.

Market scoping has been undertaken for wearable technology and a specification and tender documentation has been finalised with the Commissioning Support Unit.

When the “wards” are up and running we expect there to be 85 additional bed equivalents with clinical support.

Due to the earlier than predicted covid surge and increasing flu presentations, the virtual ward team is working with providers to bring forward respiratory virtual ward capacity.

RDUH Eastern (RD&E) and Northern respiratory capacity is being bought forward to November with UHP/Western on track for December. There are ongoing discussions about bringing forward the “wards” in Southern Devon too.

NHS Genomics Strategy

I am pleased to report that the world’s first genetic testing service for children has been trialled at the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) and was announced at the first ever NHS genomics conference in England.

This will allow the NHS to diagnose and potentially save the lives of thousands of severely ill children and babies within days, by rapidly processing DNA samples of babies and children with the use of simple blood tests. The development of this genetic testing service could help to start lifesaving treatment plans for more than 6,000 genetic diseases.

I am proud to see Royal Devon leading the trial and I am looking forward to the ongoing work which will contribute towards helping children all around the country, and beyond. It is a great honour to have Royal Devon leading in the field of genomics, and I have already sent my congratulations to Suzanne Tracey and the team.

ICB team now complete

I am pleased to report that the two newest recruits to the NHS Devon executive team have now started work.

Chief Delivery Office Anthony Fitzgerald took up his position with us on 1 November 2022 and Chief Finance Director Bill Shields, on 7 November.

I would like to take this opportunity to welcome Anthony and Bill to the team at NHS Devon.

Black History Month and our record this year

Diversity in all its forms is incredibly important to me and other colleagues working in the NHS.

There are good reasons for this. A diverse workforce not only better represents the community it serves, it also can bring different perspectives to bear on problems, increase productivity and increase workforce retention. But most of all, it's the right thing to do.

October's Black History Month has now drawn to a close. It was incredibly successful and celebrated throughout the country as well as within the NHS in Devon.

The board will be aware that NHS Devon has done a considerable amount of work this year to improve equality, diversity and inclusion for ethnically diverse patients and staff.

There has been proactive recruitment to board roles with three non-executive board members appointed from ethnically diverse backgrounds. Applications from people from diverse communities for roles within the organisation have also increased to their highest level.

We have made significant progress to improve health and care experiences for people from ethnically diverse backgrounds.

We relaunched the Devon-wide Ethnic Equality Network which brings together 80 people of diverse backgrounds to provide representation and influence our understanding of issues affecting members.

We won a national award for our COVID-19 vaccination outreach programme, which involved 1,800 people across Devon from diverse communities to help us to target over 49,000 vaccinations.

We funded the appointment of a Vaccine Outreach Involvement Manager and funded 12 voluntary sector projects, recruiting 20 vaccine ambassadors.

NHS Devon also invested in a new equality, diversity and inclusion team to increase our focus on this area.

And NHS Devon is continuing to support and promote international nurses and medics. More than 600 international nurses have been recruited to Devon in the last 15 months with NHS Devon nominated for “Best International recruitment experience” in the Nursing Times Workforce Awards.

It’s a good start and worthy of celebration for Black History Month but there is always more to do in this area, and I look forward to reporting back about further increases in diverse representation at all levels in future.

My thanks to everyone involved.

Visits and speaking engagements

I had the pleasure of returning to the Leading in the Devon NHS Healthcare System event with other healthcare partners.

I had spoken at the first of these and was asked to speak again at the closing event hosted by The Leadership Centre. The organisation works with and supports senior leaders in complex public sector environments.

The event aimed to develop system working and collaboration, nurture relationships and prepare healthcare leaders to work in the Integrated Care Systems.

It provided an opportunity for me to share my experiences of working in the NHS and challenges from a system-wide perspective within health and social care.

I also found time this month to visit another GP practice, this time in North Devon.

It was good to catch up with primary care colleagues at Ruby Country Medical Practice in Holsworthy and I extend my thanks to everyone there.

I have upcoming visits to North Devon Hospice in Barnstaple and Sidmouth Hospital which I am very much looking forward to.

Integrated Care System (ICS) executive committee updates

The following are key updates from the ICS executive committee

Clinical strategies

The latest Executive Strategy and Transformation Group focussed a significant portion of the meeting on integrating clinical strategies.

The emphasis was on the importance of ensuring there is alignment between key clinical strategies and other pieces of work this Group is accountable for.

All strategies need to be evidence-based and have a “golden thread” of alignment prior to going to other Committees or Boards within the system.

Mental health

The Group also received an update on the progress of the Mental Health Learning Disability Neurodiversity (MHLDN) Sustainability Programme.

The timeline of this programme is looking at designing the approach and methodology over the next six months in preparation for sign off in March 2023.

Updates on progress for this programme will continue to come through the Executive Strategy and Transformation Group for check and challenge, to ensure alignment and no duplication of work with other key programmes or strategies, particularly the Peninsular Acute Sustainability Programme (PASP).

A Memorandum of Understanding / Operating Model is currently being drafted and will be brought to a System meeting for sign off following the MHLDN Provider Collaborative meeting in October.

Children’s services

An update was provided on the Children’s Services Strategy and the Primary and Community Care Model (formerly the GP Strategy and Community First Strategy).

Work is ongoing in both of these areas, with proposed scopes returning to the Executive Strategy and Transformation Group for check and challenge and agreement.

Virtual Wards

Phase 1 of the virtual ward set up is underway and NHS England is enthusiastic regarding the design of our model. We are in the process of identifying a site for physical staff and clinical spaces, which is being dealt with by our Estates team.

NHS Devon is being encouraged to maximise the use of virtual wards and we are committed to putting these plans in place.

Ambulance Handovers

The System Delivery and Improvement Group has advised that a funding allocation of £6 million from the Devon Demand and Capacity fund is to be used to enhance hospital capacity and improve the flow of emergency and urgent care patients outside of A&E. This

funding is to be split between the four hospitals to allow the availability of additional beds, equipment, and staff.

NHS Devon Integrated Care Board ICB Meeting – Public

Assurance process for Tier 1 & Tier 2

Date of committee	Date report produced
16th November 22	3rd November 22

Author(s)		Report approved by	
Name and title:	John Finn, Executive Director Urgent & Elective Care	**Name and title:**	John Finn Executive Director Urgent & Elective Care
Phone:	01392 675365	**Date: 03/11/2022**	
Email:	John.finn@nhs.net		

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

Executive summary

This paper is to give assurance to members of the Devon Integrated Care Board that the ICS has assurance of the self-certification process required by Providers for Tier 1 and Tier 2 Elective Recovery Programme

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

None

Key recommendations and actions requested
1. Board members to note the paper giving assurance to the ICB of the self-certification process

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	The assurances that we have received will support the continuing work to support the elective recovery programme
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	This paper will give assurance that provider organisations have a process in place to support the Tier 1 and Tier 2 elective recovery programme
Health inequalities	
Workforce	
Resources and finance	
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Self-Certification process for Tier 1 and Tier 2 for provider organisations in Devon

NHS England ask

There is an ask in the Tier 1 and Tier 2 letter of 25 October from NHS England that each provider in Devon will undertake a Board self-certification process and have it signed off by Trust Chairs and CEOs by 11 November. The copy of this letter and request is appendix A submitted with this paper.

Assurance

At the time of submission of papers (04/11/22), the Devon ICB has received written confirmation from Torbay & South Devon Foundation Trust, University Hospital Plymouth and Royal Devon University Healthcare NHS Foundation Trust that the assurance statements for each organisation will be signed off by the relevant Trust Boards before the 11 November.

Process

Post sign-off by the individual boards, John Finn, Executive Director Urgent and Elective Care will submit the assurances to NHS England by the requested deadline of 11th November.

Request to Board

Members of the NHS Devon Board meeting on 16 November are asked to accept this paper as assurance that the appropriate actions are being taken by each provider and that John Finn, Executive Director of Urgent and Elective Care will ensure that the appropriate self-certification details are shared with NHS England by 11 November as requested.

To: NHS Trust and Foundation Trust chief executives and chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

25 October 2022

Dear colleague,

Next steps on elective care for Tier One and Tier Two providers

On 18 October, NHS England wrote to the NHS outlining further plans to boost capacity and resilience for services over the coming challenging winter period. This letter now sets out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives around 78 week waiters and 62 day cancer waits are met.

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days respectively. Activity levels compared to pre-pandemic are increasing but we can still do more. There is no one silver bullet, but through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity, we firmly believe that we can continue to make genuine progress.

We realise that there are a lot of asks on providers and that each of you will know best your local circumstances and what works well. However, through each wave of Covid over the past two years, hospitals have got better and better at protecting elective and cancer care. There are significant learnings from individual organisations across the country that can make a huge difference if adopted collectively. That is why we are now asking all colleagues to step up efforts on all of the measures outlined below. With this in mind, we ask that you complete the Board self certification, (see appendix A) to allow us to support you where you are having the greatest challenges. The fundamentals that we have, collectively, proven to work are:

Excellence in the Fundamentals of Waiting List Management
Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance. All patients past 62 days for cancer and 78

weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

Validation

The validation and review of patients on a non-admitted waiting list is important for the appropriate use of outpatient capacity and to provide clean visible waiting lists to ensure timely and orderly access to care. There are three phases to validating waiting lists that providers are required to undertake routinely – technical, administration and clinical and, following on from guidance sent out on 16 August available here, we expect providers to meet this timeline:

a) By 23rd December 2022
   Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

b) By 24th February 2023
   Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

c) By 28th April 2023
   Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted

Appropriate surgical and diagnostic prioritisation

We know that 85% of patients waiting longer than 62 days from their referral for urgent suspected cancer are waiting for a diagnostic test. For cancer in particular, the significant demand for additional diagnostic capacity means that Trusts need to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway, but should at all times have a maximum backstop timeframe of 10 days from referral to report. Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

Trusts should ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single PTLs across the system. Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.

Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

Cancer pathway re-design for Lower GI, Skin and Prostate

There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.

Lower GI: Full Implementation of FIT in the 2ww pathway

As set out in the joint guidance on FIT issued by the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (ACPGBI), and reinforced in this letter, most patients with suspected colorectal cancer symptoms but a FIT of fHb <10 µg Hb/g, a normal full blood count, and no ongoing clinical concerns should not be referred on a LGI urgent cancer pathway. Where referred, teams should not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways as set out in the letter.

Full implementation of teledermatology in the suspected skin cancer pathway

All Trusts should work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances to tackle the backlog and meet increasing demand. NHS England's guidance on the implementation of teledermatology pathways is endorsed by the British Association of Dermatologists and supports a Best Practice Timed Pathway for skin cancer which has been published this week.

Implementation will require provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers. This could be delivered by primary care, a separately contracted service delivered by primary care, in a community image taking hub setting, or by medical illustration departments in secondary care. Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans. Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required.

Full implementation of the Best Practice Timed Pathway for prostate cancer
All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy. Using pre-biopsy mpMRI means patients can be triaged towards a biopsy so at least 25% can avoid it, over 90% of significant cancers can be diagnosed on imaging and fewer insignificant cancers are diagnosed. Use of local anaesthetic transperineal biopsy where clinically indicated provides increased accuracy and reduced risk of infection, without the resource intensity of procedures done under general anaesthetic.

Implementation will require all patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received. Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set, with frequency of mpMRI slots sufficient to support delivery of timely biopsy. Maximum use of local anaesthetic transperineal prostate biopsy should also be ensured, with general anaesthetic biopsy used only where clinically indicated or for patient preference. Pre-biopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.

Outpatient transformation
Outpatients make up around 80% of the total waiting list and it is crucial that, over the winter period, providers continue to keep a strong operational focus on providing these services. Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

a) As part of this, trusts are asked to continue the expansion of patient initiated follow up (PIFU) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.
b) Continue to deliver at least 16 specialist advice requests per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.
c) Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings
d) In order to enable a personalised approach for outpatients and where it is clinically appropriate to do so, outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments. Remote consultation guidance and implementation materials can be found on NHS Futures here.

Surgical and theatre productivity

It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter. As such we expect providers to:

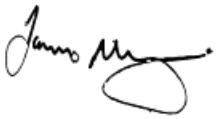
a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working 'shoulder-to-shoulder' with a senior clinician – to succeed we need both groups working together.
b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.
c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%, and helping to free up valuable inpatient beds for complex work.
d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, eg hand surgery, cyctoscopy, hysteroscopy
e) Adopt best practice pre & peri-operative medicine pathways to reduce issues of under booking of lists, on the day cancellations, and pro-longed length of stay, as well as providing better care for patients.
f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach.
g) Not performing those interventions identified as 'must not do' on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.

Board Self-certification

As part of the above priorities, we are asking each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by November 11, 2022. If you are unable to complete the self certification process then please could you discuss next steps with your Regional team. The details of this self certification can be found at Appendix A.

Thank you for all of your continued hard work in addressing what are two critical priorities for the NHS over the winter period. Please share this letter with your Board, key clinical and operational teams and relevant committees, and do email england.electiveopsanddelivery@nhs.net should you have any questions.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Elective Recovery Self certification **Appendix A**

The Chair and CEO are asked to confirm that the Board:

a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.

b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.

c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.

d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.

e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.

f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.

g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.

h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.

j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.

k) Confirm your SROs for theatre productivity.

l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.

Signed by CEO Date:

Signed by Chair Date:

Devon Integrated Care Board Meeting

A summary, including next steps within Devon, for Committee: *Reading the signals – Maternity and neonatal services in East Kent – the Report of the Independent Investigation*

Date of committee	Date report produced
16.11.22	21.10.22

Author(s)		Report approved by	
Name and title:	Sara Wright, Head of Nursing & Quality	**Name and title:**	Darryn Allcorn, CNO
Phone:		**Date:**	24.10.22
Email:	Sara.wright4@nhs.net		

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

Executive summary

The report comprises 182 pages divided into 6 chapters and opens with a letter from the Chair of the Investigation, Dr Bill Kirkup CBE to the Secretary of State for Health and Social Care and The Chief Executive of the NHS.

The 6 chapters are:

Chapter 1	Missed opportunities at East Kent – our Investigation findings
Chapter 2	The Panel's assessment of clinical care provided
Chapter 3	The wider experience of the families
Chapter 4	What we have heard from staff and others
Chapter 5	How the Trust has acted and the engagement of regulators
Chapter 6	Areas for action

Open letter – the letter from the Panel Chair to the Secretary of State for Health and Social Care and the Chief Executive of the NHS acknowledges the devastating loss for families and quotes a bereaved mother and her experience of the aftermath. The Chair sets out that rather than a long list of recommendations he has compiled 4 key themes for this Trust, other Trusts, NHS bodies and other organisations to address.

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

Nil

Key recommendations and actions requested

1. For the Board to endorse the recommendations

Outline the implications of matters covered in this report for the following areas (if none, please state)

Area	
Quality of services	Maintaining safe standards in maternity care.
Health inequalities	None, but variation in standards across services/ areas.
Workforce	Increased pressures within maternity and obstetric workforce. Need to address training of staff. Human factor implication- teams having a common purpose.
Resources and finance	None
Legal	Consider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
Digital and Data	The need to improve data collection and use to improve safety.
Involvement, Engagement and consultation	Families feeling they are or are not listened to; working in partnership with families.

Main Report:

1.0 Background:

On 13 February 2020 the Minister of State, DHSC, confirmed in Parliament that, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSEI) had commissioned Dr Bill Kirkup CBE to undertake an independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust.

On 20 October 2022, Sir David Sloman, Chief Operating Officer, Dame Ruth May, Chief Nursing Officer and Professor Stephen Powis, National Medical Director wrote to all Trust Chief Executives, Trust Chairs, ICB Chief Executives and LMNS Chairs. The letter stated:

"We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'….The publication of the delivery plan should not delay your acting in response to this report and the actions you are taking in response to the report of the independent investigation at Shrewsbury and Telford NHS Foundation Trust."

2.0 A Summary of the Report:

The report identifies 4 areas for action. The NHS could be much better at:

- identifying poorly performing units
- giving care with compassion and kindness
- teamworking with a common purpose
- responding to challenge with honesty

The following summarises the report's open letter, chapters and recommendations:

- **Open letter** –

The letter from the Panel Chair to the Secretary of State for Health and Social Care and the Chief Executive of the NHS acknowledges the devastating loss for families and quotes a bereaved mother and her experience of the aftermath. The Chair sets out that rather than a long list of recommendations he has compiled 4 key themes for this Trust, other Trusts, NHS bodies and other organisations to address.

- **Chapter 1** –

Focuses on the ability of the organisation to focus on the finding the signals among the noise. The chapter also covers the need to ensure that data on which to base decisions and interventions is timely, meaningful and risk adjusted. There is a preference for effective use of SPC data.

- **Chapter 2** –

The main thrust of this chapter relates to standards of clinical behaviour. The report sets out the need to ensure a lifelong commitment to learning at every level from graduate to post graduate and ensuring compassion is a central theme. The recommendation from this chapter

is to also ensure that Royal Colleges and oversight organisations provide greater direction and clarity on behaviour.

- **Chapter 3** –

Whilst this chapter focusses on the experience of families the main summation is on the poor behaviour and teamwork which has led to reduced trust, reduced patient safety of mothers and babies and a reduced level of information being shared among clinical colleagues. The report states that from the testimonies there was a complacency and lack of accountability but instead a culture of blame often directed towards the most junior staff member or in some cases the mothers' themselves. The panel found an inappropriate promotion of 'normal' birth as the ideal and a polarisation between midwives and obstetricians in the pursuit of 'normal' birth. A lack of common purpose among professionals was also cited as a causative factor.

- **Chapter 4** –

This chapter was about how the Trust has presented itself, and other Trusts too in the pursuit of presenting well but performing badly for patients. The panel found that this Trust has prioritised reputation and reducing liability via litigation which has then become a barrier towards learning and optimised patient safety.

- **Chapter 5** –

This chapter relates to the role of regulators and also about how regulators were received in the Trust. CQC had been met with a defensive approach with extensive responses to inspection reports. HSIB had been met by a previous Chief Executive in a dismissive manner and had told the panel that its relationship with the Trust ie *contrast sharply with the response of other trusts in the region.* There are also references to RCOG, NHS England and its predecessor formations, Monitor and the local CCG.

3.0 Report Recommendations:

Chapter 6 sets out the areas of action and 5 recommendations which are:

- **Recommendation 1**

The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

- **Recommendation 2**

Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning. Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions of non-compliance.

- **Recommendation 3**

Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.

Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.

- **Recommendation 4**

The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

- **Recommendation 5**

The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

4.0 Devon Actions:

Devon LMNS has just completed a series of insight visits, with the NHSE Regional Team, to review each Trusts self-evaluation of compliance against the interim Ockenden Report. These insight visits form part of a strengthened approach to perinatal quality surveillance and will be part of an annual cycle of onsite reviews by the ICB. There is a well established safety and governance sub group within the LMNS programme which proved a monthly Perinatal, Quality Surveillance (PQS) Report to the LMNS Board and up to the regional PQS Systems Group. Further actions include:

- Appointment of a perinatal quality and safety midwife to coordinate and deliver the strengthened model of surveillance
- Appointment of a lead Obstetrician
- Learning and recommendations from this report will now be factored into the work of the Local Maternity and Neonatal Services Board (LMNS) governance processes.
- Meaningful outcome measures will be developed further through our quality reporting processes, including to the LMNS Board and ICS.

NHS Devon and Devon Local Maternity & Neonatal System (LMNS) have been deeply saddened to read about the experiences of women, birthing people and their families in the recent report into maternity services in East Kent -'Reading the Signals'.

The LMNS is committed to fulfilling its role in ensuring that maternity and neonatal services in Devon are safe and high quality. We will work in partnership with maternity & neonatal services across Devon to confirm the actions that need to be taken in order to meet the 4 key areas for improvement:

1. **Monitoring safety performances – earlier warning signs needed before significant harm is caused**
2. **Standards of clinical behaviour – instances of harmful lack of professionalism**
3. **Flawed teamworking – the teamwork was found to be dysfunctional**

4. **Organisation behaviour – attempting to look good while doing badly**

The role of the LMNS in implementation of the East Kent report will include:

1. Surveillance & assurance of action implementation
2. Sharing good practice
3. System wide support
4. Acting as a conduit to the regional and national maternity transformation team where clarifications and further guidance are required.

This will occur through our LMNS Safety & Governance meeting and be reported to the Devon LMNS Strategic Board.

We will also work with our Maternity Voices Partnership chairs to provide support and guidance in response to queries and concerns from women, birthing people and families.

On the 17th of November a meeting will be held with the Heads of Midwifery to discuss their views, immediate actions and any support required for the initial response whilst we await further implementation guidance. In the meantime, we will continue to work towards implementing the actions contained in the Ockenden Report.

5.0 Recommendations:

- For the Board to endorse the recommendations

Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready) (publishing.service.gov.uk)

Board Meeting

NHS Devon (ICB) Finance Report Month 6

Date of committee	Date report produced
16th November 2022	9th November 2022

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:**	9th November 2022
Email:	kevin.wheller@nhs.net		bill.shields2@nhs.net

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

Executive summary (250 words max) – high level overview of the content of the report and the reasons why it is being presented

The presentation of the Integrated Care Board (ICB) financial position in this report seeks to provide the necessary assurance to the Integrated Care Board.

The report details the ICB financial position for the period ended 30th September 2022, setting out the year to date and forecast financial position as well as the risks to deliver a break-even plan.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
The Finance Committee reviewed and approved the report.

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
The Board is requested to: Consider, review and discuss the ICB financial position as at the period ended 30th September 2022.

Impact on NHS Devon objectives	
Objective	**Impact**
Make more efficient use of our resources	To enable the delivery of the ICB control total

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Resources and finance	Delivery of financial sustainability

NHS Devon ICB Finance Report

Month 6 – 30th September 2022

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

Executive Summary

- The position to Month 6 includes the final reported position of the NHS Devon CCG to the 30th June 2022.
- Based on the year to date position the ICB is expecting to meet its target of break even for the year.
- The delivery of savings and efficiencies is off plan at month 6 by £5.2m, driven by a slower than expected delivery of savings linked to prescribing, placements and targets associated with the recovery programme that is on progress.
- Savings plans are forecast to deliver to target by 31st March 2023 and actions are being taken to improve the delivery going forward.
- The ICB risk profile has changed from month 5 due to expected non-recurrent flexibilities resulting in a net risk of £ nil.

Summary Financial Performance

Service	Year to date				Forecast			M5 YTD Variance £000
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000		Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	
Acute	619,551	620,479	(928)	↓	1,240,293	1,242,073	(1,780)	600
Mental Health	134,605	134,484	122	↓	270,389	271,638	(1,249)	1,599
Community Health	149,801	148,666	1,136	↓	303,392	302,131	1,261	4,005
Continuing Care	72,537	74,653	(2,117)	↓	145,129	149,617	(4,488)	(410)
Primary Care	225,749	227,244	(1,494)	↓	452,024	460,951	(8,927)	2,719
Other Programme	17,618	16,761	856	↑	33,965	34,982	(1,017)	91
Total Commissioned Services	**1,219,861**	**1,222,287**	**(2,426)**	↓	**2,445,192**	**2,461,392**	**(16,200)**	**8,604**
Running Costs	11,629	11,557	73	↓	22,919	22,919	(0)	329
Net Expenditure	**1,231,490**	**1,233,844**	**(2,353)**	↓	**2,468,111**	**2,484,311**	**(16,201)**	**8,934**
Reserves/Contingencies	8,464	6,112	2,352	↑	40,790	32,660	8,131	(8,934)
Tptal Net Expenditure	**1,239,955**	**1,239,956**	**(1)**	↓	**2,508,901**	**2,516,971**	**(8,070)**	**(0)**
Resource Allocation	(1,239,956)	(1,239,956)	0	→	(2,508,901)	(2,508,901)	0	0
Additional Roles Reimbursement Scheme allocation expected	0	0	0	→	0	(8,070)	8,070	0
Total Commissioned Services	**(1)**	**0**	**(1)**	↓	**0**	**0**	**(0)**	**(0)**

Summary Financial Performance

- The position to Month 6 and for the year ending 31st March 2023 includes the final reported position of NHS Devon CCG to the 30th June 2022.
- As reported at Month 5 the budget profile has been reviewed and finalised in month 6, providing a clearer picture of the ICB variances.
- The majority of the **Acute** YTD and FOT overspend is due to patient transport costs, linked to increase journeys as a result of COVID and the discharge to assess policy.
- Emerging pressures in **Mental Health** relating to addressing ADHD waiting lists and SMI physical health checks indicate a potential forecast overspend. Funding solutions are being explored but cannot be guaranteed at this stage.

Summary Financial Performance

- The YTD and FOT overspend in **Continuing Care** is largely a result of a small number of high-cost cases at circa £4m full year effect which emerged in months 4 and 5. The CHC team are working on mitigating plans for these cases. Part of the variance reported here relates to Torbay & Southern Devon FT placements position there reverse of which contributing to an underspend in Community Healthcare.
- **Primary Care** is overspending YTD and FOT due to prescribing costs £2.2m, with the remaining variance relating to the Additional Roles Reimbursement Scheme, funding of which will come from NHS England.
- **Reserves** and **contingencies** mitigate the overall YTD and FOT overspends resulting in an expected ICB break even position for the year.

Savings and Efficiencies

Scheme	RAG Status	Rec/ Non-Rec	% of Budget	Year to date				Forecast			
				Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable/ (Adverse) £000		Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable/ (Adverse) £000	
Prescribing		R	2.7%	2,850	2,375	(475)		5,704	5,704	0	
Running Cost Inflation		R	2.3%	264	264	0		525	525	0	
Placements		R	3.7%	1,974	1,377	(597)		3,945	3,945	0	
Primary Care Commissioning Review		R	0.8%	1,002	1,002	0		2,000	2,000	0	
Commissioning Review		R	0.8%	1,500	1,500	0		3,000	3,000	0	
Covid Reduction		NR	78.0%	1,800	1,800	0		3,600	3,600	0	
Acute		R	1.4%	390	390	0		784	784	0	
Unidentified		NR		990	0	(990)		2,967	2,967	0	
SDF		NR	11.1%	2,001	1,500	(501)		6,000	6,000	0	
Workstream stretch		NR		2,667	0	(2,667)		8,000	8,000	0	
Total				**15,438**	**10,208**	**(5,230)**		**36,525**	**36,525**	**0**	
Recurrent				7,980	6,908	(1,072)		15,958	15,958	0	
Non-Recurrent				7,458	3,300	(4,158)		20,567	20,567	0	
Total				**15,438**	**10,208**	**(5,230)**		**36,525**	**36,525**	**0**	

Savings and Efficiencies

- The majority of identified savings plans are delivering to plan as at Month 6.
- The Placements year to date savings plan is reported as being off plan, although currently actions taken to date are forecast to deliver the £3.9m savings target. The savings plan in this area focuses on reviews of high cost placements, timely post discharge assessments and reviews of personal health budgets.
- The ICB is in the process of engaging external assessment resource which is expected to realise financial benefits.
- The unidentified savings and workstream stretch target are linked to the recovery plan actions.
- The ICB has recently appointed a small team (funded by the Recovery Support Team) to instil pace and traction to the recovery plan and improve on the in-year financial benefit.

Risks and Mitigations

Headline	Description	M5 £000	M6 £000	Movement £000	Risk at Plan £000
CIP shortfall	Non-delivery of workstream stretch efficiency	8,000	8,000	0	8,000
CIP shortfall	Non-delivery of unidentified CIP	2,967	2,967	0	2,967
CIP shortfall	Partial delivery of SDF Review efficiency	3,000	3,000	0	3,000
Hospital discharge	Unable to manage costs of hospital discharge within budgets set	2,500	0	(2,500)	2,500
Prescribing prices	Increases in prescription drugs prices	1,500	3,900	2,400	1,500
Total Risk		**17,967**	**17,867**	**(100)**	**17,967**
Non-Recurrent flexibility	Release of balance sheet accruals	7,376	7,376	0	7,376
s256 funds	Use of s256 funding held by Local Authorities	2,500	2,500	0	2,500
Non-Recurrent flexibility	Other non-recurrent benefits	5,000	7,992	2,992	0
Total Mitigation		**14,876**	**17,867**	**2,992**	**9,876**
Net Risk		**3,092**	**0**	**(3,092)**	**8,092**

- The ICB risk profile has changed from month 5 due to expected non-recurrent flexibilities resulting in a net risk of £ nil.

Resource Allocation

Allocation Description	Year to date		
	CCG M1-3 £000	ICB M6 £000	Total £000
Core allocation	520,549	1,538,927	2,059,476
Primary care commissioning	49,960	148,548	198,508
Ockenden maternity review	365	1,093	1,458
Running costs	5,645	16,933	22,578
Core - Additional Inflation Funding		22,720	22,720
Primary Care - Additional Inflation Funding		1,331	1,331
Recurrent Allocation	**576,519**	**1,729,552**	**2,306,071**
Health Inequalities Funding	931	2,794	3,725
COVID funding	11,828	35,482	47,310
Running cost pension contribution	340		340
Service development fund (SDF)	9,073	29,124	38,197
Elective Services Recovery Funding (ESRF)	9,874	29,623	39,497
CCG to ICB Transition Adjustment	(12,248)	12,248	0
Core - Additional Inflation Funding		7,123	7,123
New Allocations M4		3,891	3,891
New Allocations M5		14,183	14,183
New Allocations M6		48,564	48,564
Non-Recurrent Allocation	**19,798**	**183,032**	**202,830**
Total Allocation	**596,317**	**1,912,584**	**2,508,901**

Conclusion

- The ICB is expecting to deliver its target of break even for the year.

Other Financial Information

Statement of Financial Position	M6 £000
Property Plant Equipment	2,705
Intangible Assets	206
Non Current Assest	**2,911**
Inventories	896
Trade & Other Receivables - NHS	878
Trade & Other Receivables - Non NHS	7,780
Cash & Cash Equivalents	3,082
Current Assets	**12,636**
Total Assests	**15,547**
Trade & Other Payables - NHS	(13,489)
Trade & Other Payables - Non NHS	(121,659)
Other Liabilities	(3,709)
Borrowings / Cash in Transit	(3,404)
Current Liabilities	**(142,261)**
Total Assets Employed	**(126,714)**
General Fund	(126,714)
Total Taxpayers Equity	**(126,714)**

Better Payment Practice Code	M6	
	Number	£000
Non NHS Creditors - % of bills paid within target	99.62	99.02
NHS Creditors - % of bills paid within target	97.41	99.98

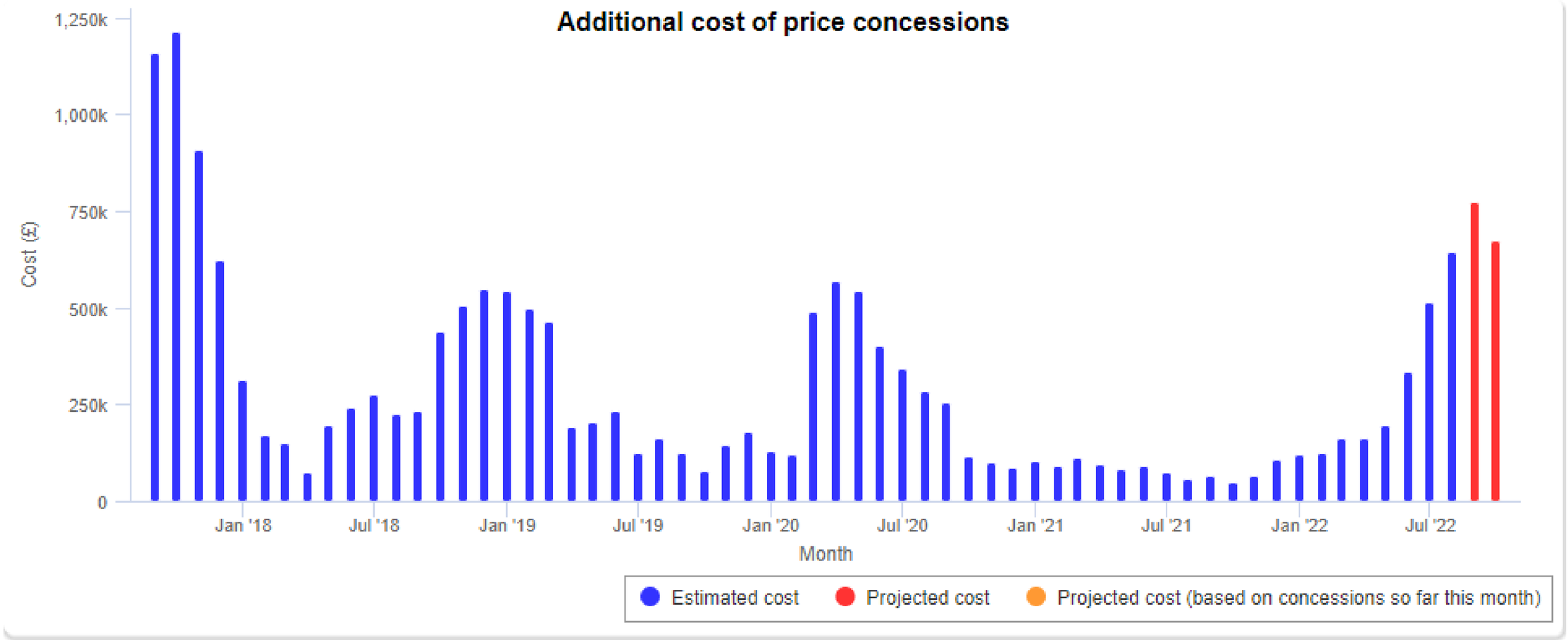
- The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.
- The target of 95% for both number and value

Update to Prescribing Forecast

Price Concession Spend Profile

- Price concessions are a short term agreement by the NHS to pay for more expensive versions of a generic medicine because pharmacists are unable to obtain the generic at its usual price. This dashboard (next slide) tracks the additional costs these concessions create.
- Price concessions also referred to interchangeably as No Cheaper Stock Obtainable (NCSO)
- Price concession spend has been minimal for most of 20/21 and 21/22.
- 22/23 budgets are based on 21/22 actuals, with a CIP target that sets a flat cash requirement
- Concessionary expenditure has been steadily growing over the last few months and is currently higher than we have seen for many years.
- Following graph shows monthly spend profile for NHS Devon, this is a similar picture for all ICBs and nationally

Price Concession Spend Profile



Price Concession Impact on forecast

- Prescribing forecasts are derived nationally using a known (predicted) expenditure profile. For instance, actual expenditure incurred in April to July represents 33.12% of total expenditure predicted to be spent in the year. The annual profile is adjusted to reflect dispensing days, known price changes, etc
- Prescribing information is collated centrally based on community pharmacy dispensaries, and is reflected back to ICBs approximately 2 months later. So month 6 YTD and FOT is based on 4 months' actuals
- Price Concessions have a faster data feed so we have more up-to-date information, so we are able to identify known concession costs that are already above the forecasting profile
- Further risk is identified should the concessionary spend continue at current month levels for the balance of the year.

Prescribing Forecast (PMD only)

	M06	M07	
	Apr - July	Apr-Aug	Movement
	£k	£k	£k
YTD Actual			
Core	66,790	83,898	
NCSO	1,266	1,906	
	68,056	85,804	
Forecast			
Core	201,661	203,143	
NCSO	3,822	4,615	
Known NCSO > profile		1,160	
Total	205,483	208,918	3,435
Risk			
NCSO M07 s/line	3,501	1,005	-2,496
Cat M	450	450	
	209,434	210,373	939
21/22 Outurn			
Core	204,034		
NCSO	1,110		
	205,144		

- Month 7 forecast will have increased by £3.4m over month 6 forecast
- NCSO spend YTD growing much faster rate than core
  - 26% increase in YTD core spend from July to Aug, compared to 51% for NCSO
  - £4.6m based on 5 months' actuals, but further actual already known for Sept/Oct add further £1.1m
- Core prescribing (non NCSO) remains £0.9m below 21/22 outturn on a like-for-like basis (budget set on flat cash)

Integrated Care Board

NHS Devon (ICS) Finance Report Month 6

Date of committee	Date report produced
17th November 2022	30th September 2022

Author(s)		Report approved by	
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Phone:	07825 027569	**Date:**	25th October 2022
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary (250 words max)
The presentation of the Integrated Care System (ICS) financial position in this report seeks to provide the necessary assurance to the Integrated Care Board. The report details the ICS financial position for the period ended 30th September 2022 against the finance plan submitted on 20th June 2022, setting out the year-to-date and forecast financial position as well as the risks to delivery of an expected break-even position at system level.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
None

Key recommendations and actions requested
The Board is requested to: Consider, review and discuss the ICS financial position as at the period ended 30th September 2022.

Impact on NHS Devon objectives	
Objective	**Impact**

Does this report have implications in any of the areas highlighted below?		
Area	**Yes (summarise implications)**	**No**
Quality of services		√
Health inequalities		√
Workforce		√
Resources and finance	Delivery of financial sustainability	
Legal		√
Engagement and consultation		√

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

NHS Devon ICS Finance Report

Month 6 – 30th September 2022

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

Executive Summary

- On 20th June 2022, Devon ICS submitted a deficit plan of £18.2m. There is a requirement that the system achieves a breakeven outturn by year end.
- For 22/23 the system has received a reduced COVID envelope from 21/22. Some COVID funding will be reimbursed on top of the system envelope, this includes spend on testing and vaccinations.
- Efficiency savings of £138.9m are required to meet the June plan.
- Elective Services Recovery Fund (ESRF) funding has been received by the system to deliver 104% of 19/20 elective activity. Delivering more / less than 104% will result in additional funding / clawback at 75% PBR value. (Outsourced activity is reimbursed at 100% subject to meeting 104% target).
- As at month 6 the Devon ICS is reporting year to date £18m deficit against a planned deficit of £14m – an adverse variance of £4m (M5 £3m).
- The reported forecast is a deficit of £18.2m which delivers to plan.

Executive Summary

- As at month 6 the Devon ICS had made efficiency savings of £43.2m (M5 £35.3m) This is £14.2m adverse to plan (M5 £10.4m).
- Forecast savings are adverse to plan by £16.4m. (M5 £16.7m)
- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of a break-even plan.
- As at Month 6 the net risk (excluding ESRF) has reduced to £50.7m. (M5 £66.8m)
- Limited data is available from central sources to confirm performance against ESRF, systems have been informed to assume no clawback for month 6 reporting.
- Internal ESRF data to July shows that although the system is not reaching the required 104% of 19/20 activity, ICB commissioned activity is ahead of plan as at July 2022 by £2.1m but NHSE commissioned activity is behind plan by £6.5m leaving a potential shortfall from plan of £4.4m.
- The month 6 position identifies risks and issues to be managed totalling £61.5m against an expectation of break-even. (M5 £77.7m)

Summary Financial Performance

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	0	(0)	(0)	→	0	(0)	(0)	↑
Royal Devon University NHS FT	(6,108)	(6,108)	0	↑	(18,263)	(18,263)	0	↑
University Hospitals Plymouth Trust	(4,581)	(4,581)	0	→	0	0	0	→
Torbay and South Devon NHS FT	(2,786)	(6,800)	(4,014)	↓	69	69	0	→
Devon Partnership Trust	(522)	(523)	(1)	↓	0	0	(0)	→
Total	(13,997)	(18,012)	(4,016)	↓	(18,194)	(18,194)	(0)	↑

- As at month 6 the Devon ICS is reporting a year to date £18m deficit against a planned deficit of £14m – an adverse variance of £4m
- The reported forecast is a deficit of £18.2m which delivers to plan.
- The system continues to work towards delivering the best position possible against the NHSE requirement to deliver a breakeven position by the year end.

Efficiency Plan 22/23

Status	Plan					
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000
Fully Developed	0	4,500	9,500	2,385	1,187	17,572
Plans in Progress	25,558	5,288	10,200	15,067	6,221	62,334
Opportunity	8,000	15,283	9,892	9,791	380	43,346
Unidentified	2,967	8,864	0	1,209	2,570	15,610
Total	**36,525**	**33,935**	**29,592**	**28,452**	**10,358**	**138,862**
Recurrent	15,958	16,435	20,092	25,302	6,018	83,804
Non-Recurrent	20,567	17,500	9,500	3,150	4,340	55,057
Total	**36,525**	**33,935**	**29,592**	**28,452**	**10,358**	**138,862**

- £138.9m savings target is needed to deliver the plan.
- £15.6m of the savings target were at the plan stage classified as unidentified.

Efficiency Plan 22/23

Category	Plan					
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000
COVID	3,600	6,600	5,500	10,400	2,100	28,200
Pay Other		2,658	6,057	9,355	50	18,120
Unidentified	2,967	8,864		1,209	2,570	15,610
Non-Pay Other		52	7,000	2,688	390	10,131
Procurement		133	500	4,795	2,321	7,750
Workstream Stretch	8,000					8,000
Primary Care	7,704					7,704
SDF Review	6,000					6,000
Continuing Healthcare	3,945					3,945
Community Healthcare Commisioning Re	3,000					3,000
Income Efficiencies		484	2,500	4		2,988
Estates and Premises transformation		249	1,400		330	1,979
Service redesign					1,200	1,200
Medicines optimisation			1,000			1,000
Other	1,309	294	300		1,397	3,300
Total (Excluding ESRF)	**36,525**	**19,335**	**24,257**	**28,452**	**10,358**	**118,927**
Productivity ESRF		14,600	5,335			19,935
Total (Including ESRF)	**36,525**	**33,935**	**29,592**	**28,452**	**10,358**	**138,862**

Efficiency Plan 22/23

- Efficiency plans (CIP) categorised by scheme.
- Schemes related to ESRF productivity are separately identified.

Efficiency Savings Delivery

Organisation	Year to date			Forecast		
	Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000	Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000
Devon ICB	15,437	10,208	(5,229)	36,525	36,525	0
Royal Devon University NHS FT	15,530	10,338	(5,192)	33,935	33,935	0
University Hospitals Plymouth Trust	9,596	11,275	1,679	29,592	29,592	0
Torbay and South Devon NHS FT	13,028	8,625	(4,403)	28,452	13,131	(15,321)
Devon Partnership Trust	3,874	2,796	(1,078)	10,358	9,299	(1,059)
Total	**57,465**	**43,242**	**(14,223)**	**138,862**	**122,482**	**(16,380)**

- As at month 6 the Devon ICS had made efficiency savings of £43.2m (M5 £35.3m) This is £14.2m adverse to plan. (M5 £10.4m).
- Forecast savings are adverse to plan by £16.4m (M5 £16.7m).

Risks & Mitigations (Excluding ESRF)

Description	Net Weighted Risks & Mitigations						Net Risks at Plan £000
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000	
CIP shortfall	(13,967)	(2,725)	(9,000)	(12,600)	(2,400)	(40,692)	(47,817)
Planned Surplus/(Deficit)		(18,263)		69		(18,194)	(18,194)
Increase in inflation		(2,800)	(4,000)	(2,500)	(1,000)	(10,300)	(6,950)
Integrated care contract				(3,000)		(3,000)	(6,000)
Hospital discharge	0					0	(2,500)
High cost drugs not met by income		(2,900)	(2,500)	0		(5,400)	(2,314)
Clinical excellence awards			0	0		0	(1,665)
Specialist commisioning rebase					0	0	(1,500)
Prescribing prices	(3,900)					(3,900)	(1,500)
OOA and staffing support					0	0	(1,300)
IPP service growth					(1,057)	(1,057)	(1,250)
MHIS and SDF income risk					0	0	(1,200)
Other		(2,367)		(2,265)	(1,317)	(5,949)	(5,545)
Total Risk	**(17,867)**	**(29,055)**	**(15,500)**	**(20,296)**	**(5,774)**	**(88,492)**	**(97,735)**
Non-Recurrent flexibility	10,367	12,200	0	2,000	5,774	30,341	14,076
s256 funds/Other	7,500					7,500	2,500
Further Excess inflation funding						0	1,375
Total Mitigation	**17,867**	**12,200**	**0**	**2,000**	**5,774**	**37,841**	**17,951**
Net Risk	**0**	**(16,855)**	**(15,500)**	**(18,296)**	**0**	**(50,651)**	**(79,785)**

Month 5	**(3,092)**	**(16,855)**	**(18,150)**	**(19,896)**	**(8,790)**	**(66,783)**

Movement	**3,092**	**0**	**2,650**	**1,600**	**8,790**	**16,132**

Risks & Mitigations (Excluding ESRF)

- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of a break-even plan.
- As at Month 6 the net risk has reduced to £50.7m. (M5 £66.8m)
- The main risks to be mitigated (in addition to the planned deficit of £18.2m) are
  - Shortfall on planned CIP delivery £40.7m (month 5 £49.3m)
  - Excess inflation costs above funded level £10.3m (month 5 £10.3m)
  - High cost drugs above funded level £5.4m (month 5 £4.4m)
- ESRF risk remains volatile, with confirmation that the clawback has been suspended for the first 6 months and ongoing discussion at national level regarding the remainder of the year. Assessed ESRF related risk is described in the next slide.

ESRF Performance/Risk

Cumulative Activity/£000 Compared to Target	ICB Year to date	
	June	July
Planned activity	97%	100%
Actual activity	98%	101%
Planned £000	(4,742.4)	(3,776.7)
Actual £000	(1,339.6)	(1,631.3)
Total	**3,402.7**	**2,145.4**

NHSE Year to date	
June	July
88%	91%
60%	60%
(2,493.8)	(2,772.8)
(6,682.1)	(9,276.5)
(4,188.3)	**(6,503.6)**

Risk By Provider	Forecast Risk £000
Royal Devon University NHS FT	(9,733.0)
University Hospitals Plymouth Trust	(5,000.0)
Torbay and South Devon NHS FT	(1,136.0)
s256 Contingency	5,000.0
Total	**(10,869.0)**

- Limited data is available from central sources to confirm performance against ESRF, systems have been informed to assume no clawback for month 6 reporting.
- Internal ESRF data to July shows that although the system is not reaching the required 104% of 19/20 activity, ICB commissioned activity is ahead of plan as at July 2022 by £2.1m but NHSE commissioned activity is behind plan by £6.5m leaving a potential shortfall from plan of £4.4m.
- The differential earning potential in the plan by provider is why the risk appears skewed.

Summary financial risks against break-even requirement

Organisation	Summary Of Risks To Breakeven							
	Reported Surplus/ Deficit £000	CIP Risk £000	Other Risks £000	Mitigation £000	Variance Pre ESRF Favourable / (Adverse) £000	ESRF Risk £000	Variance Favourable/ (Adverse) £000	
Devon ICB	(0)	(13,967)	(3,900)	17,867	(0)	5,000	5,000	
Royal Devon University NHS FT	(18,263)	(2,725)	(8,067)	12,200	(16,855)	(9,733)	(26,588)	
University Hospitals Plymouth Trust	0	(9,000)	(6,500)	0	(15,500)	(5,000)	(20,500)	
Torbay and South Devon NHS FT	69	(12,600)	(7,765)	2,000	(18,296)	(1,136)	(19,432)	
Devon Partnership Trust	0	(2,400)	(3,374)	5,774	0	0	0	
Total	**(18,194)**	**(40,692)**	**(29,606)**	**37,841**	**(50,651)**	**(10,869)**	**(61,520)**	

- The month 6 position identifies risks and issues to be managed totalling £61.5m against an expectation of break-even. (M5 £77.7m).
- This is a risk of £43.3m against planned deficit of £18.2m.
- Half of the £16m improvement from M5 is a result of a reduction in the CIP delivery risk.

Capital (CDEL)

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	15,171	12,777	2,394		33,306	33,306	0	
University Hospitals Plymouth Trust	7,740	4,958	2,782		24,080	24,080	0	
Torbay and South Devon NHS FT	11,682	9,684	1,998		18,371	18,371	0	
Devon Partnership Trust	3,286	1,806	1,480		7,448	7,448	0	
Total	**37,879**	**29,225**	**8,654**		**83,205**	**83,205**	**0**	

- System Capital spend is under plan at month 6 by £8.7m (M5 £11.0m)
- Forecast system capital spend is on plan as at M6.

Capital (Total)

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	23,980	19,886	4,094	50,562	53,717	(3,155)
University Hospitals Plymouth Trust	14,554	10,185	4,369	88,480	90,706	(2,226)
Torbay and South Devon NHS FT	12,418	13,695	(1,277)	27,007	37,213	(10,206)
Devon Partnership Trust	3,286	1,806	1,480	7,448	9,988	(2,540)
Total	**54,238**	**45,572**	**8,666**	**173,497**	**191,624**	**(18,127)**

- Total capital plan includes impact of IFRS16 - leases
- Total capital spend is under plan by £8.7m as at month 6. (M5 £12.6m)
- The forecast spend on capital by end March 2023 is over plan by £18.1m. (M5 £8.5m)
- The plan is fixed at submission and not updated as subsequent schemes are approved and PDC awarded. These schemes then show as an overspend.

Conclusion and Next Steps

- The operational financial plan submitted on 20th June 2022 recognised a significant delivery risk against the NHSE break-even expectation, valued at £95.9m (£77.7m against plan).
- At the end of month 6, this has improved by £34.4m and stands at £61.5m (£43.3m against plan)
- The most material items are shortfall against required CIP (£40.7m), eliminating the residual deficit at plan (£18.3m), excess inflation costs (£10.3m) and shortfall against ESRF required earnings (£10.9m)
- In addition to continuous drive to reduced CIP shortfall and ESRF related risks, the ICS is committed to delivering further mitigation through a Financial Recovery Plan, consisting of 12 workstreams.

Conclusion and Next Steps

- The ICB has recently appointed a small team (funded by the Recovery Support Team) to instil pace and traction to the recovery plan and improve on the in-year financial benefit.
- Progress on the Financial Recovery Plan and recent actions are set out in a separate paper.
- Whilst work continues to deliver recurrent financial improvement and to identify further non-recurrent mitigation, the system should continue to report delivery of the plan by year end.

NHS Devon Integrated Care Board (ICB) meeting

Working together to deliver service transformation in Devon, Cornwall and Isles of Scilly
Peninsula Acute Provider Collaborative

Date of committee	Date report produced
16th November 2022	18th October 2022

Author(s)		Report approved by	
Name and title:	Allison Williams Expert Adviser	**Name and title:**	Liz Davenport – CEO Torbay & South Devon NHS Foundation Trust
Phone:		**Date:**	18th October 2022
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary (250 words max) – high level overview of the content of the report and the reasons why it is being presented
Earlier in 2022, Acute Trust Chairs, Chief Executives and Medical Directors established the Peninsula Acute Provider Collaborative (PAPC) as a vehicle for joint working with Trust Board across Devon and Cornwall. The role of the PAPC is to work on behalf of individual Trust Boards to set the direction and provide the

strategic leadership across organisational boundaries to stabilise, sustain and transform acute care for the population of Devon and Cornwall.

At the same time, the Integrated Care Partnerships of both Cornwall and Isles of Scilly ICS and Devon ICS are each developing their ***Integrated Health and Care Strategy***. This strategy sets a critical context for the delivery of acute services and will be a key determinant of the future shape of healthcare across the Peninsula.

The paper attached sets out:

- The strategic ambition of the Peninsula Acute Provider Collaborative
- The principles, parameters and governance for the PAPC
- The PACP's proposed approach to address acute sustainability across Devon, Cornwall and the Isles of Scilly – with the establishment of the Peninsula Acute Sustainability Programme.
- The programme of work proposed to take place from November 2022 to March 2023
- The commitment to report back on the findings and recommendations and seek a further specific mandate from Board to proceed before exploring options for service reconfiguration, if indicated.

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

This paper has been discussed and endorsed as follows:

- Peninsula Acute Provider Collaborative – 17th October (Endorsed)
- Torbay and South Devon NHS Foundation Trust – 26th October (Endorsed)
- Royal Devon University Healthcare NHS Foundation Trust – 26th October (Endorsed) with a requirement that proposals are mandated in line with PAPC Decision-making Framework

Awaiting outcome from:

- Royal Cornwall Hospitals NHS Trust – 3rd November (Outcome not known at the time of writing)
- University Hospitals Plymouth NHS Trust – 4th November (Submission of this paper is prior to the date of the Trust Board meeting)

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do

1. **Discuss** and **endorse** the strategic ambition for the Programme as outlined in **Figure 2**
2. **Discuss** and **endorse** the design principles for the Programme as outlined in **Figure 3**
3. **Agree** that regular progress updates on this work will be brought to all member Boards
4. **Note** that the governance arrangements and the current work-plan will require any further assessment of options for potential service reconfiguration to be specifically mandated to the PAPC by the Trust Boards

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	This is the objective of the programme when implemented
Improve services and reduced unwarranted variation	This is the objective of the programme when implemented
Make more efficient use of our resources	This is the objective of the programme when implemented
Develop our culture and how we operate	The process of coproduction of design and implementation will impact this objective from the very beginning

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	This will be impacted once an agreed the implementation programme is put in place
Health inequalities	This will be impacted once an agreed the implementation programme is put in place
Workforce	This will be impacted once an agreed the implementation programme is put in place
Resources and finance	This is built into the approach
Legal	This will be reviewed once a set of recommendations have been produced
Digital and Data	This will be reviewed once a set of recommendations have been produced
Involvement, Engagement and consultation	An outline Involvement, Engagement and Consultation approach has been documented

Working together to deliver service transformation in Devon, Cornwall and Isles of Scilly

Peninsula Acute Provider Collaborative

1. Introduction

Earlier this year, the Board agreed to the establishment of the Peninsula Acute Provider Collaborative as a vehicle for joint working with other acute Trusts across Devon and Cornwall.

The Terms of reference and membership were previously approved by the Board (Annex 1) together with the establishment of the Acute Services Sustainability Programme (Annex 2) – a clinically-led programme of work that will engage staff and communities in the redesign of acute services to improve clinical, workforce and financial sustainability.

At the same time, the Integrated Care Partnerships of both Cornwall and Isles of Scilly ICS and Devon ICS are each developing their ***Integrated Health and Care Strategy***. The strategy aims to set out how, in the future, all partners in the wider health and care system will work together to deliver more joined-up preventative and person-centred care – improving wellbeing, facilitating choice and supporting independent living. This strategy sets a critical context for the delivery of acute services and will be a key determinant of the future shape of healthcare across the Peninsula.

This paper aims to summarise progress to date and seek endorsement of the work-plan that will be implemented over the next 3-6 months with the aim of bringing forward recommendations for change during 2023/24.

2. Context

In line with the rest of England, demand is growing for primary and secondary healthcare. Increases in waiting lists, waiting times and ongoing challenges with unscheduled and emergency care activity create significant challenges in balancing demand and capacity. The availability of an appropriately skilled workforce is a major limiting factor impacting directly on the provision of health and social care in the appropriate place according to people's need.

Delivering a high quality, joined-up, sustainable health and care service for the local population is a key priority and expectation of the new Integrated Care Systems across England. This requires partners to work together to:

- Improve population health and care
- Identify and address health inequalities
- Enhance productivity and deliver best value for money across the whole resource envelope
- Address the wider determinants of health including social and economic development

Success will be dependent on organisations taking individual and collective action to drive efficiencies and deliver transformational changes that will generate immediate improvements and set the foundations for clinical and financial sustainability in the medium to long term.

Back in 2019, local NHS organisations across Devon and Cornwall came together to explore strategic opportunities for transformation that would contribute to longer-term service sustainability. However, progress with the recommendations of the ***Peninsula Clinical Services Strategy*** was adversely affected by the pandemic.

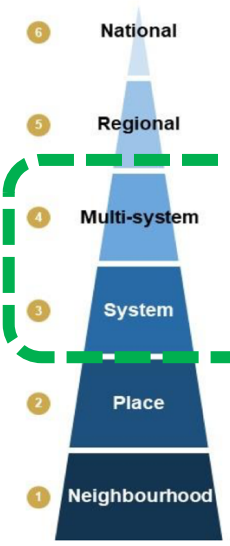
Since then, the strategic context has become even more challenging as demand for care, workforce constraints, and the underlying financial deficit have all increased.

Building on the outcome of the previous joint work, the pace and determination to develop new solutions will need to be much greater which further reinforces the need for leaders and organisations to work more closely together to make decisions to deliver service improvements in the best interest of the whole population of Devon and Cornwall.

3. Working together for success

The national framework for provider collaboratives[1] describes a range of levels at which collaborative working is expected to deliver improved services (Figure 1). Joint working in the areas of elective and non-elective secondary care are typically considered at an ICS level but the unique population demographics and flow of patients between boundaries across Devon and Cornwall suggest that collaboration of the acute providers across the whole peninsula population (circa 1.8m) would be in the best interest of local people.

Figure 1: Collaborations and activities that align with typical levels of service planning and delivery



Services	Predominant collaboration partners	Collaboration arrangements	Activities
• Life sciences • Highly specialist services	• Specialist providers • Research universities • Industry	• AHSCs, AHSNs • Public-private partnerships	• Services need to be planned and coordinated on a broader footprint than a single ICS, working with neighbouring ICSs, other providers and national commissioners. • Provider collaboratives might span levels 4 and 5 but even when they are not, they must be sighted on decisions relating to the delivery of services at levels four to six in order to understand and calibrate the use of its collective resources for the delivery of all provider collaborative priorities. • Linked to commissioning of 999, 111 and IUC over multi-ICS as a Lead Provider model
• Highly specialist services • Specialised services	• Specialist NHS providers across a large geographic footprint	• Specialist clinical networks • Provider collaboratives	
• Specialist and specialised services • Community and mental health • Access to UEC	• Providers working over multiple ICSs	• Specialist clinical networks • Provider collaboratives	
• Elective and non-elective secondary care • Inpatient, crisis and specialist mental health, learning disability and autism • Community	• Providers working across an ICS • Providers with patient flow into an ICS	• Provider collaboratives	• Services in Level 3 are primarily delivered on an ICS footprint. • These services therefore particularly lend themselves to planning, coordination and delivery through a provider collaborative.
• Community health • Community mental health • 'Front door' acute • Social care	• Providers • GPs • LAs • Voluntary sector	• Place-based partnerships • ICP contracts	• Services in levels 1 and 2 are likely to be planned and coordinated at borough (place) level and delivered at neighbourhood or borough level, depending on the service in question. The primary "vehicles" for collaboration in these layers are place-based partnerships (of which the members of provider collaboratives are key partners). • Provider collaboratives play a role in areas where they can add value for at scale collaboration, across multiple places, but they should not duplicate work within each place.
• Primary care • Public health and wellbeing • Prevention • Community health • Social care	• Providers • GPs • LAs • Voluntary sector	• Primary Care Networks (PCNs) • Integrated multi-disciplinary teams	

1 https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

On that basis, earlier this year, the Chairs, Chief Executives and Medical Directors of the 4 acute Trusts in Devon (Royal Devon University Healthcare NHS Foundation Trust, University Hospitals Plymouth NHS Trust and Torbay and South Devon NHS Foundation Trust) and Cornwall (Royal Cornwall Hospitals NHS Trust) agreed that they would establish the ***'Peninsula Acute Provider Collaborative' (PAPC)***.

The role of the PAPC is to work on behalf of individual Trust Boards to set the direction and provide the strategic leadership across organisational boundaries to stabilise, sustain and transform acute care for the population of Devon and Cornwall. The ambition is summarised in **Figure 2**.

Figure 2: Strategic ambition of the Peninsula Acute Provider Collaborative

The principles underpinning the work of the Peninsula Acute Provider Collaborative, previously agreed by the Board, are attached as **Annex 3** and these form the basis upon which members will hold themselves and each other to account for both ways of working and the development of proposals for service improvement.

4. Progress to date

Over the past 3 months, members of the Acute Services Sustainability Programme have been working to develop an approach and work-plan that will support the redesign of services to address quality, workforce and financial challenges. This has involved several workshop sessions with Medical Directors, other key Executives and subject-matter experts to identify the key factors that will inform the future shape of services and ensure these are fully embedded in the transformation process.

What has become clear is that the emerging Integrated Health and Care Strategies are outlining a direction of travel that strengthens out-of-hospital services and in the longer term will reduce the need for hospital-based care. With enhanced primary care and community-based services, the ambition is to support people to keep well and maintain their independence.

At the same time, there will always be a requirement for acute care and the evidence base is clear that the right intervention at the right time provided by clinical teams with the right skills has a direct impact on outcomes for the individual. The role of the local District General Hospital will continue to be central to local access and coordination of acute care – providing safe, high quality services as locally as possible.

Advances in medicine mean that treatment options, even for severe injuries and illness, are changing and developing at ever increasing rates. This is extremely

positive for patient outcomes but does mean that some clinical staff are, out of necessity, becoming more and more specialist and need a critical mass of patients to maintain their skills.

This is not new – the NHS has a long history of delivering high quality specialist services in specialist centres. For example, Derriford Hospital has served the whole population of the Peninsula well with major trauma, cardiac surgery, neurosurgery and other specialist services for many years. However, new technology, including remote consultation and the 'real-time' sharing of information means that the ability to provide significant elements of even the most complex care pathways remotely, closer to people's homes, is growing at pace. This opens up opportunities for delivering care in new and innovative ways – sharing expertise and extending access across wider populations.

The ability to differentiate people's care needs quickly and effectively to ensure they are then directed to the right place will become an increasing feature of future health and care services. Growing the capacity and capability of Primary Care and community services will be essential, together with access to high-quality community urgent care and diagnostic services, to enable patients to be directed to the right place according to established need. More robust pathways of care will need to be developed where the ownership, coordination and the vast majority of service delivery is local. If patients need to travel further for specialist interventions, this will need to be supported and kept to a minimum with the use of digital solutions to support remote 'work-up' and 'follow-up' of patients.

It has therefore been agreed that the starting point for establishing sustainable acute services must be to ensure that there are robust and consistent processes in place for high quality, timely, local assessment of acute care need for all people across the Peninsula, irrespective of where they live. This will then enable joined-up pathways of care to be developed across organisational boundaries supported by new technologies and digital solutions.

It is recognised that any redesign of services will need to be grounded in the reality of:

- Current and future population need including deprivation and an ageing society
- The specific challenges associated with coastal communities and rurality
- Available resources including workforce, buildings and money (capital and revenue)

Considerable work has been undertaken in recent years to explore solutions locally. The learning from these exercises together with an understanding of best practice nationally and internationally will be used to inform this process which will be clinically led.

The agreed design principles are outlined in **Figure 3** below.

Figure 3: Design principles

Work to date has enabled co-production of a methodology to engage clinicians in a process of exploring new ways of working and models of care. This has included:

- Assessing the best route in to service redesign
- Exploring critical clinical interdependencies
- Identifying the core data requirements to support the process
- Commissioning work to bring together the relevant evidence to support any emerging proposals

Careful consideration has also been given to the need to balance the time commitments of key leaders and clinicians to this process in the context of competing operational pressures.

5. Proposal

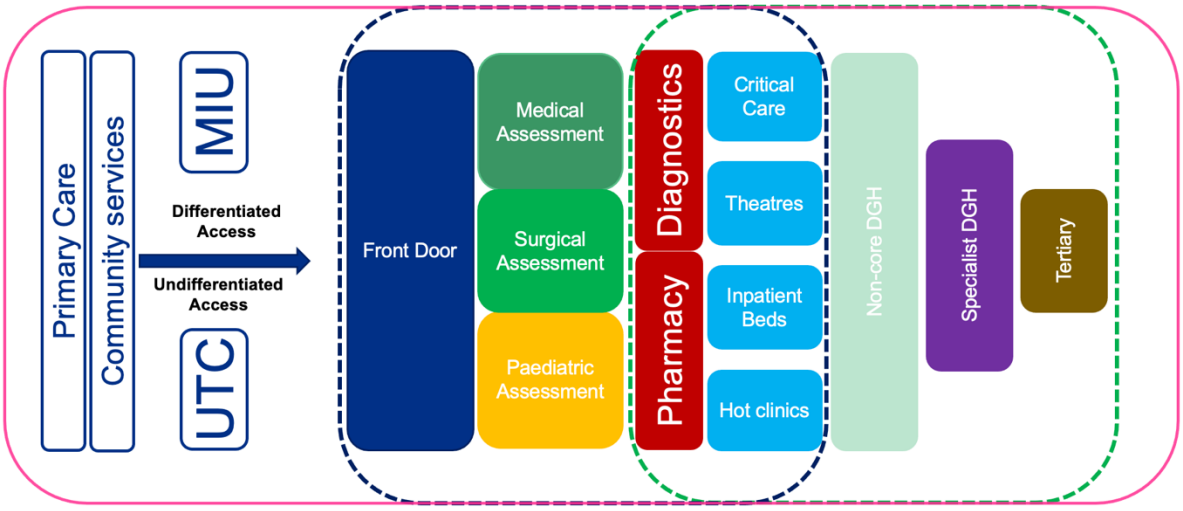
The authentic engagement of staff, stakeholders and citizens in the redesign of health and care services is central to ensuring that any process of change delivers the best possible outcome. On behalf of all Boards, it is imperative that this programme of work fully delivers on this commitment.

Clinical ownership and leadership of the initial work to explore the evidence and opportunities for change is critical to success and early discussions with Healthwatch will be essential to seek advice on the phasing of wider engagement.

A proposed approach has been put forward by the Acute Services Sustainability Programme and endorsed by the PAPC on 10th October as follows:

- The 3 index specialties for review will be medical assessment, surgical assessment and paediatric assessment. The rationale for this is that they are the key functions that operate alongside the 'front-door' of our hospitals to support the effective differentiation of need (**Figure 4**)

Figure 4: Building an acute services model



Note: Mental Health will also need to be a key consideration in the service models

- A series of 3 focused workshops (5-6 weeks apart) will be held for each of the index specialties and will involve a wide range of clinicians across the interdependent specialty, subspecialty and clinical support services.

- A series of core questions, co-produced with Medical Directors, will inform the workshop discussions. These will include assessment of critical mass for optimal outcomes, what elements of care pathways must be co-located, the future shape of the workforce and opportunities for better use of digital, technology and artificial intelligence.

- Robust workforce information will be essential to making assessments of how services can be safely and effectively staffed in the future. This will include working with the post-graduate medical Deanery to assess training requirements and optimal configuration of junior and middle grade rotas for both training outcomes and recruitment and retention of medical staff.

- There will be a clear requirement for innovative approaches to role redesign, both in-hospital and in the community, where the focus will be on the skills necessary to support the delivery of team-based care, moving away from traditional professional boundaries. This will create opportunities for new and exciting roles for staff across all professional groups together with the potential for further vocational training opportunities and better, higher skilled jobs for local people.

Following the 3rd Workshop, a summary will be produced that outlines:

- An assessment of the challenges associated with the current configuration of services and the ability to sustainably deliver the required outcomes across the whole of the Peninsula

- Opportunities, through shared staff, role redesign and pathway redevelopment, to make best use of the workforce to support the delivery of acute care across Devon and Cornwall

- Options for service redesign which will improve outcomes and make best use of the totality of the resources available (people and finance).

These will be reviewed by the PAPC and resultant recommendations generated for consideration by the Trust Boards.

It is really important that as much scope as possible is given to the teams to bring forward the best solutions. This means keeping to a minimum the number of 'givens' they need to navigate as part of their deliberations. To that end, it is suggested that the assumptions are limited to the following:

- There will continue to be 5 acute hospitals across Devon and Cornwall
- Each acute hospital will continue to have a 'front-door' providing urgent and emergency care
- There will continue to be only one tertiary centre in the Peninsula at Derriford Hospital
- Where services currently delivered in hospital can be delivered just as effectively (or more so) out-of-hospital, this should become the default model (recognising that there may need to be transitional arrangements to support shift of resources in the longer term)

The remit of the clinical workshops will not extend to 'where' services will be delivered in the future. If the outcome of the process is that certain elements of pathways can only be safely and effectively delivered on a smaller number of sites, this will need to be agreed by Boards, in public, before any consideration of where they would be located.

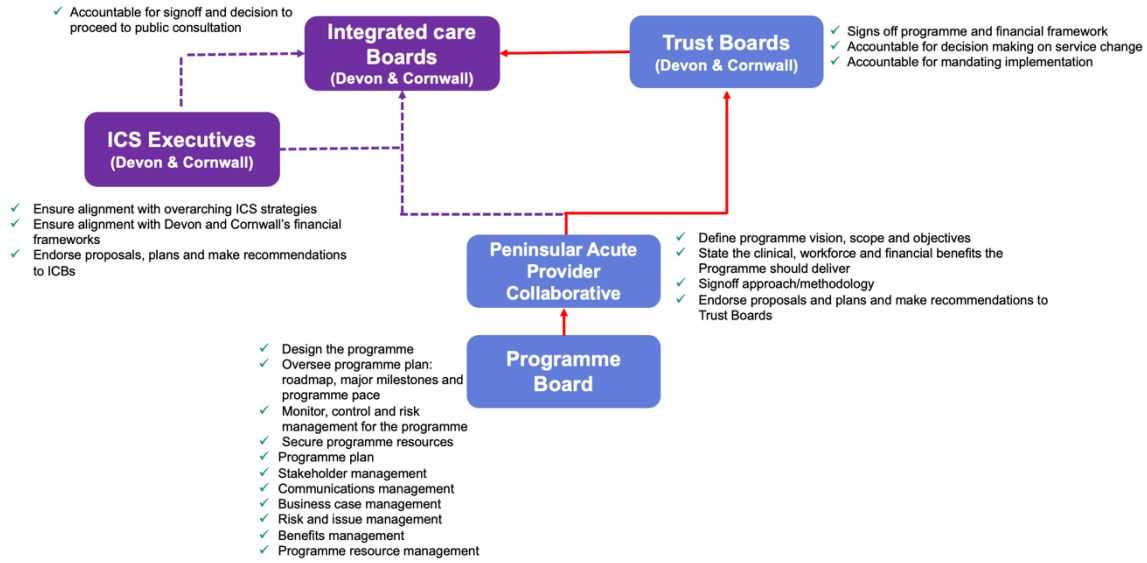
If there is any requirement to consider relocating services, options would need to be generated openly and transparently with wide engagement and consultation as required. Any recommendations would need to take full account of the potential for improved quality and outcomes; the need for clinical co-location; access for patients and their families; the best use of the current estate and any new capital investment; and affordability.

It is really important to note that the programme would need to report back on the initial workshop findings and seek a further specific mandate from Boards to proceed BEFORE exploring options for service reconfiguration if indicated.

6. Governance and decision-making

The overall governance of this programme of work is summarised in **Figure 5** below.

Figure 5 : Peninsular Acute Sustainability Programme - governance



This makes it clear that the decisions on any proposals for future service change and the sign-off of any proposals to proceed to public consultation are reserved for the Trust Boards and the Boards of the two ICBs. The previously agreed decision-making framework aims to limit the risk of different decisions being made by different Boards so that all partners move forward together in the best interest of the whole population of Devon and Cornwall.

7. Recommendations

The Board is asked to:

- **Note** the work undertaken to date by the Peninsula Acute Provider Collaborative and the Acute Sustainability Programme
- **Discuss** and **endorse** the strategic ambition for the Programme as outlined in **Figure 2**
- **Discuss** and **endorse** the design principles for the Programme as outlined in **Figure 3**
- **Discuss** and **endorse** the proposal to conduct a series of clinical workshops, commencing in November 2022, to explore opportunities for sustainable service redesign to deliver better, more equitable, clinical outcomes and make best use of resources across the Peninsula
- **Agree** that regular progress updates on this work will be brought to all member Boards
- **Note** that the governance arrangements and the current work-plan will require any further assessment of options for potential service reconfiguration to be specifically mandated to the PAPC by the Trust Boards.

Peninsula Acute Provider Collaborative - Committees in Common Terms of Reference

1. Constitutional Obligations

1.1 The ICB hereby resolve to establish a Committee of the ICB known as the Acute Provider Collaborative Committees in Common (hereafter known as the APC). The Committees in Common is established in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation and the Acute Providers supporting the Devon and Cornwall footprints (see Appendix 1).

i. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into each organisations constitution and standing orders.

ii. As per the ICB's constitution, in the interest of partnership working, this committee will operate as a 'Committees in common' with representatives from each organisation (Appendix 1)

The accountability and decision making of the committee shall remain the responsibility of the individual organisations and its Board(s).

Committee in Common
• Each Board delegates authority to the Collaborative to bring forward recommendations for endorsement • When the recommendation comes forward, each Board meets at the same time, considers the same paper, and makes its own decision • It is technically possible for there to be different decisions, but any risk would need to be mitigated by the members of the Collaborative

The APC is an assurance committee of the organisations (Appendix 1) and have the ability to execute any powers assigned to them and those specifically delegated in these terms of reference and/or through each organisations constitutional scheme of reservation and delegation.

2. Purpose

2.1 The purpose of the APC is to successfully work together to drive whole system acute services transformational change across the population in Devon and Cornwall – improving outcomes and performance, sharing skills and experience, making best use of scarce workforce resources, and realising tangible financial savings and sustainability.

The APC sits alongside the existing Mental Health Collaborative and will lead the joint planning of acute services for the population of Peninsula. This enables an opportunity to exist for greater devolved accountability for resource allocation and utilisation in future with strong alignment between strategic planning and commissioning functions.

3. Responsibilities

The responsibilities of the APC will include:

- Identifying the opportunities for joint working (operationally and strategically)
- Agreeing the acute services transformational priorities and delivery plan
- Commission specific pieces of work
- Receive recommendations and/or business cases
- Make joint decisions within any delegated authority
- Make joint decisions to be endorsed by Trust Boards and ICBs

The work of the APC will be underpinned by Task and Finish Groups and Technical Advisory Groups (e.g. Finance) as appropriate.

4. Membership

The core Membership of the Committee shall be:

The following Members have voting rights: • Acute Trust Chair(s) • Acute Trust CEO(s) • Acute Trust Medical Director(s)
Attendees <u>do not</u> have voting rights and include: • Independent Chair • APC Manager • ICB Medical Director(s)
The Chair of the APC may co-opt any non-voting Clinicians, Executive or Managing Directors, nominated deputies and lead managers as appropriate and particularly, when the APC is discussing areas of risk or operation that are the responsibility of that attendee.
Note: When a Committee Member is unable to attend, a named deputy with sufficient authority must attend in their place. Deputies will have the decision making and voting rights of the person he/she is representing.

5. Quorum

5.1 A quorum of the APC shall be at least two members from each of the organisations (Appendix 1)

5.2 With the exception of administrative matters where decisions will be made on a majority basis, decisions will be based on a consensus amongst all Members present. Where consensus cannot be achieved, the agreed decision framework will be invoked by the Chair to reach an outcome in a fair, transparent and timely way.

The decision framework is based on 3 sequential phases designed to be supportive in reaching a decision, and must be adhered to as follows:

Phase 1	each party formally laying out their concerns and suggested alternatives with the aim of achieving a negotiated outcome
Phase 2	time-limited independent mediation with those organisations directly affected by the proposals with the aim of either resolving differences or developing an alternative agreed proposal that meets the original aims
Phase 3	independent clinically led panel convened to review all evidence and make a recommendation which is binding on all organisations

5.3 People invited to attend, or those in attendance at the APC do not have the right to vote.

5.4 If the APC Chair is absent then the Members of the APC will select a chair for that meeting from the voting Members present – this will be overseen by the most senior officer responsible for governance as the Chair needs to be an independent representative of the APC

The aim will always be for consensus decisions to be made through a process of mature discussion based on clear and impartial clinical, operational and financial information. Moving to Phase 3 of the decision-making framework should be rarely, if ever, required.

6. Register of Interests

6.1 The Register of Interest will be reviewed at each meeting of the APC.

6.2 Members will be asked by the Chair of the APC to declare any interests at the beginning of each meeting. If a Member feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

7. Frequency of Meetings

7.1 The APC must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. It is expected that in the first instance meetings will be held monthly, moving to bi-monthly once the workplan is established and agreed.

This will need to be kept under review in line with the scale and pace of changes and decisions required.

8. Reporting arrangements

8.1 The APC Chair shall report formally to all organisations 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. The members shall make recommendations to their respective organisations Board(s) on any decisions made and area within its remit where action or improvement is needed.

8.2 The APC is authorised by the ICB to investigate any activity within its terms of reference and through the APC Memorandum of Understanding. It is authorised to seek any information it requires from any employee and all employees re directed to co-operate with any request made by the APC.

8.3 The APC may require the attendance at its meeting of any officer as required through agreement, and the production of any document that can ensure the APC meets its obligations as set out in these terms of reference.

The APC is authorised through its memorandum of understanding to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Minutes and reports of the meetings will be produced and held by the Administrator of the APC, accessible to the Chair, core Membership and the Director responsible for the administrative function. Extracts from Minutes will be made public as appropriate under the freedom of information act.

9. Statutory Functions, Committee Oversight and KPIs (Internal Monitoring)

9.1 The ICB has delegated the following authorities to the Committee:

• The Acute Provider Collaboratives Committees in Common has the authority to commission work from the Directors of Finance, Directors of Workforce or Clinical and Professional Cabinet, seeking any advice appropriate for distinct areas of work
• The Acute Provider Collaborative Committees in Common had the authority to establish Task and Finish Groups, drawing on the expertise of Directors and other staff from within the constituent organisations as appropriate

9.2 The APC will undertake an annual review of the performance and effectiveness to ensure that the APC structure, decision making and work plans reflect the current and future needs.

9.3 In addition, the APC will review the work of other sub groups or work streams within the organisations, whose work can provide relevant assurance to the APC's own scope of work. These may include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Public Sector Audit Appointments Ltd, National Audit Office, Financial Reporting Council) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal College, accreditation bodies).

9.4 The reviews will be spread throughout the year with an Annual Report produced by the Committee for the ICB.

10. Administration

10.1 The APC and its sub group(s) shall be supported administratively by its Administrator. His or her duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the Chair to prepare reports to Board(s)
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example, with the internal/external auditors, or local counter fraud specialists
- Advising the APC on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Providing appropriate support to the Chairperson

10.2 Following each meeting, the Administrator will:

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

11. Review

An annual effectiveness review will be undertaken by the Head of Governance as good governance practice and to ensure compliance with the Annual Governance Statement.

These Terms of Reference will be reviewed on an annual basis or sooner if required through the Head of Governance with recommendations made to the Boards for approval.

END

APPENDIX 1

Member Organisations of the Peninsula Acute Provider Collaborative

Royal Cornwall Hospitals NHS Trust
Royal Devon University Healthcare NHS Foundation Trust
Torbay and South Devon Foundation Trust
University Hospitals Plymouth NHS Trust

Membership (updated 17 October 2022)

Membership:

Name	Role	Organisation
Nigel Acheson	Chief Medical Officer	NHS Devon
Helen Skinner	Chief Medical Officer	NHS Cornwall
James Brent	Chair	University Hospitals Plymouth NHS Trust
Ian Currie	Medical Director	Torbay and South Devon NHS Foundation Trust
Dave Stacey	Deputy Chief Executive	Torbay and South Devon NHS Foundation Trust
Mark Hamilton	Medical Director	University Hospitals Plymouth NHS Trust
Adrian Harris	Chief Medical Officer	Royal Devon University Healthcare NHS Foundation Trust
Richard Ibbotson	Chair	Torbay and South Devon NHS Foundation Trust
Ann James	Chief Executive Officer	University Hospitals Plymouth NHS Trust
Mairi McLean	Chair	Royal Cornwall Hospitals NHS Trust
Suzanne Tracey	Chief Executive Officer	Royal Devon University Healthcare NHS Foundation Trust
Steve Williamson	Chief Executive Officer	Royal Cornwall Hospitals NHS Trust
Shan Morgan	Chair	Royal Devon University Healthcare NHS Foundation Trust
Allister Grant	Medical Director	Royal Cornwall Hospitals NHS Trust

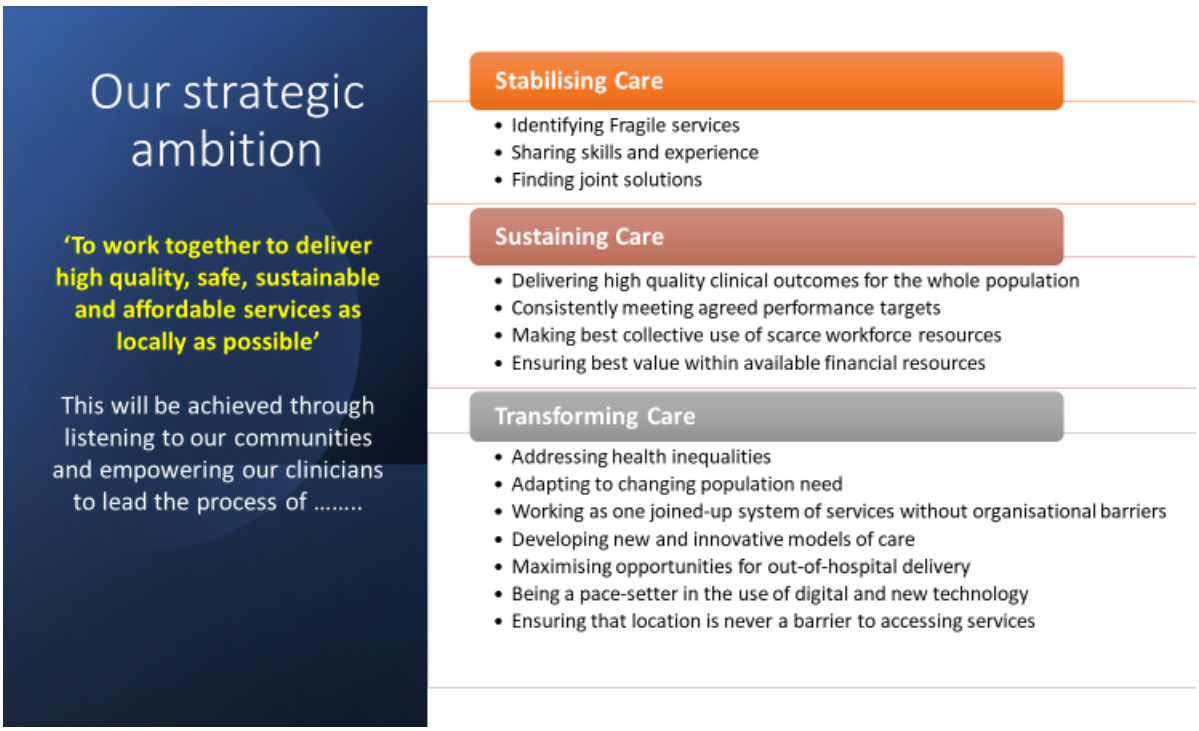
In attendance:

Name	Role	Organisation
Liz Davenport	Programme SRO (& CEO)	Torbay and South Devon NHS Foundation Trust
Allison Williams		NHSE/I

Peninsula Acute Sustainability Programme Board
Terms of Reference

Strategic ambition

The Peninsula Acute Provider Collaborative has endorsed a strategic ambition which will underpin the work of both the Collaborative *and* the Peninsular Acute Sustainability Programme. This lays the foundation for the terms of reference set out in this document. The strategic ambition is as follows:



Objectives

The objectives of the Peninsula Acute Sustainability Programme Board are to:

1. Secure a **mandate** from the NHS Devon and NHS Cornwall and Isles of Scilly leadership teams to proceed with the development and subsequent implementation of an acute sustainability programme for the Peninsula.

2. Oversee the **design and development** of the programme.

3. Oversee and ensure efficient and **effective management** of the programme.

4. Ensure that the programme defines and delivers **tangible, realisable benefits and outcomes** for the public, patients, and workforce for both the Devon and Cornwall Integrated Care Systems.

5. Ensure programme design and delivery is **aligned with the respective overarching Integrated Care Strategies and 5-year forward plans** for both Devon and Cornwall.

6. Develop a programme and implementation plan which **supports the financial assumptions and commitments** set out in the respective Devon and Cornwall financial frameworks [agreed with regulators].

Role and responsibilities

Role

The Peninsula Acute Sustainability Programme Board has the following role, to:

1. Nurture and foster a shared commitment from key stakeholders across the Peninsula to the Acute Sustainability Programme.
2. Ensure key stakeholders across Devon and Cornwall understand "what is the Acute Sustainability Programme?" and "Why we are doing it?".
3. Define the programme vision, scope, and objectives.
4. Design the programme – ensuring that there is coproduction in the design with appropriate stakeholders
5. Develop and own a financial framework which sits within the wider Peninsula Financial Framework(s).
6. Set out a clear roadmap of the major milestones for the work to be done.
7. Set the pace for the programme.
8. Agree and make proposals to the Peninsula Acute Provider Collaborative, Trust Boards, ICS Executive teams, ICBs and other leadership groups as appropriate.
9. Own and manage the relationship with regulators (e.g., NHSE SW and national teams) – to keep them informed on ambition and progress in relation to the Peninsula Acute Sustainably Programme.
10. Foster a supportive and collegiate Peninsula-wide approach to working together on the programme
11. Ensure that all enabling plans are aligned to support successful delivery of the Peninsula Acute Sustainability Programme and Plan (e.g. Cornwall ICS and Devon ICS: Integrated Care Strategies and associated 5 Year Forward Plans.
12. Formally take stock of progress with the programme every 3 months (to ensure that it continues to achieve its objectives) and seek endorsement of any proposed changes from the Peninsula Acute Provider Collaborative as appropriate.

Responsibilities

The Peninsula Acute Sustainability Programme Board has the following responsibilities:

1. Define and propose the clinical, workforce and financial benefits the programme should deliver
2. Shape and design the approach to be adopted to carry out the work
3. Ensure all proposals are evidence base
4. Make proposals regarding where business cases are required to proceed
5. Make proposals where there is a requirement to invoke the major service change process because NHSE's 5 key tests for major service change have been met.
6. Ensure that all service change is supported by appropriate involvement and engagement with the public.
7. Ensure programme risk and issues are managed – proactively
8. Task individual members of the Programme Board with stakeholder engagement tasks and activities – as required
9. Ensure oversight and implementation of communications and stakeholder engagement plans
10. Secure resources for the programme
11. Receive regular progress reports from the Peninsula Acute Sustainability Working Group
12. Monitor and control the programme
13. Adopt and embed the principles set out below:

Principles

The Programme Board should adopt and embed the principles set out below:

- ✓ Collaborative working and decision making
- ✓ Clear and defined goals – shared purpose and a focus on outcomes
- ✓ Whole Peninsula thinking – doing the best thing for Devon & Cornwall
- ✓ Shared accountability to deliver change
- ✓ Role modelling of System behaviour
- ✓ Consistent leadership – setting the right tone
- ✓ Constructive challenge – listening to all voices
- ✓ Assume best intent

Membership of the Peninsula Acute Sustainability Programme Board

Members of the Programme Board are listed in the table below.

Name	Role	Organisation
Liz Davenport	Chief Executive Officer Programme SRO & Chair of Programme Board	Torbay & South Devon NHS Foundation Trust
Allison Williams	Programme Lead – Expert Advisor (Deputy Chair)	NHSE
Nigel Acheson	ICB Chief Medical Officer	NHS Devon
Helen Skinner	ICB Chief Medical Officer	NHS Cornwall
Simon Gittoes-Davies	ICB Chief Finance Officer	NHS Cornwall
Simon Tapley	ICB Chief Transformation & Strategic Planning Officer	NHS Devon
Rachel O'Connor	ICB Director for Inclusion (Commissioning)	NHS Cornwall
Kelvin Grabham	ICB Business Intelligence Lead	NHS Devon
Carolyn Mills	Chief Nursing Officer	Royal Devon University NHS Foundation Trust
Allister Grant	Medical Director	Royal Cornwall Hospitals NHS Trust
Ian Currie	Medical Director	Torbay and South Devon NHS Foundation Trust
Mark Hamilton	Medical Director	University Hospitals Plymouth NHS Trust
Adrian Harris	Medical Director	Royal Devon University NHS Foundation Trust
Colm Owens	Clinical Director	Devon Mental Health Provider Collaborative
Andrew Millward	ICB Chief Communications & Corporate Affairs Officer	NHS Devon
Carol Beckford	Programme Director	NHS Devon

Note: A Primary Care representative will be added once confirmed

Each member may nominate a named Deputy to attend and participate with their full authority in their absence. The Chair shall be notified of this prior to the meeting.

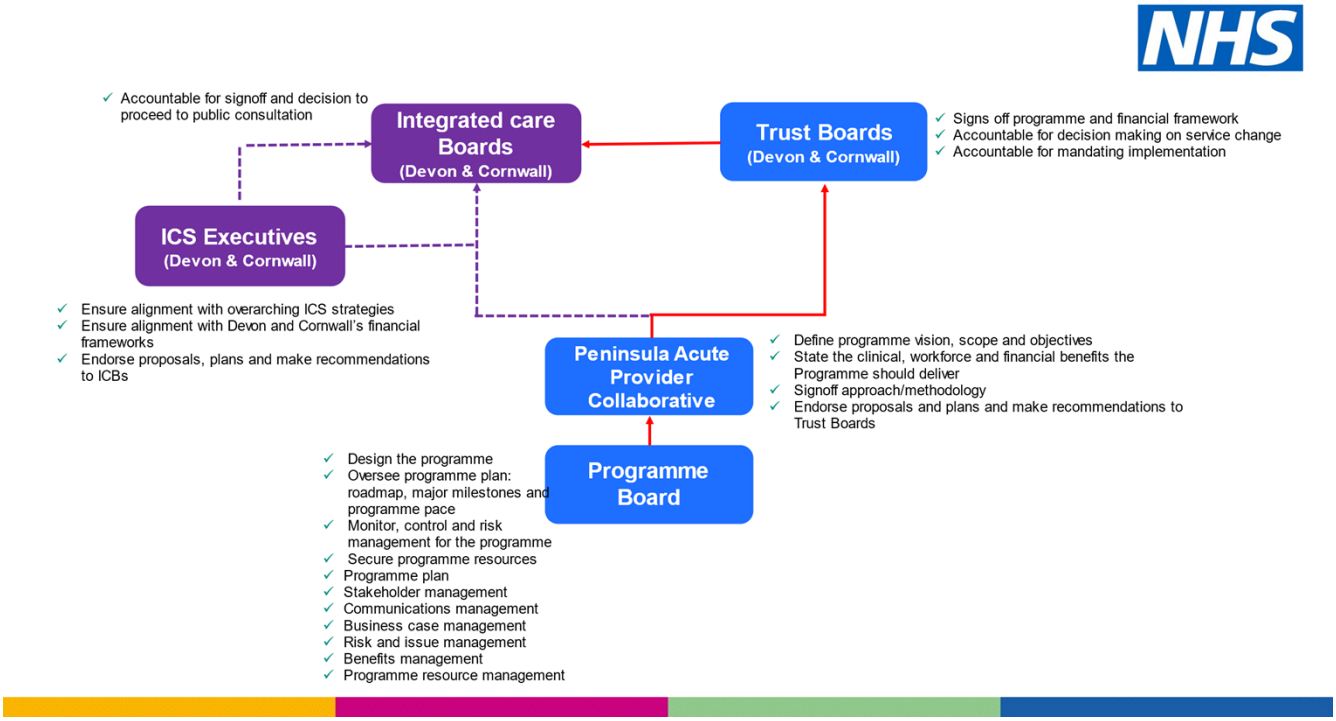
Other individuals may be invited to attend the meeting as appropriate to the agenda item.

For the programme board to be considered quorate the meeting should be comprised of:

- The SRO/Chair or Deputy Chair
- Representatives from both Devon and Cornwall
- At least one representative from Cornwall
- At least two medical directors

Accountability and reporting

Programme Governance, accountability and reporting is set out the diagram below:



The Programme Board will be directly accountable to the Peninsula Acute Provider Collaborative.

The Peninsula Acute Provider Collaborative will, in turn, secure from Trust Boards:

- Signoff to the programme (i.e., scope, approach and supporting financial framework).
- Decisions, where there a requirement to make a significant service change.
- The mandate for implementation.

Devon and Cornwall's respective ICS Executive forums will be asked to ensure:

- Alignment with their respective overarching ICS strategies and the Peninsula Acute Sustainability Programme Plan
- Alignment with their respective financial frameworks and the Peninsula Acute Sustainability Programme Plan
- They are content to endorse plans and proposals before they are submitted to Devon and Cornwall ICBs

Administration

The Peninsula Acute Sustainability Programme Board will meet at least monthly. Ideally, meetings will be scheduled for the fourth Thursday each month. The paper deadline for papers to be discussed at the meeting is the third Wednesday each month.

Administration by Peninsula Acute Sustainability Programme – Project Support Officer.

Formal minutes of the meetings will be recorded and will normally be confirmed as accurate at the next meeting of the group.

Review

These terms of reference will be reviewed by the Programme Board and Peninsula Acute Provider Collaborative on receipt of the mandate to proceed with the Peninsula Acute Sustainability Programme - current target date for this decision – November/December 2022.

Current version: updated following comments and feedback from:

- Programme Board – 29th September 2022.
- Peninsula Acute Provider Collaborative – 10th October 2022

Guiding Principles
Peninsula Acute Provider Collaborative

These guiding principles will form the basis of the working relationships and arrangements for the APC and the mechanism for holding partners to account.

All members of the APC will work together in the best interest of the whole population of Devon and Cornwall.

- The views and opinions of every member of the ACP will be respected even if there is no agreement

- Where System best interests may be considered contrary to the perceived or actual best interests of any one partner, these will be openly declared, constructively discussed and fully considered

- All members will openly share all and any information (financial and non-financial) relevant to the business of the APC

- Prior to local investment in any fragile services, consideration will be given to joint solutions that provide best outcomes and value for money for the whole Devon system

- In arriving at any decisions regarding the disposition of clinical services, the APC will ensure that:
    - There has been full clinical engagement in the process
    - Appropriate staff, stakeholder and public engagement has been undertaken throughout the various stages of the work
    - The underpinning data is robust and objective
    - A comprehensive options appraisal process has been undertaken in line with pre-determined and transparent criteria
    - No one organisation is disproportionally advantaged or disadvantaged by the decision
    - Financial and non-financial risk is fully shared in accordance with the pre-determined framework
    - Where there is a clinical requirement to centralise services on one site, full consideration is given to reciprocal transfer of other services to make overall best use of staff, estate and other resources

- If a decision is made that has a perceived or real impact on one organisation more than another, all members of the APC will stand jointly with the relevant Board and provide support both internally and externally as required

- Once a decision has been made by the APC, and endorsed by Boards, all organisations will commit to playing their full part in the implementation process

- Decisions that are made by the APC and endorsed by Boards are 'locked-in' unless new evidence becomes available that would question the efficacy of that decision.

NHS Devon Integrated Care Board

Integrated Care Strategy Development Update

Date of committee	Date report produced
16 November 2022	26 October 2022

Author(s)		Report approved by	
Name and title:	Alison Wilkinson Associate Director of Planning & Programme Management Office Jenny Turner Deputy Programme Director	**Name and title:**	Simon Tapley Chief Officer, Strategy and Transformation
Phone:	07929 846315	**Date:**	26 October 2022
Email:	alison.wilkinson1@nhs.net jenny.turner3@nhs.net		

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

Executive summary (250 words max) – high level overview of the content of the report and the reasons why it is being presented

The purpose of this report is to update the NHS Devon Board on progress with the Devon Integrated Care Strategy, which is being developed on behalf of the Partnership by the Devon Plan Working Group.

The report sets out the proposed strategic goals of the Devon Integrated Care Strategy, which have been distilled from the output of the Change Leaders event

held on 12 October, the outputs of relevant engagement previously undertaken and the proposed structure and format of the document itself.

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

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
The NHS Devon ICB is asked to:
1. note the progress to date;
2. comment on the proposed strategic goals

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

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

Involvement, Engagement and consultation	None

Integrated Care Strategy Development Update

Purpose

The purpose of this report is to update the NHS Devon Integrated Care Board on progress with the Devon Integrated Care Strategy, which is being developed on behalf of the One Devon Partnership by the Devon Plan Working Group.

The report sets out the proposed strategic goals of the Devon Integrated Care Strategy, which have been distilled from the output of the Change Leaders event held on 12 October, the outputs of relevant engagement previously undertaken and the proposed structure and format of the document itself.

Introduction

Each Integrated Care System (ICS) is required to produce an Integrated Care Strategy, to set the direction for the system, setting out how NHS commissioners, local authorities, providers and other partners can deliver more joined-up, preventative and person-centred care for the whole population across the course of their life.

The Strategy is an opportunity to work with a wide range of people, communities and organisations to develop evidence-based system-wide priorities that will drive a unified focus on the challenges and opportunities to improve health and wellbeing of people and communities throughout Devon, reducing geographic disparities in wellbeing and healthy life expectancy.

2022/23 is a transitional year and it is recognised that Strategies will evolve as ICSs mature, with an expectation that the Strategy must be refreshed on an annual basis. An initial Strategy should be published by December 2022, in order to influence the 5-year joint forward plans, which need to be published by Integrated Care Boards before April 2023.

The Integrated Care Strategy should set out the assessed needs of the population and the priority strategic goals, focused on the four core purposes of ICSs:

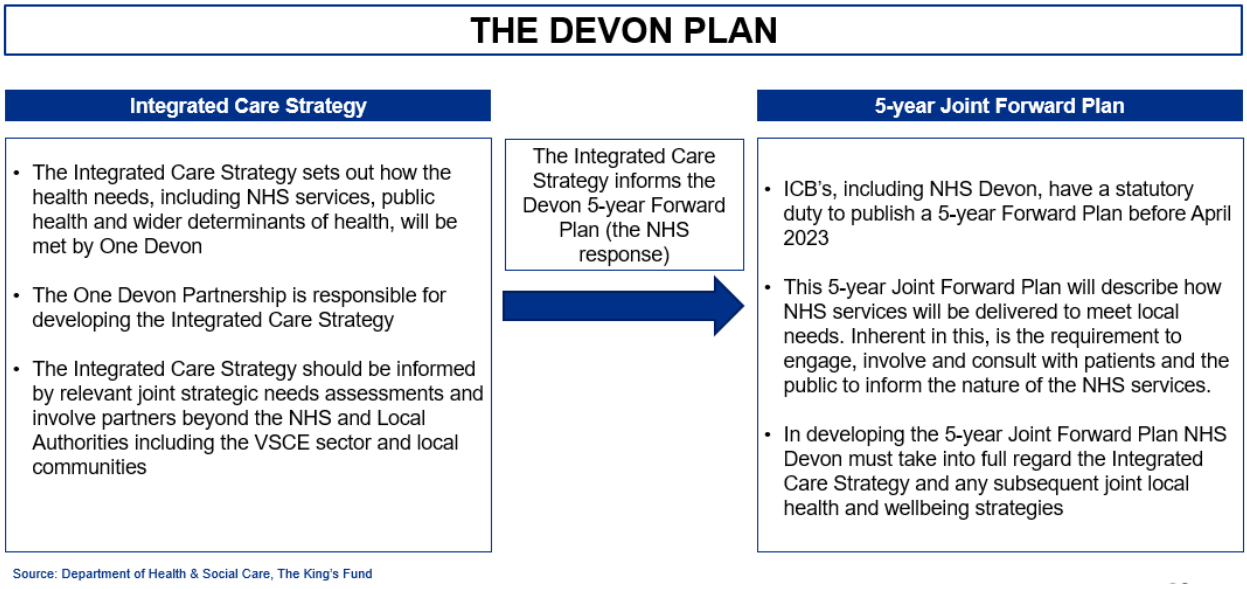
- improving outcomes in population health and healthcare;
- tackling inequalities in outcomes, experience and access;
- enhancing productivity and value for money;
- helping the NHS support broader social and economic development.

Within this, consideration should also be given to:

- personalised care;
- disparities in health and social care;
- population health and prevention;
- health protection
- babies, children, young people, their families and health ageing;
- workforce;
- research and innovation;
- 'health-related' services;
- data and information sharing.

The Devon Plan

The Devon Plan will encompass both the Integrated Care Strategy and the 5-Year Joint Forward Plan, which is the Integrated Care Board's response to the Strategy:



The Strategy will draw on the Joint Strategic Needs Assessments and Health and Wellbeing Strategies of our three local authorities, as well as the Case for Change that was produced early in 2022.

Engagement

Review of Health and Care Involvement Work 2018-2022

A comprehensive review of all published health and care involvement work undertaken between 2018 and 2022 is underway to inform the ICS strategy. The review includes insights from NHS Devon's work with people and communities, Healthwatch Devon and Healthwatch Cornwall, staff and provider engagement and from the VCSE.

Some of the key headlines, aligned to the 8 areas of consideration are:

- **Personalised care**
  - The quality of people's care is generally considered excellent, but the experience of the pathway can be very poor.
  - Choice and being involved in decisions is key
  - Being 'passed' between services reduces confidence in getting support
  - People are willing to travel, especially to a trusted clinician

- **Health protection**
  - People try to seek the most appropriate service to meet their needs however this is not always available or accessible locally.
  - Lack of Sexual Health services in Devon is a big concern
  - People actively avoid using NHS services as they don't want to be a burden

- **Disparities in health and social care**
  - People from diverse communities have poorer experiences and feel that the system does not support them effectively.
  - Lack of cultural competency should be acknowledged

- **Babies, Children, Young People, their families, and healthy ageing**
  - Younger peoples experience is poorer than most other age groups, especially around mental health (access/outcomes).
  - Involving people and giving people choice is important to all family members

- '**Health-related' Services**
  - There is a perception that people don't know what services are available to them. Considerations for any commissioned service have to properly consider transport – access to public/private transport and parking needs (including staff)

- **Population Health and prevention**
  - Any service should address and tackle health inequalities, not further compound them.
  - Rurality is a huge challenge for some in Devon and Cornwall

    - The healthcare system is very complex to understand and navigate, especially for those with additional access needs.

- **Workforce**
    - NHS staff want to see the skills and experience of the existing workforce invested in and protected.
    - People perceive that NHS staff are not able to effectively support some individual needs that require additional support (e.g. BSL users)

- **Data information and sharing**
    - Technology is used, but there is a lack of trust with older people valuing face to face more than younger people.
    - Recognise and use trusted channels and sources of information
    - Ensure content and messages are clear and accessible for all

As agreed at a previous Partnership meeting, the review is ongoing, with more insight being submitted by system partners for consideration, with the aim of being complete in the coming weeks.

Change Leaders Event – to inform development of Strategic Goals

A key element of the engagement was a Change Leaders event held on 12 October 2022, where almost 100 leaders from across the Devon system met virtually to review the current Devon context and to consider the strategic goals that should be identified in the Strategy against the four keys aims of an Integrated Care System.

At the event, eight breakout groups each considered one of the four core aims and prioritised some potential strategic goals within them. The groups identified a long list, then undertook a prioritisation process, which produced the list included as **Appendix A**.

Proposed Strategic Goals

Since the Change Leaders event, a small group has reviewed the prioritised list and has synthesised the output into the following list of proposed strategic goals:

Improving outcomes in population health and healthcare
By 2028, One Devon will reduce suicides to zero
By 2028, the One Devon workforce will have an understanding of Population Health Management and Health Inequalities so we all can act in relation to prevention
By 2028, One Devon will be sustainably achieving performance targets within an agreed financial envelope, delivered through LCPs and provider collaboratives
By 2027, One Devon will have improved the school readiness of children by 50%
By 2025, One Devon will have implemented and appropriately resourced neighbourhood teams that are preventative, pro-active and personalised, reducing crisis by 30%. Teams will include all sectors, including secondary care.

Tackling inequalities in outcomes, experience and access
By 2028, all of the One Devon population will have access to services based on need and equality of outcomes.
By 2028, suitable, warm and dry housing will be in place for our population where it will have the greatest impact on people's health and well-being
By 2028, everyone who needs end of life care is able to access it and are able to die in their preferred place
Enhancing Productivity and Value for Money
By 2028, everyone living and working in Devon will be aware of what services they can access and where.
By 2028, One Devon will have a unified approach to procuring goods, services and systems across sectors, maximising economies of scale and increasing cost effectiveness.
By 2028, One Devon will increase the proportion of our budget spent on prevention and early intervention by xx (defined by maintaining good health, improving health and optimising chronic disease) to reduce the current level of preventable admissions by 95%
By 2028, One Devon will have an available workforce that meets the needs of the population and is affordable
By 2028, One Devon will provide a unified and standardised Digital Infrastructure that provides ubiquitous access to shared systems, where it is agreed and appropriate, across organisations.
Helping the NHS support broader social and economic development
By 2026, One Devon will create and promote a publicly funded network of public transport, along with joined up policy and infrastructure that supports active travel across Devon, so people have access to affordable and frequently accessible transport service.
By 2028, One Devon will have created a system wide supported employment service and increased the number of people living with a diagnosis of severe and enduring mental illness, learning disability and neurodiversity and physical disability in employment.
By 2028, One Devon will have created the environment to work with local and county-wide businesses, education providers and the VCSE, by positioning them as equal and trusted partners to achieve best use of resources and value for money.
By 2028, One Devon will empower broader community groups, such as faith groups, and direct our collective buying power to invest in and build for longer term resilience in local communities and businesses to show a demonstrable increase in support to local people.

The Partnership has reviewed the proposed strategic goals and have provided feedback.

Structure of the Strategy

The proposed structure of the Strategy is as follows:

Integrated Care Strategy purpose: A plan to address the wider health care, public health and social care needs of the population.

1. Executive summary	2. What is the integrated care strategy?	3. Devon's Context	4. Health, public health and social care needs	5. Strategy for Devon	6. Conditions for success	7. Further development of the Integrated Care Strategy
	1. National context/guidance 2. Purpose of the Integrated Care Strategy 3. Who is involved? 4. What has fed into this Integrated Care Strategy e.g., Specific Needs Assessments, Engagement etc.	1. General - population, economy, health needs 2. Health/ICS Landscape – Partners; Link to other documents e.g. Operating model; SOF 4; Current state of escalation	1. Summarise and align Needs Assessments 2. Address key areas of consideration as stipulated in guidance: • personalised care • addressing disparities in health and social care – including underserved populations • population health and prevention • health protection • babies, children, young people and their families • healthy ageing 3. Identify analysis gaps in the current Needs Assessments	1. What are the system strategic aims/objectives? 2. How will this vary by LCP & Health and Wellbeing Board? 3. Timeline for delivering strategy and roles of organisations	1. How we will work together – values and behaviours? 2. Address strategic programmes: • workforce • digital transformation • estates • finance • communications 3. Address key areas of consideration as stipulated in guidance: • workforce • research and innovation • health-related services • data and information sharing	1. Future engagement and contact details 2. Future iterations

One Devon

The Devon Plan Working Group has agreed leads for each section of the Strategy and a draft will be taken to the next One Devon Partnership meeting on 1 December.

Timeline and Next Steps

- Draft strategy: During November the Working Group will draft the Strategy, drawing on existing material (Joint Strategic Needs Assessments, Case for Change, etc) for sections 2, 3 and 4 and on the work on the Devon Operating Model and Values Based Approach under section 6.

- Further development of strategic goals: Subject to advice from the Partnership, the draft strategic goals will continue to be iterated and will form section 5 of the Strategy.

- Engagement: Finalise review of health and care involvement and engage further with Overview and Scrutiny committees

- The One Devon Partnership will review the Strategy at their meeting on 1 December.

Conclusion and Recommendations

The NHS Devon ICB is asked to:

- note the progress to date;
- comment on the proposed strategic goals

Alison Wilkinson
Associate Director of Planning & Programme Management Office
26/10/2022

Appendix A

Improve outcomes in population health and health care	**Group 1**
	By 2028 the Devon ICS will take a zero target approach to suicide. Zero suicide is the national policy and the good practice that should be adopted.
	By 2028 the Devon ICS will have developed an approach that **allows community power and focus on what's strong and what's wrong**.
	By 2028 the Devon ICS will have created **a mandatory programme on PHM and HI training for the entire workforce so we all understand and can act in relation to prevention**.
	By 2028 the Devon ICS will have **5 respected strong effective well led LCPs that fully represent local people and families ..... with a clear multiagency/partners plan targeted at inequality for children young people and families**
	By 2028 the Devon ICS will have a **clearly resourced and prevention focused mental health pathway for young people (up to 25 years of age) resulting in a 25% reduction of first time referrals to tier 3 and 4**.
	By 2028 the Devon ICS will have **reduced delays to mental health support for young people by 50%**
	Group 2
	We will agree a realistic focused set of targets that improve the quality of life of Devon residents.
	Based on the JSNAs, by 2027 we will have transformed services and right-sized capacity relative to need, so that we provide timely access to urgent, emergency, elective, cancer and mental health care, equal to all. Reduce the incidence of avoidable harm. Use current metrics to measure timely access.
	By 2027 we will have **improved the school readiness of children by 50%.**
	By 2025 we will have implemented and appropriately resourced neighbourhood teams that are preventative, pro-active and personalised, **reducing crisis by 30%.** Teams will include all sectors, including secondary care.
	Focus on main causes of poor health (diabetes, cardiovascular, cancer and respiratory) in terms of health behaviours.
	We will make terms and conditions for Population Health project management staff favourable to allow us to deliver population health outcomes.

Tackle Inequalities outcomes, experience and access	
	Group 1
	By five years, c**ommissioning will be based on deep understanding of place and people's needs.** This will enable us to set a five-year aim of **equity of access and population experience** By 2027. **Specific outcomes could be (examples):**
	• Improved access to primary care, ensuring that everyone has the same level of care. We will have achieved levelling up, improving health outcomes. Reduction in CV events, increased cancer diagnosis in the next five years.
	• Reduce the life expectancy gap for people with Serious Mental Illness and Learning disabilities by 2 years in the next 5, by ensuring that every single person in Devon who wants one has access to an annual health check and we make reasonable adaptations in our physical health services so that people get the right onward care and support to live well longer
	• In the next 5 years, every new housing development will include appropriate options for people who need adjustments and support and every NHS or Public sector property that is sold for housing development will have this expectation in the planning requirements
	• Halve the number of children who are not ready for school in five years. This will have numerous benefits
	We will produce a **single portal for access** to care in Devon through supporting the public and workforce we will lead to a systemwide approach to those who are not digitally enabled. Addressed in next 2 years. This translates as support and navigation to the right support and right time.
	Within 5 years, everyone in Devon gets **good access to end of life care**. 50% People dying in their preferred place in the next 5 years. This avoids people dying alone, in pain. We aspire to people having a good death.
	Group 2
	Workforce – a workforce able and skilled to work proactively in their communities, across usual boundaries – understanding their communities looking at the whole to support improvement in health inequalities - to understand our workforce needs and by 2027 have developed a workforce who know how and able to work with their communities across physical, psychological, and social needs
	Disruption - Disrupt our clinical models in response to need - actions to change will require us to be willing to disrupt current thinking based on understanding of where inequalities exist and the need to move resource (money and perhaps workforce)
	Empowerment – our health, social care, VCSE and community assets work with our populations to avoid ill health where possible, and to work with people to help support their self-management of ill health if it develops. Our health, social care, VCSE and community assets to work with our populations to help them to avoid ill health where possible, and to work with people to help support their self-management of ill health if it develops
	Equitable access to health and wellbeing but noting inequalities are not equal and resources will need to be realigned
	Heathy lives improving the lives of all from birth to death. Measurable outcomes:
	• Smoking - every contact counts - reduce by 50
	• Life expectancy improves in our most deprived areas by 2027
	• Investment in prevention and communities increases by 20% by 2027

Enhancing productivity and value for money	**Group 1**
	‘We will have holistic approach to the whole family for people and services – no wrong front door’
	Public awareness of what is best provided close to home and what specialist services need travel (which should be supported) and prevention focus to avoid need for acute admission
	By 2028, Devon ICS will have developed an **integrated paid carers plan** which encompasses recruitment, pay, working conditions, training and careers pathway.
	We need a **unified approach to procuring goods, services and systems** across sectors, maximising economies of scale and making it easier and more cost effective to provide ongoing support to users and "colleagues doing their best work, when the can, for as long as they can". One of the impacts will be to reduce admission to acute care
	By 2028, Devon ICS will **increase the proportion of our budget by xx on prevention and early intervention** (defined by maintaining good health, improving health and optimising chronic disease) to achieve a preventable admissions rate of 95%. For the 5% of preventable admissions, these should be investigated for learning points
	By 2028, Devon ICS will have **100% of available workforce deployed in redesigned/multiskilled roles** across sectors that they feel are rewarding, are supported and suit their circumstances. Where people are looking to step away from a role, we support our ICS Partners to be maximally flexible. "The success of our Devon ICS will be realised by all colleagues doing their best work, when the can, for as long as they can." one of the impacts will be to reduce admission to acute care
	Within 5 years we will collaborate to provide a unified and standardised **Digital Infrastructure** that provides ubiquitous access to shared systems, where it is agreed and appropriate, wherever and whatever organisation you work for, and we will have addressed the IG issues associated with shared system
	Group 2
	We are evidence based, monitoring impact, and making changes where needed by 2025
	Telling our story only once. Development of share care record by 2024
	Reduce workforce vacancies across sectors and roles to 5% by 2028
	Transferring 70% services into our communities, with provision of sustainable funding by 2028
	All major organisations are role modelling as **anchor institutions** at place and linking with others by 2028

Help the NHS support broader social and economic development	
	Group 1
	In Devon by 2026 the NHS will work with Partners to support creating, and promoting, use of a publicly funded network of public transport (trains and shuttle buses) and joined up policy and infrastructure that supports active travel across Devon (including rural areas) so people have access to affordable and frequently accessible transport service
	By 2028, One Devon will have increased the number of people living with a diagnosis of severe and enduring mental illness, learning disability and neurodiversity in employment by creating a system wide supported employment service.
	By 2028, Devon ICS will have an effective workforce strategy to recruit, attract and increase retention of staff through effective training, development and career pathways in order to address market sufficiency issues and system flow challenges
	By Devon 2028, Devon ICS will have transformed the way primary and secondary care interact through using digital innovations, empowering our population through use of technology, using multi-specialty joint clinics and multi-disciplinary virtual ward rounds to reduce the burden of multi morbidity on both the patient and services in order to reduce unwarranted contacts
	By 2028, Devon ICS will have transformed our economic development through involvement of the VCSE (including sharing of resources and allocation of funding) to achieve best use of resources, value for money and strengthening localism and community assets
	Group 2
	By 2028 through working with the local population to ensure there are as many people as active in the employment and VCSE market as possible. Giving assurance through a demonstrable increase in workforce we have made every effort to get people involved in employment or voluntary roles where possible.
	By 2028 develop the incentives and support to workforce in the social sector (in the same way that key workers are) to see in increase in the retention of staff
	By 2028 Devon ICS will have created the environment for LCPs to work with local and county-wide businesses, education providers and the VCSE by positioning them as equal and trusted partners to enable and empower them to make decisions on how to reduce health inequalities in that community
	By 2028 through building relationships with the LCPs and empower broader community groups such as faith groups, and directing our collective buying power to invest in, and build for longer term resilience in local communities and business to show a demonstrable increase in support to local people to including the development of secure housing for the population including key workers.
	By 2028 a focus on having a population that is physically, psychologically and socially healthy to have a demonstrable longer term impact on the urgent care system, the primary care system and the social care system with the aim of giving more timely access, to support life expectancy improvements and showing a reduction in tackling health inequalities
	By 2028 One Devon will have demonstrably improved the employment and economic opportunities of its citizens, through active participation in local economies and offering employment with liveable wages; investing in skills and opportunities and fundamentally, addressing the health inequalities preventing local people accessing economic opportunities

Integrated Quality, Performance and Finance Report

Date of committee	Date report produced
November 2022	27th October 22

Author(s)		Report approved by	
Name and title:	Performance Team	**Name and title:**	Sam Wadham-Sharpe Director of Performance and Assurance
		Date:	27th October 22

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

Executive summary (250 words max)

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

The IQPR is submitted to the Quality and Performance Committee, and the Finance Committee to identify areas of operational, quality, or financial performance that require further investigation and assurance. Areas of concern or interest identified by the IQPR review may result in further investigations or a deep dive being undertaken to seek greater assurance on the actions associated with improvement and the effective management of safety and experience for patients within services.

The outcomes of the IQPR review and any subsequent deep dives will be escalated to the NHS Devon Board within the Committee Chairs Reports to provide assurance on the identification of any issues and the actions associated with improvement. The Committee Chairs Reports will also provide any recommendations requiring NHS Devon Board approval.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Quality and Performance Committee Finance Committee NHS Devon (ICB) Board Outcomes would be escalated as part of chair reports

Key recommendations and actions requested
The Board are asked to note the report

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

Does this report have implications in any of the areas highlighted below?			
Area		**Yes (summarise implications)**	**No**
Quality of services		Outlines current operational and quality performance and actions	
Health inequalities			
Workforce		Outlines current workforce performance and actions	
Resources and finance		Outlines current financial performance and actions	
Legal			
Engagement and consultation			

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

Integrated Quality, Performance and Finance Report (IQPR)

Table of contents

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 to the ICS, at both place and system level that issues are being identified and addressed.

The One Devon system has submitted its 2022/23 Operating Plan which will include plans to work towards delivery of key elective care targets and address underlying issues that restrict ability to deliver elective activity. However, the financial forecast currently sits at an £18.2m deficit.

Operationally the ICS remains under extreme pressure and although Covid inpatient numbers are declining, the summer surge of visitors, elective backlogs and staffing challenges has meant that services continue to compete for resources. This has resulted in a sustained position of increased risk, including delays in urgent care and delayed discharges due to poor community capacity. Emergency Departments (ED) performance and ambulance conveyancing targets have continued to decline impacting on operational performance against both urgent and elective care standards across the system.

Planned Care 104 week waits continue to reduce, but NHS Devon continues to have significant numbers of patients waiting beyond 104 weeks at the end of July 2022 (target of zero). System wide work is underway to understand the implications of harm in relation long waits in elective pathways. In addition, and in response to ensuring the system addresses the elective care backlog - multiple actions are in place to maximise efficiencies, capacity and ensure safe and high-quality care is delivered. Our principle remains that we ensure elective care is safely, sustainably, and reliably provided as a system.

Statistical Process Control (SPC) charts have been introduced into the IQPR to demonstrate the system performance alongside the NSHE accepted standard reporting format. The use of this reporting will be phased in across future iterations of this report. The table in the page below explains how to use the icons in the SPC charts to understand performance against the metrics displayed.

Key to Variance & Assurance Icons

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
~	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
○				There is insufficient data to determine either special cause or common cause variation. Assurance cannot be given as there is no target.

Performance

Urgent and Emergency Care – System Overview

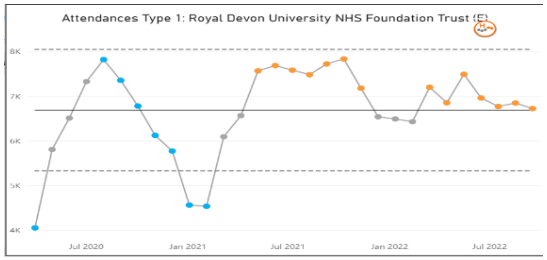
			System			Royal Devon University NHS Foundation Trust			Royal Devon University NHS Foundation Trust (E)			Royal Devon University NHS Foundation Trust (N)			Torbay and South Devon NHS Foundation Trust			University Hospitals Plymouth NHS Trust		
	Metric	Target	Latest Date	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance
UEC	A&E all types seen within 4 hours	95%	2022-09	58.0%			56.6%									60.2%					
	A&E Type 1 seen within 4 hours	95%	2022-09	45.2%			48.1%									39.6%					
	Attendances Type 1		2022-09	23,894						6,723			4,074			5,585			7,512		
	Type 1 Admissions (conversion rate)		2022-09	28.3%						32.8%			23.7%			21.8%			31.4%		
	Emergency Admissions via A&E		2022-09	6,752						2,208			967			1,217			2,360		
	ambulance arrivals delayed over 30 mi...		2022-09	45.2%						17.9%			42.3%			59.0%			72.4%		
	12 hr trolley waits	0	2022-09	1,391						157			192			301			741		
	Time lost to Ambulance Handover Del...		2022-09	9,323						642			571			2,683			5,427		
	Mean ambulance response times cat 1	7	2022-09	11																	
	Mean ambulance response times cat 2	18	2022-09	70																	

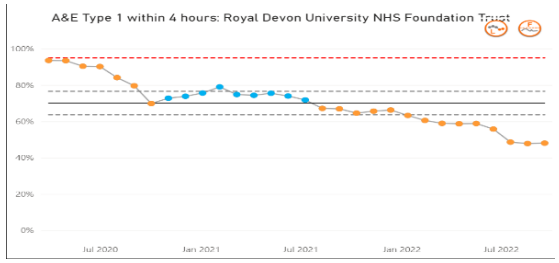
Analytical Summary: This month has seen a deteriorating position against most metrics across the system, with assurance indicating a failing position. UHP has seen its first improvement in emergency department admissions this month and a second month of improvement for TSD. Continued improvement is needed to provide assurance of an improved process/system.

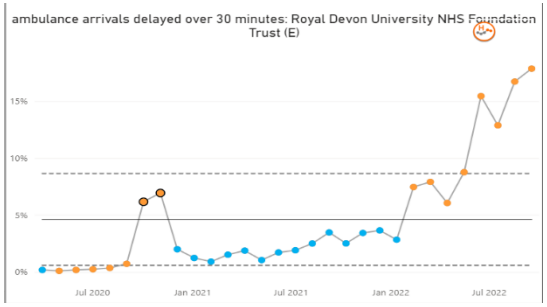
The next slides focus on Trusts' performance against the following metrics: type one emergency department attendances, four-hour performance, ambulance handover delays of +30 minutes and total time lost to ambulance handover delays.

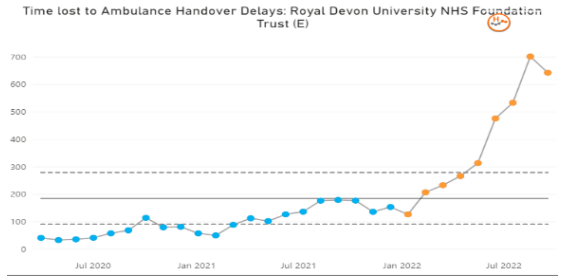
Urgent and Emergency Care – Royal Devon University Healthcare (Eastern)

Data









Analytical Summary

- The number of ED attendances is variable but is within the expected range.
- There is a statistically significant downward trend in performance against the 4-hour standard. The target of 95% will not be met without system change
- There is a statistically significant upward trend in the number of ambulance arrivals delayed for over 30 minutes
- There is a statistically significant upward trend in the total hours lost to ambulance handover delays.

Operational Summary

Causes (**Eastern** area):

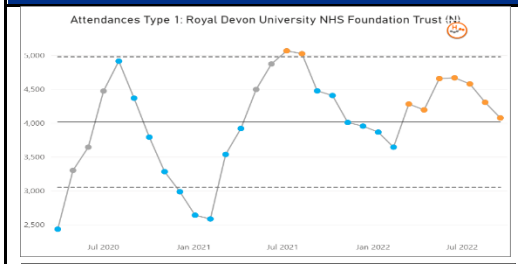
- 111 call abandonment rate 31% of and lack of primary care streaming
- Bed capacity pressure and restricted flow to beds in the hospital, numbers of patients, for September the average number of patients with no criteria to reside was 92.
- Weekly closures at Sidwell Street MIU due to staffing.
- Current vacancies and sickness in Medical and Nursing teams at end of September there were 77 covid related absences

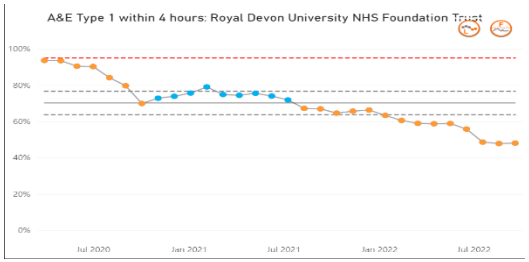
Actions: (based around recruitment following internal investment in urgent care in 2021/22 including which aim to address all current gaps)

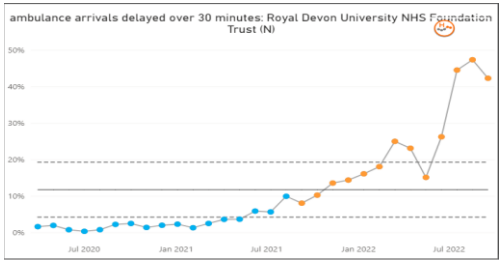
- Re-set week took place between 3rd – 11th October and provided valuable learning into flow opportunities, currently being evaluated.
- Additional staffing funded through winter monies, including Discharge Coordinator
- Discharge lounge now operating at weekends to further increase flow

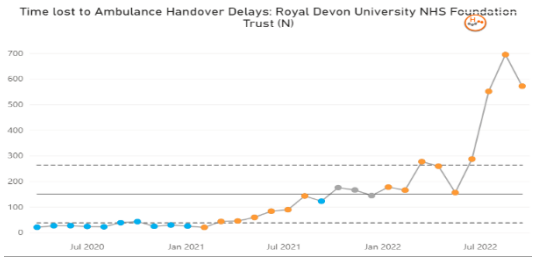
Urgent and Emergency Care – Royal Devon University Healthcare (Northern)

Data









Analytical Summary

- The number of ED attendances is variable but is within the expected range.
- There is a statistically significant downward trend in performance against the 4-hour standard. The target of 95% will not be met without system change
- There is a statistically significant upward trend in the number of ambulance arrivals delayed for over 30 minutes
- There is a statistically significant upward trend in the total hours lost to ambulance handover delays.

Operational Summary

Causes (**Northern** area):

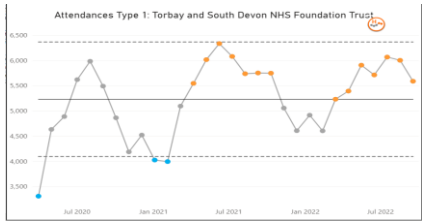
- Poor flow with a September average of 62 patients with no criteria to reside resulting in a reduced active bed base.
- Impact of Covid on bed occupancy and workforce, covid numbers in hospital rose to 17 in September. Covid related staff sickness.

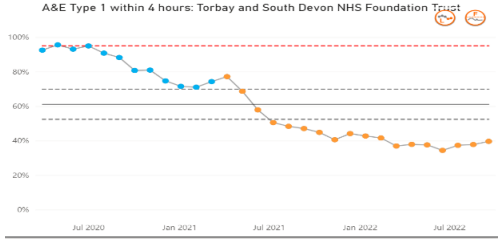
Actions:

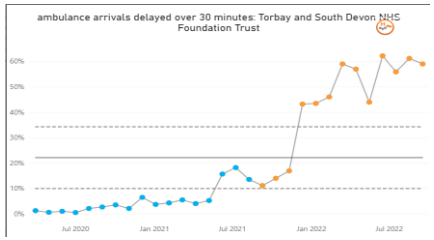
- Re-set week took place between 3rd – 11th October and provided valuable learning into flow opportunities, currently being evaluated.
- Ilfracombe Community Hospital MIU weekend provision (Friday-Monday) extended to March 2023.
- Additional porter services for winter surge to support flow efficiencies at time of increased demand.
- Recruitment for permanent discharge lounge staffing and business case for new location and facilities in process for approval.
- Recruitment for additional staffing to support flow and discharge – 7/7 DISCO rota, liaison and transfer team and doctors' assistants.
- New Head of Operations post filled following successful recruitment process.
- Criteria-Led Discharge (CLD) has strong clinical engagement and a staggered implementation/ plan/targets for wards is underway.
- Clear communication and referral pathway to One Northern Devon VCSE support for discharge.
- Additional porter services for winter surge to support flow efficiencies at time of increased demand.

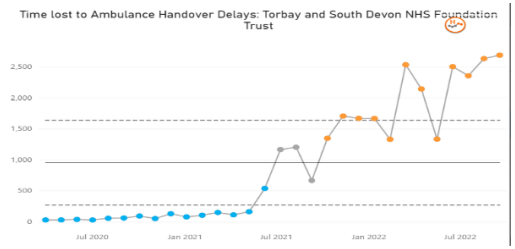
Urgent and Emergency Care – Torbay & South Devon

Data









Analytical Summary

- The number of Emergency Department (ED) attendances is variable but is within the expected range.
- There is a statistically significant downward trend in performance against the 4 hour standard. The target of 95% will not be met without system change
- There is a statistically significant upward shift in the number of ambulance arrivals delayed for over 30 minutes, this appears to be in line with a downwards deflection in minors but an increase in higher acuity Resus and Majors patients within the attendance totality.
- There is a statistically significant upward shift in the total hours lost to ambulance handover delays. This is linked with the above.
- TSD noted a higher and earlier than expected Covid surge which culminated in an inpatient position of 120 adult G&A beds affected by IPCC restrictions in a small and limited bed base.

Operational Summary

Causes:

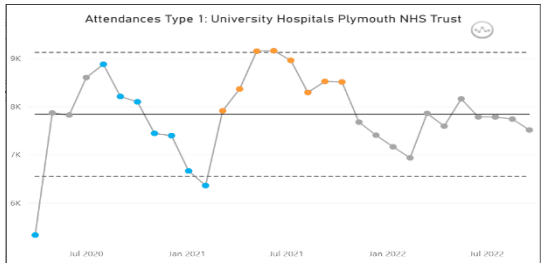
- 111 call abandonment rates of 31% and lack of primary care streaming
- Bed capacity pressure and restricted flow to beds in the hospital a September average of 45 beds occupied by patients with no criteria to reside.
- High numbers of Pathway 0 patients with a length of stay >7 days within the general and acute bed base, bed occupancy of 95%
- Current vacancies and sickness in Medical and Nursing teams.

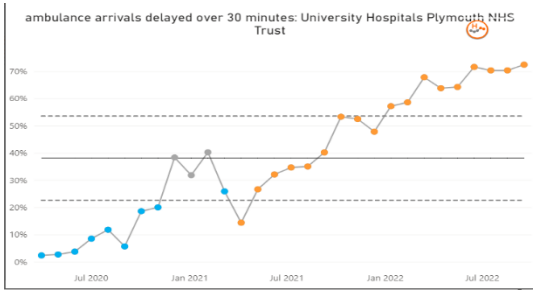
Actions:

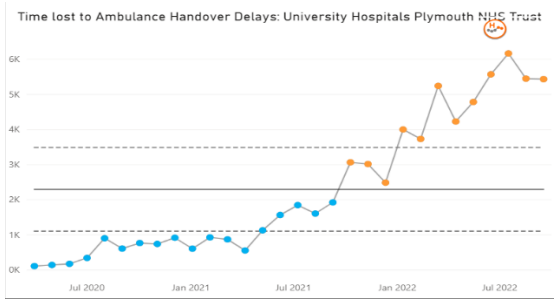
- Support of direct off-load of Cat 2 and above ambulance patients into the clinical footprint (utilisation of a "red" trolley)
- Clinical review for all those awaiting handover by an appropriate ED clinician, and a brief handover accepted by the nursing staff.
- Joint Emergency Team patients within the ED being on-boarded to the Discharge Lounge for review and onward treatment plans, to open capacity within the ED.
- Embedded escalation process of utilisation of the Discharge Lounge and Cardiac Catheter Lab overnight to enable flow at the beginning of each day.
- The Trust has been at OPEL 4 for a significant amount of time, and with the added pressures of the COVID surge the decision was made to open the "Winter Command Room" earlier than expected to enable ISU engagement and tighter data and narrative response. Now meeting 4 times a day with touch points in between. Bed management team staff this 24/7.
- Daily review of all complex patients through the Discharge Hub.
- Weekly review and ownership by the bed management team of all Pathway 0 >7day length of stay patients.
- Tight focused work underway with Exec sponsorship on weekend discharges and 33% of discharges from the adult G&A prior to 12.00. Starting to see traction from the focus.
- AIM Consultant of the Day reviewing appropriate patients from 08.00 to kick start flow and support appropriate SDEC/discharge options.

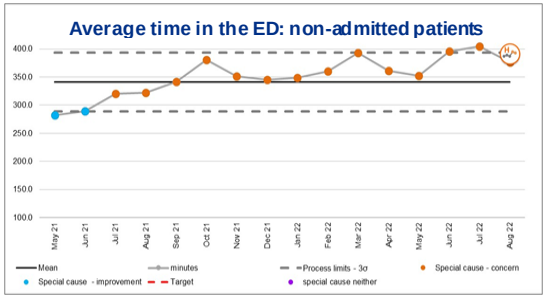
Urgent and Emergency Care – University Hospitals Plymouth

Data



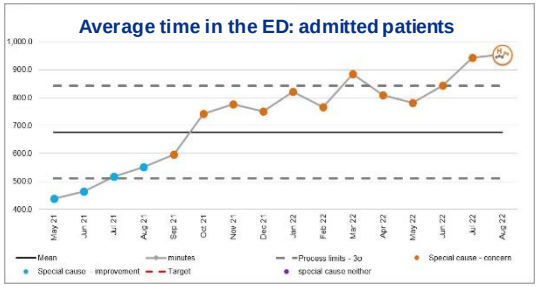






Analytical Summary

- The number of ED attendances is variable but is within the expected range.
- for both admitted and non- admitted patients there has been a sustained upward shift in the length of stay in ED. It is unlikely that performance will improve without system change
- There is a statistically significant upward shift in the number of ambulance arrivals delayed for over 30 minutes
- There is a statistically significant upward shift in the total hours lost to ambulance handover delays.



Operational Summary

Causes:

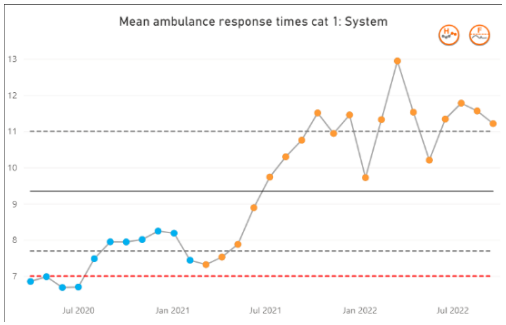
- Flow through the hospital being compromised due to delays to discharge. For September there was a daily average of 137 patients without the criteria to reside
- 111 call abandonment rates of 31% and lack of primary care streaming

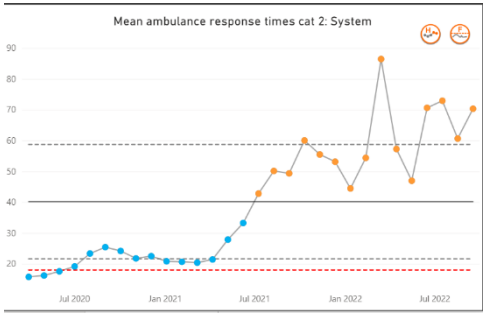
Actions:

- The creation of additional surge capacity within the ED with additional space and staffing.
- An increased Same Day Emergency Care (SDEC) offer with additional 6 spaces from 15th September to increase to 10 in line with recruitment.
- A new Acute Medicine Model to Improve flow in ED to enable an increase in Same SDEC overall by 10%.
- Increased Surgical SDEC and a restart of GP take through Medical Admissions Unit/Acute Ambulatory Unit.
- Increased falls provision from Urgent Care Response and Out of Hours nursing services.
- Increased resource for the Hospital to Home pathway 1 service, enhanced clinical support to care homes with high admission rates and targeted support to the top 7 high referring practices across the city with a Multi-Disciplinary Team approach.
- A review has taken place into the reasons for high Mortality in the ED. Findings include a significant number of End of Life patients being sent to the ED for pain control etc instead of remaining in their chosen place. The UHP Mortality group and the System Mortality Group will assess this data and initiate any actions needed.

Ambulance response times (Cat 1 and Cat 2)

Data





Analytical Summary

There has been a statistically significant upward shift in the mean response time for both category 1 and category 2. The targets of 7 minutes for category 1 and 18 minutes for category 2 will not be met without system change.

Overall demand is down on the same period in 2019, 2020 and 2021. The percentage of patients conveyed to ED remains low, 38% through August.

Call answering times in September increased on previous months to 52% of calls answered in 5 seconds (target 95%). Mean call answering time, also improved to 56 seconds.

Operational Summary

Cause:

- Ambulance response times have a positive correlation with hospital handover delays. South Western Ambulance Service Foundation Trust (SWASFT) category 1 and 2 response times are amongst the worst in England. SWASFT also have the highest average handover time in England. Derriford and Torbay Hospitals routinely have delays in excess of 250+ hours per week.

Actions:

- All systems have submitted trajectories to reduce hours lost; however, the trajectory is not being met. Handover improvement plans are in place for Derriford and Torbay, monitored fortnightly through the Devon ambulance cell.
- Through August, a "pathway to paramedic" role was advertised, where recruits start as an EMD (Emergency Medical Dispatcher). There has been significant interest in the role, and it is anticipated this will enhance the numbers of EMDs to meet the trajectory of 250 EMDs by end March 2023.
- The Trust have authorised retention payments to EMDs to reduce turnover.
- To mitigate the effect of handover delays on response times, SWASFT are providing additional conveying resource hours per week (double crewed ambulance and patient support vehicles) than their "People Plan 2" forecast suggests would normally be required. This includes the provision of third-party ambulance response. During winter, a "risk share" has been agreed across all the south-west systems. If hours lost to handover across the south-west increase above 3900 hours per week, additional payments are made to SWASFT against the system trajectory and SW position. The funding will purchase additional response resource, including third-party provider.
- A SW transformation sub-committee will oversee the delivery of the 2022-23 transformation plan. There are three priorities: availability of alternative response models (e.g. UCR), access to clinical information (summary care record) and, simplified pathways to support 999 with appropriate redirection of the patient.

Planned Care: System Overview

		System			
Metric	Target	Latest Date	Value	Variation	Assurance
RTT Incomplete Waiting list		2022-08	173,706		
RTT 18 weeks	92%	2022-08	53.4%		
RTT over 104 weeks	0	2022-08	694		
RTT over 78 weeks		2022-08	3,344		
RTT over 52 weeks		2022-08	16,285		
Diagnostics within 6 weeks	99%	2022-08	65.8%		
Diagnostic Total activity		2022-08	39,145		
Cancer 2 week wait	93%	2022-08	61.8%		
Breast Symptomatic 2 week wait	93%	2022-08	47.6%		
Cancer 31 day First	96%	2022-08	93.1%		
Cancer 31 day follow-up drug	98%	2022-08	99.4%		
Cancer 31 day follow-up sugery	94%	2022-08	82.5%		
Cancer 31 day follow-up radiotherapy	94%	2022-08	98.8%		
Cancer 62 day urgent	85%	2022-08	64.4%		
Cancer 62 day screening	90%	2022-08	74.2%		
Cancer 62 day Upgrade	85%	2022-08	32%		
Cancer Faster diagnosis	75%	2022-08	73.2%		

RTT

Diagnostics

Cancer

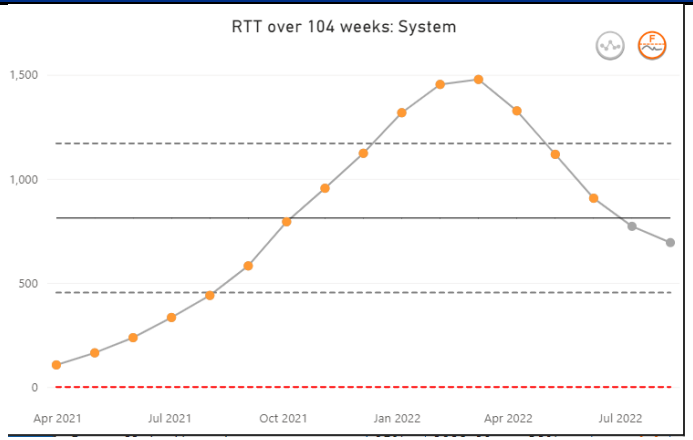
The majority of system performance for the month has been within normal common cause variation indicating no significant change. However, a significant number of the metrics are failing to achieve the national targets and will continue to do so without process intervention.

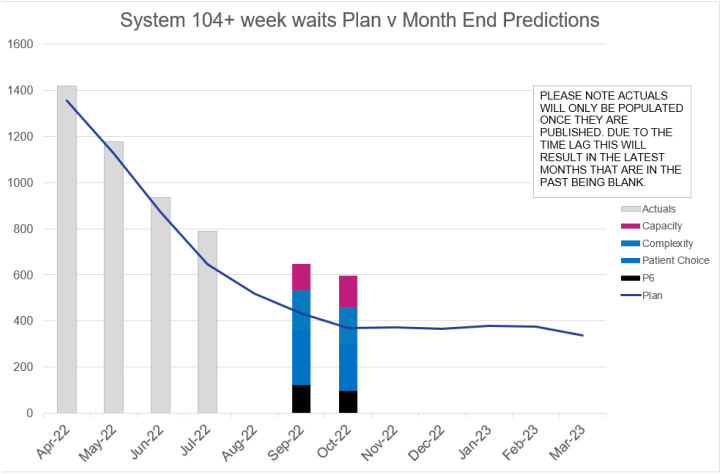
The system has seen an improvement in the total number of patients waiting over 104 weeks from referral to treatment, however a worsening in performance has been seen in RTT, cancer and diagnostic pathways.

An audit of serious incidents is being undertaken by the ICB to ascertain the level of harm specifically due to long waits. Providers have also been asked to share their data on harm, including lower-level incidents and complaints. Further information will be reported in December 2022.

Planned Care: System 104 Week Wait

Data





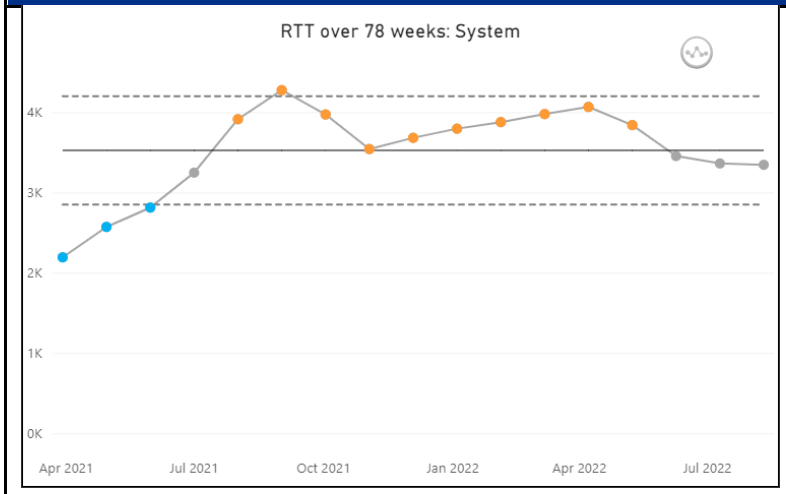
Analytical Summary

The RTT 104 week wait metric exhibits special cause variation which raises concern. It continues to fail the target of zero 104-week waiters at individual acute provider and system level.

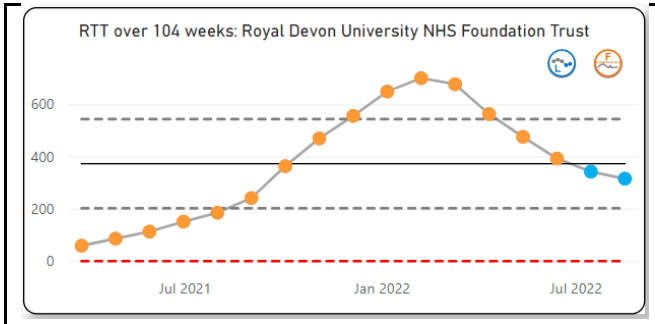
Operational Summary

- The current forecasted position for Devon at the end of October is 588 which is 155 adverse to trajectory submitted in June 22.
- Long waiting patients continue to be a priority workstream across the system with weekly meetings with regional and national colleagues in place.
- UHP are piloting a direct provider to provider mutual aid pathway with Schoen Clinic to manage the end-to-end process for patients. This process also includes direct reporting to NHSE/I on progress for regional oversight and governance.
- The Devon system has been informed that South West London Elective Orthopaedic Centre is able to ringfence 20-25 mutual aid slots for Devon patients. This capacity is not being fully utilised at present and an urgent piece of validation work is underway to identify suitable patients to be able to be transferred for mutual aid to ensure that this capacity is utilised.
- Royal Gloucester Hospital has come online as an additional mutual aid provider, along with Nuffield Guildford & Woking, Great Western Hospital Swindon, the Hampshire Clinic Basingstoke, and Great Ormond Street Hospital. As of 18 October 102 patients transferred for mutual aid, with 44 of these having received treatment.
- There has been an update to national guidance regarding patient choice and providers are validating waiting lists to match to the revised guidelines. This will mean that some patients who chose to postpone their surgery will be removed from the waiting list until such time as they are available for their treatment. This will be managed with clinical oversight to ensure patients are fully understand the implications of delaying their treatment.

Planned Care: System 104 Week Wait Continued

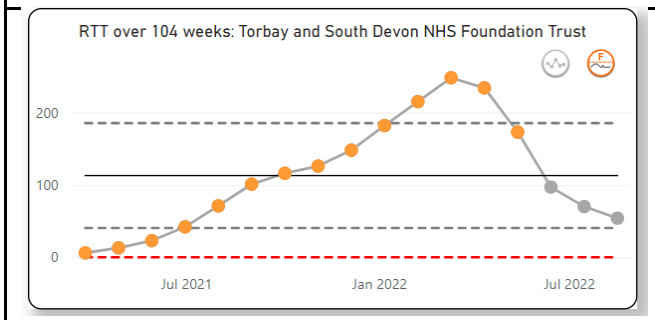
Data	Operational Summary
	• Focus is now moving to patients waiting beyond 78 weeks. 78ww trajectories remain a challenge across the system with a particular focus on Colorectal / ENT / Gastro / Neurology / Respiratory Medicine and Urology. This is driven by capacity and recruitment challenges across the system. • Additional activity is being sought across the system through insourcing opportunities There have been delays in the full mobilisation of insourcing opportunities due to capacity, however it is expected that this will be at the projected levels by December. • Work is underway across the system to reduce the number of patients who have not yet had their first outpatient appointment, with NHSE proposing a new ambition of no patients >60 weeks for either 1st Outpatient or on a non-admitted pathway by 3rd February 2023. Meeting this target will be a significant challenge in Devon and work is being undertaken to quantify the total number of patients involved. • A process is being developed to enable the clinicians to identify the patients requiring 1:1 clinical review. A questionnaire has been developed to cover the majority of pre -operative questions that would be asked in pre op assessment, patients will complete this remotely, leaving the clinician to assess which patients need to be reassessed due to changes, pre-existing comorbidities or inability to complete the questionnaire. The aim is to increase the speed at which patients are escalated for Mutual Aid options and to reduce the number rejected further down the process. • Work is underway to assess unwarranted variation within pathways and to facilitate system learning from best practice. The aim is to find the solutions quickly and to support the providers to implement action plans to improve efficiency. • Learning has been taken from the patient feedback to improve the processes around Mutual Aid, examples include financial recompense for being accompanied to travel and responding to patient complaints with feedback on the changes made following investigations.

Planned Care: Trusts 104 Week Wait



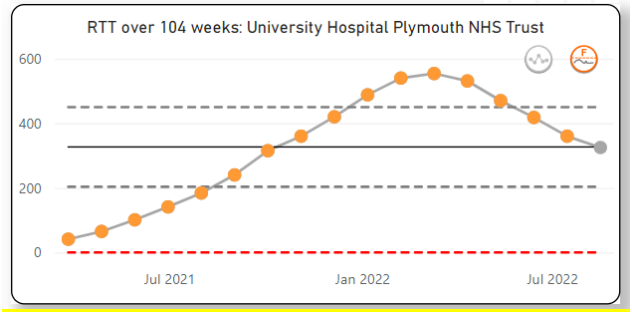
RDUH Operational Summary

- RDUH are currently forecasting 253 104 week waiters at the end of October.
- Current trajectory for November is 213 patients. This trajectory is updated weekly.
- Most challenged specialities are orthopaedics which will have 159 patients waiting at the end of October and colorectal surgery which will have 45
- Key risks to this position are, impact of urgent care pressure on bed base leading to elective cancellations, Covid staff sickness, and impact of blood guidance.
- Glanso lists are in place throughout November and December to support additional capacity at weekends. Key focus will be on Orthopaedics, ENT and General Surgery
- Key challenges: specialist surgeon capacity for complex colorectal patients & competing cancer demand, soft tissue knee, and spinal.
- Improving consultant capacity to facilitate soft tissue knee surgery to deliver by December



TSD Operational Summary

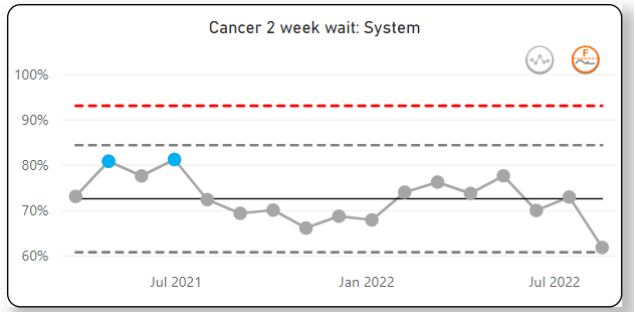
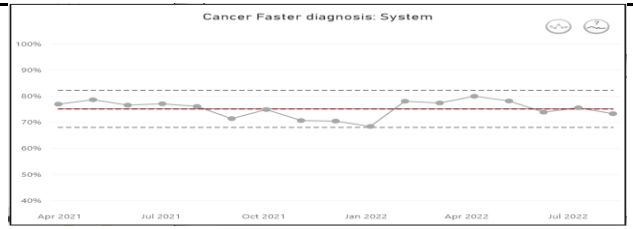
- TSD are currently forecasting 49 104 week waiters at the end of October 22.
- Current trajectory for November is a worsening position to 83 patients.
- Most challenged speciality is orthopaedics which will have 21 patients waiting at the end of October. There are also 14 patients on non-admitted pathways that will be waiting at the end of October.
- Patients continue to be booked, however covid and operational pressures have led to a fall in trajectory. Capacity has been confirmed for all non-P6 Orthopaedic and ENT patients, with other specialties still to be confirmed. Non-complex orthopaedic work is being supported by the Nightingale Hospital SWAOC.
- TCI capacity for all patients in orthopaedics and ENT in November has been confirmed however there remains an issue with patients choosing to wait longer for their treatment.



UHP Operational Summary

- UHP are currently forecasting 286 104 week waiters at the end of October 22. The trajectory is updated weekly.
- Current trajectory for November is 261 including 88 patients that will breach this standard in that month.
- Most challenged specialities are orthopaedics which will have 178 patients waiting at end of October and neurosurgery which will have 109. Plans are in place to treat 77 of these patients in November across both specialities.
- Insourced activity is increasing to improve long waiter trajectory
- Direct provider to provider mutual aid pilot with Schoen Clinic is in place additional
- Internal additional lists are planned in addition to increased validation of waiting lists.

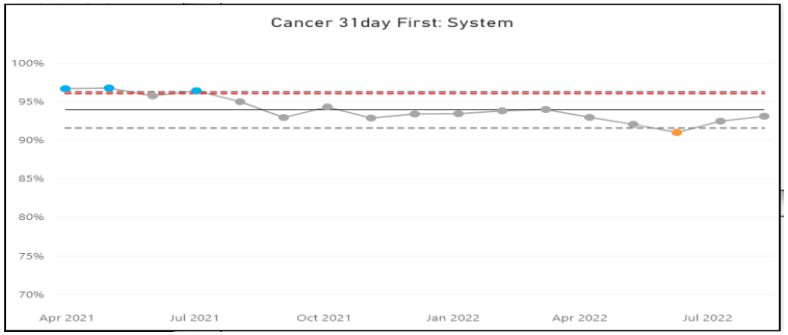
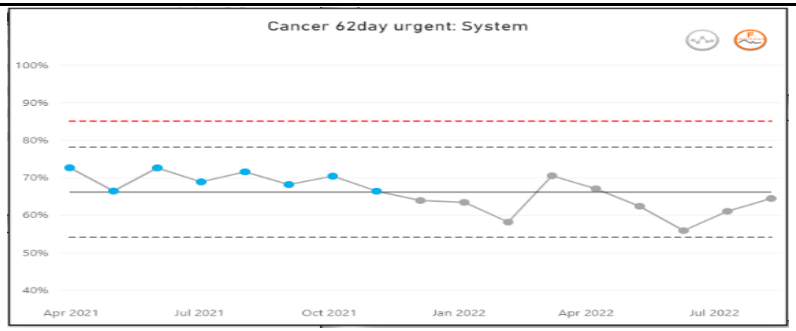
Cancer 2 Week Wait and 28 day faster diagnosis: System

Data	Analytical Summary
	• The Cancer 2ww metric is consistently failing the target, it displays common cause variation, there is no significant change nor indication of improvement in this system wide metric • Position – August performance 59.7% against an 93% standard. • Slight improvement for TSDFT but impacts of implementation of EPIC in NDDH affected the overall performance, where a planned reduction in activity through the go-live and reduced throughput in dermatology had particular impact.
	• The Cancer 28 day (faster diagnosis) standard for the system shows common cause variation as it oscillates around the target, achieving 72.47% in August against a 75% standard. • This performance is in line with the trajectory submitted within the 22/23 operating plan.

Operational Summary

- The three most challenged tumour sites for 2ww across the system are Lower GI, Breast and Skin.
- Caused by increased demand and capacity issues with endoscopy, LGI outpatients, breast radiology and dermatology outpatient capacity.
- Actions –
  - All Trusts being monitored in delivering imaging within the standard and are all achieving within 14 days. Performance against the 28-day cancer diagnosis standard is 72.5% against the national standard of 75%. This in line with the trajectories submitted in the 22/23 operating plan.
  - All Trusts have a cancer recovery action plan in place. Trusts, ICS, and Cancer Alliance meet weekly to actively monitor and mitigate issues as they arise. All Trusts are meeting the trajectories submitted in the 22/23 operating plan.
  - 2ww recovery includes partial redirection to a provider in Plymouth for LGI and implementation of the FIT (Faecal immunochemical Test) pathway.
  - Additional capacity for Prostate biopsies, endoscopy and gynae pathways is being commissioned through funding from ICB and Cancer Alliance.
  - Dermatology services are providing additional clinics and converting routine activity to 2ww to support reduction in backlogs.
  - The UHP and RDUH cancer pathway mapping process is complete, and the action plans and notes are currently being circulated for comments. The teams will then be working through the series of interventions identified, before agreeing timeframes for implementation.
  - TSDFT are supported by the NHSE Intensive Support Team focussing upon the recovery of the cancer targets (28 days, 31 days and 62 day).

Cancer 31 day first seen and 62 day Urgent: System

Data	Analytical Summary
	The Cancer 31day metric is currently failing the target, there is no significant change or indication of improvement in this system wide metric. Delays in booking surgery and delivery of oncology and radiotherapy continue have an impact on achieving this standard. For August performance was 93% against a 95% standard.
	The Cancer 62day metric is consistently failing the target, it displays common cause variation, there is no significant change or indication of improvement in this system wide metric. August performance slightly improved 66% against an 85% standard

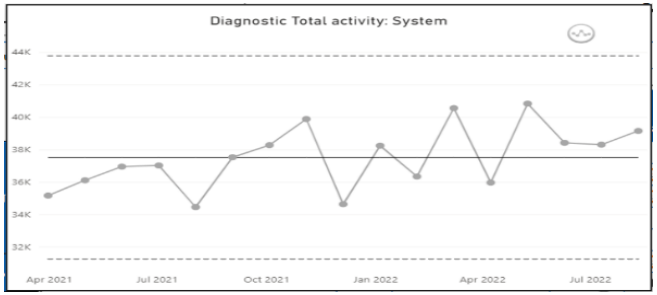
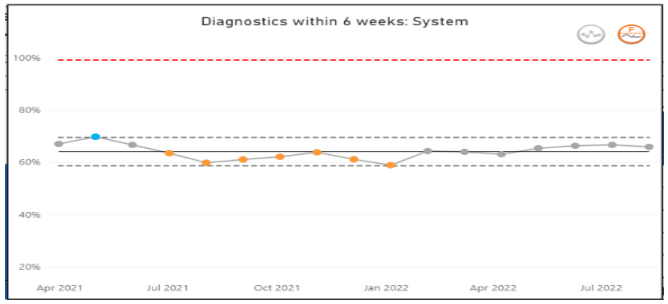
Operational Summary

- The two most challenged tumour sites in the system for this standard are Urology and Lower GI.
- Devon's 62 day performance was under pressure pre Covid and has not recovered post pandemic.
- Staff vacancy rates and service capacity, particularly within diagnostic elements of pathways are the primary cause of pathways not meeting the standard.

Actions:

- Additional trans perineal capacity (prostate pathway) commissioned from Nuffield to end of year for system began 3/10/22
- Successful finding request via cancer alliance £1.8m for mobile capacity to deliver trans perineal biopsies, cystoscopies and hysteroscopies across all providers, awaiting confirmed delivery date
- Approved additional prostate biopsy capacity for UHP. Start Nov 22 pending confirmation of equipment delivery providing an extra 50 biopsies per month.
- Expansion of a pilot in Northern Devon with independent sector for increasing dermatology capacity is being investigated
- Extended faecal testing pathway has been agreed to improve outpatient pathways in Lower GI.

Diagnostics

Data	Analytical Summary
	**Activity** The total diagnostic activity is yet to show significant sustained improvement, the variation to date appears to be common cause.
	**Performance** The system wide performance against the 6 week diagnostic standard continues to show common cause variation and is consistently failing the target. In August 65.8% was achieved against a target of 99%. The national target has been amended to 75% currently during post pandemic recovery.

Operational Summary

Narrative:
The most challenged modalities in the system for this standard are endoscopy and radiology imaging
The investment in Exeter Devon Diagnostic Centre (also known as CDC or Nightingale) has supported the performance remaining consistent across the year within imaging. Activity peaks show the impacts of Wait List Initiatives and weekend insourcing, mitigating external pressures upon demand and capacity.
A monthly activity report for the Community Diagnostic Centre (CDC) is produced and shared at Planned Care Board.
There are 15 modalities measured by this standard, not all modalities have received investment.

Actions:

- Endoscopy mobile unit now operational at Torbay maximising capacity towards 7 day working with insourcing on alternative weekends
- Capital bid for £1.7to provide a staffed unit at Tiverton for recovery to mitigate the effect of enabling works decision due 21/10/22
- Endoscopy funding request for £800k for additional endoscopy capacity awaiting approval in December
- Each Trust has a DM01 group that is working on achieving the set performance target of 75% and zero 26ww by end of March 2023

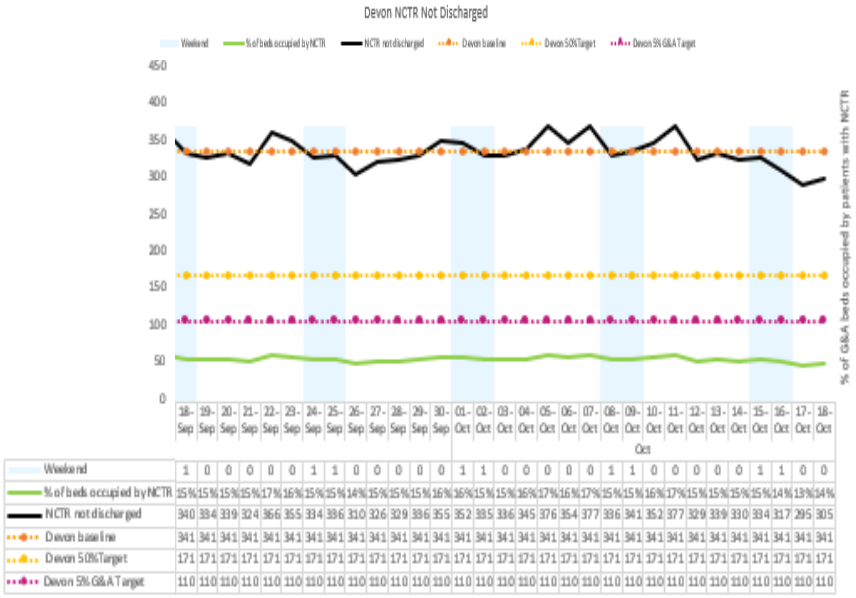
Hospital Discharge

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
No Criteria to Reside (NCTR)	5%	13/09/2022	15%		

KPI Description

% beds occupied by patients with no criteria to reside

Trend Chart



Analytical Commentary: Devon has agreed a target of no more than 5% (110) beds occupied by patients with no criteria to reside. As of 18th October, there were 14% (305) beds occupied across the acute trusts in Devon.

Operational Summary: Challenges and actions are split between simple and complex discharges:

Pathway 0 – Simple Discharges: Time of discharge remains a significant challenge within excess of 40% of patients being discharged after 5pm every day across all trusts. Actions to address this include:

- Promotion of Help me Home for Lunch initiative
- Criteria Led Discharge

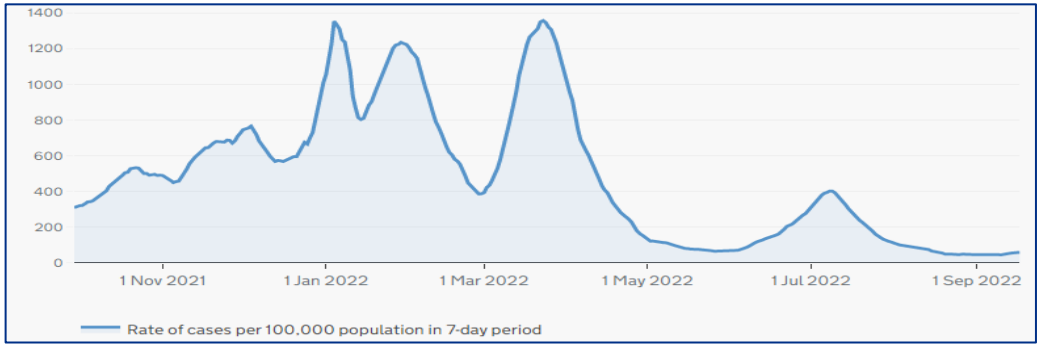
Delivery of these vary by trust, but trajectories show October delivery in most areas

Pathway 1-3 Complex Discharges:

- Demand & Capacity (community capacity creation) – investment of c.£9m in schemes to create beds ahead of winter. Locality level plans are in delivery/development. This additional capacity will support reduction of delays due to available social care market capacity, Delivery varies by scheme and area, but incremental mobilisation is November/December
- National Hospital Discharge Plan 100 Day Challenge – implementation of 10 initiatives proven to improve hospital discharge. Progress has been made across schemes, including the 4 areas previously scored red (now amber), and 2 areas now moved to green. Further progress to ensure delivery (or clear plan for delivery) required by 30/09/2022. Impact of this intervention has been a notable improvement in the proportion of individuals being discharged earlier in the day and a stronger proportion of discharges at the weekend compared to regional average position.

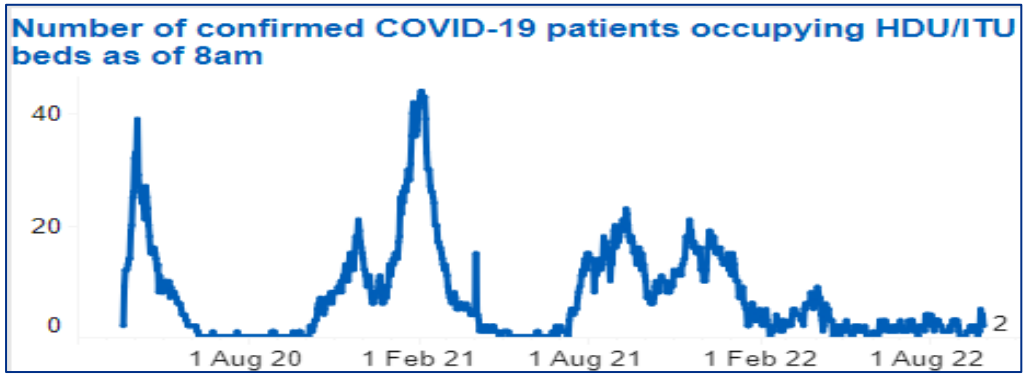
Covid Update

Covid infections are increasing again as we move into an Autumn wave that is likely to peak in November. Changes in national testing processes mean actual cases are likely to be significantly higher than the reported position.



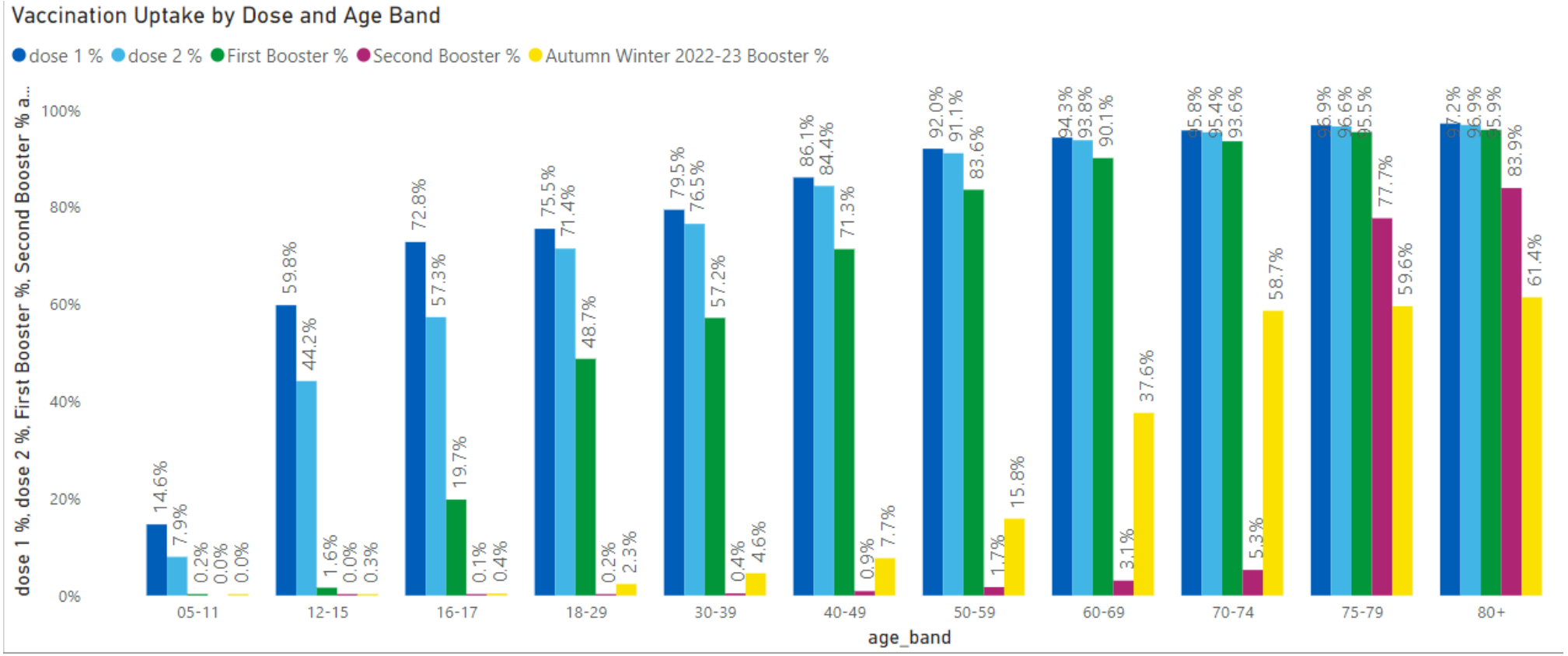
The number of Covid patients in hospital beds have reduced since the peak of 353 at the beginning of July down to a low of around 50 in early September. However, numbers have risen to 189 as of 28th September.

Covid patients in ICU continue to remain low. As of 28th September, there were 2 patients with Covid occupying an ICU bed.



Covid Update: Vaccinations

The focus of the vaccination programme is now on providing Autumn boosters. Good progress being made particularly for older age groups. 30.2% of over 80s and almost a quarter of 75-79 year-olds have now received their Autumn booster. (all figures as of 28th August)

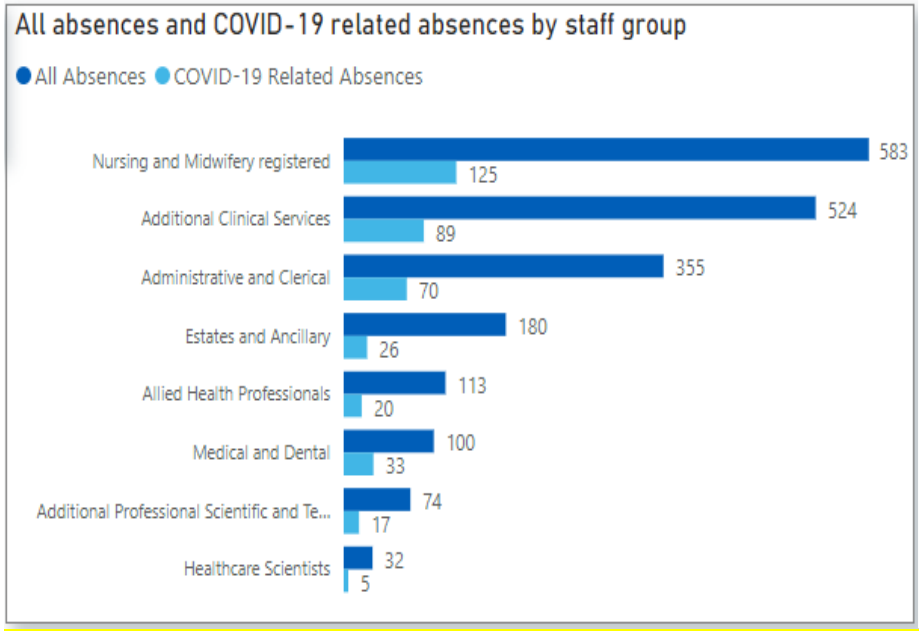


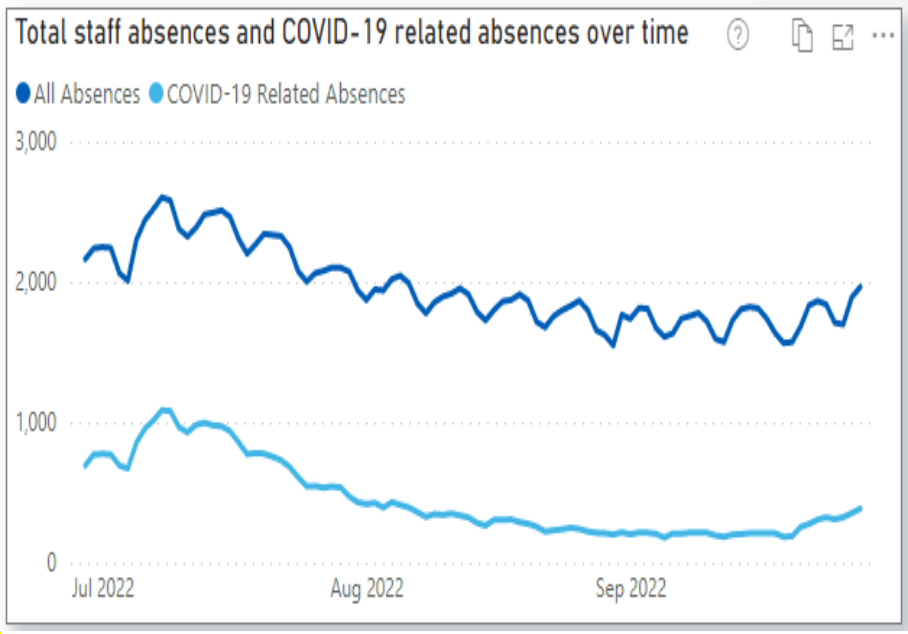
Covid Update (workforce absence)

Covid-related absences decreased at a steady rate since the middle of July across all providers, flattening at around 0.5% of working days in early September.

However, rates are now rising with latest figures showing 4.4% of staff are absent in total across Devon's providers, 1.1% of which were Covid-related (although still much lower than the 3% Covid absences seen at the start of July).

The level of both Covid and non-Covid absences are highest amongst the Nursing and Midwifery and Clinical Services staff groups





Primary Care: Clinical Activity

Theme: General Practice Clinical Activity Backlog

Underlying cause: Since the start of the pandemic a significant amount of General Practice activity has been deferred owing to both national directives (focusing on vaccination programme and those most in urgent need) and patients electing to postpone appointments to minimise attendance at clinical premises. This will inevitably have led to a backlog in clinical activity across primary care, although the extent of this backlog is not readily quantifiable.

Data: Whilst some activity can be measured and compared, e.g. 21/22 activity against 18/19 activity, the true backlog of the complexity of delayed presentations may not be possible to measure in its entirety. Work is ongoing with Business Intelligence (BI) to identify what data can be used.

Potential influence contributing to this clinical backlog may be attributed to workload shift. Workload shift continues to factor highly in incident reporting and NHS Devon continues to work with Primary Care and the LMC to fully understand this issue and continues to share this data and is awaiting further LMC intelligence and trends relating to this issue.

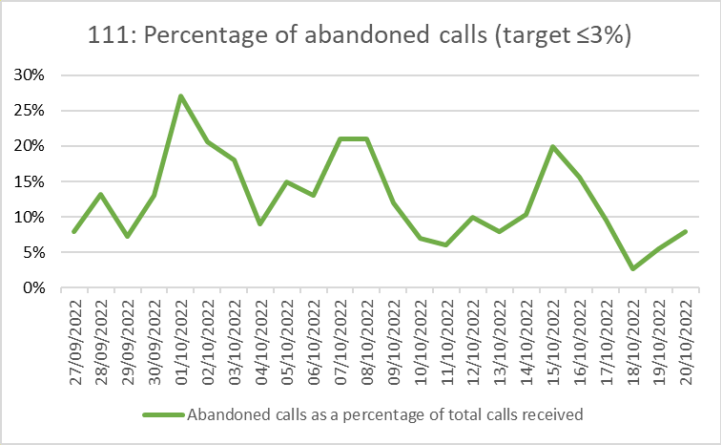
Primary Care: Clinical Activity

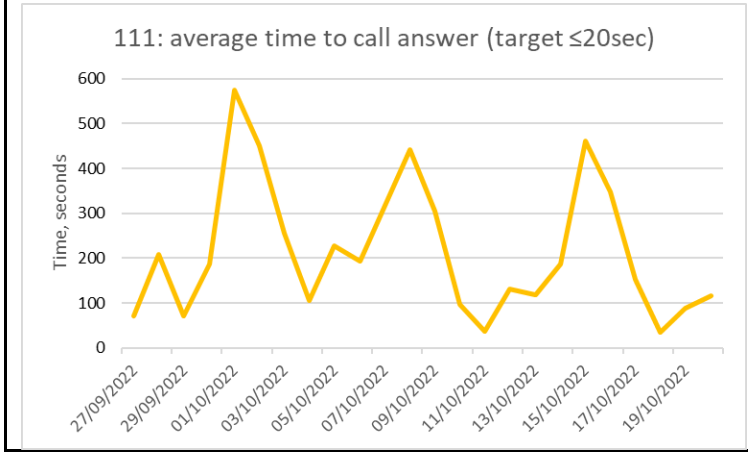
Actions undertaken in last month:	Impact:
Primary Care completed action to access BI Team to review quantification of activity data that could be utilised to monitor accumulation of delayed work, for example QOF (Quality Outcomes Framework), Public Health screening metrics, immunisation rates and referral activity. Further work to develop and present this data is planned.	Potential data sources identified to help identify backlogs. Once available, this data will be used to assess the extent of delayed services and plan improvement.
Re Devon Spring Action Fund (DSAF), practices received their balancing payments in September or October.	Additional financial support will enable practices to secure extra clinical sessions, from both existing staff providing additional sessions and locum practitioners.

Actions for next month/s:	Intended impact:	Date impact will be realised:
Continued work with BI to quantify outstanding practice and provision of services including review of LTC (Long Term Conditions) associated QOF data, comparing where possible to pre-pandemic levels.	Will support a system-wide understanding of the impact of COVID on clinical backlog in partner organisations; and identify the interdependencies and potential impact of system wide provision on other partners.	Ongoing, work will continue. During the next month, QOF data interrogation will be undertaken to enable some assessment of clinical backlog related to LTC management.
DSAF – 4 practices have outstanding queries prior to final payment of DSAF funding being made, these are being resolved at present. Some practices have not been able to spend their original allocation and in these cases a clawback will be enacted.	Additional financial support has enabled practices to secure extra clinical sessions, from both existing staff providing additional sessions and locum practitioners.	Once all claims have been finalised it will be possible to look at the number of sessions that have been funded.

Integrated Urgent Care Service: NHS 111

Data





Introduction

Practice Plus Group (PPG) started delivery of the new Integrated Urgent Care Service (IUCS) contract on Tuesday 27 September, following their successful competitive tender for the service.

Initial Reporting

Due to the early stages of the contract, it is difficult to forecast future performance. However, early indicators suggest that the service is performing relatively well against key performance metrics.

Average percentage of abandoned calls is currently at 14.18%. Whilst higher than the target of 3%, last year, performance in October was at 40%.

The average time to call answer is currently at 225 seconds. At the same point last year, average time to call answer was over two and half times longer at 626 seconds.

The service has been operational for less than 4 weeks therefore datasets with the wider range of services will be available soon.

Mental Health: System Overview

Key Performance Indicator	Target	Actual	Variation	Assurance
Community Mental Health access (2+ contacts)	N/A	16,190		N/A
Children & Young People's Access (1+ contacts)	12,514 (Q1)	12,025		
Children & Young People Eating Disorders routine cases	95%	50.36%		
Children & Young People Eating Disorders urgent cases	95%	85.71%		
Dementia Diagnosis Rate	66.7%	55.3%		
IAPT Access	9,310	7,144		
IAPT Recovery	50%	52%		
IAPT – first appointment within 6 weeks	75%	94.13%		
IAPT – first appointment within 18 weeks	95%	100%		
Early Intervention in psychosis (EIP): Proportion entering treatment waiting two weeks or less	60%	67.19		
Individual Placement and Support (IPS) access	300	397	N/A	N/A
Perinatal Access Rate	10%	8.52%		
Physical health checks for people with severe mental illness (SMI)	60%	36.6%		
Inappropriate out of area bed days	0	479		
Annual health checks for people with a learning disability	75%	72%		
Reducing the number of adults with LD in specialist inpatient beds	31	10		
Reducing the number of CYP with LD in specialist inpatient beds	7	0		

Analytical Summary: This month has seen a deteriorating position against half the metrics across the system. There is varied assurance in the system with aligned CYP targets showing deteriorating performance, IAPT maintaining common cause variation and areas such as perinatal access showing improvement.

The next slides focus on providers performance against the following metrics: Severe Mental Health Illness – Physical Health Checks, CYP eating disorders and inappropriate out of area placements.

Data as at June/July 2022.

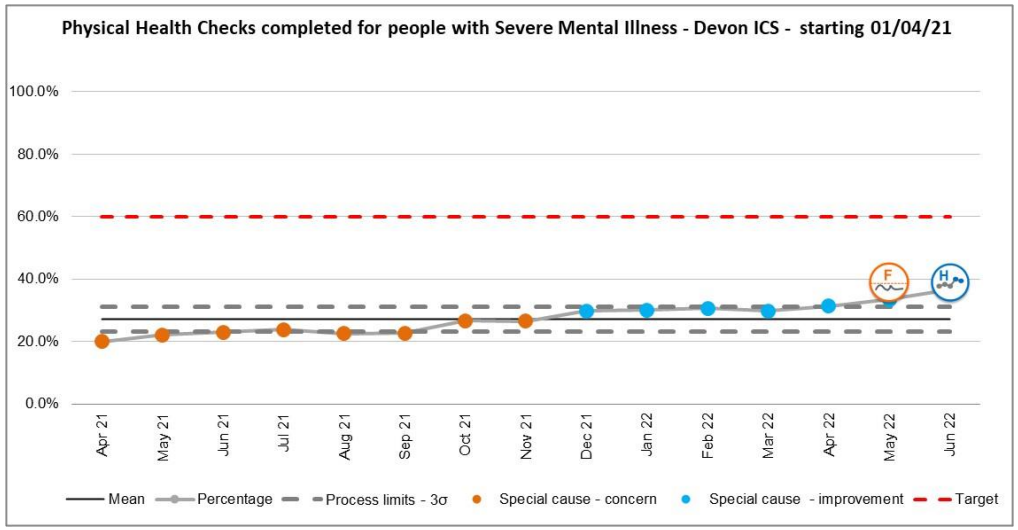
Mental Health: Severe Mental Illness – Physical Health Checks

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Physical health checks for people with severe mental illness (SMI)	48.9% (Q1)	Jun-22	36.59%	H	F

KPI Description

Percentage of people with severe mental illness (SMI) to receive the complete list of physical health checks in the preceding 12 months.

Statistical Process Chart



Analytical Commentary

The measure is showing special cause of an improving nature but is consistently failing the target.

Operational Summary

NHS England identified a target of 60.0% of people with SMI accessing physical health assessments in 2022/23. ICS Devon submitted a trajectory to reach this by the end of quarter 3.

As of June 2022, nationally performance against the target is at 72.5% of the expected level. Regionally performance against the monthly access measure is at 78.5% of the expected level. ICS Devon's performance against the national target is 61.1%.

As of July 2022, ICS Devon is underachieving against the quarter 1 and quarter 2 trajectory expectations.

Actions and Assurance

Monthly trajectory and recovery plan in place which includes:

- Utilising additional capacity through our commissioned independent provider to increase access
- Targeting the component of the check that is preventing achievement of all six components to meet the target

Additional capacity to become increasingly operational and the other actions start to demonstrate impact.

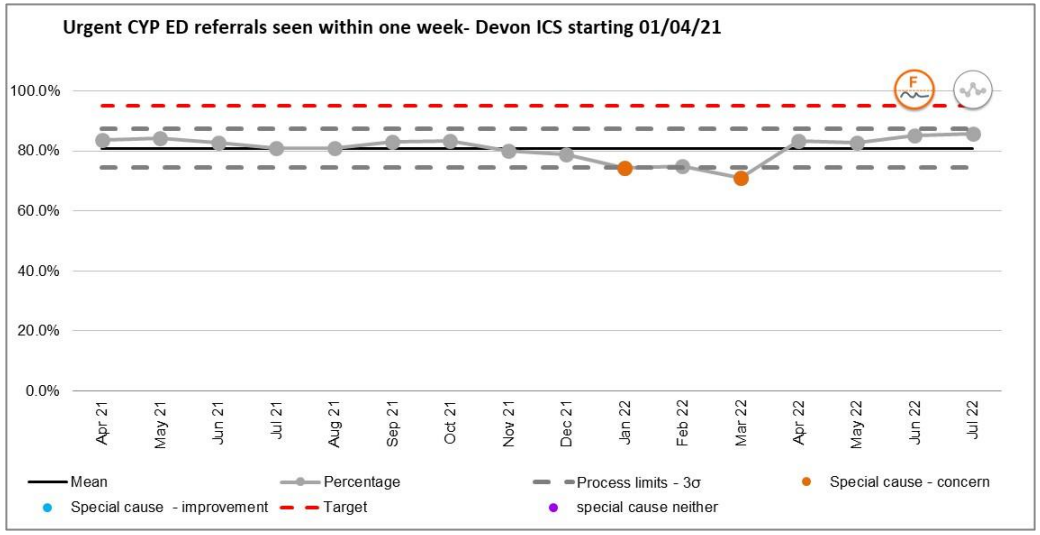
Mental Health: CYP Eating Disorders Urgent

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Children & Young People Eating Disorders urgent cases	95% (national) 85.7% (system)	Jul-22	85.71%		

KPI Description

The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment.

Statistical Process Chart



Devon ICS = 6/7 (85.71%)
CFHD = No urgent referrals received
Livewell = 6/7 (85.71%)

Analytical Commentary

This KPI is within common cause variation with an upward trend. The KPI is expected to consistently fail without intervention.

Operational Summary

In 2021/22 ICS Devon has not achieved the wait time standards for urgent or routine CYP ED services. This is related to increased demand and acuity reflected nationally and challenging recruitment conditions. CYP ED routine access rates in July-22 are exceeding the expected level for Q2 based upon the 2022/23 operating plan.

Actions and Assurance

Plans to support achievement of these deliverables will be monitored through the CYP EHWB Programme Area to monitor and assure delivery and improved performance proceeds as planned.

As per the agreed Mental Health Operating Plan for 22.23, providers continue to implement recruitment plans for community based eating disorder pathways in CAMHS.

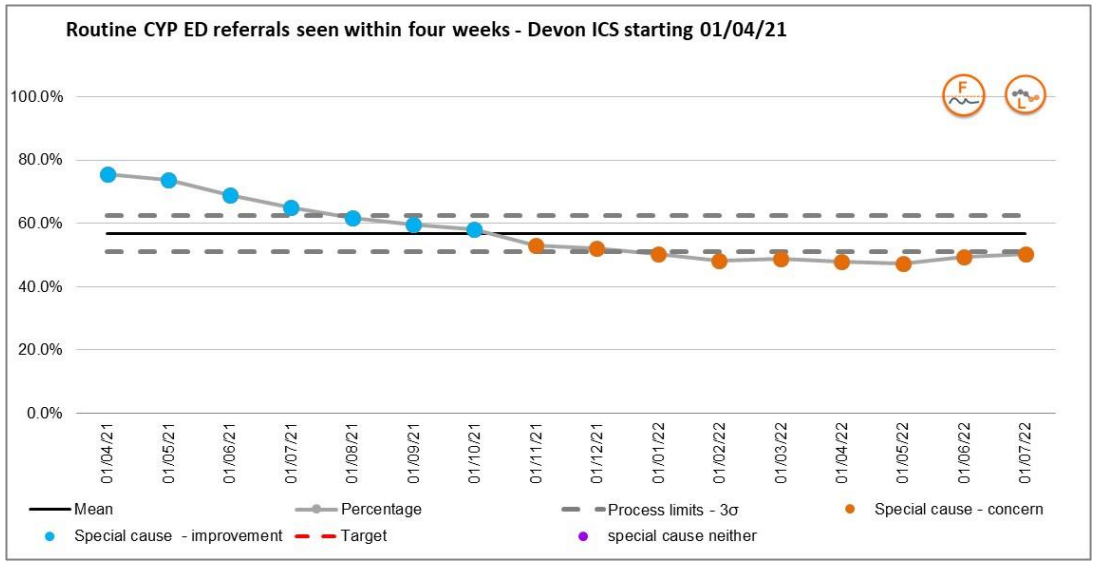
Mental Health: CYP Eating Disorders (ED) Routine

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Children & Young People Eating Disorders routine cases	95% (national) 46% (system)	Jul-22	50.36%		

KPI Description

The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment. Rolling 12-month target.

Statistical Process Chart



Devon ICS = 140/278 (50.36%)
CFHD = 90/213 (42.25%)
Livewell = 50/65 (77%)

Analytical Commentary

This KPI is experiencing special cause variation of a concerning nature and will consistently fail the target unless a process change is implemented.

Operational Summary

In 2021/22 ICS Devon has not achieved the wait time standards for urgent or routine CYP ED services. CYP ED routine access rates in July-22 are exceeding the expected level for Q2 based upon the 2022/23 operating plan.

Actions and Assurance

Plans to support achievement of these deliverables will be monitored through the CYP EHWB Programme Area to monitor and assure delivery and improved performance proceeds as planned.
As per the agreed Mental Health Operating Plan for 2022/23, providers continue to implement recruitment plans for community based eating disorder pathways in CAMHS. CYP who are waiting to access this service are supported whislt waiting to monitor and manage the risk of harm and to help prepare them to engage with the service when it is available.

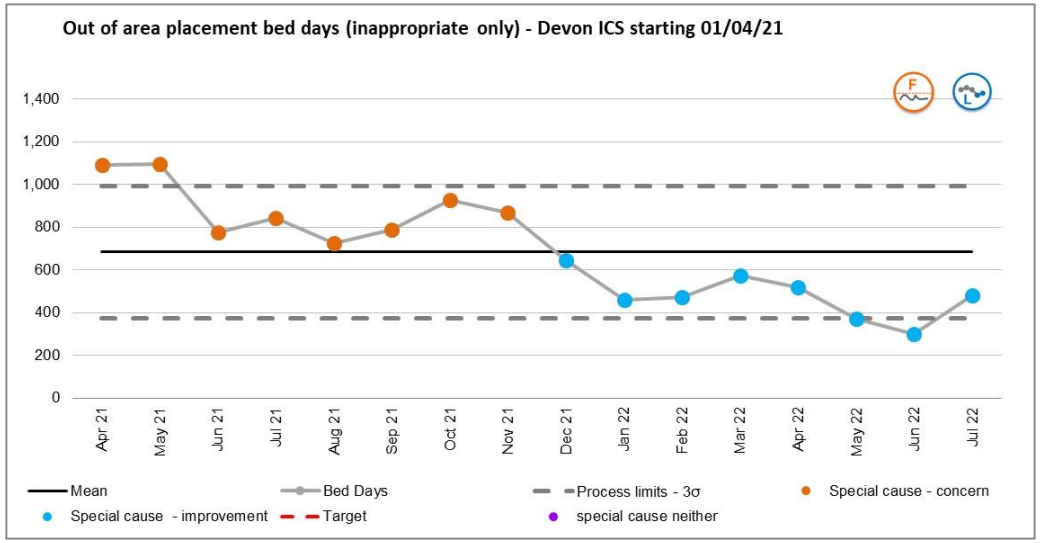
Mental Health: Out of Area Placements/Bed days

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Inappropriate out of area bed days	0	Jul-22	479		

KPI Description

The total number of days in which patients have been placed out of area due to unavailable beds in their usual network.

Statistical Process Chart



DPT = 235 bed days
Livewell SW = 244 bed days

Analytical Commentary

The measure is showing special cause improvement with a run of eight points below the mean and close to the lower process limit.

Operational Summary

At the end of June ICS reported 8 adults placed out of area inappropriately. This represents significant progress towards the elimination of inappropriate out of area placements at a time of increased pressure in bed-based care in the system and across the Southwest and in the context of increases nationally. The ongoing impact of Covid across the Southwest will impact upon achievement of the planned trajectory.

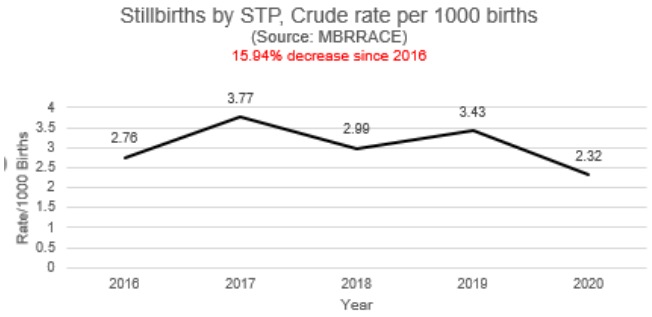
As per the ICS Devon Mental Health Operating Plan for 22.23, providers are:

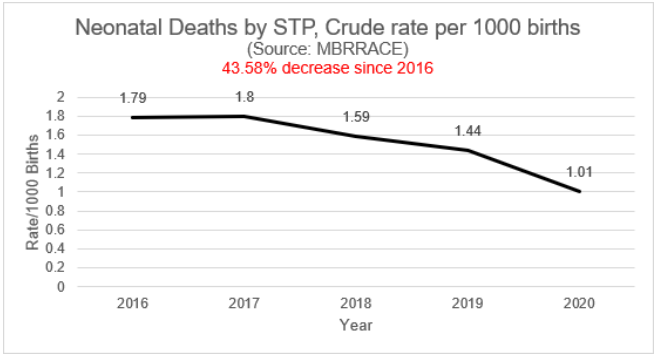
- implementing peer/senior clinician reviews at length of stay trigger points in DPT.
- Evaluating the model ward pilot (aligning local beds to local people).
- Initiating a 'Right to Reside Review' in the LSW footprint
- In addition, supplementary bed-based capacity is being introduced in the Winter period to manage demand.

LMNS (Local Maternity and Neonatal System) update

Key Performance Indicator	Target/Plan	Actual	Variation	Assurance
Stillbirth & Neonatal Death	Stillbirth: 1.38/1000 births by 2025 Neonatal Death: 0.89/1000	2.3/1000 stillbirths 1.44/1000 neonatal deaths	-	NA

KPI Description: 50% reduction in stillbirths & Neonatal deaths by 2025 (based on revised 2016 LTP baseline)





Latest Period: Stillbirth & Neonatal Death to 2020

Analytical Summary

Latest MBRRACE publication (2022 pub. for 2020 data) indicates that Devon has met & surpassed the interim ambition of 20% reduction in neonatal deaths. Although it has not met the ambition for a 20% reduction in stillbirths.

Operational Summary

Transformational activities that are targeted to reduce stillbirth & Neonatal Death include:

Smoking cessation: Delayed. Smoking at delivery rates may remain high without implementation of specialist smoking cessation services; the number of women and birthing people with increased risk of stillbirth and neonatal death will remain at a high level. Delays due to workforce levels.

Saving Babies Lives Care Bundles: On track. Recommendations made to reduce risk of stillbirth and neonatal death have been met in all Trusts. Sonography capacity is a risk. Preterm birth rates for Jun21-Jun22 are an average of 6.4% for Devon, slightly above the 2025 target.

Ockenden Report (Interim): On track. Recommendations to improve maternity safety have been implemented in all Trusts.

Continuity of Carer: Delayed. Enhanced Continuity of Carer will be delayed for famillies for whom it would reduce the risk of adverse outcomes. National targets and ambitions have been removed in response to insufficient workforce levels. Scoping underway to understand what developments will continue locally.

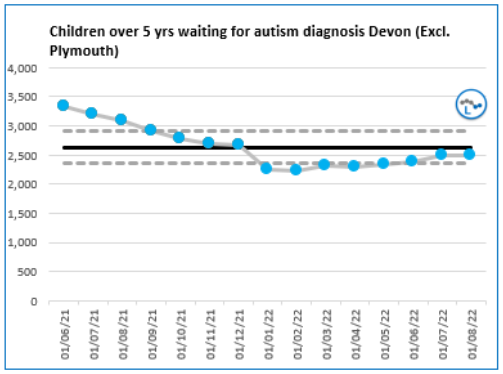
Inequalities: Initiation. An equity and equality plan (5 years) has been produced to reduce the impact of inequalities that lead to adverse outcomes including stillbirth and neonatal death. This is currently under review by NHSE.

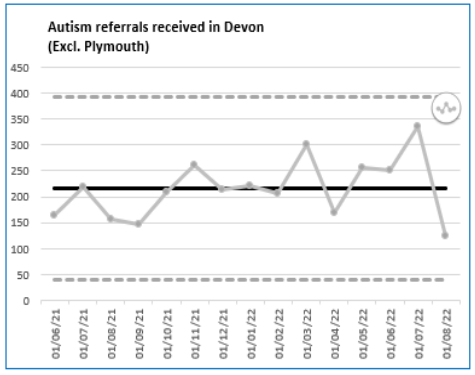
Children & Young People (CYP): Autism Diagnosis waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Autism Diagnosis	< 18 wks.	Aug 2022	84.3 wks.	L	F
Autism Diagnosis	NA	Aug 2022	NA		NA

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

Statistical Process Charts – Devon & Torbay





Average wait = 84.3 weeks
Longest wait = 176 weeks

Analytical Commentary
Whilst the metric is currently experiencing Special Cause Variation of an improving nature, average wait times are four times greater than target. Process/delivery change is required for improvement.

Operational Summary – Devon & Torbay

What are the causes?

- Now action- urgent escalation meeting agreed with CFHD to set new trajectories within existing resources and to clarify workforce plans
- Short-term: new model for Neurodiversity developed- priority aligning diagnostic pathways across paediatrics and CAMHS - 1st workshop 11th November
- Medium-term: new model for Neurodiversity developed – strengthen universal offer to minimise harm through enhancing key worker provision and strengthening education, health and care pathway.
- Joint clinics running for pre-schoolers between CFHD and TSDFT seeing CYP from Community Paediatric waiting list.
- Promotion of workshops and resources available for families on waiting list and those post assessment.

Is there any risk/harm caused to children by waiting longer?

- CYP and families do not know what support is available or are unable to access it due to not having a diagnosis.
- 'Requests for Help' are triaged to identify children at risk and prioritise as appropriate.

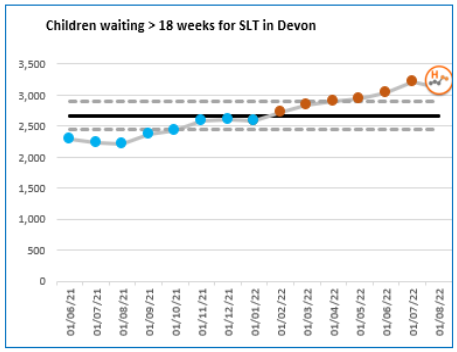
<u>When will we see an improvement?</u>
Trajectory 31st March 2023 will not be met. Review with provider for those waiting >18, 52, 104 wks. Strategic long term Neuro Diversity improvement plan over 5 years.

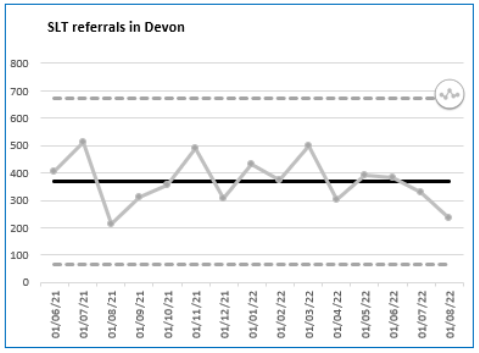
Children & Young People (CYP): Speech & Language waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Speech and Language waiting times	< 18 wks	Aug 2022	34 weeks		
Speech and Language referrals	NA	Aug 2022	NA		NA

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

Statistical Process Control Charts – Devon, Torbay and Plymouth





Average wait: 34 weeks
Longest wait = 103.65 weeks

Analytical Commentary:

Wait times: Metric is currently experiencing Special Cause Variation of a concerning nature and the position is deteriorating. Process/delivery change is required for improvement.

Operational Summary – Devon, Torbay and Plymouth

What are the causes?

Continued workforce vacancies, recruitment issues reduced clinical capacity. Increased demand for Requests for Help (referrals) at Getting Advice and Getting Help stage impacting on capacity to complete assessments.

What are we doing/what are the challenges?

CFHD - 12 month non recurrent funding from DCC being used to recruit 8.85 wte to focus on those waiting >18 wks; >35 wks; >52 wks (4 wte recruited). Implementation of agreed action plan to triage, risk assess, offer and deliver appropriate intervention or assessment as appropriate

Livewell – numbers waiting including long waiters (>52 wks) gradually reducing. Business case for 6wte additional SLTs in development.

Is there any risk/harm caused to children by waiting longer?

Potential for poor development of language and communication skills. 'Requests for Help' are triaged to identify children at risk and prioritised as appropriate.

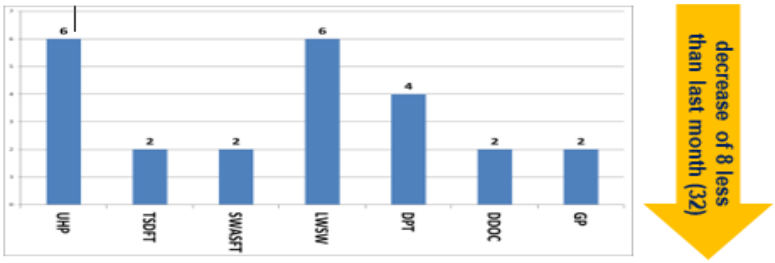
When will we see an improvement?

CFHD trajectory for DCC funded planned improvement by August 2023. Service trajectory including Torbay requested. Livewell trajectory due October.

Quality

Serious Incidents

During September 2022 there have been **24 serious incidents** reports, these are broken down by Provider in the chart below:



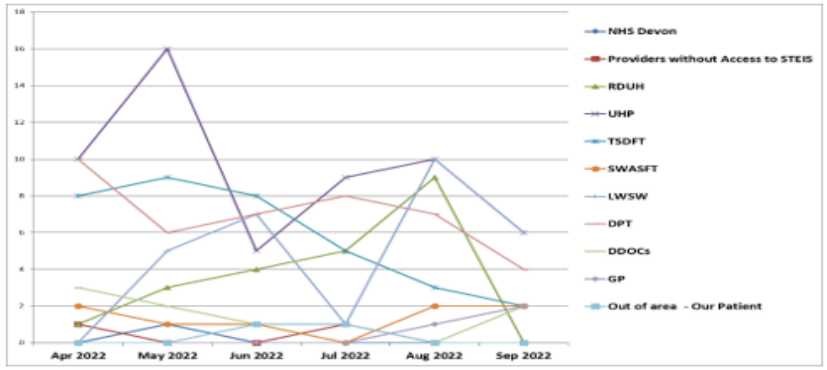
There were **no never events** reported in **September 2022.** However, since April 2022 there have been **11 never events reported**, which is a significant increase compared to the same period last year (3). These will continue to be monitored by the SST.

The **top five Serious incident** types reported in September 2022 were:

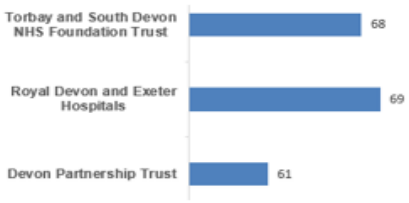
- Apparent/actual/suspected SI self-inflicted harm (7)
- Slips/trips/falls meeting SI criteria (4)
- Treatment delay meeting SI criteria (3)
- SI - Diagnostic incident including delay (3)
- Pending review for category (2)

There are currently 18 open serious incidents that have been identified as multi-agency. These are being investigated jointly to help improve identify what went wrong throughout the patient's care leading up to the incident. This also enables joint learning across Providers.

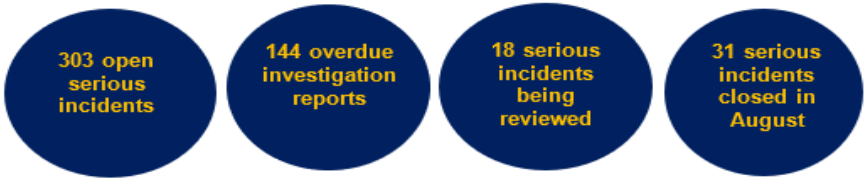
The below chart shows the number of **reported serious incidents** since April **by Provider:**



The total number of **overdue investigation reports** that have not yet been completed and submitted to the ICB remains a concern for the ICB. The safety systems team are continuing to provide support to all providers in reducing their overdue incidents. The three Providers that have the highest % overdue are shown in this diagram.

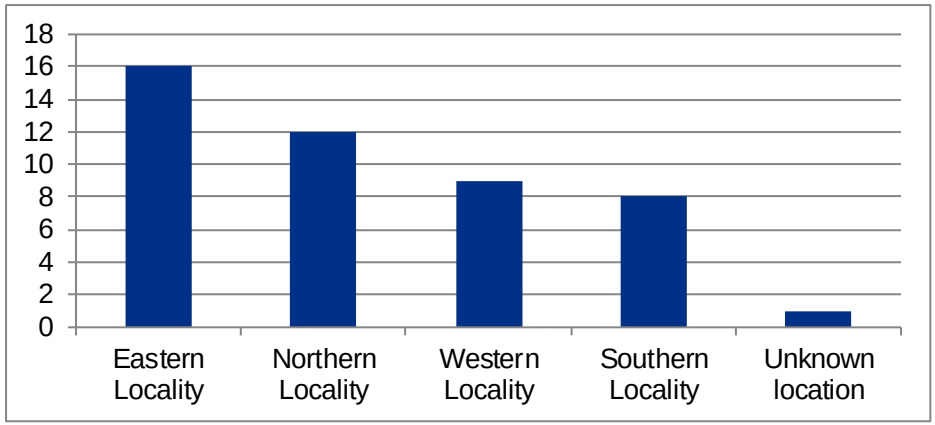


Current SI status



Peer Improvement Tips for Care and Health (PITCH)

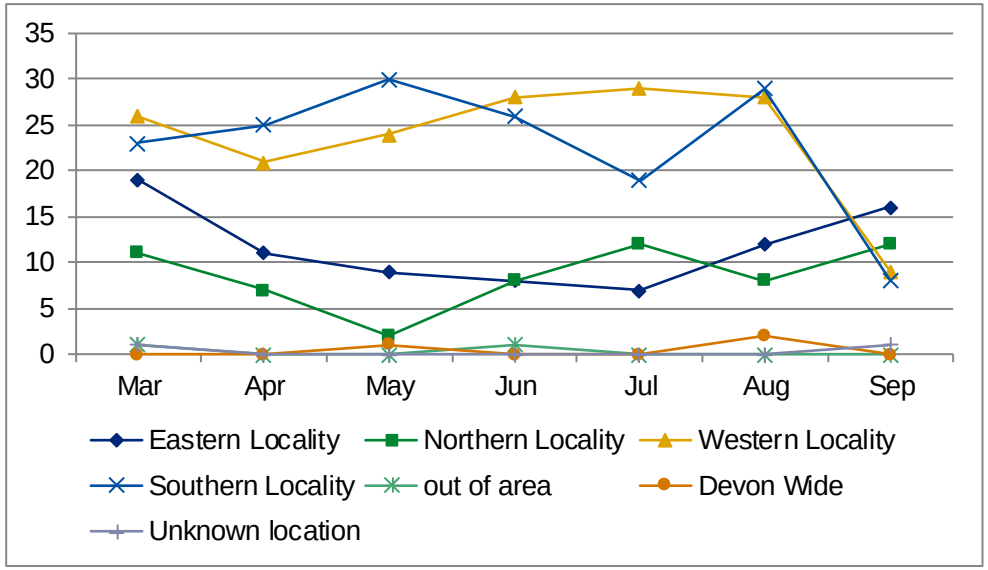
During September there have been **46 PITCHs** reported, these are broken down by locality in the chart below:



The **top three PITCH concerns received in** September were:

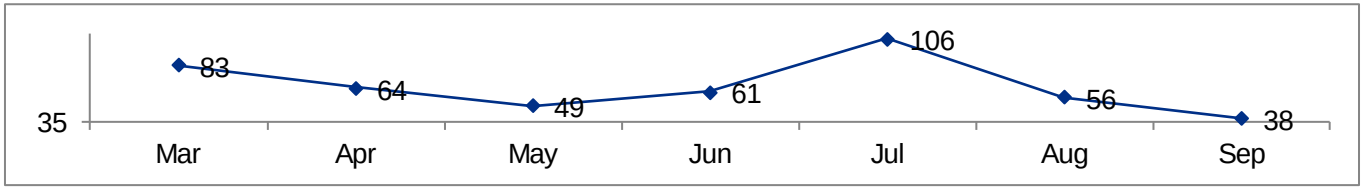
- Unsafe discharge (10)
- Referrals (7)
- Communication/Discharge Summary (8)

The below chart shows the number of **reported PITCHs** since March **by locality:**



PITCH submissions were low in September compared to previous months, due to small numbers reported during the week of mourning the Monarch's passing and partly due to a system issue for 10 days with the PITCH form, which has now been resolved. Recent trending of concerns being reported relate to 111 services transitioning to PPG and unable to get through to the service provider. Approximately half the unsafe discharges relating to medication and clarity on the care a patient needs after discharge.

During September 38 PITCHs were closed compared to 56 last month. The chart below illustrates the number of closed PITCHs per month since March 2022:

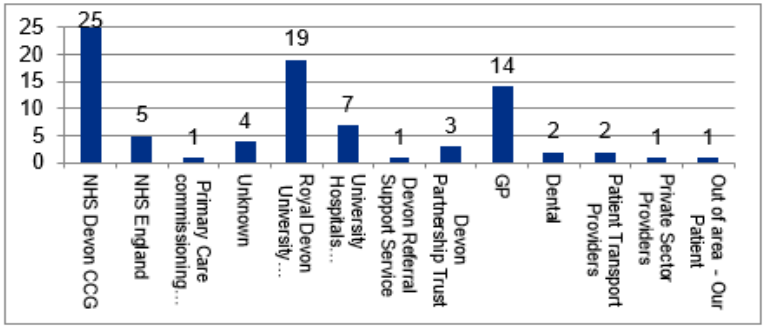


75 open PITCHs remain open

Priority next month – Processing and sharing themes

Patient Experience (NHS Devon): Patient Contacts

During September there were **85 new patient experience** feedback and concerns to manage, these are broken down by Provider in the graph below:



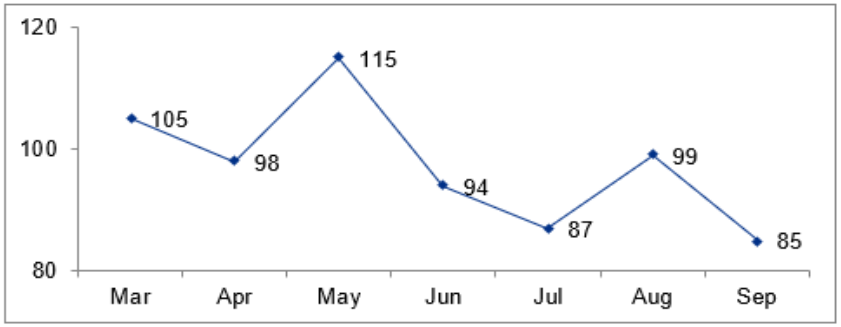
The **top three patient experience concerns received in** in September were:

- Quality of Care (12)
- Access to Services (10)
- Other (10), varying subjects from vaccines to commissioning services

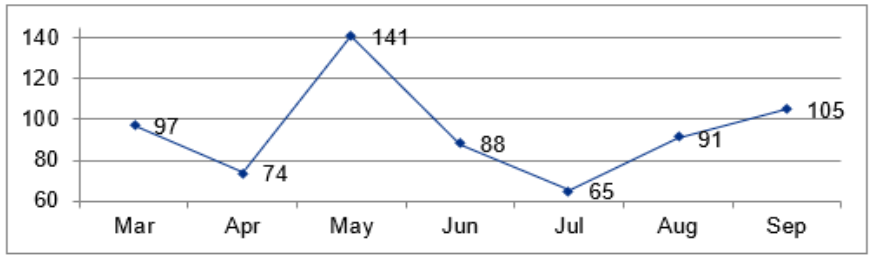
Continued focus on ADHD/Autism services, particularly care after 'right to choose'. Increased contact regarding lack of menopause clinic services in Devon, including GP inequity in treatment and knowledge.

- No **formal complaints** were raised during September for the ICB.
- There has been **1 contractual review received** and in progress, which are required and form part of Primary Care complaints which are managed by NHS England.
- There is **1 request for information** from the **Parliamentary Health Care Ombudsman (PHSO).**

In the last 4 months volumes of **patient experience concerns** have stabilised to a monthly average of 91 cases. This is a reduction from the second quarter of this year, however, remains higher than 2020/2021.



In August, the team closed **105** patient experience concerns as shown below:



Safeguarding: Adult Enquiries

Issue: The Safeguarding Adult Team has robust internal processes to ensure system oversight of themes and trends arising from Safeguarding Adult Enquiries (Section 42.2) and learning is shared to drive improvement across the health community.
Safeguarding Adult Enquiries (Section 42.2) are undertaken when concerns about abuse and neglect within health care settings are raised. Learning will be identified in the process. The statistics below are in relation to new S 42.2's caused out by the 3 Local authorities in Devon for the month of August 2022 and the primary themes of the concerns.

Data	Underlying cause

Local Authority	Total number of S 42.2 enquiries	Change	Poor Quality of care	Discharge	Pressure Ulcers	Medication
Devon	3	↓7	1	1		1
Torbay	1	↓5	1			
Plymouth	1	↓2			1	

There has been a decrease in the monthly number of concerns from 19 in July 2022 to 5. Concerns vary with each enquiry, but themes include: -

- A decrease from 6 to 2 where there was poor quality of care.
- No new allegations relating to Person in a Position of Trust (PiPoT)
- Poor discharges have reduced from 3 to 1.
- Both Medication and Pressure Ulcers have been identified as two areas of concern that were not present in July
- Communication didn't feature in any of the new cases.

Actions undertaken in last month	Impact
To mitigate risk providers undertake immediate actions as required when the concern is raised. Both the medication and pressure ulcer concerns were identified after discharge from acute hospitals. Pressure Ulcer with either grade 3 or 4 skin damage are also reported as serious incidents	Identification and sharing of learning from Enquiries to enable improvements in service delivery.

Actions for next month/s	Intended impact	Date impact will be realised
Work with local authority, provider and ICB colleagues in relation to identified themes and trends.	Improved quality of care and experience for users of healthcare services	ongoing

Safeguarding: Children in Care (CIC)

Issue: The inconsistencies in provider reporting across the system, means that we are unable to provide an accurate or consistent data set. This is coupled with late notifications and requests for health assessments by the local authorities.

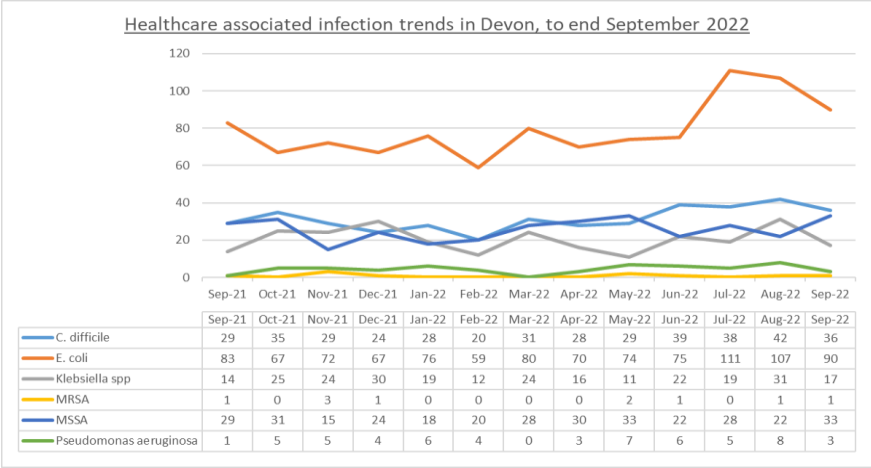
Underlying cause
Each provider submits performance data in a different format. Initial Health Assessments have historically not had a clear process. Data flows from the Named Doctor to the Designated CIC team and relies on established professional relationships and not reported via contracting arrangements. Review health assessment data is reported via contracting processes with each provider submitting data sets on their own developed templates. All data then relies on the Designated Professional team to collate, analyse and report on the nine separate data performance reports. Current delayed notifications and requests for health assessments from the local authorities reduce the time providers have to complete and return health assessments within statutory timescales.

Actions undertaken in last month	Impact
Outcome framework measures for CIC for community providers have been reviewed and updated in preparation for discussions with children's commissioners and providers. Meeting booked for these discussions. The submitted business plan for a project lead to standardise IHA and RHA data flow is in progress and led by children's commissioning team. Designated Doctors have developed a standard IHA reporting form which will need a system process to support. A report has been completed to give a comprehensive oversight of present challenges with suggested recommendations.	Delayed impact as a whole system approach needs to be centralised with protocols developed. Individual areas are working with Designated professionals and the local authorities to improve notification process. This work is still ongoing.

Actions for next month/s	Intended impact	Date impact will be realised
1. Data set reporting to be agreed with providers and commissioners. 2. ICB to have an agreed protocol for how IHA and RHA data is managed and processed. 3. Project lead to commence work.	To have a centralised process for IHA and RHA performance data, with accurate, consistent data sets and reporting.	December 2022

Infection Prevention and Control

Theme: Healthcare associated infections trends and national ambitions

Data	Infection Highlights
	*E. coli* numbers have risen over the summer months, especially in community onset cases and predominantly in areas with an older population (Torbay). This is consistent with previously observed seasonal increases in *E. coli,* with hydration status in hotter weather a likely factor.
	Influenza (seasonal and avian)
	The vaccination programme for seasonal flu is under way, and weekly monitoring meetings have been set up to identify emerging issues with the vaccine rollout. A change of provider for antiviral prophylaxis in flu outbreak situations is underway, with a new contract in train and a bridging process in place.

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
C. difficile	29	35	29	24	28	20	31	28	29	39	38	42	36
E. coli	83	67	72	67	76	59	80	70	74	75	111	107	90
Klebsiella spp	14	25	24	30	19	12	24	16	11	22	19	31	17
MRSA	1	0	3	1	0	0	0	0	2	1	0	1	1
MSSA	29	31	15	24	18	20	28	30	33	22	28	22	33
Pseudomonas aeruginosa	1	5	5	4	6	4	0	3	7	6	5	8	3

Actions undertaken in last month	Impact
Antiviral prophylaxis recommissioning.	Antiviral prophylaxis contract near completion, with bridging process in place.
Setting up and chairing of community flu group.	Monitoring of primary care and pharmacy vaccine rollout.

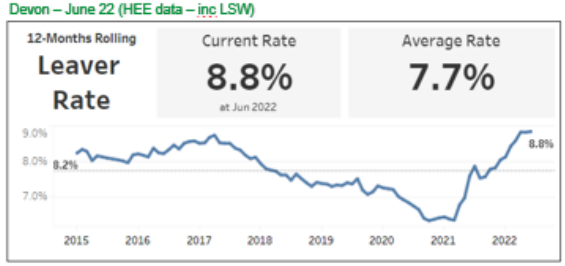
Actions for next month/s	Intended impact	Date impact will be realised
Antimicrobial resistance group to restart, with potential joint working with Cornwall.	System antimicrobial resistance workstreams, sharing of good practice.	November 2022.
Engagement of care & residential home staff with infection prevention education.	Improved infection prevention knowledge among care home staff, improving patient outcomes, reducing emergency department attendances, reducing outbreak duration.	December 2022.

Workforce

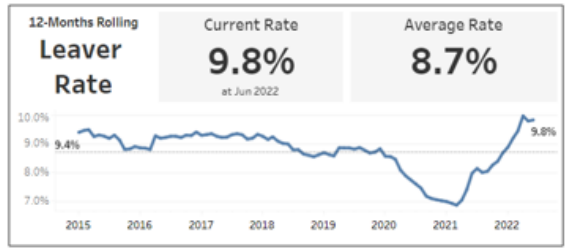
Workforce: Metrics

Leaver rate (leavers outside the NHS)

Devon – June 22 (HEE data – inc LSW)



South-West – June 22 (HEE data)



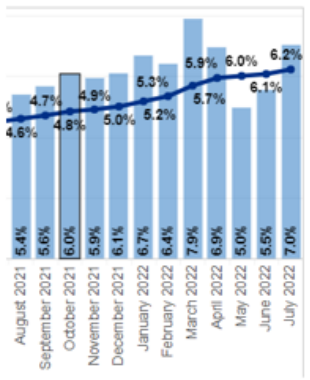
Turnover rate (leavers including to other Trusts)

Devon – June 22 (HEE data – inc LSW)

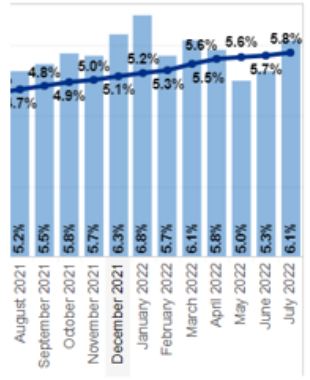
South-West – June 22 (HEE data)

Absence

Devon (HEE data)



National (HEE data)



Sickness Absence Rate by Month and 12 Monthly Rolling Rate

Vacancies

Aug 22 (inc LSW) – local data

Total vacancies for ICS - Aug 2022				
This month vacancies	Previous month vacancies	This month previous year vacancies	Vacancies as % of funded establishment	Substantive WTE
2,216.79	2,479.72	1,650.21	6.55%	31,650.16

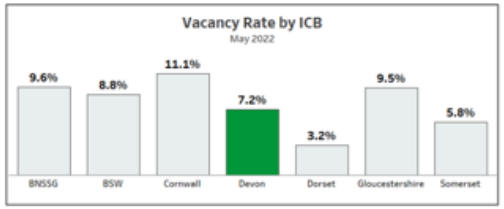
Consultant: 127 wte ↑

Nursing 705 wte ↓

AHP 320 wte ↓

HCA 348 wte ↑

Trust data (not inc Primary or Social Care)



Spend £ against operational plan 22/23

April 22 – July 22 – local data

	Plan YTD	Actual YTD	Variance	M12 plan
Agency	£12,026M	£21,060M	(9,034)	28,034
Substantive	£573,379	£580,011	(6,632)	1,376,702
Bank	£32,928	£36,298	(3,370)	73,988

NB: LSW did not complete operational plan submission, so unable to track wte or £ against plan

WTE against operational plan 22/23

Aug 22 – local data

	Plan M5	Actual M5	Variance
Substantive	29,952 wte	29,401 wte	551
Bank	1,532 wte	1,882 wte	(350)
Agency	380 wte	523 wte	(143)

Workforce: Workforce Strategy

Strategic Workforce Planning

Minimum Viable Product (MVP) scoping for Strategic Workforce Planning tool:

- Three 'Requirements' workshops held in September.
- Two 'Data Mapping' workshops held in September & October.
- Workshops brought together Strategic Workforce Planning Leads, Data and BI leads from providers and the system BI team.
- Review of workshops and next steps meeting held with system co-sponsors on 4th October 2022.
- Further meeting planned w/c 18th October 2022 to map agree basic principles.

Further Strategic Workforce Planning activity:

- No appointment currently to the HEE 1 year funded B8a Workforce Planner role (2 rounds of interviews).
- WITNe (Workforce Intelligence & Transformation Network) meeting held on 3rd October 2022.
- Workforce Planning Apprentice (B4) will start in the Workforce Team in January 2023.

Workforce Strategy

- On track for deliver by the end of March 23.
- **Six 'Future Facing Scenario workshops'** have been held with 89 attendees.
- Live microsite for resources will be updated to support next phase https://devon2035.horizonsresearch.org
- Analysis meeting with HEE and Staff College to be held on 18th October and to plan next stage.
- **10 '7 questions for the future' have been held** with senior executive directors across the Devon System. Using 7 Questions Futures Technique - Futures, Foresight and Horizon Scanning. 100% complete with output expected on 18th October 2022.
- **First draft of Workforce Strategy chapter written** pending review and templates.

Workforce: Learning, Education and Strategy

- **Learning and Education Strategy:** A set of Principals has been shared and agreed amongst the group and plans are in place to begin the mapping of the project to deliver the Strategy in the agreed timescales.

- **Placement expansion:** Data has been collected from all relevant providers on Student Placements for last year and capacity for the upcoming academic year. This will be shared on 25th October 2022 amongst providers with a view to planning placements for next year. It also puts us in a good position to populate the new HEE In-Place portal in November and a meeting is scheduled to onboard Devon to the Pilot.

- **CPD Strategy:** A new formulated group are reviewing the current provision and allocation, alongside the development of a Devon approach to Continuing Professional Development (CPD) with further outcome measures being progressed. Still awaiting decision of national funding from 2023/2024 onwards for CPD and is a risk which we are quantifying currently.

- **Apprenticeships:** A Devon system approach to levy sharing has been socialised with further refinements to be applied, alongside plans to develop a business case for joint health and care apprenticeships for the future especially in job roles with the highest demand across the system. We have shared funding of £100k from 2022/23 levy to support Apprenticeships elsewhere in non-levy paying organisations which is a positive step forward.

- **ICS Learning Academy:** Devon proposal for the ICS Learning Academy will replace the Learning Education Strategy Group as the strategic arm and the current LESG will become the Operational Delivery Group from November 2022.

- **Community Upskilling Funding:** Following the successful System bid for Community Upskilling funding a new group has been established for Upskilling and will have a first meeting w/c 31 October 2022 to ensure the priority areas are delivered and appropriately represented from across the system.

Workforce: Best Place to Work (BPTW)

- **Inclusive Health and Wellbeing (HWB) Strategies:** Health and Wellbeing Working Group established to further develop and inform inclusive HWB Strategies across the Devon System, considering HWB offers available to staff. HWB Working Group met 21.09.22 to consider outcomes from the stocktake exercise of HWB provision and progress development of inclusive HWB Strategies across Devon
- **HWB bid**: 'Wellbeing Support Buddies and Champions Programme' supporting 300 staff to create peer networks to enable sustainable longer term health improvement and increased resilience across the system is being promoted with 100 staff expressing an interest to date across a mix of organisations and sectors, 2 cohorts begin October 22
- **Retention**: Continued roll out of excellent retention practice across the ICS including career coaching pilot; stay conversations and guidance for managers; careers on a page guidance; leadership pilot using 360 and development on the people promised statements; use of people's retention stories using a variety of media; Continue to reduce turnover rates for identified groups, recognising the top retention drivers of: Feeling valued/recognised; Work/life balance; Supportive line management; Career/development opportunities; Flexible working pilots; Support Devon system to complete gap analysis using Nursing and Midwifery Self-Assessment Tool; Recruitment and set up of system legacy mentors and career navigator role. Following nursing and midwifery self-assessment, BI team will produce a retention heatmap showing best practice and areas for attention.
- **Cultural and wellbeing dashboard**: Wellbeing and Culture **Dashboard** designed and in place with licences for provider organisations obtained to enable organisation and system intelligence to be utilised by individuals, teams and Committees. Working group now in place to develop further the KPIs, narrative, reporting and users.
- **Absence management:** The ICS partners across the Devon System completed a review and implementing actions using the NHSE/I publication 'Deep dive into factors affecting non covid sickness absence North West NHS Trusts 2020' (NW Tool) to focus within their organisation on addressing and improving Sickness Absence. Policy on managing sickness and absence aligned to just and learning culture being shared with system members during October 22 for adopting / progressing. Task & Finish Group set up to progress policy and guidance development, NW Tool, Data & Measurement and proactive service proposal.
- **Staff Survey**: Analysis undertaken at organisation and system level with system actions identified (Workforce Capacity; Speaking Up; Appraisal Tools; Respect Campaign).

Workforce: Workforce Capacity

- **Network/System First**: New programme of work (under the financial recovery plan) to determine planned non-medical vacancies at 8C and above across the rest of the financial year, and of those, what could be considered as sharable across Trusts. The first meeting occurred 3rd Oct and is planned to reconvene on a two-weekly basis.
- **Reservists:** Current focus remains attracting and recruiting Reservists. Later in the year will determine how programme will move into business as usual.
- **Collaboration of banks**: Plans are being formulated to commence a sharing collaborative of nursing banks across the system to add to the already established medical collaborative bank. This programme of work will be in place by end March 2023.
- **Bank and agency spend**: New agency framework will help standardise agency rates for the remainder of 2022/23 and formalise the approach to the agency tiering and cascade process. We are formulating plans to eradicate the use of non-framework agencies whilst preventing staff level deterioration. This work is complex and requires robust clinical assurance and governance protocols, our System plans to support this work are currently being developed in collaboration with our provider colleagues and will go live in October.
- **Medical Support Workers:** Supporting overseas doctors into Trusts to become NHS Doctors. Good success in TSDFT with 18 doctors who have now joined. (Awaiting update on other Trust numbers). Waiting to hear if programme will be funded next year and exploration of expansion into Primary Care.
- **Attraction**:
    - Attraction Strategy and Plan of events conversation deferred to Oct Steering Group
    - ICS Virtual Fair on track for October
    - Medical Recruitment Campaign – website live. First video produced, and draft of second video received.

Finance

Financial Summary

- On 20th June 2022, Devon ICS submitted a deficit plan of £18.2m. There is a requirement that the system achieves a breakeven outturn by year end.

- For 22/23 the system has received a reduced COVID envelope from 21/22. Some COVID funding will be reimbursed on top of the system envelope, this includes spend on testing and vaccinations.

- Efficiency savings of £138.9m are required to meet the June plan.

- Elective Services Recovery Fund (ESRF) funding has been received by the system to deliver 104% of 19/20 elective activity. Delivering more / less than 104% will result in additional funding / clawback at 75% PBR value. (Outsourced activity is reimbursed at 100% subject to meeting 104% target).

- As at month 5 the Devon ICS is reporting year to date £14.6m deficit against a planned deficit of £11.6m – an adverse variance of £3m (M4 £0m).

- The reported forecast is a deficit of £18.2m which delivers to plan.

- As at month 5 the Devon ICS had made efficiency savings of £35.3m (M4 £23.8m) This is £10.4m adverse to plan (M4 £6.8m).

- Forecast savings are averse to plan by £16.7m. (M4 £12.5m)
- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of the deficit plan.
- As at Month 5 the net risk (excluding ESRF) has reduced to £66.8m. (M4 £79.8m)
- Limited data is available from central sources to confirm performance against ESRF, systems have been informed to assume no clawback for month 5 reporting.
- Internal ESRF data to July shows that although the system is not reaching the required 104% of 19/20 activity, ICB commissioned activity is ahead of plan as of July 2022 by £2.1m but NHSE commissioned activity is behind plan by £6.5m leaving a potential shortfall from plan of £4.4m.
- The month 5 position identifies risks and issues to be managed totalling £77.7m against an expectation of break-even. (M4 £90.7m)

Summary Financial Position as at 31 August 2022

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	0	0	0	0	0	0
Royal Devon University NHS FT	(3,880)	(3,883)	(3)	(18,263)	(18,266)	(3)
University Hospitals Plymouth Trust	(4,077)	(4,077)	0	0	0	0
Torbay and South Devon NHS FT	(3,037)	(6,015)	(2,978)	69	69	0
Devon Partnership Trust	(582)	(583)	(1)	0	0	0
Total	**(11,576)**	**(14,558)**	**(2,982)**	**(18,194)**	**(18,197)**	**(3)**

- As at month 5 the Devon ICS is reporting a year to date £14.6m deficit against a planned deficit of £11.6m – an adverse variance of £3m
- The reported forecast is a deficit of £18.2m which delivers to plan.
- The system continues to work towards delivering the best position possible against the NHSE requirement to deliver a breakeven position by the year end.

NHS Devon board meeting

Committee chair report – Quality and Performance Committee

Date of board meeting	Dates of committees covered in this report
16 November 2022	2 November 2022

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

Reports discussed and assurances received

The Committee received updated reports as detailed below:

1. **System Patient Safety Papers**

Patient Safety Incident Response Framework (PSIRF) Training paper

- Incident reporting changing with emphasis on thematic analysis of safety issues and harm
- Need for assurance on measuring 'harm' in areas that may not be reported
- Safety systems team to work closely with providers
- Primary care encouraged to engage with PSIRF

Learning from Patient Safety Events (LfPSE)

- Change for all providers to comply with nationally-mandated reporting system (to be in place by September 2023)
- The new system is still evolving and for the time being the PSIRF will be used to share learning from events.
- Options for primary care to continue using Peer Improvement for Care (PITCH) which would then be uploaded to LfPSE after the systems review ensures PITCH matches the requirements of LfPSE.

New Patient Safety Curriculum

- Implications for mandatory training for staff

2. Integrated Quality and Performance Report (IQPR)

- Performance team to be commended for the Quality of the report. Actions are now part of the report but need to specify 'time frames' for when actions are to be completed.
- Discussion covered the following areas:
  i. *Urgent and Emergency Care*.
     Expected levels of improvement have not been seen. Planned regional Team visit to UHPNT in relation to 'ambulance handovers'. Other domains e.g. category 2 patients remain a significant issue across the system as well.
  ii. *Planned Care*.
     The majority of system performance for the month has been within normal common cause variation indicating no significant change. However, a significant number of the metrics are failing to achieve the national targets and will continue to do so without process intervention. The system has seen an improvement in the total number of patients waiting over 104 weeks from referral to treatment, however a worsening in performance has been seen in RTT, cancer and diagnostic pathways**.** There is a need for further assurance on the impact of waits on patient safety and the occurrence of harm.

     *Expected levels of Improvement for Urgent and Emergency care have not been realised with a need for intervention***.** This includes all domains such as ambulance handover and category 2 patients. There is a planned visit by the Regional Team to UHPNT in relation to handover.
  iii. *Mental Health*
     This month has seen a deteriorating position against half the metrics across the system. There is varied assurance in the system with aligned CYP targets showing deteriorating performance, e.g Eating disorders for Children and Young People. There is an urgent need to understand and get assurance on the effectiveness of interventions to address these areas.
  iv. *Speech Therapy waiting times for Children and Young People*. Waiting times targets are consistently not met and the committee decided to have a 'deep dive' into this area in the December meeting.

3. National Paper: Reading the signals – Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation

Maternity**:** Board to ward assurance is currently lacking. There is a need to ensure that senior leaders walk through units and assess for themselves levels of care provided. There are national concerns regarding midwifery and obstetrics

Reports received and noted

- 1. Patient partners paper

Risk register review updates

- Verbal report received in view of the ongoing review of this area

Committee decisions

- None

Items of concern to be escalated to the board

National Paper: Reading the signals – Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation

- Need for system action to respond to findings in the report

Recommendations for the board

- To note the reports received and positions of assurance by the Quality and Performance committee

Recommendations for other committees

- Interaction between Q&P Committee and Executive and provider Quality groups. Please see updated ToR

Terms of reference or other committee effectiveness issues

Updates to the Terms of Reference:

- Sarah-Lou Glover, NEM of ICB admitted as a member of the committee
- Deputisation for members of the Executive team is by exception and deputy to have the knowledge and authority in relation to area(s) deputised for.
- The Chief Nurse highlighted a proposal to move 'Performance' from the Quality and Performance (Q&P) Committee to the Finance Committee to coincide with the new Chief Financial Officer starting their role. This proposal is to be included the Chair's report and will be discussed as part of the Governance review.
- Q&P Committee (NED-led) is the Assurance Committee providing assurance to the ICB. The Quality Transformation Improvement group (all providers) and the ICS Exec EQOG (oversees the core delivery of the statutory and mandatory functions) will send their reports to the Q&P committee as the single conduit for provision of assurance to the ICB.

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 Board Meeting

Committee chair report – Audit and Risk Committee

Date of board meeting	Dates of committees covered in this report
09 November 2022	16 November 2022

Chair	
Name and title:	Graham Clarke, Non-Executive Member Audit and Risk
Phone:	
Email:	Graham.clarke8@nhs.net

Reports discussed and assurances received

- Internal Audit progress report including revised internal audit plan – The committee were assured that work is underway on 2022/23 audit plan and this will be reviewed at future meetings to ensure it remains fit for purpose.

- Internal Audit Annual Report.

Reports received and noted

- Risk Management Framework
  There were some questions raised around scope being system or ICB organisation specific, as well as where the risks are being held and monitored. It was requested to understand what happens with the risks that the organisation cannot do anything about. A clear set of principles has been requested to be included in the policy.

- Draft CCG HIAO

Significant assurance provided except for the BAF and risk management. The HIAO includes third party letters of assurance which include areas of error or risk from the full year 2021/22. The final version of the HIAO will be submitted with the Annual Governance Statement of the CCG.

- Internal Audit Annual Report
  The consortium annual report provided assurance that despite the challenges the NHS faced during 2021/2022, business as usual standards were maintained by ASW, balanced Head of Internal Audit Opinions were delivered to meet year end requirements, a number of key valued added reviews were undertaken, and the Counter Fraud Functional Standard Return was submitted in line with NHS Counter Fraud Authority requirements.

- Invite to tender document for external audit services was noted

- Losses and special payments were noted

- Counter Fraud report
  The potential of cyber-enabled bank mandate fraud attempts was highlighted, due to the recent local and national attacks on NHS organisations. National NHS losses to mandate fraud equated to £1.43m between 2019-2021. Organisations in the South West have recently lost a combined total of £340,000 preventing a further of loss £343,000.

  Organised Crime Groups are hacking supplier email accounts, resulting in spurious attempts to change bank details from email addresses associated to those suppliers. NHS Finance staff must remain hypervigilant to any change of detail requests, ensuring that previously established email addresses, telephone numbers and correspondence addresses held on financial systems are the only ones used to verify change of detail requests.

Risk register review updates

- There is risk seminar scheduled for 10 November which will cover the strategic objectives and risk appetite. The work which will come out of the seminar will support a new approach and model of risk management.

Committee decisions

- N/A

Items of concern to be escalated to the board

- The Risk policy framework is in draft form and although endorsed by the committee, requires further strengthening and additional elements, to follow the risk seminar. The framework will be a key building block for the risk management of the organisation. It was highlighted that the governance team will take the framework forward operationally as well as work around

the mechanics of reporting risk as an ICB which will be undertaken by the governance team.

- External audit contract bidding process is underway with one confirmed bidder and a possible four others who have reviewed paperwork but not yet submitted a bid. There remains a risk that there will not be adequate external audit provision in place for auditing of finances.

- CCG HIAO has been presented in draft form providing significant assurance except for the BAF and risk management which has limited assurance due to this not being in place.

Recommendations for the board

- N/A

Recommendations for other committees

- N/A

Terms of reference or other committee effectiveness issues

- N/A

Management of conflict of interests:

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NHS Devon board meeting

Committee chair report – People & Culture Committee

Date of board meeting	Dates of committees covered in this report
16th November 2022	26th October 2022

Chair	
Name and title:	Dr Thandiwe Hara, Non-Executive Director of Inequalities and Population Health

Reports discussed and assurances received

- Nigel Acheson, Chief Medical Offer for NHS Devon attended the Committee to update on the work that is currently being undertaken to create a system-wide approach to innovation. Their first step is to appoint a director post with the South West Academic Science Health Network (ASHN). The Committee welcomed this approach and highlighted the importance of this to enable the required workforce changes for the future in terms of skill mix and new roles

- Natasha Goswell, Professional Practice and Workforce Lead attended to discuss and gain approval for the Devon Learning Oversight Group. The group were informed that the terms of reference would be approved at the first meeting taking place in November. The Committee approved this approach but highlighted that the membership of the group appeared potentially too large and advised that the group would need to be very focussed on a small number of key issues

- The Executive Workforce pillar update was received by the Committee. Good progress was noted especially in the Capacity pillar. The Committee requested that the reporting needs to be improved from November onwards to ensure that monthly progress is more easily tracked

- International recruitment was highlighted as having successfully delivered over 500 nurses in the last 18 months and that the feedback from the nurses in relation to pastoral care was good. It was also highlighted that International social campaign started in October, with over 700 applicants already received. It was reported that it was likely that the initial target of 175 recruits can be exceeded, however funding will need to be found to enable this. The Head of International recruitment will attend the January Committee to update and provide assurance over the quality of the pastoral care

- The Committee reflected on the way the meetings have operated since its inception. It was concluded that too much data was being received and that a highlight report should be received from the Director of Strategic Workforce to assist the Committee members to important issues.
  It was also agreed that the agenda needed to be clearer in terms of why a paper was coming to Committee and for papers to be sent out in a more timely manner.

Reports received and noted

- Devon Learning Academy was presented to the group and noted.
- Workstream Pillar Updates were presented to the group and noted.
- Executive Workforce Report was presented to the group and noted.

Risk registers review updates

Nil

Committee decisions

- Quality Improvement and Innovation direction was welcomed. The objectives and plans to be brought back to the Committee once drafted
- Devon Learning Oversight Group – agreement in principle for this to be set up. Final Terms of reference to be shared.

Items of concern to be escalated to the board

N/A

Recommendations for the board

N/A

Recommendations for other committees

N/A

Terms of reference or other committee effectiveness issues
n/A

Management of conflict of interests:

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NHS Devon board meeting

Committee chair report – Primary Care Commissioning Transitional Committee Private Meeting

Date of board meeting	Dates of committees covered in this report *Minutes of these committee meetings to be available as an addendum*
November 16th 2022	PCCTC 27/10/2022

Chair	
Name and title:	Judy Hargadon Non-Executive Director for Primary Care
Phone:	
Email:	judy.hargadon@nhs.net

Reports discussed and assurances received

- The committee reviewed the monthly report from NHS England of **dental, optometry, and community pharmacy services**. The NHSE relationship manager for NHS Devon informed the meeting that the NHSE Director with portfolio for dentistry would like to present the new road map for dentistry in Devon soon. This plan should begin to cover the options and opportunities to face the many challenges which lie ahead.

- PCCTC reviewed and discussed the **Quality Report** which focused on the information being gathered from the increased serious incident reporting, in response to the Quality and Performance team's initiative to prevent under-reporting of incidents in primary care. Themes that have emerged involve self-inflicted harm, medication, information governance breaches, diagnostic and treatment delays and, increasing instances of aggressive patient behaviour. There has been a review of the operational process which is part of the new Patient Safety Framework.

- The PCCTC were briefed on the practices in each of the 31 **Primary Care Networks** and the challenges which some of these may have as neighbourhood and community-based service and provider collaboration becomes more of a priority. The meeting discussed the learning which can be taken and shared from current areas which already exhibit attributes of effective working across areas of out-of-hospital care.

- The PCCTC were given a first look at the **metrics** proposed for measuring the impact and delivery of the new Primary Care strategic framework when it has been approved by the ICB.

Reports received and noted

- PCCTC was updated on **contractual, and resilience matters** in a high-level overview report. This drew the committee's attention again to **GPAS** (General Practice Alert Status): The initiative to set defined responses to the weekly GPAS report has progressed well in the last month. The PC team and LMC have jointly set out how practices can be supported. A further meeting with the LMC will take place shortly, which was requested by them to ensure we are empowering practices to be honest and raising issues requiring the system response. The GPAS work has been shared with 70 other LMCs in England and Scotland.
  Croft Hall Medical Practice – registration was cancelled due to an administrative timing error with the ordering of the registration process. PC Team is liaising with the CQC and the practice to take learning on how this mistake can be prevented in the future.
  Mayflower Medical Group- There is good news of very positive comments from patients and Plymouth MPs on the improvement in these practices since the contract was taken over by Livewell Southwest.

- PCCTC received the third **finance report** of the ICB. The report was explained in some detail to ensure newer members of the committee were fully conversant with the Primary Care finance situation.
  Members discussed the **cost improvement plan budgeting** and its impact on Primary care, which is less than in some ICB areas as most General Practice contract funding is set nationally.
  Concern was raised again over the **convergence monies**, to bring Devon PC funding up over the next 3 years in line with National funding. This is expected to be about £6million; however, NHSE have not so far committed to any payment after the current financial year.
  The point was also made that, although **contingency money** is needed in the short term to support Mayflower as the new management are realising improvements in service standards for patients and dealing with recruitment challenges, there needs to be a sustainable model for rescuing practices that are in difficulty, which can be replicated and is affordable in the long term.

- The **Deputy Director's Report** highlighted
- Additional winter support – there is more national guidance due out and there will be opportunities for some repurposing of funding to help with pressures in general practice.
- Good news – The Primary Care nursing legacy scheme is working excellently and has had some national recognition. It has also had the unexpected benefit of reinvigorating mentors as they pass on wisdom to the next generation.

Risk register review updates

- Risk management work under review, no risk report to review.

Committee decisions

- PCCTC Reviewed the **Primary Care Strategic Framework** final draft**.** Refinements have been made to sharpen the focus and ensure it is suitably succinct without losing core messaging. The primary care team are content that the document honours the original ambition to be a framework of principles for the future of Primary Care built on the recent system-wide engagement process. The Chair noted that the Strategy and Transformation executive group will also consider it, with a view to ensuring it is a good foundation for the planned out-of-hospital strategy.
  After discussion **PCCTC agreed to support the PC Strategic Framework to go forward to be approved by the ICB Board, in November if possible.**

- PCCTC reviewed a paper on the proposal by **Blake House Practice** to amend their contract. There remains a business continuity concern as the practice will have a single clinical partner, a resilience concern which requires considerable additional assurance to assuage. Technically the proposed variations are within the National Single Handed Assurance Framework, which would suggest that the committee approve the proposal, however there are issues with resilience which would make the decision to approve opposed to the strategic direction of the ICB.
- **PCCTC agreed** for the Primary Care Executive team to discuss the recommendation, make a decision, and feed back to the next PCCTC

Items of concern to be escalated to the board

- Devon's distance from target for Primary Care funding and lack of clarity about convergence funding timetable.

Recommendations for the board

- Support for Primary Care strategic framework when presented.

Recommendations for other committees

- None

Terms of reference or other committee effectiveness issues

None

Management of conflicts of interest:

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NHS Devon

Integrated Care Board Meeting - Action Log								
Action Number	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**OPEN/CLOSED**
3	21.09.22	Share Dr Hooper's report on long waits during covid	Oct-22	Simon Tapley	12.10.22 - Report is not ready to share yet as it won't be going to the relevant Board meeting in Urgent and Elective Care until November now (17 November) therefore this will be circulated with the minutes of the November ICB meeting.			**In progress**
6		A forward planner for the Board to be developed to ensure a clear understanding of when things will be happening	Oct-22	Andrew Millward	01.11.22 - Forward planner has been developed which includes colour coding for approval, discussion and for information. This will be shared regularly when requesting papers for Board meetings so that Executives can see when there are reports due. Request to close			**Request to close**
7		Work with colleagues to access adult social care data from the local authorities.	Oct-22	Simon Tapley	10.10.22 - Kelvin Grabham, Head of Business Intelligence is progressing this item and will feed back to the board (linked with action 20) Request to close			**Request to close**
11	19.10.22	Request an amendment to NA declaration on the Declaration of Interest register	Nov-22	Jodie Howland	20.10.22 - Decleration of interest register has been updated for Nigel Acheson.			**Request to close**
12		To meet with Sanita to see where the board can support to improve international nurses' and other health and care professionals' experiences in Devon	Nov-22	Paul Renshaw	02.11.22 - Paul Renshaw meeting with Sanita on 11 November. Request to close			**Request to close**
13		Include on the board forward planner an inclusion item for Sanita to return later in the year	Feb-22	Jodie Howland	26.10.22 - Item added to the forward planner for March 23. Request to close			**Request to close**
14		Include progress on work within the Chief Executive reports and system progress on a quarterly basis	Nov-22	Jane Milligan	20.10.22 - Communicated to Nick Pearson who confirmed system progress will be included on a quarterly basis. Request to close			**Request to close**
15		Include system progress within the IQPR on a quarterly basis.	Nov-22	Darryn Allcorn	20.10.22 - Communicated to Sam Wadham-Sharpe. Darryn Allcorn has confirmed this will be iterative and I will be covered off verbally during the item on each meeting agenda. Request to close			**Request to close**
16		Provide clarity to JH where medicines optimisation sits as part of primary care in terms of efficiency savings.	Nov-22	John Dowell	31.10.22 - Medicines Optimisation (Primary Care Prescribing) savings make up £5.7m of the total £7.7m identified in the report as "Primary Care". This is now clearly set out in the monthly ICB finance report. Request to close			**Request to close**
17		Add workforce challenges updates to the forward planner	Nov-22	Jodie Howland	26.10.22 - Item added to the forward planner for Jan 23. Request to close			**Request to close**
18		Work to share learning of the Plymouth peer review of the BCF	Nov-22	Simon Tapley Anna Coles	01.11.22 - Learning from the Plymouth Discharge taskforce workstream review has been shared with Board members via email and will be referred to when planning further reviews. Request to close			**Request to close**
19		Liaise with regional colleagues to provide feedback of the inappropriate timelines for developing and implementing the BCF plans and inform that the plans from our organisation will be submitted at a later date to ensure these are in line with the Devon operational plan.	Nov-22	Simon Tapley	01.11.22 - Simon Tapely to discuss with Jane Milligan			**In progress**
20		Work with locality leads and acute leads to ensure there is appropriate information available to the board ahead of the moneys being allocated for 2023/24 for the BCFs.	Feb-22	Simon Tapley	01.11.22 - Derek Blackford, Locality Lead is working with Kelvin Grabham, Head of Business Intelligence to ensure all information required is available for BCF allocation in 2023/24. Request to close			**Request to close**
21		Present the One Devon Operating model implementation plan to the board when developed.	Dec-22	Simon Tapley	26.10.22 - Scheduled for December on the forward planner following guidance from Simon Tapley. Request to close			**Request to close**
22		Add One Devon Operating Model Implementation plan to the forward planner	Nov-22	Jodie Howland	26.10.22 - Scheduled for December on the forward planner following guidance from Simon Tapley			**Request to close**
23		Add a freedom to speak up session to the forward planner	Nov-22	Jodie Howland	26.10.22 - Request to FTSU Guardians to understand what they wish to cover to ensure the forward planner is updated and scheduled appropriately.			**In progress**

Paper number: ICB2223/061

Board meeting of the Integrated Care Board (ICB)

Agenda item: Report of the chief executive

Date of meeting: 10 November 2022
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.

Amendment to October Board Report

I would like to advise the Board of an error reported to our October meeting with regards to Category 2 ambulance response times within the report regarding performance. The graphic in the ICB report was correct however the typed figure was inaccurate. The mean response time for Category 2 calls in July 2022 was 2hrs 44 minutes, not 7hrs 17 minutes. The mean response time for Category 1 calls in July 2022 was 16 minutes 06 seconds, not 30 minutes. The relevant report has been removed from the website for correction.

Covid-19 vaccination update

As a system we are on target to deliver the ambition of 250,000 Covid19 vaccinations, covering 80% of the eligible population and remaining the highest in the region for booster uptake (SW 51.3%, CIOS 54.2%)

166,151 vaccines have been delivered through the booster programme with 164,192 (some 75%) being housebound and care home residents to date, and 1,959 to people who are presenting for their first, second or third dose. Nearly 49,000 have had this co-administered with the seasonal flu vaccine.

A proactive communication campaign is underway promoting Covid19 and Flu vaccination boosters to all eligible cohorts and ensuring there is good accessibility for vaccination across all delivery sources, working closely with specific groups to maintain equity for maximum vaccination uptake.

Communications and engagement

Cornwall Pride took place in 11 locations across Cornwall, to bring Pride closer to local communities, with 2022 marking the 50th anniversary of Pride in the UK.

The LGBTQ+ employee network members agreed to attend and run a stall at 3 of the Pride events. The events were busy days, and our NHS stalls were well attended. We gave out lots of NHS 111 messages, were able to talk about recruitment and apprenticeship opportunities, give out information about mental health, take part in the parade, and talk about barriers to accessing health services. In addition, the chaplaincy service ran a multi-faith stall over the August bank holiday weekend.

We'd like to give a huge thank you to members of the LGBTQ+ employee network group who helped to plan our attendance at Cornwall Pride, the System Executive Group (SEG) for collaboratively sponsoring the event, the many allies and volunteers who gave their time and energy, recruitment team members, and Rachel Tofts, Ben Mitchell, Kathy Brooke and Mikey Stevens for organising a great NHS presence. We're already looking forward to next year!

Primary care roles campaign – a new communication campaign has been created to raise public awareness of the additional roles which exist within primary care – *"GP? Think of me"* – the aim being to take pressure off demand for GP appointments and to help people appreciate there are other professionals who may be better placed to support with their particular need. This will go live in November and will run through to February next year, across the county. The campaign features real people from our communities.

Outputs will include social media animations, bus stop posters, waiting room posters, TV display screens (in GP surgeries, acute and community hospitals). There will also be a leaflet for distribution via pharmacies, inside prescription bags – to reach the non–digitally engaged. The campaign will be further supported with a media release shortly after launch.

Visits, networking, events and speaking activities

National System Leadership Event for ICB and Trust Chief Executives – Steve Williamson, Debbie Richards and I attended this national event chaired by Amanda Pritchard, NHS Chief Executive, which brought together all Chief Executives to build on the progress made since our last event together back in April this year. This event also provided further opportunity to work together as a single leadership team on the immediate priorities and key longer-term strategic issues for the NHS.

Preventing Falls and Promoting Aging Well – Cornwall's Transformative Approach Conference – I was delighted to be asked to attend and be part of the Panel for the question and answer (QA) sessions, at this conference organised by Louisa Forbes, our Consultant Nurse for Care Homes, Community and Virtual Wards and Kieran Bignell, Director of Integrated Urgent Care Services, in partnership with Fleet and Reach Cornwall. The day was also live streamed by CHAOS TV. The audience was made up from colleagues across Cornwall's Integrated Care System including acute, community, primary care, care home, home care, SWAST and third sector organisations.

The purpose of the event was to showcase the simple things that make a big difference to people's happiness, health and outcomes. There were excellent national speakers throughout the day including Sir Muir Gray, former chief knowledge officer of NHS and Founder of Live Longer Better and Dr Andrew McDowell, Clinical Psychologist with TPC Health.

North and East ICA Forum – I was also delighted to be asked to join the North & East ICA Forum this month which gave an excellent opportunity for discussion and debate on current projects and planning for the future to help support our local communities now, over winter and longer term. I personally feel it is good to be having so many events face-to-face again and the enthusiasm of participants was evident.

Action Deafness – I met with Craig Crowley MBE FRSA, Chief Executive Officer of Action Deafness. During our conversation we spoke about exploring beneficial opportunities to working together. The key points of our conversation were:

- Hearing Loss Cornwall and Action Deafness to produce a market narrative explains BSL interpretation and translation services operating in Cornwall and the Isles of Scilly.
- Establishing a process to measure the effectiveness/quality of BSL interpreting and communication support services in the deaf and hard og hearing community.
- Exploration of the use of remote interpreting to augment the current face-to-face provision in the rural areas.

Carolyn Andrews, ICB Director of Transformation & Partnership will be taking the lead on this work, in liaison with colleagues at Action Deafness.

Meeting with the Unions – Patrick Weir and I met informally with representatives of the health and care trade unions (TU) on 26 October. The meeting was set up not to replace or cut across the formal joint consultation arrangements in partner and provider organisations, but to engage TUs at system level ahead of winter and potential industrial action. It was noted that our ICS would be working to establish a local social partnership forum with TUs and proposals for the establishment of this would come through the workforce committee shortly.

The meeting was welcomed by TU colleagues as helpful early sight of the system control arrangements for winter and the likely impacts to staff. Whilst being clear on the statutory rights of the TUs in respect of potential industrial action, the TUs were willing to engage at system level ahead of potential industrial action to minimise risks to care and a further meeting will be set up in early November.

Winter improvement collaborative launch event – I attended this launch event of the major new Winter Improvement Collaborative aimed at rapidly improvement ambulance handover and response times, and this will be an integral part of our "going further on winter resilience" plans which were previously announced by NHS England in October. The collaborative will take a fresh, more "bottom up" approach to transformation by enabling frontline leaders to rapidly identify best practice solutions and collectively roll them out at scale.

This event kicked off a 10-week, clinically led programme, and the objectives of the event were to:

1. Discuss collectively what action we can take to improve patient flow and response times and improve the situation from a patient and staff perspective
2. Use data to allow us to prioritise resources on the initiatives that are having a measurable impact to support ambulance handovers, response times and excess time spent in emergency departments
3. Understand what is needed to remove the barriers to progress and empower local decision making and action
4. Agree how we will collectively move forward following the event to work and learn together to deliver the initiatives at pace and at scale

System wide matters

Royal College of Paediatrics and Child Health – Dr Camilla Kingdon (President) and Dr Mike McKean (Vice President for Health Policy) wrote to me to let me know they are recruiting a network of RCPCH Ambassadors who are paediatricians with local knowledge and experience of children's services who will be support by the expertise of the College. These Ambassadors will engage with leaders in their ICS area to advocate for the needs of children and young people to be understood and prioritised. Central to the aim is understanding and addressing health inequalities, harnessing data and digital, and securing a well-trained and resourced child health workforce. The Royal College is aiming to recruit the Ambassador for Cornwall & Isles of Scilly soon.

The ICB will have a duty to engage and consult with children, young people and their families. The Royal College has produced a short leaflet (published in June 2022) which looks at how we can amplify children and young people's voices, work collaboratively and support meaningful engagement. The link to this leaflet is: Children and young people's engagement in your ICS (Integrated Care Systems) | RCPCH

I have asked Susan Bracefield, the ICB Chief Nursing Officer to be our lead with the Royal College to take forward this important work.

ICB system incident response plan exercise – will be taking place on Friday 4 November as part of the NHS England mandated requirements to test the System Incident Response Plan. Colleagues from across the Integrate Care System will be involved in this exercise, taking place at the Emergency Centre at County Hall in Truro.

System control centre (SCC) - The SCC will operate at ICB level and will lead and facilitate collaboration of system performance and risk through senior system level clinical leadership and strategic oversight. The model will ensure efficient flows of intelligence on operational pressures, patient effectiveness, preventable harm and risks across the system

are visualised in a single live data pack which will drive actions in response and highlight areas of concern or increasing risk profile.

The senior responsible officer for the SCC will have given delegated authority on behalf of the CEOs to operate the requirements and decisions need surge and incident actions. Providers will also deliver their own Incident Control centre function to manage the winter response which will link into the SCC

The model will ensure there is a concerted effort on existing and emergent issues which impact patient flow including ambulance handover delays and delayed discharges. Other key benefits will include improved situational awareness and lessen the risk of non-delivery of holistic, real-time management of capacity and performance.

By employing live data flows and creating a four-week rolling average performance metrics, the SCC will be able to monitor trends and emergent issues and allow support to be focused on the area of greatest or risk.

The overarching aim of the SCC is to ensure alignment and delivery of the areas covered by the NHSE assurance framework across the core domains.

- improving the support and service response for patients
- aligning demand and capacity
- improving discharge
- improvements in ambulance service performance
- improving NHS 111 and 999 performance
- admission avoidance and alternative ‘in hospital pathways’ to improve flow
- preparing for new Covid-19 variants and respiratory challenges
- workforce and communications

Integrated Care Board matters

Governance arrangements – we continue to work with PWC on a review of the governance arrangements when we transitioned from the CCG to the Integrated Care Board. This work is not due to be completed until mid-November. At that point a set of recommendations will come through a governance improvement programme that will be shared with colleagues once finalised. Some of the recommendations are already being implemented through the work we are currently doing to develop the governance arrangements therefore this makes the document fairly fluid at this point in time.