NHS Devon Integrated Care Board (ICB) meeting

Pomona House, Torquay

18 January 2023

10.00 to 12.15 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 meeting in public

The quorum for meetings of the Board is :

a) Chair or Vice Chair
b) At least two Executive Directors
c) At least two additional independent members
d) At least one Partner Member
e) At least one of the members must be a registered clinician.

	Board pre-meet	**Lead**	**Action**	**0930**
	Members Pre-meet	All members	Discussion	
	Introductory items	**Lead**	**Action**	
1	Welcome, introduction and apologies Apologies – Nigel Acheson, Paul Renshaw (Mark Sowden deputising)	Sarah Wollaston, Chair	Discussion	10.00
2	Conflicts of Interest register	Sarah Wollaston, Chair	Noting	
3	Draft Minutes of the meeting held on 21 December 2022	Sarah Wollaston, Chair	Approval	
	Citizen's Voice			
4	Citizen story – being an asylum seeker in Devon	An asylum seeker and Barry Coakley, General Practitioner	Discussion	10.05
	Leadership	**Lead**	**Action**	
5	Chair's report	Sarah Wollaston, Chair	Noting	10.25
6	Chief Executive's report	Jane Milligan, Chief Executive Officer	Noting	10.30
7	Staff Survey	Andrew Millward, Chief Communications and Corporate Affairs Officer	Noting	10.35
	Assurance and system oversight	**Lead**	**Action**	
8	Reducing and Mitigating Health Inequalities in planned care	John Finn, Director of Commissioning Urgent & Elective Care	Noting	10.40

		Helena Posnett, Consultant in Public Health (Health Inequalities) Claire Hooper, Strategic Clinical Lead for Elective Care		
9	Operational pressures verbal update	Anthony Fitzgerald, Chief Delivery Officer	Discussion	10.45
10	Quality and Performance Committee December meeting update	Hisham Khalil, Non-Executive Director	Review and discuss	11.55
11	Integrated Quality Performance and Finance Report (IQPR)	Darryn Allcorn, Chief Nursing Officer	Review and discuss	11.00
12	Finance Committee January meeting verbal update	Kevin Orford, Non-Executive Director	Review and discuss	11.10
13	Finance reports I. NHS Devon month 8 report II. ICS month 8 report	Bill Shields, Chief Finance Officer	Review and discuss	11.15
13.1	Financial Forecast	Bill Shields, Chief Finance Officer	Noting	11.25
Break				
	Governance and risk	**Lead**	**Action**	
14	Audit and Risk Committee December meeting update	Graham Clarke, Non-Executive Director	Review and discuss	11.45
15	Primary Care Transition Commissioning Committee December meeting update	Judy Hargadon, Non-Executive Director	Review and discuss	11.50
16	Cornwall, and the Isles of Scilly Board update	Kate Shields, Chief Executive Officer CaIS	Noting	11.55
17	Action Log	Sarah Wollaston, Chair	Approval	12.00

Public Questions - on publication of the agenda, members of the public are invited to submit any questions related to agenda items no less than 2 days prior to the meeting to d-icb.governance@nhs.net. Appropriate questions and responses will be shared during the meeting and published on the website following the meeting				
18	Questions from members of the public	Sarah Wollaston, Chair	Discussion	12.05
19	Any other business	Sarah Wollaston, Chair	Discussion	12.10
	Close			**12.15**

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

Register last updated 11 January 2023

Title	Surname	First name	Role or Position held with the ICB	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest 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 Devon Urgent Care Strategy Oversight Group Peninsula Acute Sustainability Programme	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			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
	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 Devon Urgent Care Strategy Oversight Group	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 Being Centre in Plymouth	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, Communities and Prosperity	ICB Board	No interests declared		19/11/2020		09/11/2022				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
	Cooper	Ann	Interim Strategic Governance Adviser	ICB Board Audit and Risk Committee	Contractor with TIAA ltd – internal audit services Bank contract as governance adviser with NHS Frimley		01/06/2022		24/11/2022			Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	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	Director of Torbay Pharmaceuticals		24/11/2016		21/06/2022				Torbay and South Devon NHS Foundation Trust
	Fitzgerald	Anthony	Chief Delivery Officer	NHS Devon Finance Committee ICB Senior Executive Meeting System Delivery and Improvement Meeting Risk Management ICB Board Session ICB Board ICS Executive Committee	No interests declared		15/11/2022		15/11/2022				NHS Devon ICB
	Green	Joanne	Interim Board Secretary	ICB Board	No interests declared								

	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 leave the meeting if necessary.	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 Community group which may have potential to give rise to influence decisions made by the ICB.		28/06/2022		28/06/2022				NHS Devon ICB
Cllr	McInnes	James	Chair of One Devon Partnership Board (ICP)	ICB Board	Elected member of Devon County Council		2005	2025		General Interest		Where a piece of work or an item on a Board agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote	Devon County Council
	Milligan	Jane	CEO ICS for Devon	ICB Senior Executive Team Senior Leadership Team (SLT) Audit and Risk Committee (If required) ICB Board NHS Devon Finance Committee ICS Executive Committee Executive Workforce Committee People & Culture Committee Remuneration & Internal ICB Workforce (If Required)	Member of Cornwall and Isles of Scilly ICB	Partner Trustee for Action for Stammering	31/12/2020		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 Committe Peninsula Acute Sustainability Programme	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University Non-Executive Board member of Delt Shared Services		19/06/2018	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 Devon Urgent Care Strategy Oversight Group	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 Primary Care Commissioning Transitional Committee Eastern LCP Executive Group South LCP Executive Group ICS Executive Committee Peninsula Acute Sustainability Programme		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. Relative is a registrar in Anaesthetics on the south West training scheme and currently	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

NHS Devon

I

Minutes of a meeting of NHS Devon Integrated Care Board held in public at County Hall and via Microsoft Teams and livestream on Wednesday 21 December 2022 between 10am and 12.15pm	
Name and initials	*Title and organisation*
Board Members:	
Dr Sarah Wollaston (SW) Chair	Independent Chair, NHS Devon
Graham Clarke (GC)	Non-Executive Member, Audit and Risk, NHS Devon
Thandiwe Hara (TH)	Non-Executive Member, People and Culture, NHS Devon
Judy Hargadon (JH)	Non-Executive Member Primary Care, NHS Devon
Hisham Khalil (HK)	Non-Executive Member, Quality and Performance, NHS Devon
Kevin Orford (KO)	Non-Executive Member, Finance and Remuneration, NHS Devon
Jane Milligan (JM)	Chief Executive Officer and Accountable Officer, NHS Devon
Nigel Acheson (NA) *minute 13 only*	Chief Medical Officer, NHS Devon
Bill Shields (BS)	Chief Finance Officer, NHS Devon
Andrew Millward (AM)	Chief Communications and Corporate Affairs Officer, NHS Devon
Paul Renshaw (PR)	Director of Strategic Workforce, NHS Devon
Simon Tapley (ST)	Chief Transformation & Strategic Planning Officer, NHS Devon
Partner Members:	
Sarah-Lou Glover (SLG)	Mental Health Representative
Tracey Lee (TL)	Chief Executive, Plymouth City Council representing local authorities
Frank O'Kelly (FOK)	Primary Care Representative
Steve Brown (SB)	Director of Public Health, Devon County Council
Liz Davenport (LD)	Chief Executive Officer, Torbay and South Devon NHS Trust representing acute trusts
In attendance:	
Helen Braid (HB)	Head of Governance, NHS Devon
Ann Cooper (AC)	External Governance Consultant
Joanne Green (JG)	Interim Board Secretary, NHS Devon
Jodie Howland (JHo)	Governance and Facilities Business Manager, NHS Devon
Cllr James McInnes (JMc)	Chair Devon Integrated Care Partnership
Kate Shields (KS)	Chief Executive Officer, Cornwall, and Isles of Scilly ICB
Apologies for absence	
Sheena Asthana (SA)	Non-Executive Member
Anthony Fitzgerald (AF)	Director of Delivery, NHS Devon
Darryn Allcorn (DA)	Chief Nursing Officer, NHS Devon

Minute number	
1	**Welcome and Apologies for Absence** The Chair, Sarah Wollaston (SW) welcomed those in attendance and in particular Kate Shields, Chief Executive Officer of NHS Cornwall, and the Isles of Scilly Integrated Care Board to the meeting. It was noted that, due to current extreme operational pressures, several items had been deferred to next month's meeting. Apologies for absence were received from the Chief Nursing Officer Darryn Allcorn, the Director of Delivery, Anthony Fitzgerald and the Chief Medical Officer, Nigel Acheson who were all supporting the System with operational pressures due to the current industrial action. Non-executive Member, Sheena Asthana had also submitted apologies for the meeting. It was agreed the Chief Medical Officer would join the meeting for minute 13. SW advised that immediately after this meeting the Board would meet in private session to discuss a confidential financial forecasting report, which would subsequently be presented in public and a report relating to a named individual.
2	**Conflicts and Declarations of Interest** Members noted the Conflicts of Interest Register which had been circulated as part of the meeting pack. No new declarations were made. The meeting was deemed quorate.
3	**Minutes of the previous meeting held on 16 November 2022** The minutes of the above-mentioned meeting were approved as an accurate record.
4	**NHS Devon - Management of Industrial Action** The Director of Strategic Workforce, Paul Renshaw reminded the Board that, for some time, health and social care had been under exceptional pressure and he acknowledged the right of individuals to express their views and be involved in strike action. Staff who remained working during the strikes were also acknowledged, and the increased pressure they would be under as well as the impact this had on patients. ***(a) Nursing*** The Royal College of Nursing (RCN) members strike, on 15 December 2022, had seen 10,000 nurses striking nationally with the Southwest making up 25% of this number. In Devon this was 17% of nurses from the Royal Devon United Hospitals, 12% from Devon Partnership Trust, 11% from United Hospitals Plymouth (UHP) and 5% from Torbay and South Devon NHS Trust. Trusts had prepared well and were operating similar processes which would be in place on Christmas Day, with local derogations being negotiated. It was noted that, unfortunately, UHP had been unable to derogate the Urgent Treatment Centre or Minor Injuries Unit. However, other acute trusts had been able to achieve this which would be helpful. Demand for services continued at a similar level from the population. Members were advised that 530 inpatient procedures and 320 outpatients' appointments had been rescheduled due to the industrial action. The strike held on 20 December 2022 had seen a larger number of nurses taking strike action and the view from the front line was that attitudes were hardening. It was expected that strikes would continue into 2023 and it was likely that just 24 hours' notice of any such strikes would be given. Overall, he considered the NHS Devon Integrated Care System was well prepared, and thanks were extended to all colleagues who had been involved in ensuring emergency preparedness was robust. ***(b) Ambulance*** National derogation for the ambulance strikes had agreed there would be 75% coverage and that all category one calls and category two calls external to the home would be prioritised, together with other significant clinical episodes e.g., strokes and cardiac episodes. It was

	noted that in Devon, Southwest Ambulance Trust had brought in 60 colleagues from the military to provide cover. St John's Ambulance and other local providers were also being brought in to help cover gaps. Performance reported this morning, showed Devon was holding at around a three hour response time. Silver and gold command controls were in place with collaboration across the System in place. However, it was clear that harm could occur today and on 28 December 2022 when the next strike was due to happen. It was also likely this action would continue into January 2023 with resultant continued disruption to services. The Board was also advised that the Chartered Institute of Physiotherapists had balloted for industrial action, however in Devon, the only mandate for this would be Torbay. In addition, it was anticipated that junior doctors would hold a ballot for strike action in the New Year. The Chief Executive, Jane Milligan (JM) extended her thanks to all involved in the work to support services during this time. JM advised there was an industrial action plan in place which coordinated acute trusts, local authorities and other partners and which included colleagues from finance, pharmacy, and human resources. It was noted Devon had been in a critical incident since 17 December 2022 and the System had been identifying how best to use the System at Capacity Protocol, including the triggers for going in and out of a critical incident. The Chief Nurse, Darryn Allcorn, as executive director overseeing emergency preparedness, resilience and response had been working closely with the Local Resilience Forum to support the plans. Communications were in place to ensure people had the information they needed. The Chief Communications and Corporate Affairs Officer, Andrew Millward confirmed that communications with the public were on behalf of medical directors locally and regionally, in addition to national guidance and advised what people should do during industrial action, including how best to look after themselves. There had also been extensive social media communication, paid for advertising and text messaging. The Chief Executive of Torbay and South Devon NHS Foundation Trust, Liz Davenport (LD) commented that the plans set out to manage the demand and capacity across the System and included a coordinated effort with primary care, community services and social care. She advised the discipline of the plans would be key to ensuring risk-based decisions were made to make best use of capacity. LD commended staff within the System who had coordinated the response to protect patient safety, whilst respecting the rights of their colleagues to strike, which she felt was testament to the values of the workforce within Devon. A Non-executive Member, Graham Clarke (GC) referred to possible industrial action taking place within schools, which might impact workforce availability and questioned if the System would be able to cope. In response, PR confirmed that possible school strikes were under review and would form part of the planning for 2023. JM commented that, while the vaccination programme was going well in terms of covid and flu boosters in the over 75 age bracket, there remained challenges in vaccine take up by the younger population and this was being shown by the increasing number of infections. Further work would be undertaken to promote the flu vaccination, with routine vaccinations being offered to all patients during other appointments. A Non-executive Member, Thandiwe Hara, sought assurance about how children and young people were being supported during the ambulance strikes and in response JM confirmed that primary care colleagues were working to support these groups. The Handi App was referenced which was being actively promoted on social media to support children, in addition to the use of primary care hubs. SW added her thanks to all staff who were working through the strike action.
5	**Chair's report** SW shared that she, along with Jane Milligan and Tracey Lee (TL), had recently met with the Minister for Social Care, Helen Whatley, for an introductory meeting as part of a national review of integrated care systems. She considered the meeting had been very constructive, with colleagues being able to set the scene and background to the pressures faced in Devon and the plans for dealing with performance over the next year. TL concurred and commented the Minister had been interested to hear about what was happening within the System. JM

	advised that over the coming weeks, either the Secretary of State or one of the Ministers would be holding introductory meetings with Chairs and Chief Executives of Integrated Care Board across the country. The Chief Executive Officer of NHS Cornwall and the Isles of Scilly ICB, Kate Shields (KS) advised that she had also met with the Minister the day before and considered the meeting had gone well and the Minister had been particularly interested in workforce issues, which she suggested was positive. The Board **noted** the report.
6	**Chief Executive's report** JM referred to the recent celebrating staff event, which had seen exceptional staff being commended for their hard work and expressed her thanks to colleagues who had been instrumental in making the event happen. The Board **noted** the report.
7	**Urgent Care and Winter improvement** In the absence of the Director of Delivery, the Chief Executive presented the report. ***(a) Urgent Care*** Work continued to incorporate urgent and elective care and to address other challenges across the System. Further work was required to identify key actions to be completed over the next 3, 6, and 12 months, to comply with the conditions of the System being removed from System Oversight Framework (SOF) 4. This needed to accurately reflect the actions of organisations on an individual basis and working in partnership, in addition to a review of the financial and infrastructure resources needed to support this. The Board noted the governance requirements of SOF were being finalised with the Regional Director of Improvement which would include a board-to-board meeting held in January 2023 where the plans and positions would be presented. Work continued to develop the improvement plans of individual organisations and the integrated system plan, in terms of primary care and the enablers such as workforce, digital and estates. The meeting would provide the opportunity for the team to reflect on previous meetings and progress achieved to date and to agree any future support required for Devon. JM advised there were a number of national support processes already in place across Devon e.g. ambulances in the Plymouth system and releasing the Chief Transformation & Strategic Planning Officer. Simon Tapley to support discharge and patient flow processes and the national team, comprising a chief executive, chief operating officer and a chief nurse who will also provide support. In addition, a ten week improvement plan was being supported by Michael Wilson. The Chief Executives of the peninsula Systems were working together to ensure the flow for Cornwall patients was coordinated to support University Hospitals Plymouth NHS Trust and ensuring the 10 bedded care hotel in Plymouth was utilised. Members acknowledged the coordination, governance and oversight of all programmes of work needed to be fit for purpose and form part of a longer term plan. JM confirmed that the next iteration of the report would clearly show this alignment and other schemes which would become available. ***(c)Winter Improvement*** JM reminded members about the tactical control process, established in 2021, which had been strengthened with an operating framework and continued to develop. A physical Tactical Control Centre had been established at County Hall with a number of staff appointed to support this resource. Local authority colleagues were also involved to support a local system of escalation, as well as local GP practices. The Board was also advised that Julian Head, the National lead for urgent care would be visiting Devon, Cornwall, and Bristol tomorrow to review plans. KS considered this was happening too early for ICBs and suggested that when this was reviewed this would be clear. She therefore considered this visit and oversight would be challenging and she hoped that Julian Head would see the respective ICBs as a work in progress.

	SLG asked if the mental health data from the voluntary, community and social enterprise groups would be available and was advised by JM that some data was available, and she was keen to draw on the work being undertaken within local care partnerships to strengthen this. She further advised that daily System calls involved representatives from all sectors.
8	**Quality and Performance Committee - update** The Chair of the Committee, Hisham Khalil, provided an oversight of the deep dive undertaken into Children and Young People's access to speech and language therapy and autism services. It was noted that both services had been subjected to a recent service improvement process. This had led the Committee to discuss its approach to deep dives which concluded that assurance could not be provided simply by provider presentations and data from the Integrated Quality and Performance report (IQPR). The Committee agreed it would be helpful for Non- executive Members to undertake ad-hoc visits to services. Development of the approach to be taken would be advised to the Board in due course. The IQPR data had been discussed and members had concluded that there had been no significant improvement in performance on the included metrics. HK asked the Board to consider a suitable time for a set of actions to be proposed to improve areas and when any contingency plans should be considered. The Board **noted** the report.
9	**Integrated Quality, Performance, and Finance report** The Board received and noted the report and acknowledged the report continued to be refined and the answer to the 'so what' question continued to be developed. A Non-executive Member, Judy Hargadon (JH) acknowledged and thanked colleagues for the improvements made to the report. She advised that the manager who presented the report to Quality and Performance Committee was able to draw out conclusions contained in the report, and she suggested this could be included as narrative in the executive summary presented to the Board. JM wished to see the report develop to include accountability for actions arising from the content. She reflected that, during the recent meeting with the Minister, the good performance on discharge had been mentioned and she suggested that should be an area of focus for future improvements.
10	**Finance Committee - update** The Board received and noted the update by the Chair of the Committee a Non-executive Member, Kevin Orford who advised the financial position of the ICB would be covered fully in minute 11. He also referred to the work to align the financial reports to the Integrated Quality and Performance report which he hoped would be presented to the Board next month.
11	**ICS and ICB Month 7 finance reports** The Chief Finance Officer, Bill Shields (BS) shared that the ICS financial plan, which included the provider organisations for whom oversight was provided, continued to project an £18.2m deficit which was in line with the plan submitted to NHS England. The plan was predicated on efficiency savings of £139m. He advised concern about the ability to deliver the plan, the risk of which had been discussed in detail at Finance Committee and identified at the last meeting of the Board. These were of a size and scale which called into question the ability of the ICB to meet the target. Work was in progress within the ICB and each organisation within the System to clarify financial positions, including what actions had been taken and what mitigations had been put into place. These would be considered further as part of the review of the ability to continue to forecast the deficit. If the overall target and individual targets could not be met there was a detailed process, which would be shared with the Board, to change the in-year forecast position. This consisted of a very detailed protocol and required approval by NHS England. This would involve stringent controls and severely limit the ICB's own financial controls, in addition to increased reporting and scrutiny. Members were aware the recovery of the current financial position needed to be achieved as quickly as possible and all efforts would be doubled to ensure the position did not deteriorate further into 2023/24. The board **noted** both finance reports.
12	**Integrated Care Strategy – Final Draft** Chief Transformation and Strategic Planning Officer, Simon Tapley (ST) presented the above to the Board to note. ST advised there had been a robust and collaborative approach to the development of the Strategy, including a detailed review process before the final draft had

	been shared with stakeholders today. He advised the Strategy would continue to be iterative and develop as the Partnership matured. Councillor James McInnes, (JMc) thanked everyone involved in producing the Strategy in such a collaborative way. With regard to highways and transportation not being included, he explained this was due to these services being beyond the immediate scope of health and care. Members noted that positive feedback on the Strategy had been received, in addition to suggestions to further strengthen it for the next iteration. The Chair (SW) confirmed that One Devon Partnership would hold the System to account for delivery of the Strategy. JM advised that the aim was to capture the Strategy as a "plan on a page" and it would therefore be important to identify relevant metrics and shape and hone these collaboratively. Work would continue to promote ownership of the Strategy across the System and to learn from other Systems and their respective strategies. In the longer term the Board would ensure linkages which held all strategies and plans together. The Board **noted** the report.
13	**Memorandum of Understanding (MOU) between NHS Devon and NHS England** The Chief Medical Officer, Nigel Acheson (NA) joined the meeting and presented the MOU which had been submitted for approval and thanked the Board for allowing him to support current operational pressures across the System. NA confirmed that the MOU did not change the statutory roles and responsibilities of either NHS Devon or NHS England, and it did not change the duties or accountabilities of any NHS provider organisations. It would allow the two organisations to work together to discharge their respective duties, thus ensuring the people of Devon had access to high quality and equitable care. NA explained the MOU set out ways of working, system priorities and deliverables at a national, system and place level, health inequalities, together with locality priorities and responsibilities, the operating model and ICS development. The Board **approved** the MOU. *NA left the meeting.*
13	**Assurance Committee - updates and escalations** The Board received and noted the following reports from its committees: ***(a) People and Culture Committee*** The Committee Chair (TH) advised the Workforce Strategy was in development, in addition to the Workforce Development Programme. A Non-executive Member (HK) asked about provision of workforce training and PR confirmed this would be included. ***(b) Audit and Risk Committee*** The Committee Chair (GC) advised the position regarding the appointment of an External Auditor. The regional team was aware that an appointment had not been made and would be approaching the National Audit Office for support. The process for noting approval of single action waivers had been discussed, as these were currently being submitted to both Finance and Audit and Risk committees. The Board was therefore asked to include this in its Governance Review which would include the Terms of Reference of its committees. He further advised the Board Assurance Framework continued to be developed and had been reviewed by the Committee with feedback provided for the next iteration. Finally, the Chair advised he was organising a risk review workshop for the Audit Chairs Forum, which would look at how risk was dealt with across the System. **Action 26 – The Devon Audit Chairs' forum to hold a risk review workshop and feed back to the Board.** ***(c) Primary Care Transition Committee***

	The Chair of the Committee (JH) sought clarity about the cost of locum staff within primary care. She understood the costs were being supported by the ICB which appeared to be causing issues across practices. ***(d) Remuneration and Strategic Workforce Committee*** The Committee Chair (KO) confirmed an extraordinary meeting of the Committee had been convened to approve the pay award for Very Senior Managers
14	**Action log** A correction to action 3 was agreed, which would not be closed. All other actions were **agreed** to be closed.
	Questions from members of the public No questions had been received from members of the public.
	Any Other Business None. On behalf of the Board the Chair (SW) took a further opportunity to thank all staff for their hard work during the year and extend season's greetings to all.

Minutes approved	Date:	Signed by chair:

NHS Devon

NHS Devon Integrated Care Board Meeting

Report of the NHS Devon Chair

Date of committee	Date report produced
18 January 2023	9 January 2023

Author(s)		Report approved by	
Name and title:	Nick Pearson, chair and chief executive's office	**Name and title:**	Dr Sarah Wollaston, ICB chair
Phone:	-	**Date:**	9 January 2023
Email:	Nick.pearson@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

This document represents the chair's report and includes updates on the Integrated Care Partnership Board, Ministerial meeting, Operating Plan, staff awards and recent visits / speaking engagements.

The report is for information only.

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**
Objective 1	**Reporting only**
Objective 2	**Reporting only**
Objective 3	**Reporting only**
Objective 4	**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

Integrated Care Board Meeting

Report of the NHS Devon Chair

A note from the Chair

I would like to start by wishing everyone a very Happy New Year and extending my thanks to all of those that worked over the Christmas period, including frontline hospital and community teams and all those supporting their work. Thank you too to all those involved with setting up and running the new control room which has given greater visibility of the scale and spread of system challenges and helped to guide the response on behalf of the people who rely on our services.

Your efforts and dedication are hugely appreciated, and patients, public and indeed our board recognise that you took time away from your friends and family over the festive period to meet the needs of others. Thank you.

Ministerial Meeting

Prior to Christmas Jane and I had the pleasure of meeting Helen Whately, Minister of State for Social Care, with a number of representatives from the Department of Health as part of a series of meetings with ICBs across the country to better understand local systems

We were joined by NHSE regional director Elizabeth O'Mahony and Plymouth City Council chief executive Tracey Lee.

It was a wide-ranging meeting with the main areas of focus including:

1) How LAs and NHS are working together
2) Elective care backlog, specifically which initiatives were helping
3) Discharge numbers and links between Cornwall and Devon system, particularly at UHP.
4) Workforce fragility
5) DWP initiative in domiciliary care

The minister showed interest in a number of areas, particularly in understanding what is working well, our challenges as well as our plans for improvement.

She also singled out our discharge numbers in the Plymouth area for praise, adding that they were better here and in the wider system than the national average.

Overall, the meeting was very positive, and we look forward to further meetings as and when requested.

One Devon Integrated Care Partnership Board

During the first One Devon Partnership Board meeting of 2023, members were updated on the operational pressures across the system, which had come from a number of sources including significant flu outbreaks, Covid, Strep A and other respiratory illnesses, as well as Norovirus. As a result, hospitals were required to take additional measures to keep these infections separate, decreasing the number of available beds for patients. These illnesses have also had a significant impact on staff resulting in higher levels of sickness absence.

Members heard how the system had been in critical incident twice during December. However, Chief Delivery Officer Anthony Fitzgerald has set up an effective control centre, which brought together colleagues from across the system to work collaboratively on addressing the issues. I would like to express my thanks to Anthony and his team for their hard work and commitment to handling operational pressures in this difficult time.

A further update was provided on the Integrated Care Strategy, which had been refined and circulated. Members were advised that a response to the strategy was being prepared, which is known as the Joint Forward Plan. The paper will be prepared in accordance with the 2022 / 23 Operating Plan and the draft is intended for completion in March, with final submission in June. Members agreed that the plan should be a shared collaborative delivery plan bringing NHS and local authorities together.

Finally, members heard about anchor institutions, which seek to develop the role ICS organisations can play in reducing health inequalities. It was highlighted that within the public sector, Devon employs 45,000 people, excluding voluntary and private sector workers and factors that affect people's health are wider than just health care itself. An anchor institution network would look at what is happening and learning that can be shared, which would allow opportunities to reach out to big employers in the private sector to see how partnerships can be developed.

The board were supportive of this work and following progress.

2023/24 Operational Planning Guidance

NHS England released its Operational Planning Guidance and Priorities for 2023/24 (the Guidance) prior to Christmas.

The planning guidance requires all NHS organisations to produce and submit an Operating Plan for the financial year ahead. Operating Plans focus on organisational priorities and actions that will respond to planning guidance, while maintaining organisational development goals and local commissioner requirements.

The Guidance sets out the ongoing need to recover our core services and improve productivity, through 32 national objectives. The planning guidance is shorter than in previous years, which is welcome, but equally there are areas that have been omitted that I feel it is nevertheless important for us to continue to prioritise for example, commitments on equality, diversity and inclusion.

The objectives are centred around three key priorities for 2023/24:

1. **Recovering core services and productivity**

To improve patient safety, outcomes and experience it is imperative that systems are required to:

- Improve patient safety, outcomes and experience it is imperative that we:
  - improve ambulance response and A&E waiting times
  - reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
  - make it easier for people to access primary care services, particularly general practice
- Whilst continuing to narrow health inequalities in access, outcomes and experience, including across services for children & young people and maintaining quality & safety in our services, particularly maternity.

2. **Delivering against the key ambitions in the NHS Long Term Plan**

ICSs are required to create stronger foundations for the future, with the core goals of the NHS Long Term Plan.
These include commitments to:

- Improve mental health services and services for people with a learning disability and autistic people.
- Continue to support delivery of the primary and secondary prevention priorities and the effective management of long-term conditions.
- Ensure that the workforce is put on a sustainable footing for the long term, including publication of an NHS Long Term Workforce Plan.
- Level up digital infrastructure and drive greater connectivity, including development of the NHS App to help patients to identify their needs and get the right care in the right setting.

3. **Continue transforming the NHS for the future**

NHSE has asked ICSs, as best placed to understand population needs, to agree specific local objectives that complement the national NHS objectives. As set out in Operating Framework, NHS England will continue to support the local NHS [integrated care boards (ICBs) and providers] to deliver their objectives and publish information on progress against the key objectives set out in the NHS Long Term Plan.

Funding and planning assumptions

The Autumn Statement 2022 announced an extra £3.3bn in both 2023/24 and 2024/25 in response to the unprecedented and significant pressures the NHS is facing. However, there is an expectation that systems deliver a balanced net system financial position for 2023/24 and achieve their core service recovery objectives and must meet the 2.2% efficiency target agreed with government and improve levels of productivity. To support this ambition:

- NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations [including COVID-19 and Elective Recovery Funding (ERF)] are flat in real terms with additional funding available to expand capacity.
- Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. Capital allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that deliver agreed budgets in 2022/23.
- The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay unit prices for activity delivered. System and provider activity targets will be agreed through planning as part of allocating ERF on a fair shares basis to systems. NHS England will cover additional costs where systems exceed agreed activity levels. ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners. Further details will be set out in the revenue finance and contracting guidance for 2023/24

Next steps

ICBs are asked to work with their system partners to develop plans to meet the national objectives set out in this guidance and the local priorities set by systems. To assist them in this, the guidance identifies the most critical, evidence-based actions that systems and NHS providers are asked to take to deliver these objectives. These are based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

System plans should be triangulated across activity, workforce and finance, and signed off by ICB and partner trust and foundation trust boards before the end of March 2023.

Staff Awards

I was delighted to join Jane in hosting the first NHS Devon Exceptional People Awards in December.

A total of 36 staff, teams or projects received awards for outstanding work undertaken during 2022.

Special congratulations to Paul Green who won the People's Choice award, which was voted for by staff live at the event.

The ceremony was really important in enabling us to recognise the hard work of so many people across Devon, and it was wonderful that we were able to come together in-person.

I'd like to thank everyone who attended and helped to put the event together and, of course, congratulations to our winners

Each Trust also has its own awards ceremony, which is a welcome opportunity to celebrate front line staff.

Chair's visits and speaking engagements

I was delighted to be welcomed to the Resilient Young Minds Programme in Okehampton.

This is a pioneering nature-based social prescription programme that aims to tackle health inequalities with a focus on psychological distress and marginalised young people.

I was specifically invited to experience first-hand their community session at the end of the programme. It was a great opportunity to meet the young people who took part in the programme and see the programmes being run in our communities.

The visit was the last of my visits of 2022.

I visited a wide range of different facilities and programmes / initiatives during the year and I very much enjoyed meeting everyone involved in improving our health system, whether in acute facilities, GP practices or in the community.

I am very much looking forward to the visits and speaking engagements that I have lined up for 2023 and will of course report back on these following each visit.

NHS Devon Integrated Care Board Meeting

Report of the chief executive

Date of committee	Date report produced
18 January 2023	9 January, 2023

Author(s)		Report approved by	
Name and title:	Nick Pearson, chair and chief executive's office	**Name and title:**	Jane Milligan, Chief Executive
Phone:	-	**Date:**	9 January, 2022
Email:	Nick.pearson@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
This document includes summary updates on Covid-19, Flu and vaccinations, industrial action, Social Care Recruitment Partnership, HSJ Awards, winter pressures 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**
Objective 1	**Reporting only**
Objective 2	**Reporting only**
Objective 3	**Reporting only**
Objective 4	**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

NHS Devon Integrated Care Board Meeting

Report of the chief executive January 18

Operational pressures over the Christmas period

The NHS in Devon has been extremely busy throughout the Christmas and New Year period. An increase in demand, flu, COVID, norovirus and staff sickness all combined to make this year's festive period among the toughest we have seen.

Even in the week before Christmas emergency department attendances were some 16 higher than the previous year and calls to NHS111 up by almost a half. We expect the statistics to show they were even higher over Christmas.

The pressures are also being felt nationally. At the end of December there were 3,746 people in hospital with flu across England; seven times the number at the end of November (520).

Our staff have been doing all they can to support and care for people while trying to ensure that patients are seen at the most appropriate locations for their needs.

There was a big media push. Clinicians from across Devon were interviewed and recorded videos for social media urging people not to come to hospital if they had symptoms of Covid, flu or norovirus, unless of course we'd asked them to.

Family and friends were also urged to collect patients when they are ready to be discharged from hospital and only call 999 or attend an emergency department if they had a life-threatening emergency.

All in all, it was – and is, a very difficult period.

I would like to place on record once again, our thanks to the clinicians, porters, cleaners, receptions and "back office" staff who continue to go beyond the call of duty to care for patients.

Ambulance staff too need special recognition. I know it is not easy for anyone at the moment but time and again, despite the pressure, staff across NHS and social care continue to step up.

You all deserve our praise and recognition – and that of our patients and public - and I hope that they can get some down time during a post-New Year period in which we are unlikely to see much let up.

Of course, the best way that people can protect themselves and the NHS during times of heightened pressure is to get vaccinated, and plenty are taking this up.

The vaccination programmes for flu and Covid-19 in Devon are now very well established with more than 460,000 autumn booster jabs given in Devon and well over 3.5 million doses of the vaccine given since the vaccination was launched just over two years ago. It's never too late, even if you haven't been vaccinated. Look online for the latest or speak to your GP surgery.

Winter pressures

As noted above, Devon remains under extreme pressure with increasing Covid / Flu inpatient numbers combined with an increase in community infections placing pressure on primary care. This has resulted in extended delays in urgent care, ambulance conveyancing and waiting times.

No Criteria to Reside figures have reduced as winter funding plans have delivered extra capacity, although average length of stay remains higher than previous years.

But there have been increased waiting times against Emergency Departments (ED) and ambulance conveyancing standards have continued to decline, with a resultant impact to patient care.

Mitigations have been implemented to reduce risk and improve performance and these will be reviewed within the context of the revised operating frame.

Industrial Action

Industrial action took place during last month, with nurses and ambulance staff striking various days in December. The action took place only where the threshold was met as part of the Royal College of Nursing ballot. For Devon, this included:

- Royal Devon University Healthcare NHS Foundation Trust
- Torbay and South Devon NHS Foundation Trust
- Devon Partnership Trust
- University Plymouth Hospitals NHS Trust
- NHS Devon ICB

In addition, ambulance workers also undertook industrial action on 21 December, which affected Barnstaple, Derriford, Exeter and Torquay. The planned industrial action on 28 December was postponed.

The Safer Staffing risk framework that was utilised during the Covid pandemic was reviewed, refreshed and implemented during the industrial action to ensure sufficient staffing levels. Staff members that were not striking were asked to support other areas where staffing levels were at a minimum.

Urgent and elective care was affected during the industrial action, with both inpatient and outpatient procedures being rescheduled across Devon.

There is further industrial action planned for the month of January. Nurses intend to strike again on 18th and 19th January in Somerset and Cornwall, although Devon is not directly affected on this occasion.

In addition to this, ambulance workers in all areas will be taking industrial action on 11th and 23rd January for a 24-hour period, commencing at midnight. South West Ambulance Service are meeting with ICS's on Monday 9th January to provide an updated plan for industrial action.

Finally, the British Medical Association have announced that ballot to strike will open on 9th January. If the ballot is successful, junior doctors will begin with a 72-hour full walkout in March.

Refugee and Asylum Seekers health needs

I would like to further update the board on the work NHS Devon undertakes with refugee and asylum seekers living in Devon.

As previously updated, with greater numbers of refugees and asylum seekers arriving in the UK, there has been a growing need for a wider dispersal of people across the country with Devon now seeing higher numbers of refugees and those on resettlement schemes.

November and December 2022 saw a steep increase in the asylum seeker arrivals in Devon due to the fast-paced set up of asylum seeker hotels in Torquay, Ilfracombe and Exeter. A contingency hotel in Paignton had already been established in September 2022.

There has been a local media report that another asylum seeker hotel may be opening imminently in Exeter but this has not yet been confirmed by the Home Office.

Devon also continues to host two refugee bridging hotels that were set up in 2021 in Exeter and Exmouth for refugees from Afghanistan.

NHS Devon (as delegated through NHS England) continue to have a lead role in coordinating the health services for refugees and asylum seekers arriving in Devon, including meeting their longer term health needs as their hotel stays are prolonged.

NHS Devon has deployed a refugee and asylum seeker Lead as a temporary measure for the next three months to support the teams working in each of the locality areas, where they work closely with local partners to plan and deliver health services.

The Lead will support the Devon health system in creating effective processes for the longer term and resolve challenges with regards to health access and provision across the wider Devon footprint.

NHS Devon's Refugee and Asylum Seeker System Health Group supports and oversees the work with refugee and asylum seekers, this includes identification of health need at a strategic level and planning appropriate services in the hotels and for the wider population including guests from Ukraine and individuals on other resettlement schemes.

This is a partnership at a system level and involves Locality colleagues, NHS Devon system, Public Health and Local Authority colleagues.

Our patient story this week involves someone seeking asylum and I'm sure we all look forward to hearing about this often overlooked area.

New CEO for Devon County Council

Members will no doubt be aware that Devon County Council will soon have a new chief executive.

Donna Mason is set to replace Dr Phil Norrey as Chief Executive, having been Chief Executive of Scotland's largest rural authority, The Highland Council, since 2018.

I reached out to Donna before Christmas, and I'm pleased to have been in touch with her prior to her starting in Devon next month.

Donna has a background in Education and Children's Services in three Scottish councils, having started her career in teaching.

I look forward to fostering a good working relationship with Donna.

Social Care Recruitment Partnership

I am pleased to report that a successful joint recruitment campaign led by NHS Devon has resulted in more than 1000 applications for social care roles in the county.

NHS Devon has been working with local authorities on a recruitment campaign targeted at experienced and trained overseas social care staff.

Staff shortages in social care are well documented (circa 2000 across Devon) and this campaign aims to bridge some of that gap.

We expect to reach our target of 175 new starters joining us and significant focus is on ensuring the highest possible level of pastoral care is given to these new colleagues. To date we have the first 5 new colleagues arriving from 17 January and aim for all to have arrived and be working in social care no later than May.

The partnership has allowed a unique opportunity to develop an integrated approach for international recruitment and should help to ease the strain within social care.

It is a really positive initiative and one we can all be proud of.

Awards Success

There have been more success for Devon projects in the HSJ Awards 2023.

University Hospitals Plymouth NHS Trust (UHP) is recognised for its Primary Care Heart Failure Service, alongside a number of partners in both the Best Education Programme for the NHS and Most Impactful Project Address Health Inequalities categories.

In addition, UHP is also recognised in the Mental Health Partnership category, in collaboration with the University of East Anglia, for their work establishing and training a new psychology workforce for the NHS.

Exeter-based Chime Social Enterprise is also a finalist in the Best Not for Profit Working in Partnership with the NHS category, for their work future-proofing NHS audiology.

I would like to extend my thanks to all of the teams involved in these nominations and wish them all the best at the awards ceremony in March. Let's hope we can celebrate wins.

Shared Learning Programme

NHS Devon is working in partnership with the King's Fund, homelessness charity Pathway and non-profit homelessness organisation Groundswell as part of a shared learning programme.

It is an interesting scheme which will run until April 2023 and focuses on improving outcomes for groups whose needs are not currently being met.

The scheme helps those experiencing homelessness, substance abuse and those from traveler and refugee communities.

The aim of the scheme is to establish consistently good services to address these groups 'needs and then to scale these up across Devon.

I will report back in due course of how the project is progressing.

Visits and speaking engagements

Given Christmas and how busy I and my colleagues have been since my last report to the Board, it has not been possible for me to take time out to visit the frontline this month.

I wish I had more time to dedicate to this as the feedback and learning that I receive during them is invaluable.

I am pleased to have had the opportunity to visit a range of hospices, GP practices, hospitals and community settings last year.

Feedback obviously influences the way we look at our services, of how they are changing to meet the pressures and demands of the service – but also how we commission them in future.

I see visits as a vital part of my job and very much enjoy meeting staff and clinicians to see the excellent work that everyone is continuing to do for our health service.

I cannot thank you enough for your hard work and dedication and look forward to meeting more of you this year – and if you hosted a visit this year from me, a special thank you.

NHS Devon

NHS Devon Integrated Care Board meeting

Reducing & Mitigating Against Health Inequalities in Planned Care

Date of committee	Date report produced
18 January 2022	02 December 2022

Author(s)		Report approved by	
Name and title:	Dr Claire Hooper, Strategic Clinical Lead for Planned Care Dr Helena Posnett, Consultant in Public Health (Health Inequalities)	**Name and title:**	John Finn, Director of Commissioning Urgent & Elective Care
Phone:	01392 675365	**Date:**	07 December 2022
Email:	claire.hooper2@nhs.net helena.posnett@devon.gov.uk		

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

Executive summary
This paper sets out background information regarding Health Inequalities, the tackling of which is a long-standing NHS policy objective. Health inequalities existed pre-COVID-19 Pandemic, with the Pandemic worsening this. The Pandemic has highlighted and worsened existing inequities in planned/elective care both in terms of access, outcomes, and experience of people when on waiting lists. Research has

shown that the growing backlog has not been experienced equally by patients and has only further exacerbated Health Inequalities faced, including likely impacting those already at risk of worse health outcomes and more challenging access to healthcare first.

This paper sets out the Health Inequalities requirements for Planned/Elective Care placed on Devon (and across the country) by NHS England for 2022/23. It details where we are against these requirements as well as the next steps the system is taking to push the Health Inequalities agenda forward for Planned Care.

This is a paper that the Board is asked to note. There are not any specific questions being asked of the Board or any recommendations the Board is asked to make.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
The Strategy & Transformation Directorate's Senior Leadership Team in the ICS approved this paper on 2 December 2022. This followed a discussion at the ICS Planned Care Programme Board on 29 November 2022.

Key recommendations and actions requested –
1. Board members to note the paper regarding where we are with Health Inequalities in relation to Planned Care and to note the steps going forward

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	
Improve services and reduced unwarranted variation	The assurances that we have received will support the continuing work to support the Health Inequalities programme
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	None

Health Inequalities	This paper will give assurance that provider organisations and the system have a process in place to continue to move forward with the Health Inequalities agenda in Planned Care
Workforce	None
Resources and finance	None
Legal	None
Digital and Data	None
Involvement, Engagement, and consultation	None

NHS Devon

Reducing & Mitigating Against Health Inequalities in Planned Care

Dr Claire Hooper, Strategic Clinical Lead for Planned Care in Devon

Dr Helena Posnett, Consultant in Public Health (Health Inequalities)

ICB Board for Devon

18 January 2022

One Devon

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

Table of Contents

1 What are Health Inequalities?

1.1 Introduction

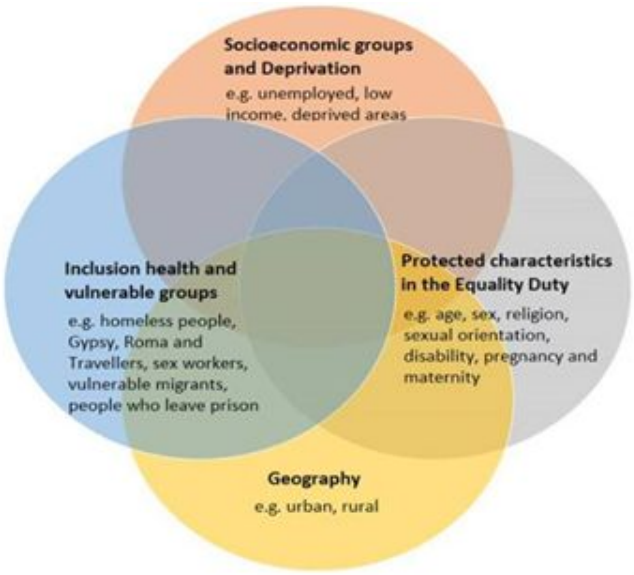
Health inequalities are systematic, avoidable, and unjust differences in health and wellbeing between different groups of people. There is clear evidence that reducing Health Inequalities improves life expectancy and reduces disability across the social gradient. Tackling Health Inequalities is therefore a core part of improving access to services, quality of services, and health outcomes for the whole population.

Health Inequalities are ultimately about differences in the status of people's health. But the term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status. Health Inequalities can therefore involve differences in:

- health status, for example, life expectancy,
- access to care, for example, availability of given services,
- quality and experience of care, for example, levels of patient satisfaction,
- behavioural risks to health, for example, smoking rates,
- wider determinants of health, for example, quality of housing.

This means that when we talk about 'health inequality', it is useful to be clear on which measure is unequally distributed, and between which people.

Health Inequalities in England exist across a range of dimensions or characteristics, including the nine protected characteristics in the Equality Act [(1)]: socioeconomic position, occupation, geographic deprivation and membership of a vulnerable group. As shown in the diagram below, these dimensions overlap, compounding the impact on persons affected.



[(1)] The 9 protected characteristics in the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Access to services refers to the availability of services that are timely, appropriate, easy to get to and use, and sensitive to user choice and need. Inequitable access can result in particular groups receiving less care relative to their needs, or more inappropriate or sub-optimal care, than others, which often leads to poorer experiences, outcomes and health status. Access to the full range of services that can have an impact on health includes access to preventive interventions and those which enable self-management, and social services; as well as primary, community, and secondary health care; and includes those delivered by voluntary, community and social enterprise sector partners, both formal and informal

Inequitable access might mean that a group faces particular barriers to getting the services they need, such as real or anticipated discrimination or challenges around language. It can mean that information is not communicated in an easily understandable or culturally sensitive way.

Sources: The King's Fund www.kingsfund.org.uk/publications/what-are-health-inequalities;
Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

1.2 What is the evidence of Health Inequalities in Planned Care?

Tackling inequalities in health is a long-standing NHS policy objective. Variation in the experiences and outcomes of different communities during the COVID-19 Pandemic served to bring this issue back into focus.

1.2.1 Pre-Pandemic

Health Inequalities existed pre-COVID-19 Pandemic, with the Pandemic worsening this. Pre-Pandemic, persons from more deprived areas were accessing Planned Care less, and at risk of presenting late with more complex conditions. There is also evidence that decreased rates of planned care amongst lower socio-economic groups is associated with a rise in Emergency Department attendances. NHS Digital published hospital activity data in September 2020 which highlighted that during 2019/20 the most deprived decile had 7% fewer admissions for elective procedures but 51% more emergency hospital admissions than the least deprived.

Source: Socio-economic inequalities in access to planned hospital care: causes and consequences | The Strategy Unit (strategyunitwm.nhs.uk)

1.2.2 Recovery

The Pandemic has highlighted and worsened existing inequities in elective care both in terms of access, outcomes and experience of people when on waiting lists. Research has shown that the growing backlog has not been experienced equally by patients and has only further exacerbated Health Inequalities faced, including likely impacting those already at risk of worse health outcomes and facing difficulties in accessing healthcare.

For instance:

- The elective recovery backlog has not grown equally across the country. Devon has experienced a c. 65% increase in elective referral waiting lists between April 2020 and July 2021, in excess of the c. 42% increase nationally.
- On average waiting lists have increased by 55.2% in the most deprived areas in England, compared to 36% in least deprived areas.

Source: NHS England

The Pandemic has placed considerable strain on planned service delivery, which was already under pressure. Consequently, there are now significant waiting lists across the country with potentially more patients still to come forward, alongside a system focus on reducing these backlogs to meet the challenging targets regarding long waits that have been set.

If Health Inequalities is looked at in relation to elective/planned care recovery since the Pandemic, specific concerns include:

- Missing referrals – who is not on the waiting lists who we would expect to be?
- Digital exclusion – who cannot access virtual appointments?
- Clinical validation favours the educated.
- Treatment offers further from home may exclude:
    - Those on lower incomes and / or in rural areas (transport access).
    - Those with more complex conditions (more likely to live in deprived areas.

Source: Socio-economic inequalities in access to planned hospital care: causes and consequences | The Strategy Unit (strategyunitwm.nhs.uk)

Failure to consider Health Inequalities in elective recovery plans risks harm to those most in need, widening of pre-existing inequalities, and individuals seeking help late leading to a worse prognosis and increased pressure on health and care services.

2 What the Devon system is doing to reduce Health Inequalities in Planned Care

Given the importance of tackling Health Inequalities for our population and the importance of tackling the elective recovery waiting list, Devon continues to have a focus to ensure Health Inequalities are incorporated in the planning activities.

2.1 Operations Planning process for 2022/23

As part of the Operations Planning process for 2022/23, NHSE has asked systems to undertake specific work relating to Health Inequalities. This includes the following requirements:

1. Complete and publish an **Equality and Health Inequalities Impact Assessment (EHIA)** or provide a date when this will be published by, for elective recovery plans locally i.e., in Devon.
2. **Publish Board papers** (ICSs and trusts) including analysis of waiting times disaggregated by ethnicity and deprivation, or provide a date when these will be published by:
    - Use waiting list data (pre & during Pandemic), including clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and Black and minority ethnic (BME) populations.
    - Prioritise service delivery by taking account of the bottom 20% by IMD and BME for patients on and not on waiting list, including through proactive case finding.
    - Use system performance frameworks to measure access, experience and outcomes for BME populations and those in bottom 20% of IMD scores.
    - Evaluate the impact of elective recovery plans on addressing pre-Pandemic and Pandemic related disparities in waiting lists, including for clinically prioritised cohorts.
    - Demonstrate how the ICS's responsible officer for Health Inequalities will work with the board and partner organisations to use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes, and ensure performance reporting allows monitoring of progress to address.
3. Ensure an ongoing commitment to the **validation process and prioritisation programme**. This includes taking the person and wider determinants of health into account.

2.2 Why have systems and trusts been asked to do this?

Concerted, systematic and sustained action is needed to address the multiple and overlapping web of factors that drive Health Inequalities – from differences in experiences and quality of healthcare through to the wider determinants of health. This includes, but goes well beyond, the health and care system.

Addressing Health Inequalities remains a key element of elective recovery and the Ops Planning 2022/23 submissions to NHSE required additional narrative detail on how system plans will ensure inclusive recovery and reduced Health Inequalities where they are identified. This emphasises the importance of this work.

3 Health Inequalities work plan for Planned Care

3.1 Assessment of progress

In Devon to ensure that planned care plans enable inclusive recovery, and reduce Health Inequalities where they are identified, we aim to embed a focus on Health Inequalities within all workstreams and actions to ensure that there is a focus on equity of outcomes in all the work we do. We aim to create an environment where action on Health Inequalities is seen as business as usual rather than an additional workstream, by embedding into all job descriptions and plans, workstreams and project plans.

As part of the planning process, the ICS has developed a Health Inequalities and Prevention Programme of work to further progress the Health Inequalities agenda and reduce the inequalities gap.

3.1.1 Progress against work plan for Planned Care

Details of the key Health Inequalities actions in the Planned Care work plan can be seen below. This covers the action, output(s) and benefits. Progress against each of these actions can be seen in the table on the following pages.

To support this work programme, best practice examples are being sought to ensure learning from elsewhere.

Action	Output	Benefit	RAG Rating & Comment(s)
An Equality and Health Inequalities Impact Assessment for the system elective recovery plan has been completed and has been / will be published MUST-DO	A completed NHSEI template to highlight the beneficial and detrimental impacts of Devon's elective recovery programme on persons at risk of experiencing Health Inequalities e.g., those in protected characteristic groups and/or inclusion health groups (persons who are homeless or from the Gypsy, Roma or Traveller community) – and the mitigations in place and/or required to be implemented by the Devon System	Assurance that Devon's elective recovery does not inadvertently widen Health Inequalities and/or where risks exist, mitigations are in place and/or planned for, and being monitored	In progress, first draft due end Dec, which will include a SMART action plan
The ICS will ensure board papers are published that include an analysis of waiting times disaggregated by ethnicity and deprivation MUST-DO	Published intelligence in relation to waiting lists, disaggregated by IMD and ethnicity and other priority factors** with actions plans in place including in relation to improving data quality and completeness (e.g. ethnicity coding) and other elements from https://www.england.nhs.uk/wp-content/uploads/2021/12/B1269-elective-recovery-planning-supporting-guidance.pdf: ▪ *Use waiting list data (pre & during Pandemic), including clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and Black and minority ethnic (BME) populations.* ▪ *Prioritise service delivery by taking account of the bottom 20% by IMD and BME for patients on and not on waiting list, including through proactive case finding.* ▪ *Use system performance frameworks to measure access, experience and outcomes for BME populations and those in bottom 20% of IMD scores.*	Assurance that inequalities in relation to access to waiting lists are understood, action plans are in place to address, and progress is being monitored	Sitrep sent to trusts, the results of which can be seen in Section 3.1.2, UHP has made this data available; RDUH and TSD to make available by the end of the financial year Action plans can be developed once this information is available across the system

	▪ *Evaluate the impact of elective recovery plans on addressing pre-Pandemic and Pandemic related disparities in waiting lists, including for clinically prioritised cohorts* ▪ *Demonstrate how the ICS's responsible officer for Health Inequalities will work with the board and partner organisations to use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes, and ensure performance reporting allows monitoring of progress to address* ** for example, age, sex, other protected characteristics, Core20PLUS5, area of residence, rurality.		
The ICS and its acute providers will actively engage with the clinical validation and prioritisation programme including taking the person and wider determinants of health into account MUST DO	Agreed processes by which the person and wider determinants of health should be taken into account in the validation process. Consideration of the use of tools which take the person and their wider determinants of health into account when prioritising waiting lists e.g., HEARRT tool. All patients who are on long waiting lists are offered support to remain well while waiting.	Assurance that the validation process does not disadvantage certain groups. Assurance that prioritisation processes take the whole person into account when determining clinical need and therefore reflecting overall health need, reducing impact on other services and narrowing the historical gap in inequalities. Assurance that the Devon system is supporting long waiting patients in terms of wellbeing, information and maintaining fitness for surgery while waiting.	Need system agreement of process, including prioritisation
Incorporation of consideration of population needs and possible Health Inequalities	Agreed processes to ensure Health Inequalities are taken into account early in business case and service development	Assurance that business case processes are fit for purpose and meet Devon System and NHSEI needs	In progress - to ensure is part of the process we automatically do at the beginning (Heat tool)

at an early stage into business/service case development – NHS Devon and Trust level (NHSEI Health Inequalities feedback received) SHOULD-DO			
Reaching those that validation process cannot (clinical and non-clinical validation) SHOULD-DO	• Develop a process to follow up persons who are unable for whatever reason to engage in the existing non clinical validation process (telephone and online based), in order to: ○ Identify barriers to engagement ○ Implement solutions as required, including reasonable adjustments to enable person-centred offer and monitor impact	Assurance that the current non-clinical validation process is able to deliver person-centred care including reasonable adjustments, and plans are in place to monitor.	Nil currently. Work needed to understand those validation process *cannot* reach in clinical and non-clinical validation process
Missing referrals – who is not on the waiting list who should be SHOULD-DO	• Identify priority pathways where referral rates have not recovered post Pandemic • Complete equity analysis to identify areas of unmet need (for example in relation to deprivation and ethnicity) • Co-develop solutions to engage with communities to encourage presentation and early diagnosis, and monitor impact	Assurance that a plan is in place to proactively encourage engagement with services where gaps are identified, and mitigate against individuals seeking help late leading to a worse prognosis and increased pressure on health and care services, and plans are in place to monitor	Nil currently
Reduce impact of digital exclusion in outpatient transformation SHOULD-DO	There are clear processes in place to ensure that virtual consultations are offered when clinically appropriate and take into account a person's needs based on their wider determinants of health.	Assurance that digital transformation of outpatient services does not increase barriers to healthcare.	Information gathering from trusts as part of OP work around offer of virtual consultations and implementation of recommendations in NHSEI EHIA

3.1.2 Assessment of progress from the trusts

A 'sitrep' from trusts was sought to provide oversight of progress against the information below and a RAG rating (Red, Amber and Green) assigned against each.

Self-assessment areas	RDUH	TSD	UHP
Board papers include analysis of waiting times disaggregated by ethnicity and deprivation			
Use waiting list data (pre & during pandemic), incl. clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and Black and minority ethnic (BME) populations			
Prioritise service delivery by taking account of the bottom 20% by IMD and BME for patients on and not on waiting list, including through proactive case finding			
Measure access, experience and outcomes for BME populations and those in bottom 20% of IMD scores			
Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic related disparities in waiting lists, including for clinically prioritised cohorts			

UHP has had additional external support from Optum, which has enabled them to be in a stronger position than the other trusts. Their support specifically focused on population health and Health Inequalities.

3.1.3 Planned Care Programme Board, November 2022

Progress against the actions has unfortunately slipped due to capacity issues. As a result, the ICS Planned Care Programme Board focused on this as part of their 29 November meeting, to further push this agenda forward. The Board also considered the sitrep information from the trusts as part of this.

The Planned Care Programme Board was requested to:

- Identify a named person responsible in each provider.
- Participate [the above people] in a 'Task & Finish' group to develop and oversee the delivery of a workplan, share learning and monitoring of progress:
    - Ensure delivery of Health Inequalities deliverables.
    - Use data to improve access, experiences and outcomes in groups identified as having inequalities.
    - Ensure publication of board papers.
    - Provide shape to and oversight of non-clinical / clinical validation process and prioritisation and report back.
    - Ensure Health Inequalities is considered early on in the business case / service development process.
    - Robust data recording – linked to Strategic Intelligence, Evidence and Outcomes Group workplan.
    - Other priorities as agreed e.g., understanding drivers of Did Not Attend (DNAs), missing referrals, understanding those not reached by validation processes.

Providers: It was agreed that each of the providers would allocate a person responsible for Health Inequalities. At the time of writing this paper we are waiting for the name of the RDUH lead.

- TSD – Paul Procter is their contact regarding reporting. However, due to movement in the Executive Team, they are currently confirming the strategic Health Inequality Lead and will confirm who this is in due course
- UHP – Mike Hollow.

Task & Finish Group: meeting will be set up with these individuals and the system, including Public Health and Health Inequalities system leads to push this agenda forward. This will happen in January 2023.

Waiting lists data by ethnicity and deprivation: It was agreed that the two trusts who have not yet published waiting lists data by ethnicity and deprivation (RDUH and TSD) will do this by the end of the financial year. Following this, the system and providers can agree what is done as a result of having this information to push this agenda forward. We will engage with Devon's Intelligence Functions Group to review the UHP waiting lists and data quality report and support RDUH/TSD analysis as required.

Areas of Focus: The Planned Care Programme Board is in agreement that it would be more beneficial to focus on a couple of high priority areas, where a real difference can be made to narrow the Health Inequalities gap. Given the context with the operational challenges the system continues to have, including the increased scrutiny by NHSE on long waiting patients, this was felt to be a reasonable pace to take this forward. It was suggested that Orthopaedics would be a good speciality to focus on as this has our longest waiting patients.

In addition, there is an opportunity to align efforts with Devon's approach to the CORE20+5 (England's national health inequaliteis programme, for adults, children and young people), as follows:

1) Devon's Priority Populations (CORE20+):
    a. the most deprived 20% of the national population living in Devon
    b. Individuals, families and communities experiencing rural and coastal deprivation
    c. Individuals, families and communities adversely affected by differential exposure to the wider determinants of health – for example, those with unstable housing or homeless, vulnerable migrants and/or those experiencing domestic abuse.
    d. Persons with severe mental illness and learning disability, and autistic persons

2) Areas of clinical focus aligning to Planned Care e.g. early cancer diagnosis, paediatric tooth extractions

These areas of focus will be agreed in a future Planned Care Programme Board meeting early next year.

EHIA for elective recovery: This is in the process of being produced and will identify the Health Inequalities gaps relating to planned care. The EHIA will have a SMART action plan to drive Health Inequalities across the system. The draft EHIA will be available by the end of the calendar year. The EHIA and action plan will come to the January Planned Care Programme Board, which will give consideration to and agree which specialities to focus on and the system-wide priority areas for action.

Health & Inequalities and Preventions Steering Group: in its meeting on 30 November, this Group agreed to support trusts in identifying leadership for these roles and also be part of the working group.

Ahead of January's Planned Care Programme Board: it was agreed that a paper relating to 'Waiting List Scheduling Tool' to take into account the wider determinants of health of a person would be sent. As part of this, we will consider the use of HEARTT™ (Health Equity and Referral to Treatment), which has been developed by University Hospitals Coventry and Warwickshire NHS Trust (UHCW). In 2020, University Hospitals Coventry and Warwickshire NHS Trust (UHCW) analysed their waiting lists and found that their most deprived patients had a longer average wait than the least deprived. To address this, they developed a software tool (HEARTT) to assign a weighting to patients that impacted their waiting list position.

It is worth noting that there is ongoing work programme of work, covered in section 3.1.1 earlier in this report, to progress this work.

3.2 Next steps

The next steps for the Devon system have been summarised below:

- Complete draft EHIA and SMART action plan – end December 2022.
- EHIA and SMART action plan to Planned Care Programme Board – 19 January 2023.
- Task & Finish Group meeting – January 2023.
- Send the 'Waiting List Scheduling tool' paper to Planned Care Programme Board ahead of the 19 January meeting.
- Agreement regarding the high priority areas of focus for Health Inequalities and planned care – early 2023 (date TBC).
- Engagement with Devon's Intelligence Functions Group to review the UHP waiting list and data quality report and support RDUH/TSD analysis as required.
- RDUH and TSD to publish waiting list data by ethnicity and deprivation – end March 2023.
- Agree what actions can be taken as a result of providers having made their waiting lists data available by ethnicity and deprivation – date TBC.
- Continuation of Health Inequalities programme of work – ongoing.

NHS Devon

NHS Devon Integrated Care Board Meeting

Committee chair report – Quality and Performance Committee

Date of board meeting	Dates of committees covered in this report
18 January 2023	4 January 2023

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

Reports discussed and assurances received

The Committee received updated reports as detailed below:

Integrated Quality and Performance Report (IQPR).

- The Committee noted that the IQPR report continues to improve in respect to data granularity/ quality, quality metrics and ability to gain assurance. The committee discussed the need for equal emphasis on quality indicators and patient outcomes in addition to performance indicators. At the request of the committee, the IQPR has now included primary care data and these will be further developed to be locality-specific.

- The Committee was concerned to note there had been an increase in the occurrence of 'Never Events' compared to last year's data and benchmarked against other ICBs. Actions were noted in respect of NHSE national/regional support, peer support and that further clinical engagement is being considered. There may be a role for the 'Learning Academy' in this process. System support at provider level is required in respect for the re-instated 'Harm Review group' and the 'Never Events' review.

Primary Care Quality Report

- The significant pressures facing primary care were discussed and in relation to the additional impact on workload of recent events e.g. Influenza, COVID and Group A Streptococcal infections and the impact this has also had on staff sickness. The CQC inspection outcomes for a number of practices were highlighted as well as the support being offered for the practices. The primary care quality dashboard was also highlighted. There was a request for the metrics of the primary care Quality dashboard to be shared with the Q&P committee.

Eating Disorders 'Deep Dive' paper

The discussion of this paper was postponed as the updated paper for this area was not submitted in time for the committee pack circulation

Reports received and noted

- National Quality Board Framework for surveillance.
- Planned Care Harm review: Position Update.
- Specialised Commissioning ICB Delegation.

Risk register review updates

- A written 'Risk and Governance' update was provided to the Committee, however there was no representation from the Governance Team, the item was deferred and attendance at future committees will be discussed.

Committee decisions

- N/A

Items of concern to be escalated to the board

- The Committee highlighted its concern in respect to continued failure of improvement against a number of key performance indicators (considered as a proxy indicator for quality), including, (but not limited to):
  - Emergency, Elective & Urgent Care.
  - Industrial Action Impact on System performance and quality.
  - Increased levels of 'Never Events' occurrence.
  - Workforce gaps and impact on quality outcomes

Recommendations for the board

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

Recommendations for other committees

- A monthly report will come from System Quality and Performance Group (SQPG) as a standing agenda Item for Q&PC.
- The operational plan for next year will be discussed in a meeting between the Director of Performance and Assurance, the Chair of the Finance Committee and the Chair of the Quality and Performance Committee.

Terms of reference or other committee effectiveness issues

- Deputy Chair to be confirmed for the February meeting.
  A named Non-Executive director will be noted within the Terms of Reference.

Management of conflict of interests:

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

NHS Devon

NHS Devon Integrated Care Board meeting

Integrated Quality, Performance and Finance Report

Date of committee	Date report produced
18 January 2023	29 December 2022

Author(s)		Report approved by	
Name and title:	Performance Team	**Name and title:**	Sam Wadham-Sharpe Director of Performance and Assurance
Phone:		**Date:**	29 December 2022
Email:			

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

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 Integrated Quality, Performance and Finance Report (IQPFR) 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 IQPFR 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 IQPFR 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	
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Does this report have implications in any of the areas highlighted below?		
Area	**Yes**	**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)

Owner: Performance Team

December 2022

FINAL Version

Table of contents

Acronyms

Acronym	Full Meaning	Acronym	Full Meaning	Acronym	Full Meaning	Acronym	Full Meaning	Acronym	Full Meaning
ADHD	Attention Deficit Hyperactivity Disorder	EOL	End of Life	LGI	Lower Gastro-Intestinal	QOF	Quality Outcomes Framework	UCR	Urgent Care Response
AHP	Allied Healthcare Professional	FIT	Faecal Immunochemical Test	LMC	Local Medical Committee	RAG	Red Amber Green	UEC	Urgent and Emergency Care
ARRS	Additional Roles Reimbursement Scheme	G&A	General & Acute	LOD	Length Of Delay	RDUH	Royal Devon University Hospitals	UHP	University Hospitals Plymouth
ASD	Autism Spectrum Disorder	GAS	Group A Streptococcus	LOS	Length Of Stay	RHA	Review Health Assessment	VCP	Vacancy Control Panel
BI	Business Intelligence	GI	Gastro-Intestinal	LSW	Livewell South West	RSV	Respiratory Syncytial Virus	VCSE	Voluntary Community Social Enterprise
BMI	Body Mass Index	GIRFT	Getting It Right First Time	LTC	Long Term Conditions	RTT	Referral To Treatment	WIC	Walk In Centre
BPTW	Best Place To Work	GP	General Practice	MDT	Multi-Disciplinary Team	SALT	Speech And Language Therapist	WITNe	Workforce Intelligence & Transformation Network
CAS	Clinical Assessment Service	HALO	Hospital Ambulance Liaison Officer	MH	Mental Health	SAR	Safeguarding Adult Review	WTE	Whole Time Equivalent
CFHD	Children and Family Health Devon	HCA	Health Care Assistant	MHLDN	Mental Health Learning Disability and Neurodiversity	SDEC	Same Day Emergency Care	WW	Week Wait
CIC	Community Integrated Care	HEE	Health Education England	MHSDS	Mental Health Services Data Set	SEMH	Social Emotional Mental Health		
CIC	Children In Care	HR	Human Resources	MOU	Memorandum Of Understanding	SI	Serious Incident		
CLD	Criteria Led Discharge	HRD	Human Resources Director	MRSA	Methicillin-Resistant Staphylococcus Aureus	SLCN	Speech, Language and Communication Needs		
CPD	Continuing Professional Development	HWB	Health and Well Being	MSSA	Methicillin-Sensitive Staphylococcus Aureus	SLN	Speech and Language Needs		
CQRM	Contract Quality Review Meeting	IAPT	Improving Access to Psychological Therapies	MTU	Medical Triage Unit	SMI	Severe Mental Illness		
CYP	Children and Young People	ICB	Integrated Care Board	NCTR	No Criteria To Reside	SOF4	System Oversight Framework (Level 4)		
D&C	Demand & Capacity	ICS	Integrated Care System	NHSE	NHS England	SOG	Strategic Oversight Group		
DCC	Devon County Council	ICU	Intensive Care Unit	NICE	National Institute for health and Care Excellence	SPC	Statistical Process Control		
DEXA	Dual Energy X-ray Absorptiometry	IHA	Initial Health Assessment	OAP	Out of Area Placement	SST	Safety Systems Team		
DPT	Devon Partnership Trust	IPC	Infection Prevention Control	OOH	Out Of Hours	SW	South West		
DSAF	Devon Spring Action Fund	IPS	Individual Placement and Support	OPA	Out Patient Appointment	SWASFT	South West Ambulance Service Foundation Trust		
DTA	Decision To Admit	IR	International Recruitment	OPEL	Operational Pressures Escalation Levels	SWAOC	South West Ambulatory Orthopaedic Centre		
ED	Emergency Department	ISU	Integrated Service Units	PCN	Primary Care Network	T&F	Task & Finish		
ED	Eating Disorders	IUCS	Integrated Urgent Care Service	PHSO	Parliamentary and Health Service Ombudsman	T&O	Trauma & Orthopaedics		
EHWB	Emotional Health and WellBeing	KPI	Key Performance Indicator	PiPOT	Person in Position of Trust	T&SDFT	Torbay and South Devon Foundation Trust		
EIP	Early Intervention in Psychosis	LA	Local Authority	PITCH	Peer Improvement Tips for Care and Health	TDSAP	Torbay and Devon Safeguarding Adult Partnership		
EMD	Emergency Medical Dispatcher	LCP	Local Care Partnership	PPG	Practice Plus Group	UASC	Unaccompanied Asylum-Seeking Children		

Key to Variance & Assurance Icons

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

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

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.

Operationally the ICS remains under extreme pressure with increasing Covid / Flu inpatient numbers combined with an upturn in community infections placing pressure on primary care. This has resulted in extended delays in urgent care, ambulance conveyancing and waiting times. A loss of 9,778 ambulance hours due to handovers was seen in November compared to 10,673 in October.

NCTR figures have reduced as winter funding plans have delivered extra capacity, although average length of stay remains higher than previous years. Increased waiting times against Emergency Departments (ED) and ambulance conveyancing standards have continued to decline, with a resultant impact to patient care. Mitigations have been implemented to reduce risk and improve performance and these will be reviewed within the context of the revised operating framework.

There are significant numbers of patients waiting beyond 104 weeks and at the end of October this figure sat at 590 compared to a target of zero. The system has seen a worsening in performance of RTT at 53.3% compared to a target of 93% and in diagnostic pathways at 67.1% versus a target of 99%. Providers are now sharing their information on harm, including lower-level incidents and complaints. This is being reported in January to the ICB Quality & Performance Committee and an audit of serious incidents will be reported in February 23. The ICB has also undertaken an audit against the Healthwatch Report Recommendations (2021) around long waiting patients to be finalised in January. Elective recovery plans are being reviewed with additional support being provided by NHSE.

Statistical Process Control (SPC) charts have been introduced into the IQPR to demonstrate the system performance alongside the NHSE accepted standard reporting format. The use of this reporting has been included for primary care this month and dashboards developed for workforce and quality. The table in the page below explains how to use the icons in the SPC charts to understand performance against the metrics displayed.

Quality	Operational Performance	
• **Planned Care:** risk to patients, due to long waits. Harm profiles received from providers • **Urgent & Emergency Care:** delays to handover and risk to patients across pathway, including at home due to ambulance conveyancing times • **IPC**: Increasing numbers of COVID-19 positive cases, flu and Strep A impacting on communities, hospitals, and workforce. • **Primary Care:** IPC impact on primary care workforce and workload due to increased community infections and staff sickness	**Planned Care** 	RTT, Diagnostic and most Cancer metrics continue to fail the national targets. At system level only the number of patients waiting over 104 weeks shows evidence of sustained improvement but is still above the zero target at 590.
	UEC 	All metrics remain under extreme pressure. Emergency Department 4-hour performance declining (44.1%). Loss of 9,778 ambulance hours due to handovers. Average Cat.1 handovers at 10 mins. and Cat 2 at 61 mins.
	Discharge 	Significant improvement in the number of beds occupied by patients with "no criteria to reside", but bed availability is under pressure from historically high non-elective length of stay across the system.
	Primary Care 	Impacted by community infections. Access targets are delivering required performance with exception of 2-week access metric. Primary care remains under pressure and performance fluctuating around required targets.
	Children 	Referrals for both SLT and ASD remain within expected levels. However, average waiting times to assessment lengthen. Both services are impacted by staff vacancies and recruitment challenges.
	Mental Health 	No significant variation across most metrics, although improvements have been made in perinatal access and physical health checks for patients with SMI. This area is also challenged by staff vacancies which impacts on timely access to services.

Finance	
At month 7 (October) Devon ICS is reporting year to date £20.9m deficit against a planned deficit of £15.9m – an adverse variance of £5m (M6 £4m).	
The reported forecast is a deficit of £18.2m which delivers to plan.	
As at month 7 Devon ICS had made efficiency savings of £52.5m (M6 £43.2m) This is £18.2m adverse to plan (M6 £14.2m).	
Forecast savings are averse to plan by £33.3m. (M6 £16.4m)	
At the planning stage net risks of £95.9m were identified to delivery of a break-even plan. At the end of month 7, this has improved by £39.4m and stands at £56.5m (£38.3m against plan) against an expectation of break-even. (M6 £61.5m)	

Operational Performance

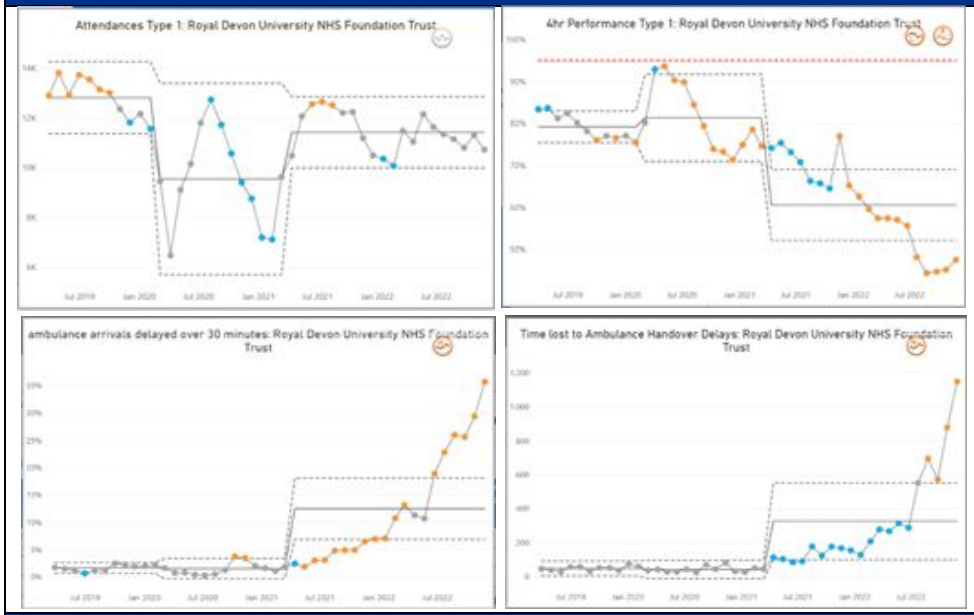
Urgent and Emergency Care – System Overview

			System				Royal Devon University NHS Foundation Trust			Torbay and South Devon NHS Foundation Trust			University Hospitals Plymouth NHS Trust		
	Metric	Target	Latest Date	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance
UEC	A&E all types seen within 4 hours	95%	2022-11-01	58.1%			59.1%			56.4%					
	A&E Type 1 seen within 4 hours	95%	2022-11-01	44.1%			49.2%			34.0%					
	Attendances Type 1		2022-11	24068			10723			5599			7746		
	Type 1 Admissions (conversion rate)		2022-11	28.4%			30.6%			21.9%			29.9%		
	Emergency Admissions via A&E		2022-11	6824			3280			1228			2316		
	ambulance arrivals delayed over 30 minutes		2022-11	51.3%			35.7%			61.5%			71.3%		
	12 hr trolley waits	0	2022-11	1665			514			294			857		
	Time lost to Ambulance Handover Delays		2022-11	9,778			1,149			2,416			5,594		
	Mean ambulance response times cat 1	7	2022-11	9.95											
	Mean ambulance response times cat 2	18	2022-11	61.4											

Analytical Summary:
Metrics relating to urgent care have seen no significant improvement in November 2022 although ambulance handover times have stabilised, albeit at a rate significantly above the target of 15 minutes target with delays totalling 9,778 hours and Type 1 four-hour performance remaining similar to October at 42.9%.

Urgent and Emergency Care – Royal Devon University Healthcare

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 further intervention
- 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 (RDUH East):

- Bed capacity pressure and restricted flow to beds in the hospital because of increased acuity and escalating infection rates (Covid, Flu and RSV). There is an increased length of stay compared to 20/21.
- Performance on NCTR numbers (see page 21) is multifactorial and is significantly influenced by high staff sickness in acute and community teams and care market challenges which lengthen delays in discharging patients on Pathways 1-3, as well as escalating infection rates as above.
- Reduced capacity of two days per week at Sidwell Street WIC. This remains a risk that closures could increase attendance for minor injury and illness. Recent audit work has identified higher attendance position for lower acuity, younger patients from more deprived areas of Exeter to ED. However, overall volumes of attendances have not increased.
- Vacancies and sickness in Medical and Nursing teams.
- Building work at ED is limiting capacity within the department until estimated January 2023, updates to timeline is changeable so more definitive dates will be available as they are confirmed.

Actions

- Winter plan, including demand and capacity funding to provide additional discharge coordinators, ward secretaries and weekend discharge lounge staffing will embed throughout with performance expected to improve in the new year as recruitment is successful.
- Additional ED consultant cover provided from November on weekdays support 4-hour performance, this equates to an additional 6.5WTE Consultants now in post, rising by a further 1.5WTE by March 2023.
- Live in carer scheme extended for winter – 13 live-in care staff are now available, and all are being utilised which has enabled additional flow.
- 1:1 support to care home placements also in place which has enabled several long stay patients to be appropriately supported into care home settings, which has reduced the number of bed days lost by those waiting in hospital.
- SWASFT direct referrals to Urgent Care Response in place, to avoid unnecessary admissions, this service went live on 1st November 2022 referral position is being monitored closely and metrics will be reported from December 2022.
- Recruitment programme for core staffing continues, with onboarding training in place. A Trust wide initiative is underway to fill vacancies and improve staff retention. The key areas for recruitment that affect urgent care are within inpatient wards, walk in centre, Emergency Department. This includes registered nurses, nurse practitioners, ward clerks, health care assistants.
- Patients on Pathway 1-3 who have NCTR averaged 84 which is an improvement on the previous month.

Causes: (RDUH North)

- Although the NCTR position has improved in Northern, Los remains high (see page 20) this still causes a challenge in reduced bed base. P1-3 patients with NCTR generally average between 20 and 40 each day depending upon demand. Length of stay remains high compared to previous years.
- Covid and respiratory infections are currently having a significant impact in relation to IPC measures required for patients further restricting the ability to support additional bedded capacity.
- Staff absence percentages remain high – around 4% as an average.
- Increased demand has required at times the use of SDEC as an escalation area, although this is stepped down as soon as possible.
- Issues discharging patients out of county, in particular to Cornwall.
- Weekend discharge performance remains challenging in relation to staffing and support services.

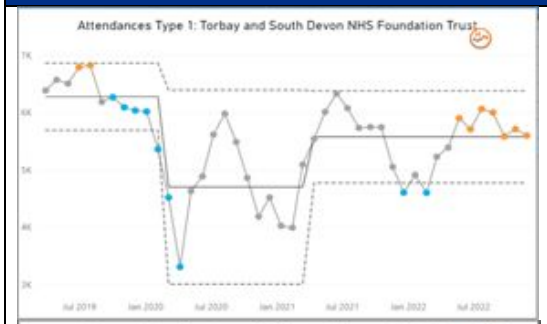
Actions

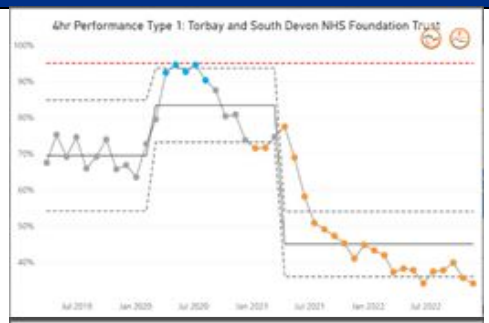
- Daily forum meeting is held each day to ensure ongoing oversight of discharge plans and any issues.
- 2 weekly meetings with Cornwall colleagues to understand and escalate discharge issues.
- Discharge lounge usage is on an increasing trajectory to support early flow (bedded care).

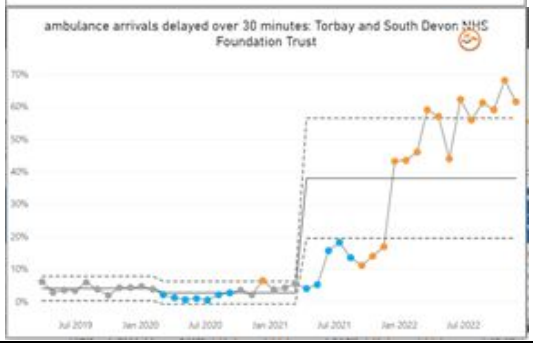
- Additional 6 block booked care home beds (in addition to the 14 care home beds already commissioned with D&C funding) to come online as soon as possible in December.
- Business case is being finalised for expansion of discharge lounge to enable bedded capacity. This will now be presented to Trust Board in January.
- Interviews for Doctor's Assistant roles in December with anticipation of successful recruitment.
- Recruitment to additional discharge coordinators to support the wards.
- Additional consultant post to support acute medicine.
- Additional transport service commissioned to support existing patient transport contract to increase flow.

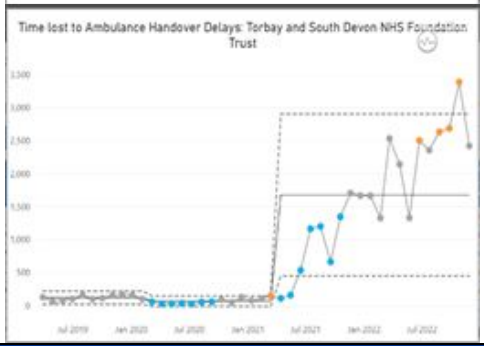
Urgent and Emergency Care – Torbay & South Devon

Data









Analytical Summary

- The expected reduction in attendances post summer holiday period has not materialised and the increase post winter 2021 has remained.
- 4hr performance continues to decline, as the ED is still struggling with flow into inpatient beds.
- 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:

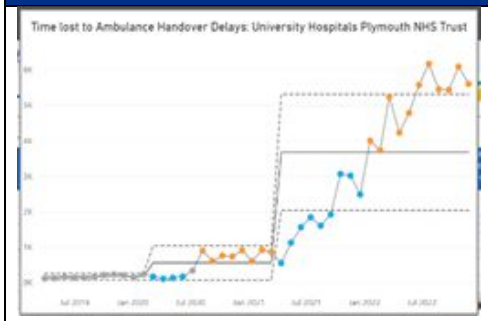
- During escalation periods the command-and-control team could not always have the data at hand to support the site position and focus.
- LoS remains high compared to prior years (see page 22).
- Flow out of the ED was not always expedited in an agreed timeframe.
- Discharge Lounge, although being utilised was not as well used prior to 12:00 or for “Golden Patients” prior to 10:30.
- Difficulty in meeting predicted discharge numbers across P0-3 pathways consistently across all 7 days of the week.
- Difficulty in staffing with consistency and skill across the 7 days of the week and in all areas, due to gaps in the establishments, short term sickness and skill deficits across all registered professional groups.
- Short Stay Ward still a general medical ward under Endocrine and not functioning in the LoS framework that was expected.

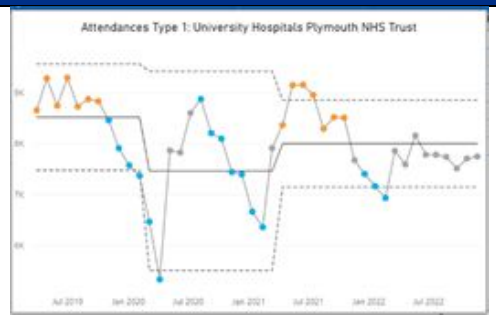
Actions:

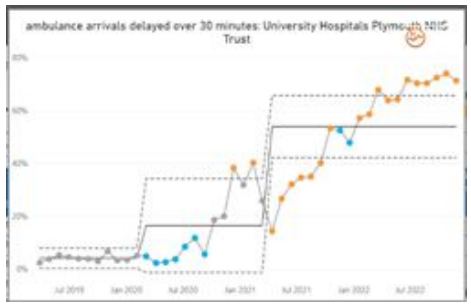
- New Grip and Control methodology via the 5 x day site meetings, with a very focused 10:30 meeting with a 100% attendance from all Integrated Service Units (ISU) with appropriate detail and information.
- New Command Centre data driven SitRep Control Form looking at predicted admissions and tracking potential/confirmed discharges.
- Short Stay Ward to be re-allocated with a frailty focused environment supported by the Frailty Team in Dec 2022. This will support the ethos of shorter length of stay for those using the environment and mirrors the local need and population age group.
- New 2 floor Acute Medical Unit opening 14/12/22 to enable a robust 08:00-00:00 medical SDEC environment and a fully monitored acute trolley-based unit for rapid turnaround or transfer to inpatient beds. This will give 24 trolleys and 12 SDEC trolley environment, plus fit to sit chairs. This gives a greater amount of SDEC and trolley space to manage acuity, rapid assessment and streaming to out of hospital bed-based care. Supporting this ethos and rapid assessment/pathway utilisation will offer right patient, right place in a responsive and rapid manner, to shorten length of stay and promote low or no bed day admissions.
- UEC Programme Board capturing full breadth of flow with weekly attendance to ensure data/performance/focus for all streams to support overall quality and performance. Focus including pre-12:00 discharges, weekend discharge teams to ensure consistent modelling throughout the week and increased usage of the Discharge Lounge by all clinical areas including ED.

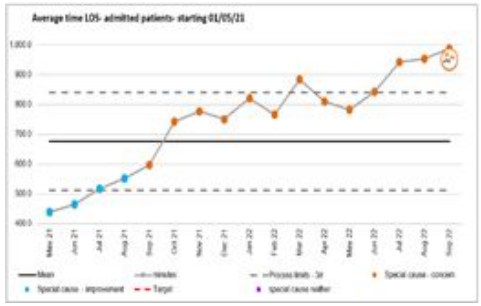
Urgent and Emergency Care – University Hospitals Plymouth

Data



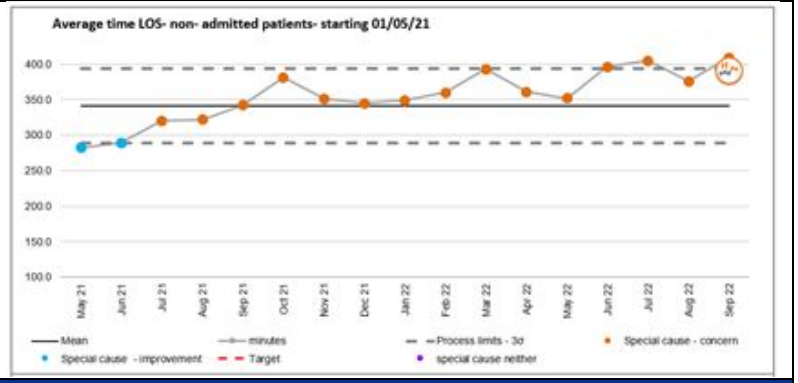






Analytical Summary

- The number of ED attendances is variable but is within the expected range.
- For admitted and non- admitted patients there has been a sustained upward shift in the length of stay in ED.
- There is a statistically significant upward shift in the number of ambulance arrivals delayed for over 30 minutes.
- There is a continued statistically significant upward shift in the total hours lost to ambulance handover delays.



Operational Summary

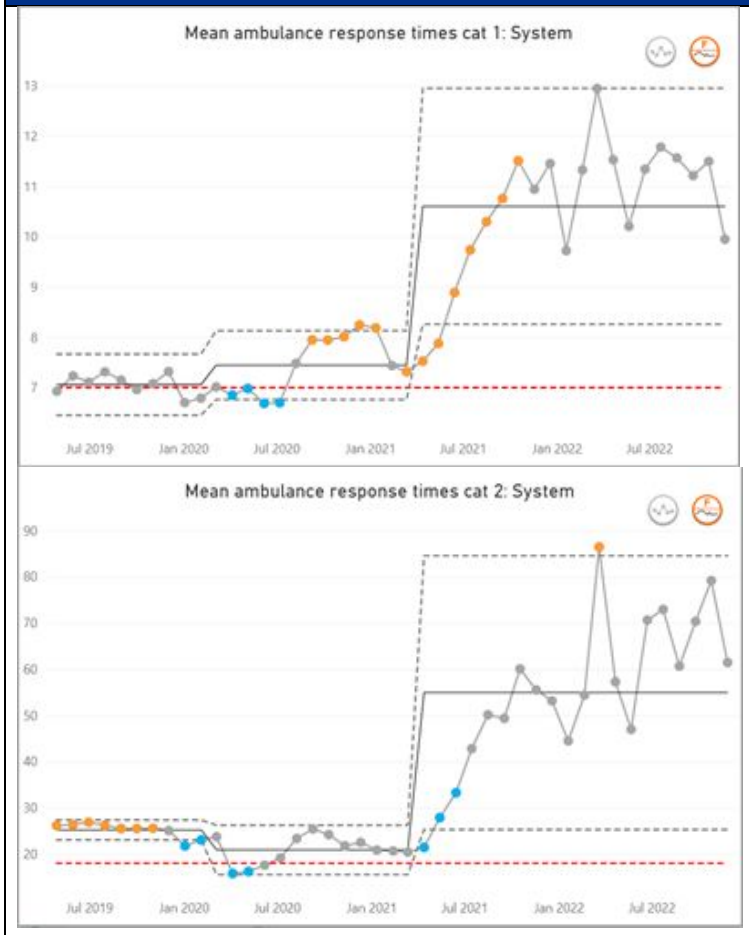
Causes:

- Approximately 75% of attendances are walk ins and seeing higher acuity and admission rates for this cohort. This is having a negative impact on flow out of ED because of increased demand for hospital beds and crowding.
- 50 to 60 walk type 4 and 5 attendances (lower acuity presentations) per day that have not chosen or been able to access alternative pathways
- Crowded ED, space constraints, staffing pressures resulting in delays in reviewing Decision to Admit (DTA) patients.
- SDEC: ability to provide senior cover, process & capacity limiting activity due to recruitment and sickness issues
- Limited capacity within front door frailty assessment service limiting full impact of admission prevention
- Improved but still challenging discharge position across all areas. Cornwall discharge position very challenging, average length of delay currently Cornwall 16.6 days, 54 patients delayed; Devon 2.9, 9 delayed; Plymouth 5.6, 35 delayed. Pathway 2 is the most challenged pathway i.e. patients waiting for care home or community hospital placements.
- Patient Length of Stay (see page 23) remains well above 20/21 levels.

Actions:

- Increased Surgical Same Day Emergency Care (SDEC) and a restart of GP take through Medical Admissions Unit/Acute Ambulatory Unit. Medical Triage Unit (MTU) model in place in Acute Assessment Unit (AAU) and Medical Assessment Unit (MAU) for 1 month, data collection underway to determine if this is assisting SDEC improvements. Frailty and SDEC aim for 50 per day, currently averaging 30 per day. Recent Infection Prevention and Control issues overcome to improve flow for covid and flu patients.
- SWAST opportunities audit undertaken, will be presented next UHP Urgent and Emergency Care board, recommendations will be available for next IQPR update.
- Audit of Criteria to Admit completed and being presented at next UHP Urgent and Emergency Care Board, recommendations will be available for next IQPR update.
- Access to Frailty Unit via ED currently running at 3 per day, additional staffing in place end November aim for 6 patients per day.
- Increased resource for the Hospital to Home pathway 1 service to reduce waits for access to service. Currently at 30 slots per day. Additional posts interviewed and offered and plan to increase capacity to 40 slots per day once staff start and complete induction. Numerating this is difficult as depends on needs of each patient and likely time required in service.
- Enhanced clinical support using Immedicare nurse-led remote technology to care homes with high admission rates. 56 care homes live by 16th December and possible further funding identified for a final 21 homes - TBC by 16th December. When fully operational target is to reduce admissions from Care Homes to ED by 20%.
- Additional Dementia support scheme went live in November 2022. 6 WTE to support 4 complex patients. 2 patients currently on scheme. Offering additional capacity to care homes to take more complex dementia patients and support discharge.
- Care hotel, 30 beds for Plymouth and Devon plus 10 beds for Cornwall, located in Plymouth from mid-October to 31st March 2023. The target length of stay for these individuals in 2 weeks with and aim for them to return home. As of 23/12/22 at capacity. These beds are to support winter pressures for pathways 1 and 2.

Ambulance response times (Cat 1 and Cat 2)

Data	Analytical Summary
	Ambulance response times are influenced by overall levels of demand, call answering times and capacity to respond which is heavily influenced by hours lost to handover. Demand: The number of ambulance attendances has been increasing since mid-October and is now close to that of 2021 and 2019. It remains above activity in 2020. The percentage of patients conveyed to ED remains low but has gone up slightly: 38% in October and 40% through November. This rate remains the lowest rate across England. Comparable information from October shows the national range is 45%-58%. Call answering: Answering times in October improved on previous months up to 55% of calls answered in 5 seconds (target 95%). Mean call answering time, is in line with previous months at 58 seconds. Response capacity: Over 49,000 conveying resource hours have been consistently available across the Trust since the beginning of October, with the end of October reaching a peak of 50,000 hours. This increase in response capacity has been put in place to partly mitigate resource lost to handover. Across the Trust, during October over 41,0000 hours were lost to handover against an improvement trajectory of 13,500 hours. Nearly 14,000 hours were lost in Devon, against an improvement trajectory of 5,360. Response times: There has been a statistically significant upward shift in the mean response time for both category 1 and category 2 post quarter 3 2020/21. The targets of 7 minutes for category 1 and 18 minutes for category 2 will not be met without further intervention.

Operational Summary

Cause:

- Ambulance response times have a positive correlation with hospital handover delays. SWASFT category 1 mean response times were amongst the worst in England in November at 10 minutes mean, against a target of 7 minutes. The range of response times nationally was 8-10 minutes. Category 2 response times are now in the mid-range across all ambulance Trusts: in November, the SWASFT response mean response time was 48 minutes against a target of 18 minutes. The range of response times nationally is 27 minutes to 1 hour. SWASFT continue to have the highest average handover times in England: 1 hour 29 minutes in October; the national range of average handover times across ambulance Trusts ranges from 16 minutes to 1 hour and 29 minutes.
- Call answering times are also influenced by duplicate/subsequent calls, which are currently accounting for 20-30% of all call activity. Duplicate/subsequent call rates increase when handover delays are higher, as callers ring back to escalate cases, get an update on response time etc.

Actions:

- Review of SWASFT border change being undertaken by NHS Devon to identify learning. The evaluation report has been drafted and is with providers for contribution and perspective. This will be reported in January.
- 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.
- SWASFT have been advertising a “pathway to paramedic” where recruits start as an EMD (Emergency Medical Dispatcher). There has been significant interest in the role. In addition, all adverts have been reviewed and refreshed, online “open evenings” held and recruiters used as a new recruitment platform. Videos for key roles are in place. Retention payments are also offered to EMDSs. Up to mid-November, there were 190 WTE emergency call takers in place.
- To mitigate the effect of handover delays on response times, SWAST 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 SWAST against the system trajectory and SW position. The funding will purchase additional response resource, including third-party provider. Through October and November, the full risk share was payable of £800k per month; the Devon payments amounted to £219k in October and £250k in November.
- 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., Urgent Community Response), access to clinical information (summary care record) and, simplified pathways to support 999 with appropriate redirection of the patient. A sub-group has been convened to start work on alternative response models including access to acute and community services (e.g., Same Day Emergency Care, mental health crisis response, falls response etc.). The group agree three priority acute pathways in November: paediatric advice for under 1s (and ideally under 5s), low risk chest pain and abdominal pain. Localities and Trusts have been asked to prioritise development of these activities in the local ambulance improvement plans, with oversight of progress at the ambulance cell.

Winter Demand and Capacity Programme (D&C)

As part of winter planning Devon ICS was awarded £24m of non-recurring funding to support extra capacity equivalent to 377 beds by March 2023. This funding has been split across the following schemes to support flow and discharges and as at the end of November 197 beds had been opened which is on target.

Scheme	Total Planned Beds	Planned beds at 30/11/22	Achieved Beds at 30/11/221	Total Scheme Cost £'000	Spend to date £'000	RAG Rating
Western LCP	**92**	**78**	**67**	**8,636**	**2,440**	**A**
Southern LCP	**89**	**44**	**45**	**4,130**	**1,075**	**G**
Northern & Eastern LCP	**93**	**66**	**77**	**7,153**	**1,994**	**G**
Mental Health	**7**	**7**	**7**	**1,000**	**333**	**G**
Virtual Wards	**96**	**1**	**1**	**2,000**	**0**	**A**
IUC Service	**0**	**0**	**0**	**1,000**	**0**	**G**
Total	**377**	**196**	**197**	**23,919**	**5,842**	

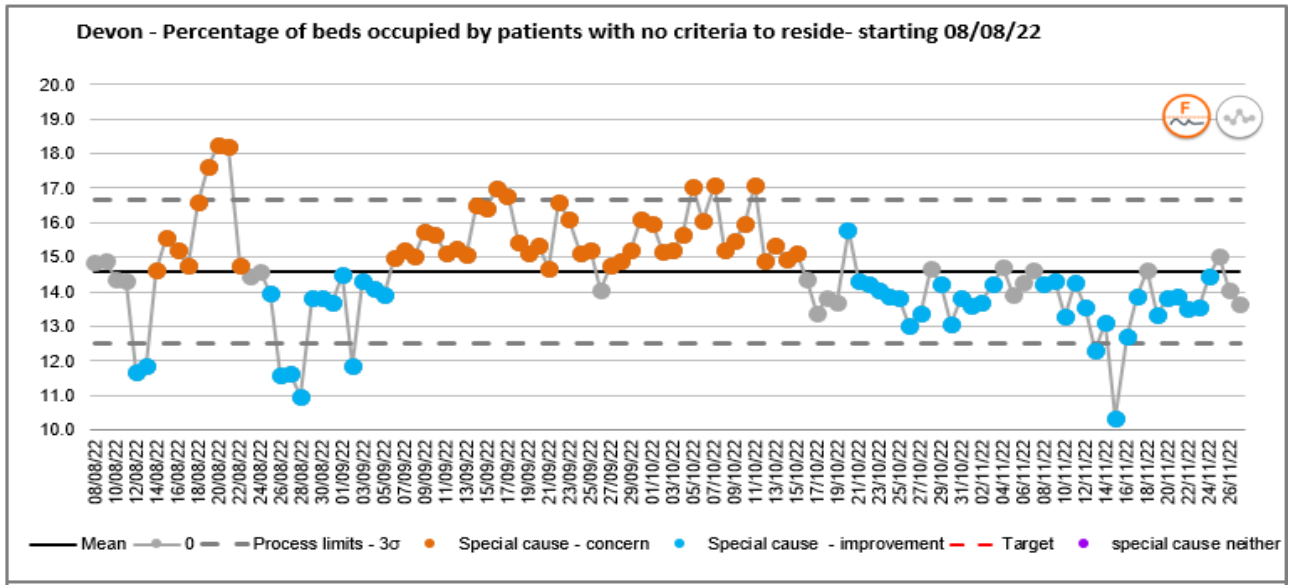
Virtual Wards: By the end of December 75 beds planned to be open across RDUH and UHP with an additional 20 beds planned to be open end January at TSDFT. The programme is on track, but risks around recruitment progress may affect go live dates which has resulted in an amber rating. It should be noted activity will be affected by patient acuity and staff availability, potentially resulting in reduced activity in the early weeks following go live.

Western LCP: constraints have delayed the opening of some beds; however, these issues are being resolved and beds will be open in January.

Further detail on other schemes is provided in the narrative below on discharges.

Hospital Discharge

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
No Criteria to Reside (NCTR)	5%	14/12/2022	13%		



Analytical Commentary: Devon has agreed a target of no more than 5% (110) of General and Acute beds occupied by patients with no criteria to reside. As of 11th December, across all 4 acute providers in Devon 13% (283) of G&A beds were occupied with patients who had no criteria to reside.

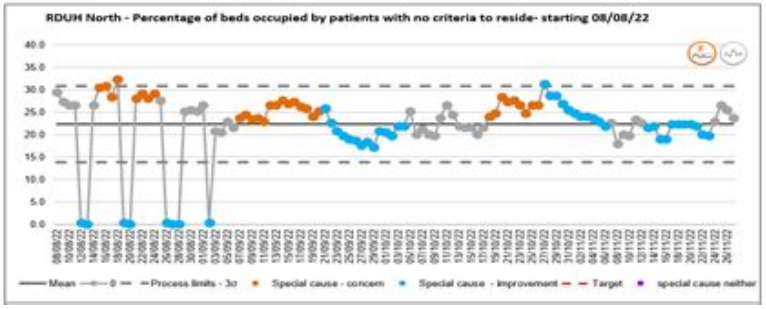
Since 11th October there have been 2 points of sustained improvement but no further change either positive or negative since middle of November. This is due to a rise in the number of flu and covid infections resulting in fall in community capacity and staffing absences. Not all D&C schemes are fully embedded including criteria led discharge and further bed capacity is expected to become available during December details are provided below by provider.

At provider level it can been seen below that despite a reduction in the number of patients with no criteria to reside, the average non-elective length of stay remains above the levels seen during 20/21 across all providers and indications are that this is being impacted on by staffing levels relating to sickness and recruitment.

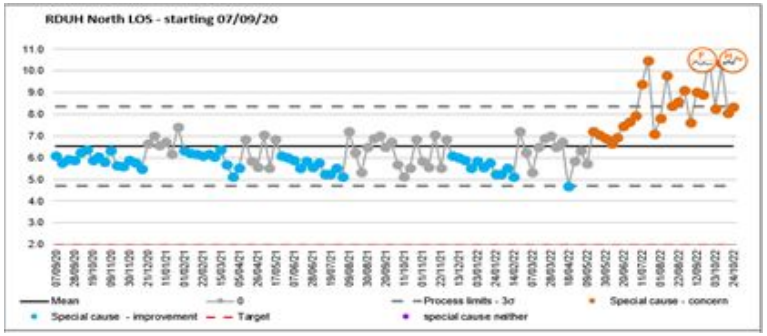
Operational Summary: Actions to address reducing the NCTR position is managed through System Flow Group and providers and localities are required to provide assurance on the following:

- Reducing Length of Delay on complex Pathways 1 to 3 through use of additional D&C schemes including Care Hotels and reablement care home beds and 1:1 support packages for those with complex dementia.
- Target of 80% of P0 planned discharges by 5pm all Trusts have now opened a discharge lounge and promoting with wards with low referral rates.
- 'Home for Lunch' initiative through use of board rounds and identifying patients the day before.
- Target of 60% of weekday discharges to be achieved at weekends through embedding the use of CLD and recruitment of 7 day working Discharge Co-ordinators and ward clerks.

Trend Chart – RDUH North



Average Non-elective Length of Stay – RDUH North

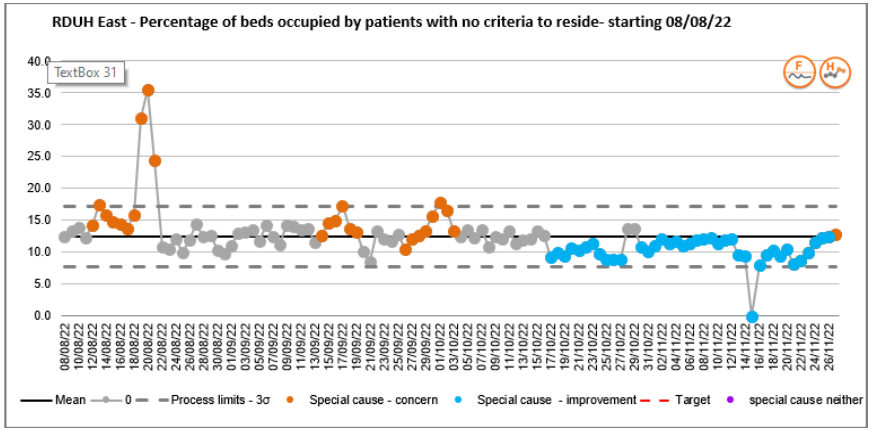


Analytical Commentary:
As of 11th December, RDUH Northern reported 18% (50) of their G&A beds were occupied by patients with no criteria to reside. The Trust continues a downward trend of improvement and have reported data issues which has had a negative impact on the numbers shown and this is being addressed. P1 and weekend discharges remain the biggest challenge over the due to staff sickness, but the Trust expect this to improve.

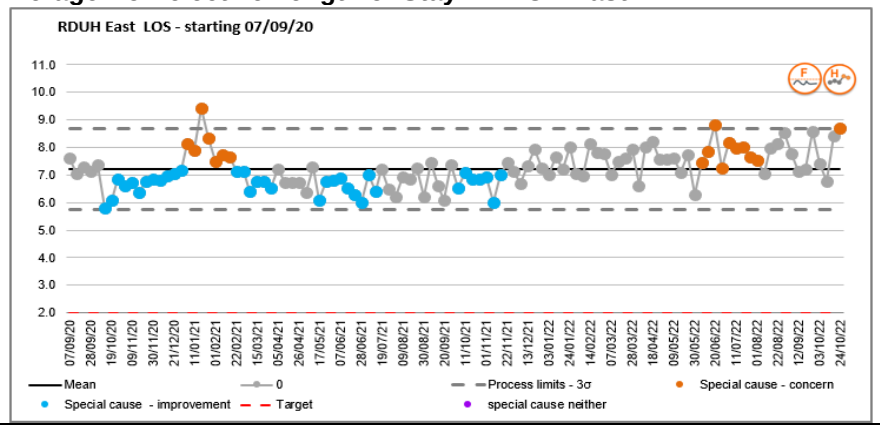
Operational Summary: Actions to address are in place with D&C capacity plans continuing to progress. An additional 29 beds/bed equivalents are now live, from a planned 35. Below describes the Length of Delay (LOD) performance breakdown by Pathway:

- P0 – Discharge lounge has opened and utilised and CLD is being embedded.
- P1 - There has been an increase workforce capacity to support reduction in LOD for those on P1. Since the mid-October (special cause concern on SPC chart) average LOD on P1, was 14 days. There is a positive downward trend improvement in reporting at 10 days for average LOD at the latest data point.
- P2 - 8 out of 14 new capacity beds are now live with the remainder expected during the winter months. Since the mid-October average LOD on P2, was 14 days. There is a positive downward trend of improvement reporting at 6 days for average LOD at the latest data point.
- P3 - There have been no plans using D&C monies to create additional P3 capacity in the care home market in the north. Since the 19/10 average LOD on P3, was 39 days. This has significantly improved to 14 days for average LOD at the latest data point.

Trend Chart RDUH East



Average Non-elective Length of Stay – RDUH East

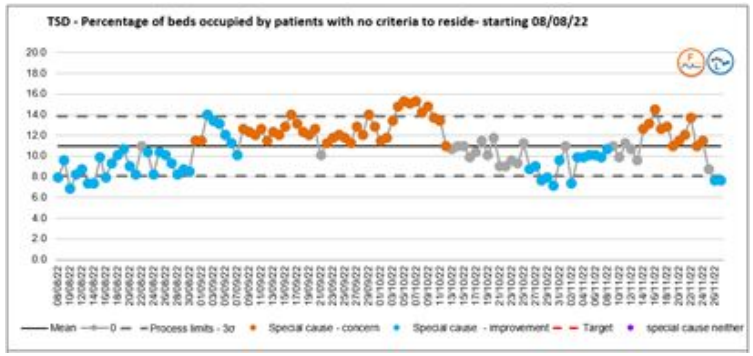


Analytical Commentary: As of 11th December, RDUH East reported 10% (71) of G&A beds were occupied by patients with no criteria to reside. The Trust has reported that while the position has remained static over the last weeks, the position is improving, and actions are ongoing including preparing for weekend discharges on a Thu/Fri and then reviewing why patients may not have been discharged on the weekend on the Monday using learning from TSDFT. CLD will also continue to be embedded together with promotion of the use of discharge lounge.

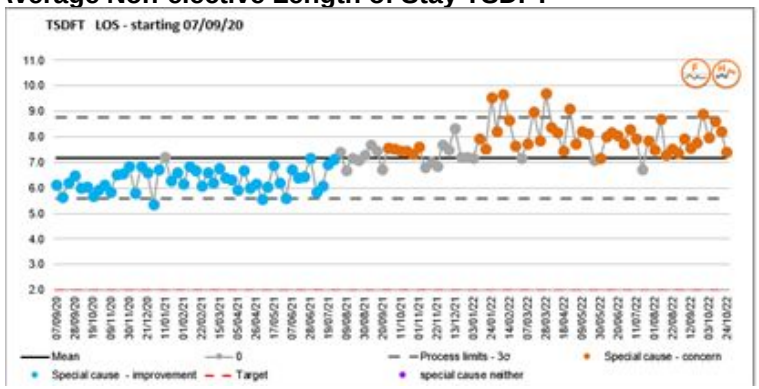
Operational Summary: Actions to address are in place with D&C plans continuing to progress, an additional 48 beds/bed equivalents are now live, from a planned 58. Below describes the Length of Delay (LOD) performance breakdown by Pathway:

- P0 – Discharge lounge has launched to open at weekends and is being utilised and CLD is being embedded.
- P1 - There has been an increase Live in Carer resource and UCR Support to SWAST capacity to support reduction in LOD for those on P1. Since the 26/09 average LOD on P1, is 4 days and has not changed.
- P2/P3 - Additional D&C schemes are supporting across both P2 and P3. 5 out 10 beds are now live with the remainder expected during the Dec. Schemes include additional 1:1 support to support complex placements and additional reablement beds. Since the 26/09 average LOD for P2 has reduced from 6 to 4 days and for P3 from 9 to 8 days.

Trend Chart TSDFT



Average Non-elective Length of Stay TSDFT

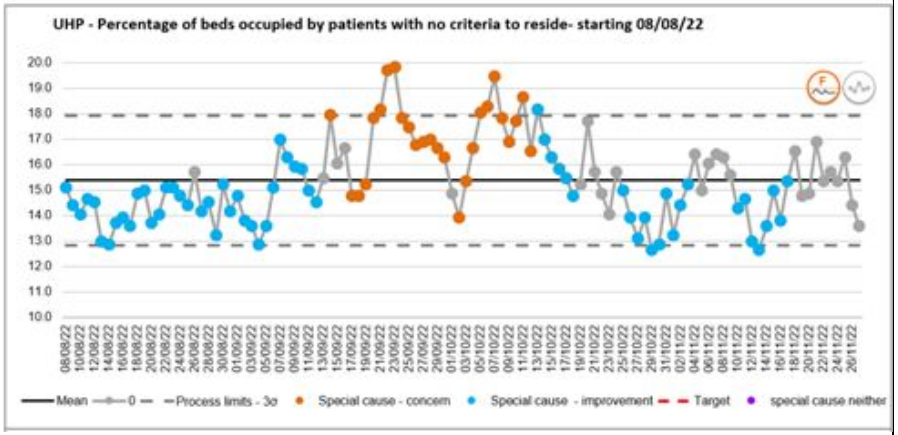


Analytical Commentary:
As of 11th December, TSDFT reported 13% (48) of their G&A beds were occupied by patients with no criteria to reside. Over recent weeks the Trust has seen significant improvement with the NCTR position however recent challenges have impacted performance. There had been a sudden increase in referrals for P2 & P3 with patients who had NCTR, the Trust is working with wards to confirm why these were not identified earlier. The Trust has seen an increase in the number of covid and flu cases impacting on staffing and bed capacity and thus LOS.

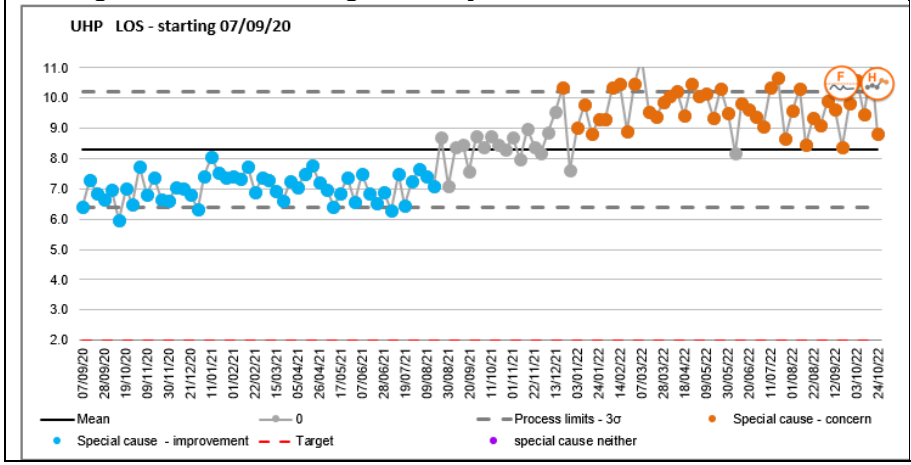
Operational Summary: Actions to address are in place with Demand and Capacity plans continuing to progress, an additional 45 beds/bed equivalents are now live, from a planned 89. Below describes the Length of Delay (LOD) performance breakdown by Pathway:

- P0 – Utilisation of the discharge lounge has increased and TSDFT are working with wards with low or late in the day referrals to increase use of the lounge and continue to embed CLD to improve in week and weekend discharges.
- P1 - No additional D&C plans have been input to P1 however since the 26/09 average LOD for P1 has reduced from 4 to 3 days.
- P2 - 27 out of 32 new capacity beds are now live with the remainder expected by January 23. Since the end September average LOD for P2 has reduced from 10 to 5 days.
- P3 - 20 new beds to support P3 discharges are expected in the coming winter months. Since the end September average LOD for P3 is an outlier and has remained the same at 11 days. Looking to increase discharges at weekend across P3 and P2.

Trend Chart - UHP



Average Non-elective Length of Stay – UHP



Analytical Commentary:
As of 11th December, UHP reported 13% (114) of their G&A beds were occupied by patients with no criteria to reside. The Trust has achieved multiple points of sustained improvement but have not been able to reduce NCTR further and overall, LOS has remained high compared to previous years. There have been staffing issues with Trusted Assessors however this is now being supported by LSW. The Care Hotel is now fully open and expecting to be utilised at pace. Weekend discharges are improving and becoming more consistent with weekend teams now in post

Operational Summary: Actions to address are in place with D&C plans continuing to progress, an additional 67 beds/bed equivalents are now live, from a planned 82. The following describes the Length of Delay (LOD) performance breakdown by Pathway:

- P1 – Launch of the Care Hotel (40 beds with 10 of these subcontracted to Cornwall to improve their P1 LOD at UHP, have been some issues with utilisation but is being addressed between commissioners) and increase VCSE capacity has supported reduction in LOD in P1. Since the 26/09 average LOD for P1 has reduced from 12 to 3 days.
- P2/P3 - Additional D&C schemes are supporting across both P2 and P3. 2 out of 6 new capacity beds are now live with the remainder expected during the winter months and through provision of 1:1 support for those awaiting a dementia care home placement. The current average for P2 11 days and for P3 23 days.

Planned Care: System Overview

Data

	Metric	Target	Latest Date	System Value	Variation	Assurance
RTT	RTT Incomplete Waiting list		2022-10	178395		
	RTT 18 weeks	92%	2022-10	53.3%		
	RTT over 104 weeks	0	2022-10	590		
	RTT over 78 weeks		2022-10	3344		
	RTT over 52 weeks		2022-10	16937		
Diagnostics	Diagnostics within 6 weeks	99%	2022-10	67.1%		
	Diagnostic Total activity		2022-10	40187		
Cancer	Cancer 2 week wait	93%	2022-10	62.5%		
	Breast Symptomatic 2 week wait	93%	2022-10	47.7%		
	Cancer 31 day First	96%	2022-10	93.6%		
	Cancer 31 day follow-up drug	98%	2022-10	99.0%		
	Cancer 31 day follow-up sugery	94%	2022-10	83.6%		
	Cancer 31 day follow-up radiotherapy	94%	2022-10	98.0%		
	Cancer 62 day urgent	85%	2022-10	58.0%		
	Cancer 62 day screening	90%	2022-10	77.8%		
	Cancer 62 day Upgrade	85%	2022-10	85.1%		
	Cancer Faster diagnosis	75%	2022-10	71.6%		

Summary

System performance for October has remained 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 intervention.

The system has seen a continued 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, and diagnostic pathways.

2 out of the 3 providers have shared their information on harm, including lower-level incidents and complaints. This is being presented in January to the ICB Quality & Performance Committee. In addition, an audit of serious incidents is currently underway and will be reported to the ICB Quality & Performance Committee February 23. The ICB has also undertaken an audit against the Healthwatch Report Recommendations (2021) around long waiting patients. This is also being reported in January and will be undertaken every 6 months until the risk significantly reduces. The Harm group is being re launched in January 2023, with Trust Quality Leads in place to support the group.

Planned Care: System 104 Week Wait

Data

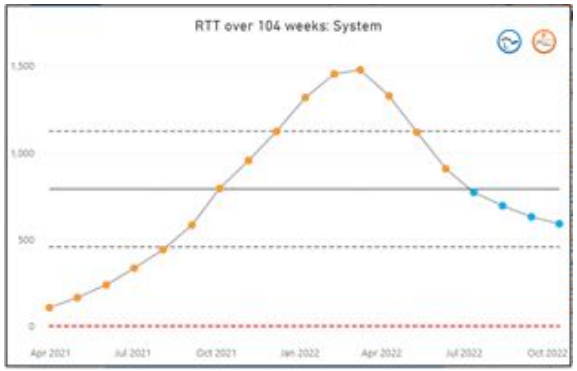
Analytical Summary

The 104 week waits measure is currently failing the target, there is special cause variation of an improving nature, however below the target.

Operational Summary

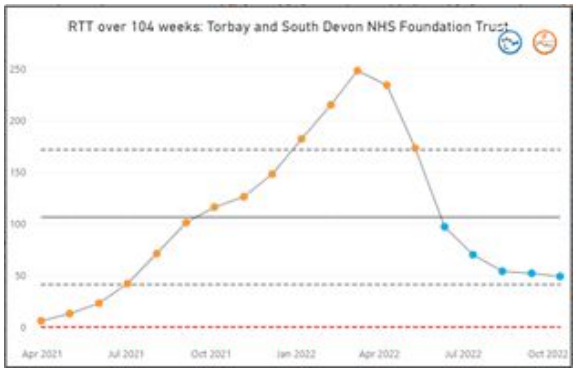
- Providers are rebasing trajectories submitted for the end of the financial year against 104ww and 78ww patients by 16th December, the new trajectories will reflect the high impact interventions that have been put in place through the NHSE 10-Week Plan.
- There is an expectation across the system that specialties with small number of patients waiting in excess of 104weeks will be cleared by the end of the financial year, leaving only the most challenged specialities i.e., Orthopaedics, Spinal surgery, Gastroenterology and Cardiology.
- Professor Tim Briggs (National Clinical Lead for Elective Recovery) visited the three acute providers on 15th November as part of a schedule of visits to Devon. The visit was to focus on Orthopaedic theatre productivity across the three Trusts in relation to the Getting It Right First Time (GIRFT) principles. He also led conversations around potential service configurations across Devon. A set of clear actions and recommendations have been provided to the system for implementation, with the initiative now being classified as a "SOF4 Intervention Programme". These interventions focus on improving productivity and rolling out best practice to expedite elective recovery
- Weekly meetings are in place with ICB colleagues and the GIRFT team to ensure pace and delivery on the SOF4 intervention.
- Out of county mutual aid continues, Devon providers are increasingly linking directly with the organisations providing additional capacity to expedite the pathway and reduce the number of transfers between organisations.
- The NHSE 10-Week Plan is in the final week (w/c 12th December). Both UHP and RDUH are in the process of updating 104ww and 78ww trajectories considering the achievements made through the initiative. This is expected to be available at the system tier 1 meeting on Friday 16th December. Key deliverables have been clearance of all low number 104ww specialities before 31st March 23, administrative validation of patients above 52 weeks and implementation of the new NHSE patient choice guidance.

Planned Care: Trusts 104 Week Wait



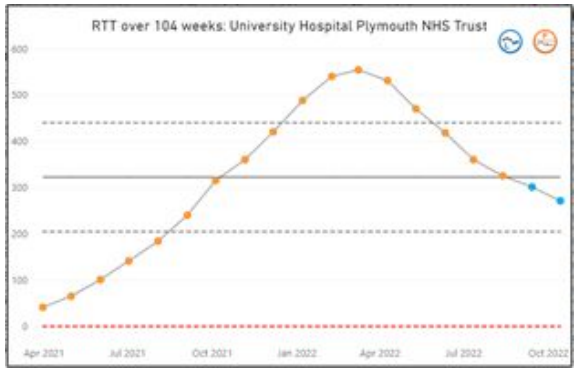
RDUH Operational Summary

- A combination of additional actions realises an improvement from previous year end position of 99 patients to a year end position of 37 patients waiting over 104 weeks
- All low number 104ww specialties will be cleared by the end of March 23 except for 37 P6 (patient choice) patients and with an additional dependence with 4 OPA/diagnostic outcomes.
- All patients on a non-admitted pathway will have their outpatient attendance by the end of December, except for 3 patients (2 x complex paediatric patients requiring multiple investigations including genetics in December). Face to face appointments scheduled on 6th December and 1 x OPA for January, which they are trying to date earlier.
- Revised criteria at Nightingale being implemented has enabled treatment of a wider group of foot and ankle surgery patients on that site.
- Work is commencing on a timeline to implement further exemplar pathways across, complex hindfoot and ankle inpatient, hip arthroscopy, soft tissue knee, shoulders, and spinal procedures at SWAOC
- Other work being progressed to reduce long waiters include complex abdominal mutual aid at Circle Health Group and cardiology and orthopaedic procedures at Cleveland Clinic London.



TSD Operational Summary

- All low number specialties 104ww specialties will be cleared by March 23. These will be in Colorectal, ENT, Upper GI, Urology, Vascular, Cardiology, General Medicine, Ophthalmology
- An agreement with Nightingale to undertake foot and ankle surgery is in place and discussions are continuing with clinical lead to enable more demanding ophthalmic surgery.
- A focused project is underway on pre-op assessment processes to identify and maintain a pool of patients who are ready for surgery. A project manager has been recruited and working with the team to develop detailed implementation plan.
- The development of a digital App for virtual screening and triage, is being accelerated to reduce face to face requirements for preoperative assessment and streamline patients into those clinics when an anaesthetist is required to be present.
- Multiple insourcing and outsourcing schemes ongoing to mitigate long waiter challenge
- A full MDT approach to seeing and treating patients is in place (i.e., use of AHPs, junior medical staff, specialist nursing).



UHP Operational Summary

- Plans are set at Specialty level with weekly monitoring to identify which specialties are off track
- The Trust is currently on track to have fewer long waiters than forecast in the 22/23 planning submission. The original trajectory was 336, latest trajectory on 18 December is 259 at March 2023 .
- Patient level reviews take place every week to ensure the 104-week patients are booked. Exceptions are patient choice delays.
- The most challenged specialities comprising the 274 patients waiting over 104 weeks as of 18th December are Orthopaedics (125 patients) and Neurosurgery (117 patients).
- Work is underway to review options to introduce high impact Saturday clinics, within Neurosurgery to mitigate the significant challenge within this specialty. If these clinics can be agreed and implemented, they will result in clearing all 104WW neurosurgery patients by 1st March 23 (c.150 patients).
- The theatre efficiency programme has successfully managed to recruit two consultant leads to head up the transformation. The challenged staffing position is being mitigated through ongoing interviews. All posts have been recruited to except for one Band 6. This position will be readvertised by 2nd December.
- All 104ww specialties with small numbers of patients are expected to be cleared before March 23.

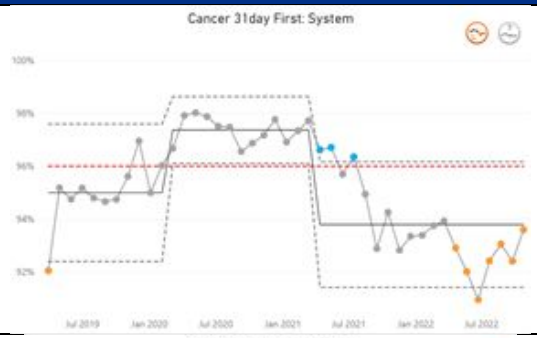
Cancer 2 Week Wait and 28-day faster diagnosis: System

Data	Analytical Summary
	The Cancer 2ww metric is consistently failing the target, it displays common cause variation, there is no sustained change to indicate an improvement in this system wide metric October performance 61.72% against an 93% standard. An improvement on the previous month. The 2ww performance remains under pressure due to the increase in referrals, this has been coupled with a scheduled reduction in activity planned for the EPIC implementation at RDUH North particularly impacting dermatology and delaying the implementation of the restoration plan.
	The Cancer 28-day Faster Diagnosis Standard (FDS) for the system, continues to exhibit common cause variation as it oscillates around the target. October performance 71.45% against a 75% standard. Challenges in the diagnostic pathway for LGI, Urology, Gynaecology and Breast continue to be the greatest risks to achieving 28 days. This performance is in line with the trajectory submitted within the 22/23 operating plan.

Operational Summary

- The four most challenged tumour sites for 2ww across the system are LGI, Urology, Breast and Skin.
- Caused by increased demand and capacity issues with endoscopy, LGI outpatients, Urology capacity, breast radiology and dermatology outpatient capacity. Actions are being put in place to support recovery and once agreed and completed the impacts will be assessed.
- **Actions:**
  - All Trusts being monitored in delivering imaging within the standard. Performance against the 28-day faster diagnosis standard is 70% 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 monitor and mitigate issues as they arise.
  - 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. RDUH North insourcing to clear backlog by the end of March 2023 These initiatives will be quantified and confirmed by the end of December.
  - 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 treatment and 62-day urgent treatment: System

Data	Analytical Summary
	The Cancer 31-day metric is currently failing the target, there is no significant change or indication of improvement in this system wide metric. For October, performance was 94% against a 95% standard.
	The Cancer 62-day 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. For October, performance was 59.21% against an 85% standard

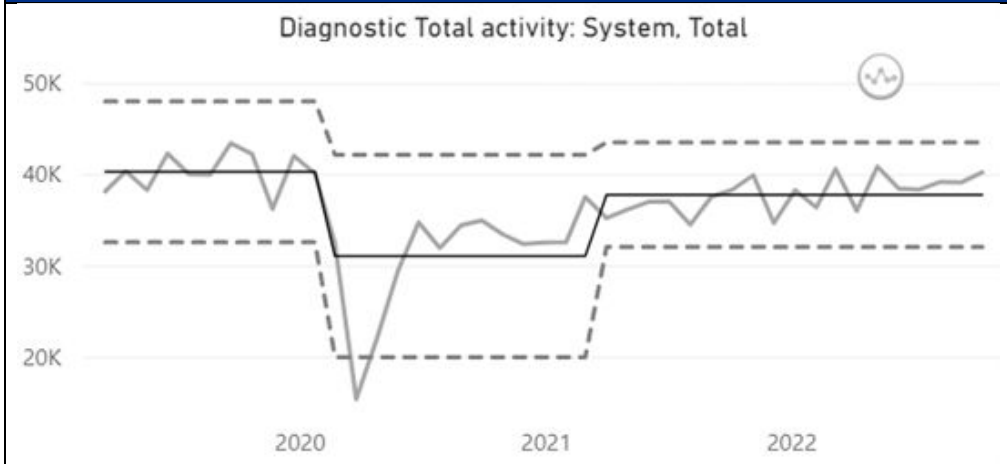
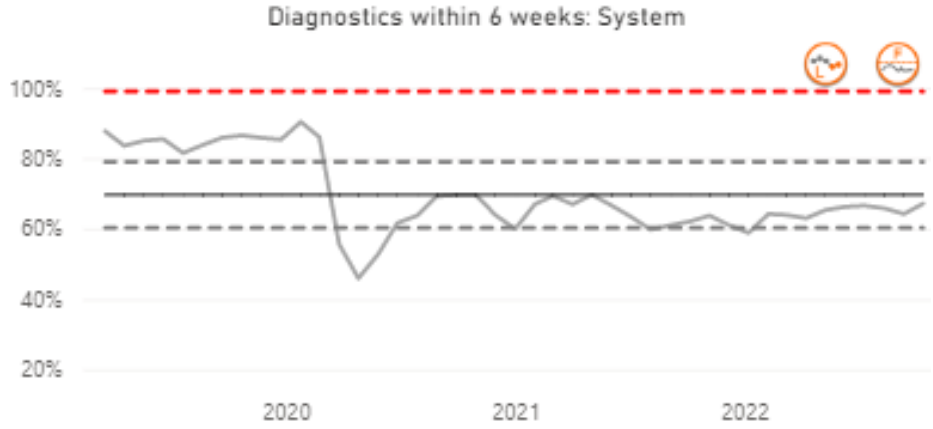
Operational Summary

- 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:

- Actions to deliver 2ww and faster diagnosis standard also support 31-day and 62-day targets.
- Additional prostate biopsy commissioned from Nuffield to end of year for system began 3/10/22. This will deliver one 3 patient session each week.
- Successful funding request via Cancer Alliance £1.8m will support capacity to deliver endoscopy, dermatology excision and biopsy activity trans perineal biopsies, cystoscopies, colposcopy and hysteroscopies across all providers, awaiting confirmed delivery date and funding approval from the Cancer Alliance. Agreed activity and recovery trajectories will be available once the funding is approved in detail in relation to the deliverable priorities.

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. Improvement in activity through additional capacity e.g. MRI and Non-Obstetric Ultrasound will be reported in December's activity return.
	**Performance** The system wide performance against the 6-week diagnostic standard continues to show common cause variation and is consistently failing the target. October's performance is 62.7% against a 75% operating plan target for patients to be seen within 6 weeks.

Operational Summary

The most challenged modalities are DEXA scanning, audiology, and endoscopy. Recovery planning for endoscopy is contained within the cancer update. Recovery for audiology is not achievable in year due to issues with the CHIME contract delivery for RDUH East.

Actions

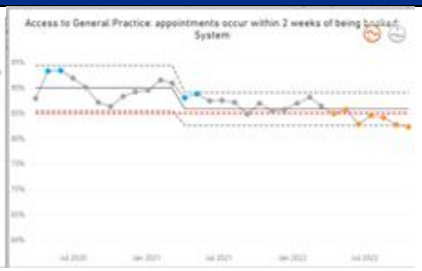
- RDUH North to develop mutual aid request to recover their DEXA position expected at next Planned care board.
- Contract discussions with CHIME to ensure 23/24 contract meets requirements to deliver the standard next year.
- NHSE funded MRI scanner based at Plymouth Radiology Academy to continue scanning until end of 2023. To 9/12/22 535 scans completed. Which has led to the UHP waiting list position improving.
- Additional ultrasound capacity at UHP now delivering activity and will continue until March 2023. The 6-week wait list has fallen from 4140 to 3776 in the period 30 /10 to 4/12 due to activity increasing by approximately 400 scans a week from a baseline of 900 per week
- Additional ultrasound capacity at RDUH North has been commissioned through an independent sector provider to commence January 2023 at Ilfracombe Hospital.
- Ongoing work to validate long waiter lists.
- Ongoing work to improve performance and develop Trusts' plans for the non-imaging /endoscopy modalities.
- Capital bid for £1.7M to provide an additional staffed endoscopy unit at Tiverton to support recovery. Decision awaited from NHSE and has been delayed.

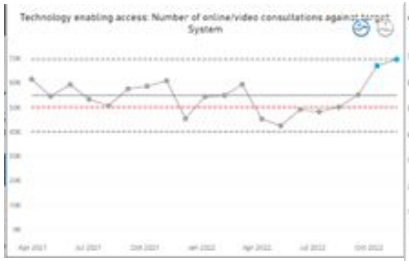
Primary Care Performance

Metrics

	Metric	Target	Latest Date	System Value	Variation	Assurance
Primary care	Access to General Practice: Increase in clinical team appointments on pre-pandemic levels (per working day)	4%	2022-10	11.0%		
	Access to General Practice: appointments occur within 2 weeks of being booked	85%	2022-10	82.3%		
	Access to General Practice: general practice appointments occur within 1 working day of request	35%	2022-10	48.1%		
	Technology enabling access: Number of online/video consultations against target	50000	2022-11	69576		

Data





Analytical summary

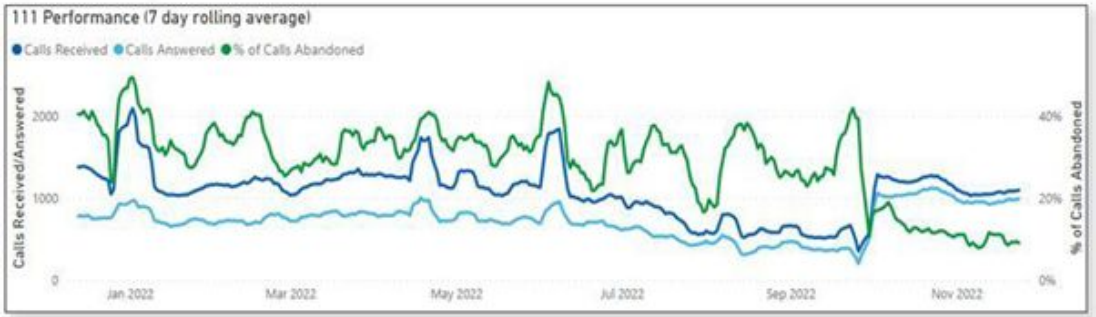
Analytical Commentary: Increase of appointments of 4% on pre-pandemic levels shows common cause variation and will not currently consistently meet the target. The target of 85% of appointments in 2 weeks is showing special cause variation of a concerning nature and is not consistently achieving target. Achieving 35% of same day appointments is showing special cause variation of a concerning nature, however, is above target and consistently passing. The number of online/video assessments is demonstrating special cause variation of an improving nature and on target to deliver 600k.

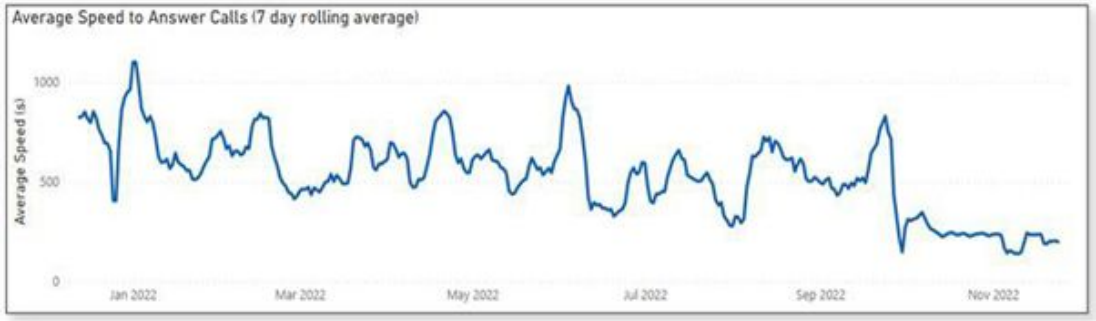
Operational Summary: Increase in appointments of 4% on pre-pandemic levels carries the most risk of not maintaining current performance. October achievement of 11% in this area is a substantial increase on previous months and very unlikely to maintain at this level. Achieving 85% appointments in 2 weeks has been close to target for the last few months and at 82% in October. The main barrier to achievement remains the continued high pressure on practices for urgent/same day need, which exacerbated during the winter months. This focus on urgent need is supported by the ICB. The same day target is achieving although has started to decline.
During the first 6 months of 2022/23 356,917 patients have had online/video consultations and the ICS is on target to meet the required 600k.GP ARRS - The current position is in line with the national average and good progress has been made to date. There is engagement with the workforce team to support achievement achieve of the position by the target of March 2023.
There is an average above 12WTE per PCN, but not all PCNs have 12WTE ARRS.
Devon has the highest GP number per 10,000 patients in the South-west and is ranked 4th highest of all ICSs'.

Workforce Metrics	Nov-22
General Practice able to offer improved multi-disciplinary care through employment of 12WTE additional roles (ARRS) per PCN by March 23	21/31 PCNs
Achieve upper quartile performance in terms of WTE GP per 1,000 population	Devon ranked 4th highest of all ICSs

Integrated Urgent Care Service: NHS 111

Data





Introduction

NHS 111 is part of the Integrated Urgent Care Service provided by Practice Plus Group (PPG) since 27 September 2022 following a competitive tender process.

Analytical summary

111 Performance shows the number of calls received and answered, and the percentage of calls abandoned, from the start of the year.

Since PPG commenced, there has been a significant improvement of percentage of calls abandoned. This is because more calls are being answered quicker.

The second chart demonstrates the average time it takes for 111 calls to be answered. It shows calls were answered quicker since PPG commenced.

It is important to note the number of calls received and answered for period mid-July to end of September were higher but not reported by the previous provider as the calls were being taken though National Contingency and a third-party arrangement. This explains the step change in the data.

Additional performance information will be included from January 2023 on the Out of Hours element of IUCS contract.

Mental Health: System Overview

Metrics

Key Performance Indicator	National Target	System Target	Actual	Variation	Assurance
*Community Mental Health access (2+ contacts)	18,942 Q4	17,452 Q4	16,360		F
*Children & Young People's Access (1+ contacts)	14,037 Q4	13,477 Q4	12,200		F
*Children & Young People Eating Disorders routine cases	95% Q1	95% Q4	49.5%	L	F
*Children & Young People Eating Disorders urgent cases	95% Q1	95% Q3	85%		F
Dementia Diagnosis Rate	66.7% Q4	60% Q4	54.95%	L	F
*Early Intervention in psychosis (EIP): % entering treatment within two weeks	60%	60%	72.3%		?
IAPT Access	9,383 Q4	7,983 Q4	6,089		F
IAPT – first appointment within 6 weeks	75%	75%	95%	L	P
IAPT – first appointment within 18 weeks	95%	95%	99.95%	L	P
IAPT Recovery	50%	50%	53%		?
*Individual Placement and Support (IPS) access	300 Q1 954 Q4	642 Q4	397	N/A	N/A
*Perinatal Access Rate	1,115 Q4	1,028 Q4	953	H	F
Physical health checks for people with severe mental illness (SMI)	7,448 60%	7,448 60% Q3	42.3%	H	F
*Inappropriate out of area bed days	0 Q4	0 Q4 n	479	L	F
Annual health checks for people with a learning disability	75%		23%	N/A	N/A
Reducing adults and CYP with LD in specialist inpatient beds	31		40		F

Not updated since July 2022 due to electronic patient record outage

System Summaries

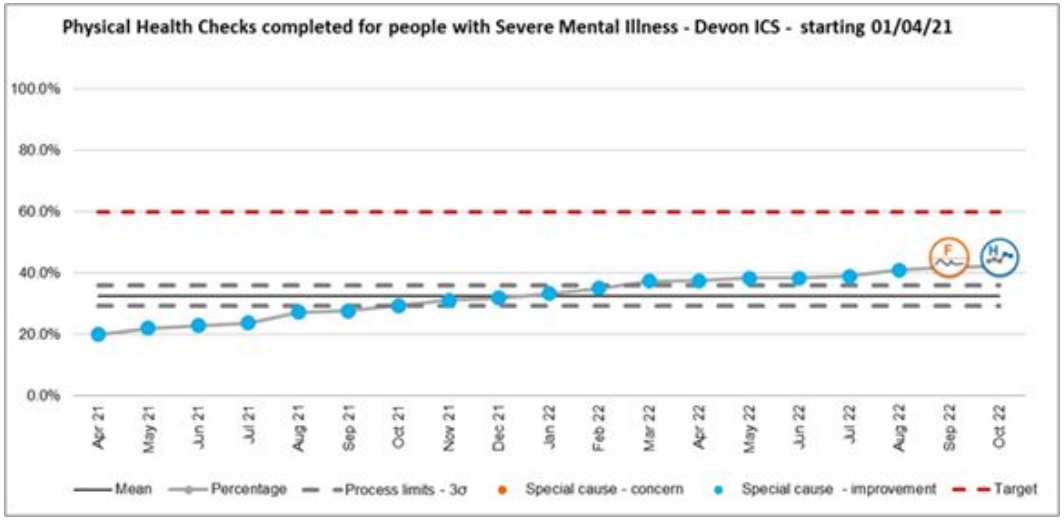
Analytical Summary

This month has seen a deteriorating position against two metrics across the system, (CYP Routine Eating Disorders and Dementia Diagnosis). There are varied levels of statistical assurance in the system with aligned CYP targets unable to provide service delivery assurance. IAPT demonstrates a maintained position exceeding appointment targets and areas such as perinatal access showing improvement, but not yet system assurance.

Operational Summary

Due to the ongoing national major incident relating to the '*Advanced'* Carenote outage, which is affecting Devon Partnership NHS Trust (and Children & Family Health Devon), performance information is not available for a number of reporting metrics, this affects both local and national reporting. The risk is mitigated in terms of patient safety and NHSE is sighted on the issues. The continued duration of the outage and the subsequent gap in data for the period of the outage will have an ongoing impact on reporting.

Mental Health: Severe Mental Illness – Physical Health Checks

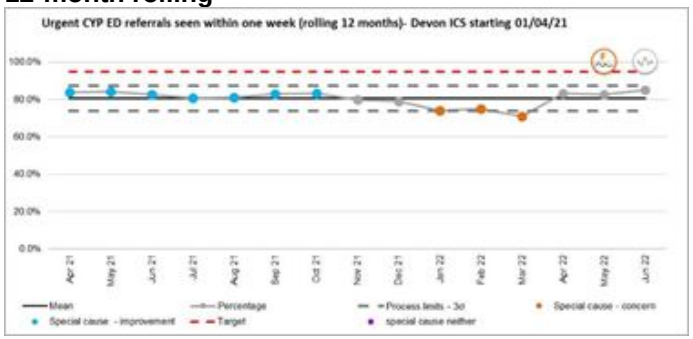
Data	Summary
KPI Description Percentage of people with severe mental illness (SMI) to receive the complete list of physical health checks in the preceding 12 months.  Data Source: GDPPR dataset, NHS Digital	**Analytical Commentary** The measure is showing special cause of an improving nature but is consistently failing the target. **Operational Summary** NHS England identified a Long-Term Plan deliverable that 60% of people on the General Practice list of patients with severe mental illness would have a complete physical health check in the last 12 months. Uptake of health checks completed continues to increase with September at 41.9% (4,411/10,529) and October 42.3% (4,463/10,550) NHS Devon has revised its trajectory to achieve this ambition to the end of quarter 4 2022/23 with 56% achievement by the end of quarter 3. This is due to a slower uptake of additional capacity offer than initially anticipated. **Actions and Assurance** • NHS Devon has commissioned independent, additional capacity to support with the engagement and completion of physical health checks of those with an SMI within primary care. • Workstream developing a delivery model that will support physical health checks, with coproduction at its core. • Targeting incomplete component of the check which prevents achievement of all six components required to meet the target. • Working with primary care through Webinars and other communications to promote uptake of additional capacity.

Mental Health: CYP Eating Disorders Urgent

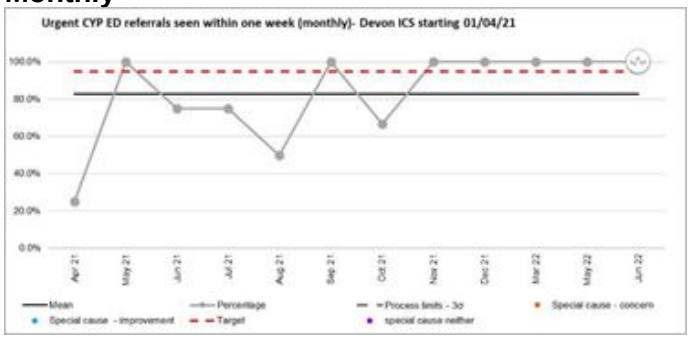
Data

KPI Description: The proportion of CYP with ED (urgent cases) that wait week or less from referral to start of NICE-approved treatment. Rolling 12-month target.

12-month rolling



Monthly



***** Data is unavailable at system level beyond June-2022 due to national electronic patient records outage. *****

Summary

Analytical Commentary

This KPI is within common cause variation with an upward trend. Devon and Torbay have not been able to report since June 2022.

Performance has been consistently high since November 2021 and so once data for July-November 2022 has been received the 12-month rolling target is likely to be achieved.

Operational Summary

NHS England identifiy a Long-Term Plan deliverable to ensure that 95% of children and young people who are referred to eating disorder services with an urgent need would have access to treatment within 1 week. NHS Devon identified a trajectory in its operating plan to achieve the national target by the end of quarter 3. As of the last available system data (June 2022) NHS Devon achieved 85% which exceeded the national and regional average performance.

NHS Devon's performance against this metric did not decline as long or as far as the regional average and has recovered more quickly. In the period between November 2021 and the latest report, the standard had been achieved consistently for all children and young people; if this postion is maintained then in November 2022 performance should be 100%.

Once reporting from the electronic patient record, Carenotes, is recovered, there will be a greater level of current system performance.

A deep dive report this will be presented in January's Performance and Quality Commitee and will provide further details on actions undertaken.

Monthly referrals received (denominator). Children seen within 1 week (numerator).

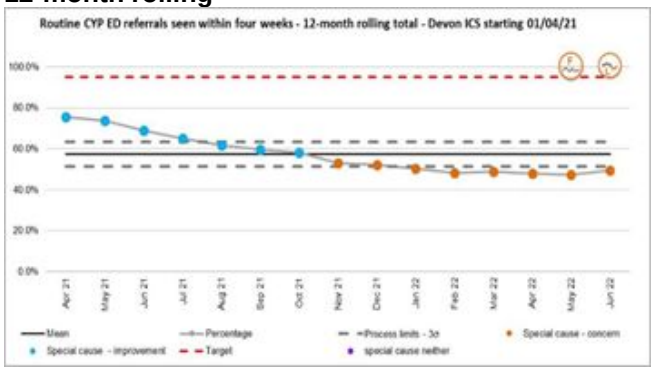
	Month	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
ICS Devon	Numerator	2	2	1	2	0	0	3	0	2	1
	Denominator	2	3	1	2	0	0	3	0	2	1

Mental Health: CYP Eating Disorders (ED) Routine

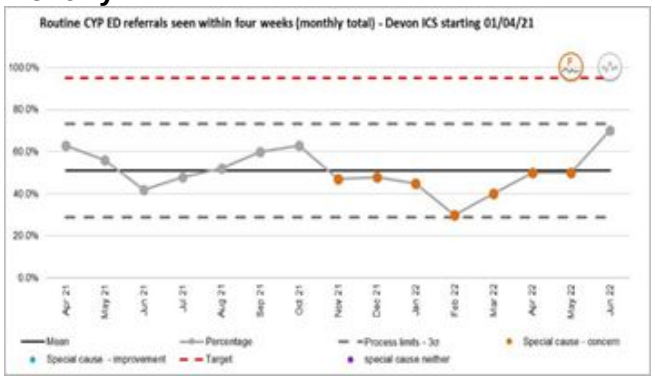
Data

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

12-month rolling



Monthly



***** Data unavailable at system level after June-22 due to national patient records outtage. *****

Summary

Analytical Commentary

This KPI is experiencing special cause variation of a concerning nature and will consistently fail the target unless changes are made to service delivery.

Operational Summary

NHS England identifiy a Long-Term Plan deliverable to ensure that 95% of children and young people who are referred to eating disorder services with a routine need would have access to treatment within 4 weeks.

NHS Devon identified a trajectory in its operating plan to achieve the national target by the end of quarter 4. As of the last available system data (June 2022) NHS Devon achieved 49.5% which is below the regional and national average performance.

NHS Devon's performance against this metric has declined for longer than regional and national trends.

Actions and Assurance

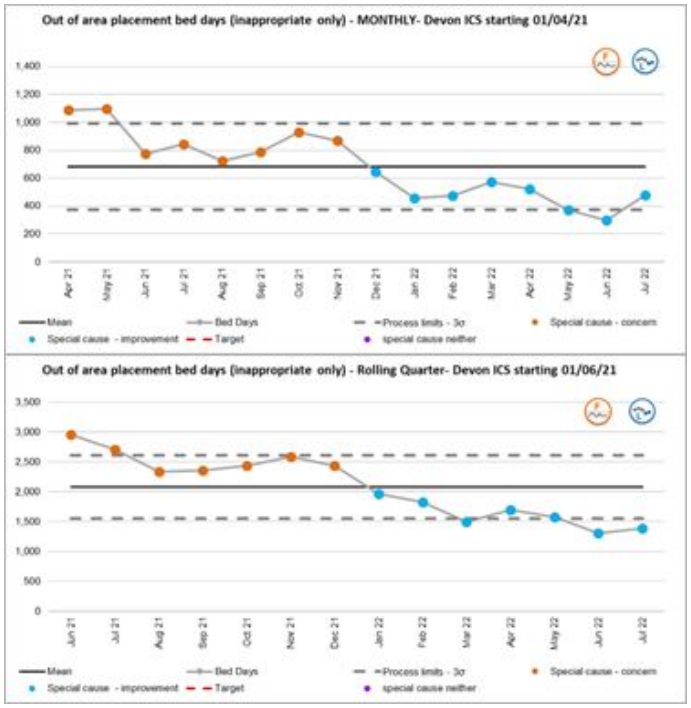
The actions set out in the Operating Plan were identified as being delivered 'on track' at the end of quarter 2. In December the MHLDN Provider Collaborative is working to review delivery against the planned actions for quarter 3.

A deep dive report this will be presented in January's Performance and Quality Commitee and will provide further details on actions undertaken.

Monthly referrals received (denominator). Children seen within 4 weeks (numerator)

ICS Devon	Month	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
	Numerator	12	15	7	14	15	8	10	12	15	14
	Denominator	20	24	15	29	33	27	25	24	30	20

Mental Health: Out of Area Placements/Bed days

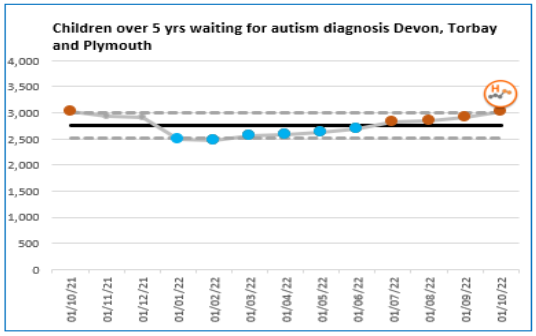
Data	Summary
KPI Description: The total number of days in which patients have been placed out of area due to unavailable beds in their usual network. **Statistical Process Chart**  ***** Data is unavailable at system level beyond June-2022 due to national electronic patient records outage. ***** Data Source: Monthly inappropriate OAPs stocktake	**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, thus demonstrating consistent progress. **Operational Summary** NHS England identify a Long-Term Plan deliverable to eliminate inappropriate out of area placements as quickly as possible. NHS Devon identified a trajectory in its operating plan to achieve the national target by the end of quarter 2. In the last available system data (July 2022 due to Carenote outage) NHS Devon had 479 inappropriate out of area bed days. NHS Devon continues to deliver progress against this metric, however, this is not at a pace required to achieve the planned trajectory. Recent analysis identifies that Devon has achieved a 60.1% reduction (improving position) in the number of people placed out of area inapproproiately between June 2020/21 and June 2022/23, this is in the context of a national increase (worsening position) of 24.2% resulting in Devon's 'share' of national inappropriate out of area placements falling from 8.2% to 2.6%. **Actions and Assurance** Actions include, implementing peer/senior clinician reviews at length of stay trigger points in DPT. To reduce average length of stay and increase the number of patients accessing the service. Additionally, initiating a 'Right to Reside Review' in the Plymouth area. This month the MHLDN Provider Collaborative is working to review delivery against the planned actions for quarter 3. Additional investment is being delivered to bolster capacity and manage increased demand for inpatient care in the winter period.

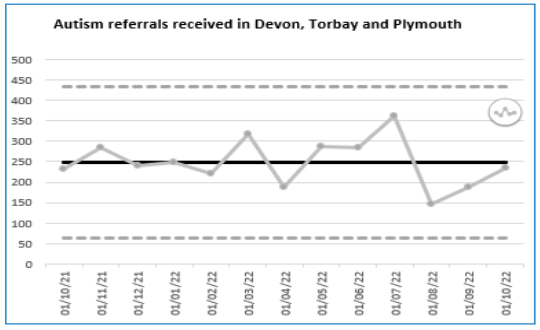
Children & Young People (CYP): Autism Diagnosis waiting times

Key Performance Indicator	Target/ Plan	Latest Period	Actual (system average)	Variation	Assurance
Autism Diagnosis (Waiting)	<18 wks.	Oct 2022	133.3 wks (Devon 166.7 / Torbay 159.3 / Plymouth 74 wks)	H	F

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

Devon, Torbay and Plymouth





Analytical Commentary
Operational Summary – Devon, Torbay & Plymouth
Waiting lists have increased by 500 children since February 2022. The service is experiencing a deteriorating position. Referrals remain within common cause variation, with a 66% increase since August.

What are the causes?
Workforce challenges remain, specifically recruitment and retention. Within Devon, establishment is at 63% of funded clinical capacity. Insufficient supply of qualified / competent agency clinicians (despite 62 interviews conducted). Ongoing reduced capacity through sickness and maternity leave.
Numbers waiting for Community paediatrics also remain high (over 600 in each acute hospital).
Providers report that the number of children assessed are more complex and therefore taking longer to assess and using multiple practitioners which has reduced the number of assessments being completed in month.

Actions
Deep dive presented by providers to the ICB Quality Assurance Committee in December. Joint clinics between ASD services and Community Paediatrics. CFHD recruitment to additional keyworker posts – pending CFHD decision to recruit fixed term and potential risks that this presents.
Parent and child programmes, are offered to families with children waiting for assessment as well as those who have been diagnosed reducing long term harm. Online resources including workshops and access to phone line are also offered. However, families still report that in order to access some services (housing options; Disability living allowance; support in school) they need a diagnosis.

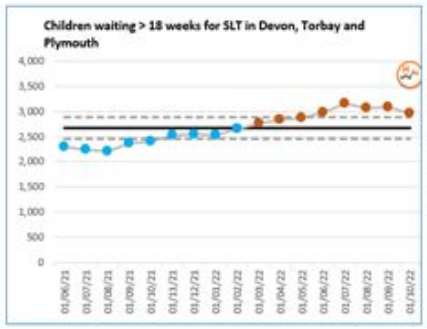
When is improvement expected?
Increased capacity to the neurodivesity pathway within Devon and Torbay is dependent with the conclusion of the CFHD staff consultation and implementation of the model. A date for this has not yet been confirmed.
The wider neurodiversity & SLCN game changer programme intends to bring about change needed across the pathway supported by a change in practice and attitiude. The current timeframe for delivery is at least 5 to 10 years.

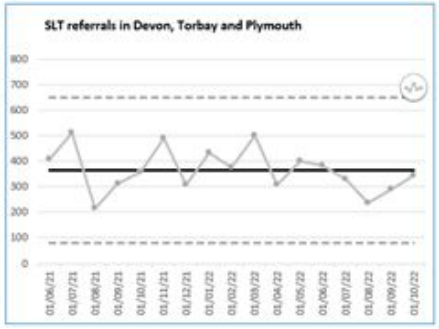
Children & Young People (CYP): Speech & Language waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Speech and Language waiting times	< 18 wks	Oct 2022	33.4 weeks (average).	H	F

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

Devon, Torbay and Plymouth





Devon System:
Average wait – 33.4 weeks.
Longest wait – 99.3 weeks.

Operational Summary – Devon, Torbay and Plymouth

What are the causes*?*

COVID legacy (service paused) which left a large number waiting. Referrals to Livewell and CFHD increased again in September and October despite a dip in August. Workforce availability remains challenged. Gap analysis undertaken by CFHD as part of the Transformation Programme identified a shortfall of 27.3 WTE SALTs required to meet needs in Devon and Torbay. This represents a 50% shortfall in SALTs. This shortfall does not take account impact of the pandemic

What are the actions/what are the challenges*?*

CFHD appointed seven staff for the DCC funded one year wait list initiative (a further two to be recruited). Telephone triage for those waiting over 52 weeks completed. Clinical triage and screening tool implemented 22.11.22. Group interventions commenced December 2022.

When is improvement expected*?*

Livewell have agreed to fund an additonal 4 WTE SALTs to address the wait list for Plymouth children. Once recruited, trajectory is to bring RTT back to <18 weeks within the next two years.

CFHD implementation of new screening tool, telephone triage and additonal staffing for DCC wait list – aims to reduce waitlist by 1,820 by August 2023.

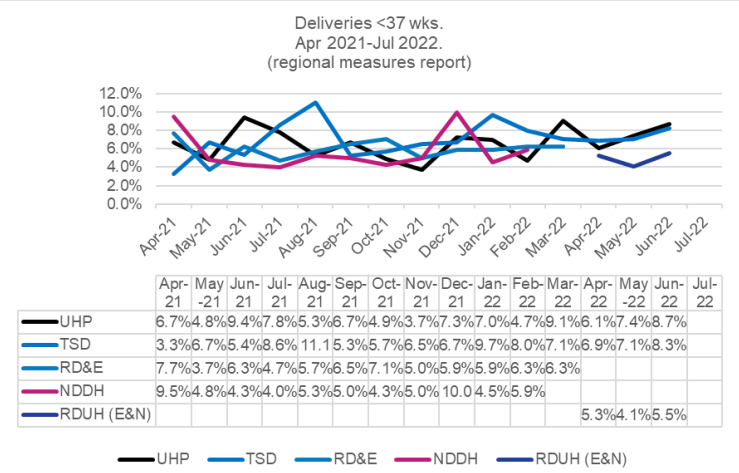
Local Maternity & Neonatal System: Preterm Birth Rate

Key Performance Indicator	Target/Plan	Actual
% Preterm (<37 week) births	<6% by 2025	6.9%

Latest Period

June 2022 Q1 & Q2

KPI Description:
A reduction in preterm birth rates from 8% to 6% by 2025



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
UHP	6.7%	4.8%	9.4%	7.8%	5.3%	6.7%	4.9%	3.7%	7.3%	7.0%	4.7%	9.1%	6.1%	7.4%	8.7%	
TSD	3.3%	6.7%	5.4%	8.6%	11.1	5.3%	5.7%	6.5%	6.7%	9.7%	8.0%	7.1%	6.9%	7.1%	8.3%	
RD&E	7.7%	3.7%	6.3%	4.7%	5.7%	6.5%	7.1%	5.0%	5.9%	5.9%	6.3%	6.3%				
NDDH	9.5%	4.8%	4.3%	4.0%	5.3%	5.0%	4.3%	5.0%	10.0	4.5%	5.9%					
RDUH (E&N)													5.3%	4.1%	5.5%	

Operational Summary – Devon, Torbay and Plymouth

In the latest reporting period (June 2022), Devon reports a preterm birth rate (<37 week) of 6.9%. In the period July 2021-June 2022, TSDFT had the greatest average proportion of preterm births at 7.6%, RDUH demonstrates the lowest average proportion at 5.9% (E) and 5.5% (N).

What are the causes*?*

Risk factors for preterm birth include medical conditions, infections, and pregnancy related disorders. Additionally, there are a number of modifiable risk factors and healthcare interventions that can reduce the chance of preterm birth. These include smoking, alcohol use, drug use and various social complexities. Age and ethnicity of the mother are also risk factors.

What are the actions/what are the challenges*?*

1) Implementation of Saving Babies Lives Care Bundles (NHSE guidance and requirements to reduce the rate of stillbirths), with note to reducing smoking.
2) Preterm birth clinics are in place in all system maternity units and will refer to the consultant if preterm labour is a risk factor. Funding has been delayed to the Trusts due to insufficient outline of funding use.
3) Implementation of specialist maternal smoking cessation services. This is currently on track in Torbay with a service offer in place, delayed in the Trusts due to staffing shortages.

Is there any risk/harm?

Preterm birth is a risk factor for neonatal death, sudden infant death syndrome, intrapartum brain injury and other childhood chronic health conditions.

When is improvement expected*?*

All units report compliance with Saving Babies Lives Care Bundle V2 at point of last survey (November 2022). Further embedding of these actions will support continuous improvement. Further improvements will be made in line with Saving Babies Lives Care Bundle V3 Publication is anticipated, but no date has been shared.

Actions

To support Trusts to obtain funding to support preterm birth reduction models/ preterm birth clinics.

Quality

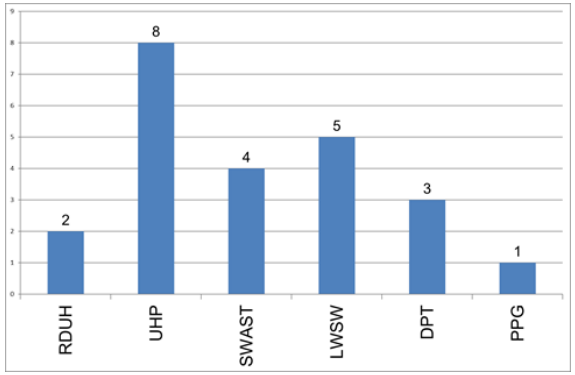
Quality Metrics

	Metric	Latest Date	System	Royal Devon University NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	University Hospitals Plymouth NHS Trust
Quality	C-Diff	2022-11	22	3	2	10
	MRSA	2022-11	3	0	0	0
	MSSA	2022-11	23	8	2	3
	E. coli	2022-11	78	15	4	12
	Klebsiella	2022-11	27	4	2	2
	Pseudomonas spp	2022-11	7	4	0	0
	SAFETY SYSTEMS: SIs within elective, planned care	2022-11	0	0	0	0
	SAFETY SYSTEMS: Total number of Open Incidents	2022-11	134	41	35	58
	SAFETY SYSTEMS: Total number of Open Serious Incidents DEATH ONLY	2022-11	2	0	0	2
	SAFETY SYSTEMS: Number of SI's that are overdue	2022-11	62	26	24	12
	SAFETY SYSTEMS: Number of Never events	2022-11	2	2	0	0
	SAFETY SYSTEMS: Total number of SIs reported in the month	2022-11	23	2	0	8
	Patient Experience: Number of open formal complaints	2022-11	0	0	0	0
	Patient Experience: Formal complaints in relation to planned elective care	2022-11	0	0	0	
	Patient Experience: Provider concerns in relation to planned elective care	2022-11	0	0	0	0
	CIC: Average % of IHAs completed within statutory timescales	2022-10	62%			
	CIC: Average % of RHAs completed within statutory timescales	2022-10	48%			
	Safeguarding Adults: S42.2 enquiries relating to care provided by services commissi...	2022-11	10			

Serious Incidents

Serious Incidents by Provider

During November 2022 there have been **23 serious incidents** reports (decrease of 14 from last month), these are broken down by Provider in the chart (right):



There were 2 Never Events reported in November 2022. Since April 2022 there have been **15 never events reported**, which is a significant increase compared to the same period last year (3). These will continue to be monitored by the Safety Systems team.

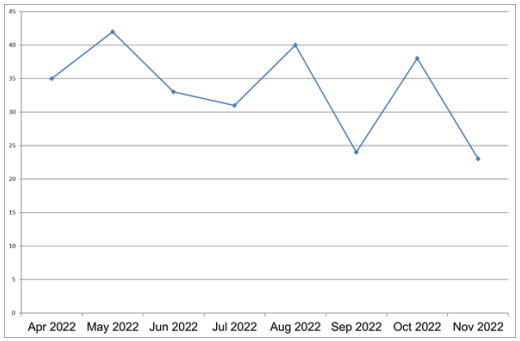
The **top five Serious incident** types reported in November 2022 were:

- Medication incident (2)
- Slips/trips/falls (4) 🡻
- Maternity/Obstetric (2) 🡻
- Apparent/actual/suspected self-inflicted harm (6) 🡹
- Treatment delay meeting SI criteria (4) 🡹

(Arrow indicates change from previous month)

Total Reported Incidents (System)/Overdue Investigations

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



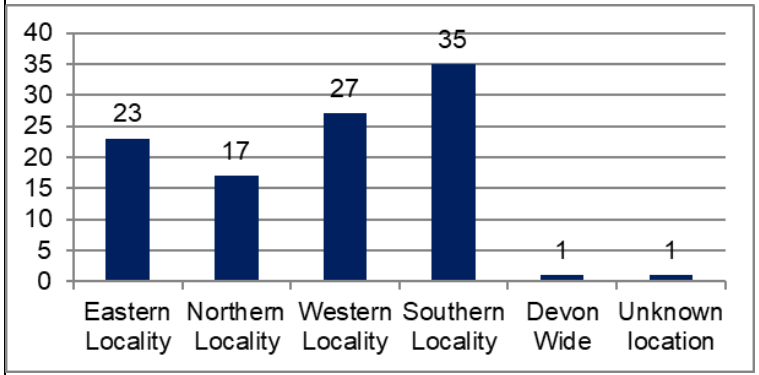
The total number of **overdue investigation reports** that have not yet been completed and submitted to the ICB remains a concern for the ICB. The numbers remain stable across all providers. The safety systems team are continuing to provide support to all providers in reducing their overdue incidents. The three Providers that have the highest % overdue are: DPT (75%), TSDFT (67%) and RDUH (65%).

Current SI Status

There are currently 17 open serious incidents that have been identified as multi-agency. These are being investigated jointly to help improve and identify what went wrong throughout the patient's care leading up to the incident. This also enables joint learning across Providers.

Peer Improvement Tips for Care and Health (PITCH)

Data



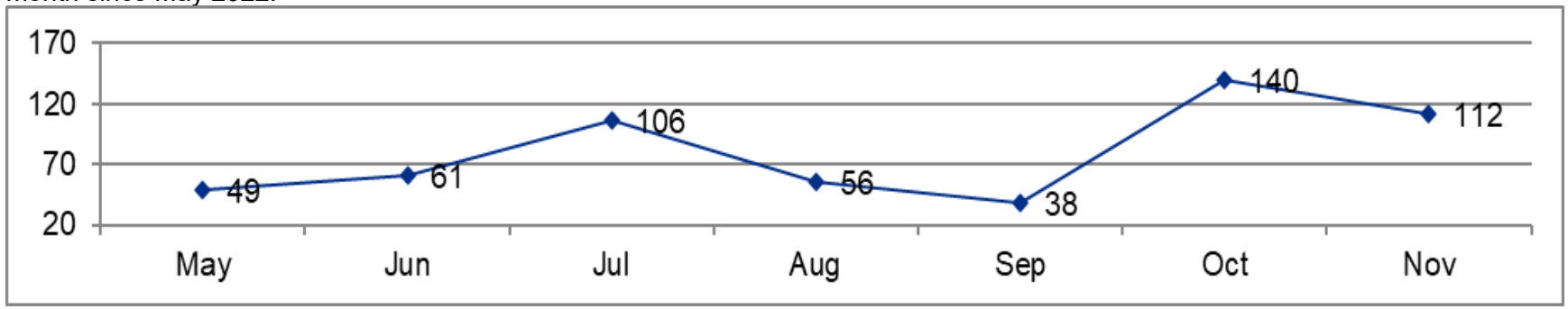
During November there have been **104 PITCHs** reported, these are broken down by locality in the chart below:
The **top three PITCH concerns received in** November were:

- Access to Services (23)
- Referrals (16)
- Workload Shift (15)

There has been continued high reporting related to out of hours access (29 submissions) long wait times for call backs from clinicians. Another identified theme is end of life care (EoL). This covers a range of issues such as just in case medication being incorrectly prescribed (no GP signature/not all meds prescribed), long wait times for 111 to visit EoL patients, difficulty accessing district nurses for EoL patients in the community, delays in verification of death for community patients (15 submissions). These are shared with EoL Programme Manager and discuss within the system for improvement.

Closed PITCHs

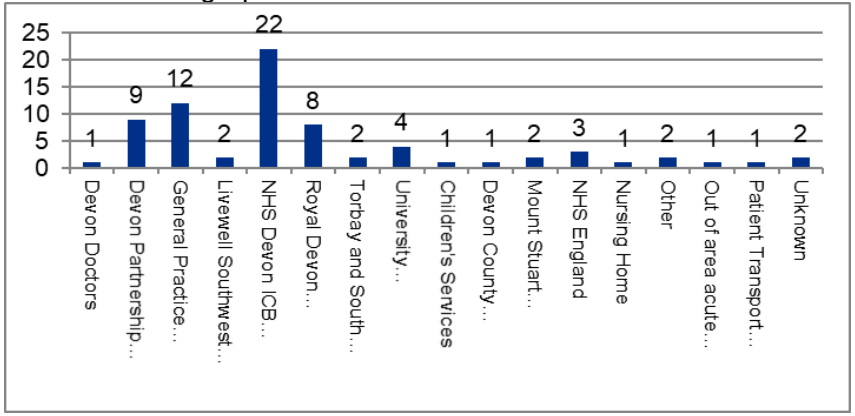
During October 112 PITCHs were closed compared to 140 last month. The below chart, illustrates the number of closed PITCHs per month since May 2022:



Patient Experience (NHS Devon): Patient Contacts

Patient Experience Reports - November

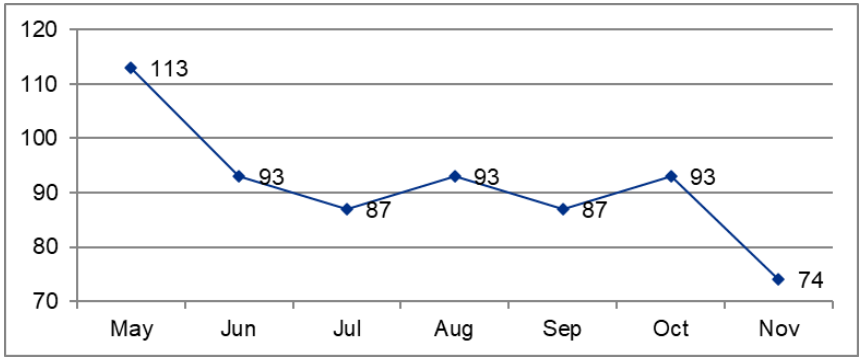
During November there were **74 new patient experience** feedback and concerns to manage, these are broken down by Provider in the graph below:



Continued contact relating to ADHD/Autism services, particularly care after 'right to choose'. However previous contact related to adult services, there is also increased contact (5) relating to children services. Commissioners are also handling additional contacts relating to this subject.

Patient Experience – Informal Concerns

Patient experience informal concerns remain stable over the last 5 months to a monthly average of 91 cases however remains higher than 2020/2021 at 69 per month and 2021/2022 at 79 per month.



The **three most frequently reported patient experience concerns received in** November were:

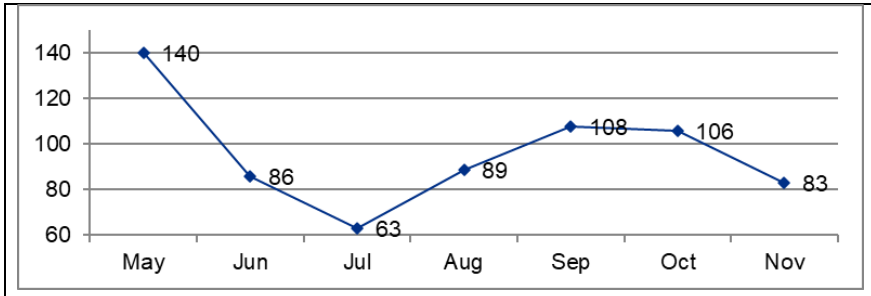
- Quality of Care **(17)**
- Access to Services **(12)**
- Procedure and Process **(10)**

Patient Experience – Closed cases

The **closing** of patient experience concerns has reduced however this is reflected in the volume of new contacts demonstrated above. The number of cases closed are illustrated below:

Patient Experience Summary

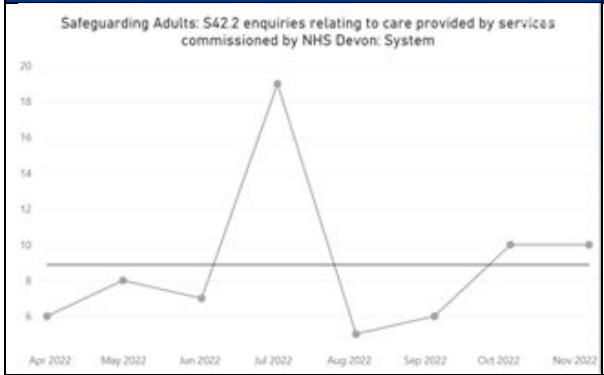
- There has been **no new formal complaint** raised during November for NHS Devon.
- There have been **3 contractual reviews received** and in progress, which are required and form part of Primary Care complaints which are managed by NHS England.
- There were **2 new requests for information** from the **Parliamentary Health Care Ombudsman (PHSO)**



6 open patient experience concerns
2 open PHSO request
4 contractual reviews from NHSE

Safeguarding: Adult Enquiries

Issue**: Safeguarding Adult Enquiries (Section 42.2) are undertaken when concerns about abuse and neglect within health care settings are raised. The statistics below are in relation to the new S42.2 caused out by the 3 local authorities in Devon for November 2022 and the primary themes of the concerns.**

Data	Underlying cause
	**Themes:** The top issues identified within new S42.2 enquiries started in November 2022 related to: • Poor quality of care, with an increase from 40% to 70% of the total number of enquires across a broad range of health and social care settings. • Two other themes relating to either discharge (two), and application of the Mental Capacity Act / Deprivation of Liberty Safeguards were featured

Initial learning from new safeguarding enquiries, closed safeguarding enquiries and safeguarding adult reviews:	Assurance
• Initial learning from poor quality of care has highlighted the need for more timely escalation of patients' physical health issues, where their primary need is mental health.	• The provider is delivering physical health training to ensure appropriate management. • There is close liaison between the ICB safeguarding adult team and the patient safety and quality team where issues such as these are identified.

Actions for next month/s	Intended impact	Date impact will be realised
Torbay and Devon Safeguarding Adult Partnership (TDSAP) published on DSAP website on 24/11/2022	Recommendations and associated actions for providers to improve care have been developed	The action plan with completion dates is being monitored by TDSAP

Safeguarding: Children in Care (CIC)

Issue: The inconsistencies in provider reporting across the system, means that the ICS is 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

1. All providers have their own paperwork and have different data flows and routes into the ICB .
2. Increase of unaccompanied asylum-seeking children (UASC) via two routes. a) children within the emergency hotels and b) the national transfer scheme.
3. No direct flow of Individual Health Assessment (IHA) data within all acute Trusts own organisations for assurance.

Authority	Numbers of UASC – December 2022
Devon	36
Plymouth	13
Torbay	19

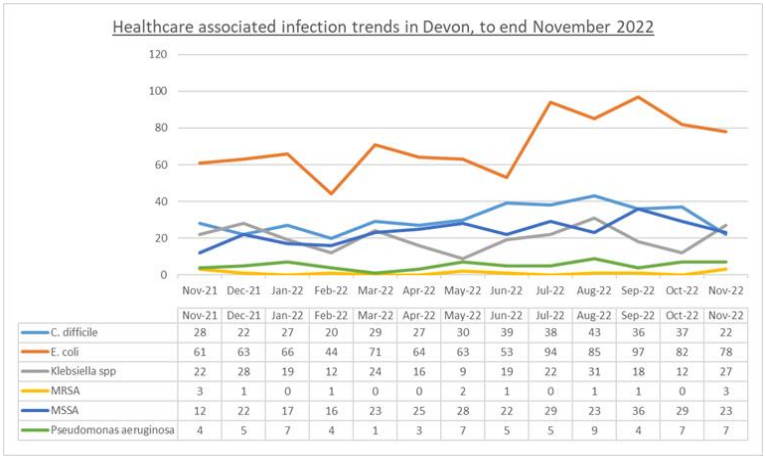
October 2022	TSDFT	RDUH - Eastern	RDUH - Northern	UHP	LIVEWELL	CFHD	System
Percentage of CIC receiving RHA's within statutory timescales (this is 6 monthly for U5s and annually for Over 5s)					**62.5% 20/32**	**42% 28/67**	**48%**
Percentage of CIC receiving IHA's within statutory timeframe of 20 working days of coming into care.	**75% 6/8**	**No data submitted**	**0% 0/4**	**77% 7/9**			**62%**

Actions undertaken in last month	Impact
1. Ongoing meetings with the three Local Authorities to improve notification process through collaborative working. 2. Designated Doctors have devised a spreadsheet that all Named Doctors can complete monthly. Aim to launch in January 2023 3. Revised Outcome Framework awaiting community providers agreement, which includes a consistent reporting method.	Requests for initial health assessments would be timelier. Consistent reporting method across Devon UASC would have their health needs assessed and

Awaiting feedback from Children's commissioners 4. Designated Doctors are writing a business plan for medical resources to undertake the increased workload. 5. Pathway for unaccompanied young people awaiting age assessments agreed with local providers, ICB and local authorities 6. Designated Nurses give expert advice to local authorities UASC process meetings	supported in a timelier and child friendly way. Adequate resources within the acute teams to manage the increased volume and complexities of the UASC IHA's.

Actions for next month/s	Intended impact	Date impact will be realised
Named Doctors to use agreed spreadsheet to report IHA activity. Monitor and evaluate implementation of UASC pathway Designated Drs to complete business plan regarding medical capacity to complete health assessment of CIC and UASC Liaise with commissioners about the outcome framework.	Robust data of health assessment activity Children receive timely health assessments	February 2023

Infection Prevention and Control

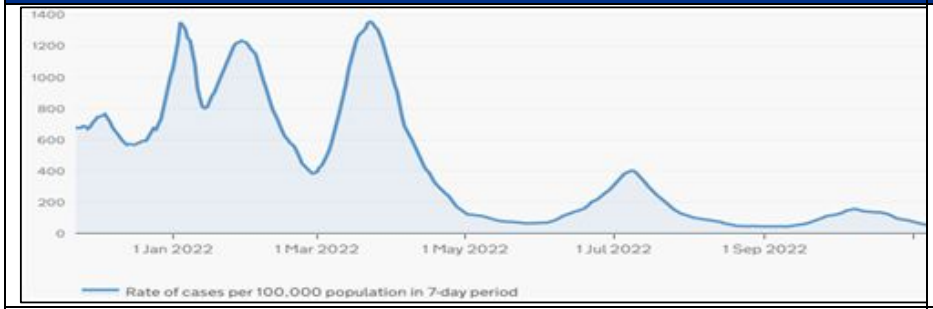
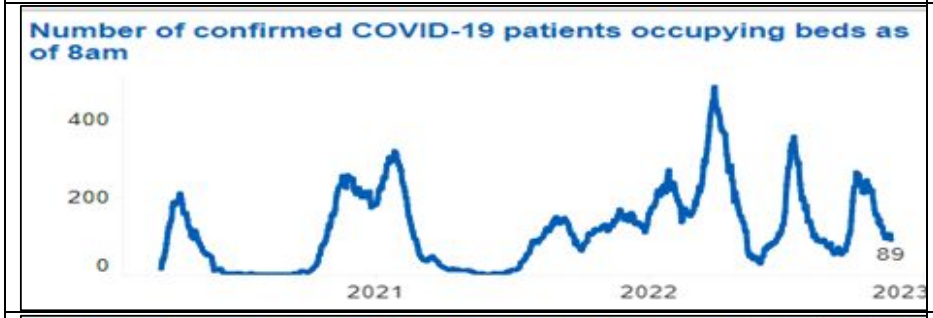
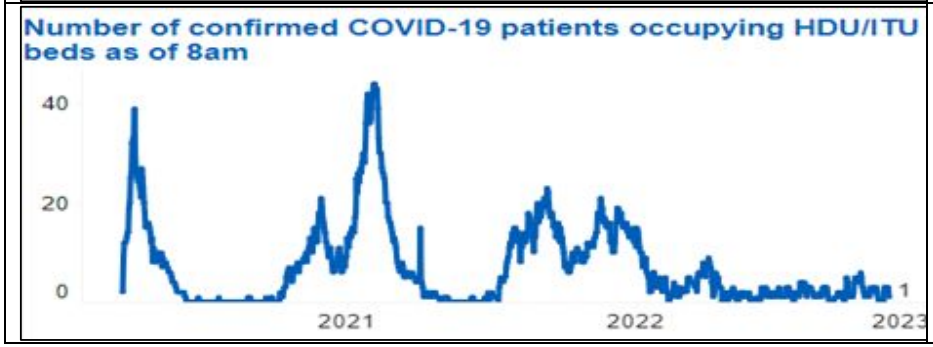
Data	Infection Highlights
	There has been a rapid deployment of infection control resources to support refugee and asylum seeker hotels in Devon. This has been successful, and the lessons learned are being used to support further work in this area. There has been a national increase in group A streptococcus (GAS) cases, and this is creating additional system pressure, particularly in primary care.
	Influenza (seasonal and avian)
	The vaccination programme for seasonal flu is continuing, with weekly monitoring meetings identifying emerging vaccine rollout issues. Vaccination of the 2–3-year-old cohort is being prioritised, following national recommendations. The Chief Medical Officer has announced that antivirals can now be prescribed for flu in primary care, due to the threshold of flu activity being reached, making 2022-23 the first flu season since 2019. 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.

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
C. difficile	28	22	27	20	29	27	30	39	38	43	36	37	22
E. coli	61	63	66	44	71	64	63	53	94	85	97	82	78
Klebsiella spp	22	28	19	12	24	16	9	19	22	31	18	12	27
MRSA	3	1	0	1	0	0	2	1	0	1	1	0	3
MSSA	12	22	17	16	23	25	28	22	29	23	36	29	23
Pseudomonas aeruginosa	4	5	7	4	1	3	7	5	5	9	4	7	7

Actions undertaken in last month	Impact
Antiviral prophylaxis recommissioning.	Antiviral prophylaxis contract near completion, with bridging process in place.
Support to asylum seeker & refugee hotels	Improved health outcomes and reduced outbreaks in these settings.

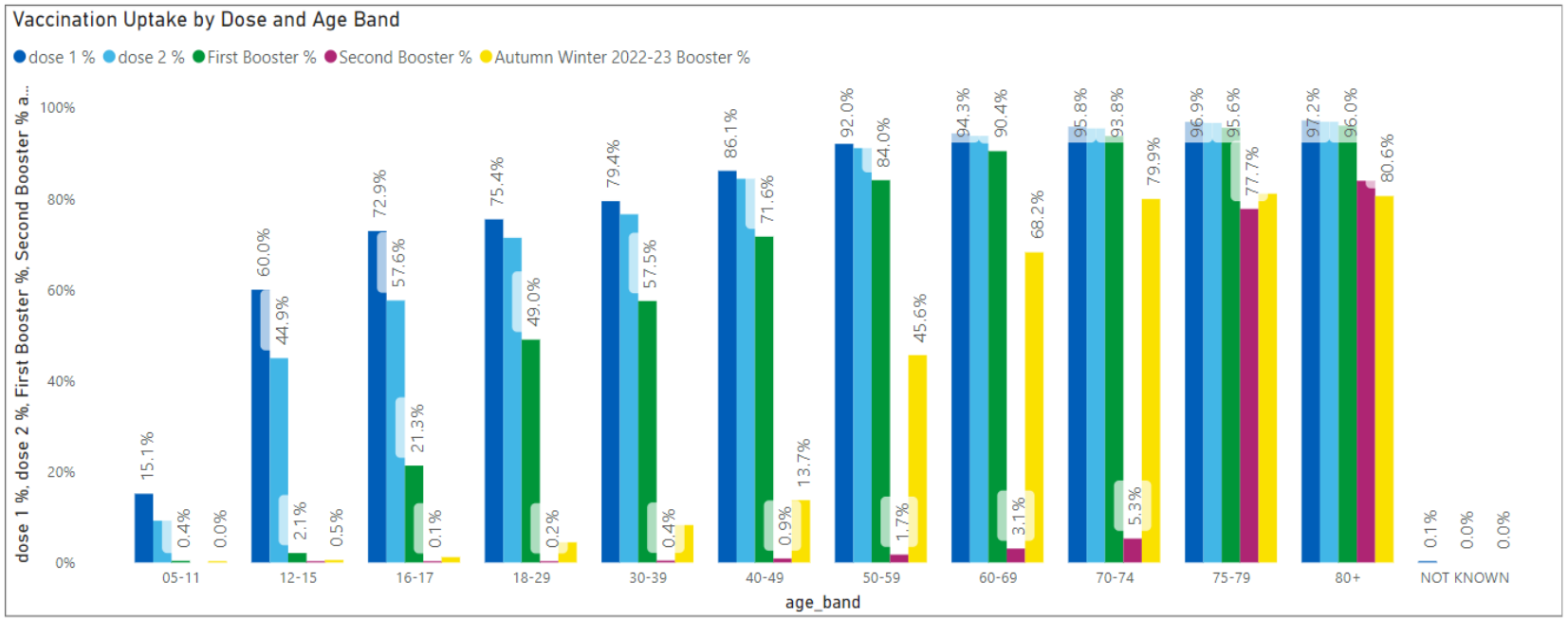
Actions for next month/s	Intended impact	Date impact will be realised
Infection control and antimicrobial resistance system meetings	Sharing of good practice, dissemination of national requests and information, system assurance. Closer linking with Cornwall.	January 2023
Tuberculosis commissioning pathway evaluation	Consistent provisioned service for tuberculosis video observed therapy and directly observed therapy.	February 2023
Tuberculosis latent screening operational pathway	Operational guidance for tuberculosis professionals regarding latent screening in the context of asylum seeker and refugee need.	December 2022

Covid Update

Data	Narrative
	Covid infections have fallen since a peak in early October but are expected to start rising again in late November/early December, with a further peak towards the end of December or early January.
	The number of Covid patients in hospital beds has reduced from the most recent peak of 264 at the beginning of October down to less than 100 in late November. However, numbers are expected to rise again from early December.
	Covid patients in ICU continue to remain low. As of 20th November, there was just 1 patient with Covid occupying an ICU bed in Devon.

Covid Update: Vaccinations

Data

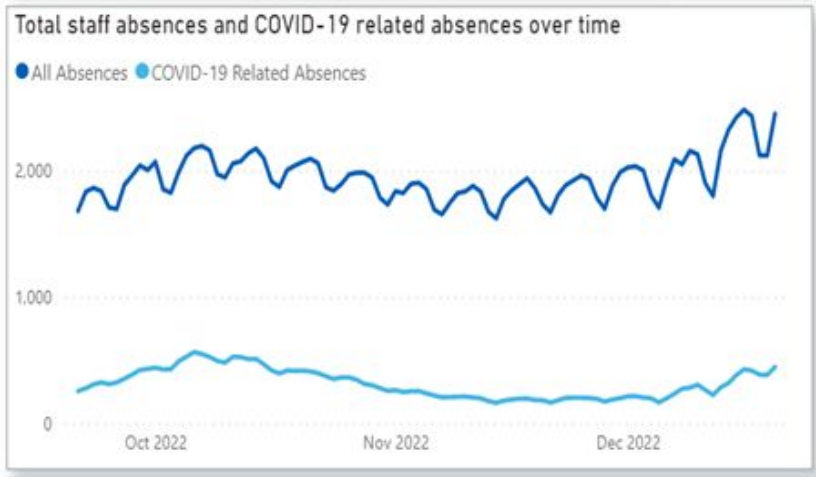


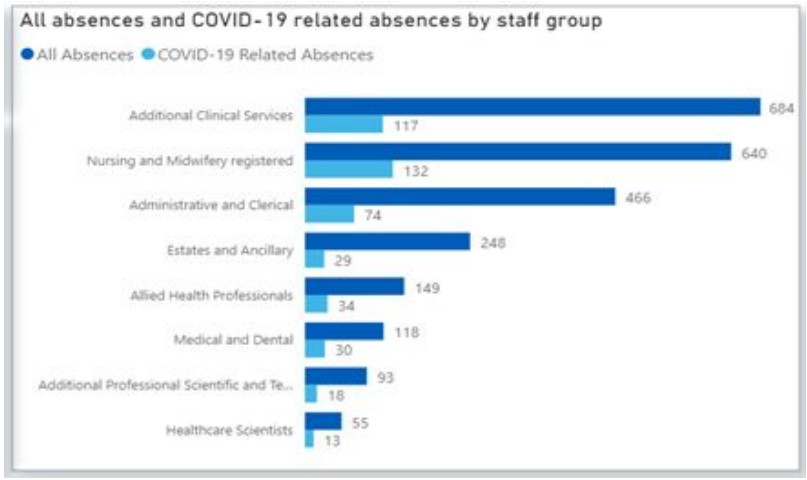
Narrative

The focus of the vaccination programme has been on Autumn boosters with good progress being made particularly for older age groups. Almost 80% of over 70s, 68.2% of 60-70 year-olds and 45.6% of 50-60 year-olds have now received their Autumn booster. (all figures as of 20th December)

Covid Update - Workforce Absence

Data	





Narrative

Covid-related absences have increased at a steady rate since the start of December across all providers, rising from around 0.5% in mid-November to 1.3% of the workforce by mid-December. Although still much lower than the 3%+ Covid absences seen during October and previous Covid peaks.

Latest figures show 7% of staff are absent in total across Devon's providers.

Workforce

Workforce: Metrics

	Metric	Latest Date	System	Devon Partnership NHS Trust	Royal Devon University NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	University Hospital Plymouth NHS Trust
Workforce	WTE Current month against plan (Variance)	2022-10	81.4	-52.5	3.19	Data unavailable	132
	WTE (Actual)	2022-10	31,895	3,649	12,226		9,521
	Medical/Dental Consultant Vacancy	2022-10	88.1	21.3	21.4		43.2
	Registered Nursing, Midwifery and Health Visiting Staff Vacancy	2022-10	408	146	260		31.7
	Allied health professionals Vacancy	2022-10	264	7.83	141		66.9
	Health care assistants and other support staff (Nursing) Vacancy	2022-10	364	-64.2	239		102
	Agency spend	2022-10	4358	547	2517		331
	Total pay bill - substantive, bank agency spend	2022-10	134963	14460	52479		41059
	Agency spend as a % of pay bill	2022-10	3.23%	3.78%	4.80%		0.806%

- There remains an issue with reliable data with TSDFT which has been escalated. A date for resolution has not yet been identified.
- DPT remains to have a high percentage of consultant vacancies (MH) at 21.3WTE which is 21%. The medical recruitment campaign and other initiatives aims to reduce vacancies by attracting and retaining more individuals within the system.
- DPT has the highest percentage nursing vacancy rate at 15.6%. Over investing in HCA workforce supports vacancy gaps in addition to international recruitment.
- RDUH has the highest AHP vacancy rate of 141WTE which is 13%.
- £40.3M (5.4%) above planned year to date total workforce costs (year-end forecast, £86.6M overspend against plan). All programmes of work support spend reduction.
- All Trusts are using higher than planned agency and bank WTE and cost, £11.2M overspend year to date.
- UHP have the lowest agency spend in October, £331k in comparison to RDUH at £2.5m. Task and Finish Groups will discuss causes and share learning with other providers to identify savings/reductions.

Workforce: Workforce Strategy

- **Strategic Workforce Planning:** Developed an agreed specification for a Strategic Workforce Planning tool proceeding to Procurement business case. HEE are training a Data and Analytics Apprentice who will start work in February 2023 with the System Workforce Team.

- **Workforce Strategy:** On track for completion by the end of March 2023. Developed a Self-Assessment Tool using the output of the workshops and interviews for organisations and stakeholders to assess their position in relation to the Workforce Vision for Devon in 2035.

Workforce: Learning, Education and Strategy

- **ICS Learning Academy:** This is now the Learning and Education Strategic Oversight Group; co-designed programme of work for 2023/24.

- **Community Upskilling Funding:** Procurement being scoped, implementation planning being completed for timeline to commence in April 23.

Workforce: Best Place to Work (BPTW)

- **Health and Wellbeing Strategies:** Shared set of principles progressed by each organisation, with a recommendation to implement Employee Assistance Programme and Employee Benefits provision across the Devon system.

- **Inclusion:** This subgroup will further develop the workforce inclusion elements to support and enable the ICS inclusion strategy, when launched, with the necessary focus on inequalities and community and patient inclusion.

- **Wellbeing Hub:** Paper demonstrates current and potential service offer, utilisation, return on investment and proposal for future service provision in the event that current sources of funding reduce.

- **Retention**: Continued focus on current project with a report being compiled to summarise the pilot outcomes, future proposals for retention including utilisation of roles that have been funded by HEE across the system, and governance and reporting arrangements.

- **Absence Management**: Paper summarising work to date from the T&F Group shared with BPTW and due to be presented to the Executive Workforce Group at the January meeting. Paper highlights necessity to share best practice and a need to measure effectiveness of initiatives.

- **Culture and wellbeing dashboard**: Designed and in place with monthly refresh of information. Business Intelligence currently unable to provide further development support in line with current priorities.

- **Priorities for 2023/24:** BPTW including forward planner, Terms of Reference and Governance Structure currently under development, with a draft to be shared at the January BPTW meeting.

Workforce: Workforce Capacity

- **International recruitment (IR):** On track to deploy the 700th Nurse by calendar year end. Social Care programme underway. Circa 600 care worker applications (for 37 providers). 24 AHP interview panels in progress.

- **Collaboration of bank:** Launch of medical collaborative bank in Oct which acts as a second layer of provision after a Trust internal bank has been utilised and before a shift goes out to agency. Work currently being undertaken to understand what spend sits outside of that, to identify further savings.

- **Bank and agency spend:** Reduction of off framework spend for Nursing. Off framework October data for Nursing is lowest spend across previous 12 months. AHP rates are the next focal point.

- **Medical Recruitment Campaign:** Website live, marketing approach in final stages of agreement with aim to go live early January.

- **MOU:** Standardised employment contract now agreed (with differing probation clauses) and is available for use by Trusts. MOU to be formally agreed via HRD's in Dec (delayed from Oct and Nov).

NHS Devon Integrated Care Board Meeting

NHS Devon (ICB) Finance Report Month 8

Date of committee	Date report produced
18 January 2023	4 January 2023

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	Bill Shields Director of Finance
Phone:	07825 027569	**Date:**	4 January 2023
Email:	kevin.wheller@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)

The presentation of the Integrated Care Board's (ICBs) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICB for the year ended 31 March 2023.

This report details the ICB financial position as at 30 November 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
Finance Committee approved on 11 January

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

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

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 Integrated Care Board

Finance Report

Month 8 – 2022/23

Contents

Appendices

1. Executive Summary

The presentation of the Integrated Care Board's (ICBs) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICB for the year ended 31st March 2023.

This report details the ICB financial position as at 30th November 2022.

On 20th June 2022, Devon Integrated Care System (ICS) submitted a deficit plan of £18.2m and an expectation that £138.9m of efficiency savings are needed to meet that plan. Within the that plan ICB's planned financial position is breakeven with a requirement to deliver £36.5m of efficiency savings

From 1 July 2022 NHS Devon CCG was dissolved and NHS Devon Integrated Care Board (ICB) was formed, requiring the CCG to produce a set of CCG accounts for the period 1 April to 30 June 2022. The first set of ICB accounts will be for 9 months, the period covering 1 July 2022 to 31 March 2023.

Throughout this report and in line with the plan the stated position is for the whole of 22/23 including the first 3 months.

Financial Position

The following detailed report reflects the budget set by the 2022/23 NHSE financial framework compared with the actual commitments against that budget for the period to 30th November 2022 and the year ending 31 March 2023.

As at 30th November 2022	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000		Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	
Total Net Expenditure	1,676,014	1,676,015	(0)	↓	2,517,446	2,525,516	(8,070)	↓
Resource Allocation	(1,676,015)	(1,676,015)	0	→	(2,525,516)	(2,525,516)	0	→
Additional Roles Reimbursement Scheme	0	0	0	→	0	(8,070)	8,070	→
Total Commissioned Services	**(0)**	**0**	**(0)**	↓	**(8,070)**	**(8,070)**	**(0)**	↓

Overall, subject to the ICB receiving the expected allocation from NHSE for the Additional Roles Reimbursement Scheme (ARRS) costs, we are reporting a balanced YTD and FOT position. The ARRS relates to primary care additional roles employed by Primary Care Networks that are funded centrally and reimbursed in arrears.

As at month 8 some service lines are currently exceeding budget including some acute services, continuing healthcare, individual placements and primary care prescribing. These variances are currently being covered by contingencies set aside at plan to manage in year variation and held in reserves.

Service line variances are detailed in the sections 2 and appendix 3

Savings Plan

The ICB's savings plan includes a saving requirement of £36.5m.

The delivery of savings and efficiencies is off plan at month 8 by £3.4m, driven by a slower than expected delivery of savings linked to prescribing, placements and targets associated with the recovery programme.

Savings plans are forecast to deliver to target by 31st March 2023 and actions are being taken to improve the delivery going forward. More detail is provided in section 3.

Risk

The ICB has identified risk to delivering a breakeven position of £17.9m at 30th November 2022 including risks relating to delivery of the savings target and increases in prescription drug prices. Actions including release balance sheet flexibilities and use of non-recurrent funding streams have been identified that fully mitigate the identified risk.

Conclusion

As at 30th November 2022 the ICB is expecting to deliver its target of break even for the year.

Given the in year service line variances mentioned above actions are being taken to improve those areas where possible to improve the ICB position and risk profile within the context of delivering the system wide plan.

2. Detailed Financial Performance

The year to date and outturn by main service heading as at 30th November 2022 is as follows.

Service	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000		Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	
Acute	824,806	826,850	(2,043)	↑	1,237,735	1,241,468	(3,734)	↓
Mental Health	180,667	181,562	(895)	↓	271,073	273,110	(2,038)	↓
Community Health	202,508	201,151	1,357	↑	306,122	306,868	(746)	↑
Continuing Care	97,779	97,574	205	↑	146,684	147,991	(1,307)	↑
Primary Care	300,392	304,605	(4,213)	↓	450,475	462,631	(12,156)	↓
Other Programme	24,755	23,167	1,587	↑	37,383	36,582	801	↑
Total Commissioned Services	**1,630,906**	**1,634,908**	**(4,002)**	↑	**2,449,471**	**2,468,650**	**(19,179)**	↓
Running Costs	15,392	15,421	(29)	↑	22,919	22,919	(0)	→
Net Expenditure	**1,646,299**	**1,650,329**	**(4,030)**	↑	**2,472,390**	**2,491,569**	**(19,179)**	↓
Reserves/Contingencies	29,716	25,686	4,030	↓	45,056	33,947	11,109	↑
Total Net Expenditure	**1,676,014**	**1,676,015**	**(0)**	↓	**2,517,446**	**2,525,516**	**(8,070)**	↓
Resource Allocation	(1,676,015)	(1,676,015)	0	→	(2,517,446)	(2,517,446)	0	→
Additional Roles Reimbursement Scheme	0	0	0	→	0	(8,070)	8,070	→
Total Commissioned Services	**(0)**	**0**	**(0)**	↓	**0**	**0**	**(0)**	↓

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

2.1 Acute Services

Acute services include contracts with our main system acute providers as well as contracts with acute providers in Cornwall, Somerset, Bristol and London. It also includes our contract with South West Ambulance, contracts for patient transport and contracts for acute procedures undertaken in the independent sector and by other Non-NHS providers.

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

Overspends in this are due to:

- Patient transport costs, linked to increase journeys as a result of COVID and the discharge to assess policy.
- Pressure in relation to out of area non-contracted activity where patients are receiving treatment that is recharged to the ICB on a case by case basis.
- Payments to South West Ambulance NHS FT for handover delays under a risk sharing agreement with the Trust.

An initial review of patient transport costs has been completed with a number of actions agreed that should reduce costs going forward and impact seen in the final months of this financial year. These actions are linked to better planning and organisation of transport and are not expected to impact on patient care. A follow up review is planned in January.

2.2 Mental Health Services

The Mental Health budget commissions services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and Livewell Southwest with the CAMHS service for Northern, Eastern and Southern localities being provided by Children and Families Health Devon through a contract with Torbay and Southern Devon NHS Foundation Trust. This section also includes spend relating to individual adult placements for mental health and learning disability services.

The main area of overspending within mental health relates to individual patient placements driven by increasing numbers of placements for learning disability and individuals receiving care under s117 of the mental health act. A review has been completed with a number of actions agreed that should reduce costs going forward and impact seen in the final months of this financial year. The actions are linked to reviewing care packages to ensure they are providing the appropriate level of care. A follow up review is planned in January.

There are also pressures emerging relating to addressing ADHD waiting lists and SMI physical health checks that indicate a potential forecast overspend.

2.3 Community Health Services

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

It also includes provision for community based acute procedures delivered through GP practice specialisms and other non-NHS providers as well as joint arrangements with Local Authorities under the provisions of the Better Care Fund.

Part of forecast overspend relates to a small number of high cost individual placements. A review has been completed with a number of actions agreed that should reduce costs going forward, some of which is already impacting on this month's position compared to Month 7. The actions are linked to reviewing care packages to ensure they are providing the appropriate level of care. A follow up review is planned in January.

The remaining overspend relates to increased costs of post discharge care under the discharge to assess policy that impacts on bed availability in our acute hospitals.

2.4 Continuing Care

Placements includes Continuing Care budgets comprising of Continuing Care Administration, Continuing Healthcare (CHC), Interim Funding, Joint Funding, Children's Continuing Care and Funded Nursing Care (FNC).

The placements budget represents a particular risk to the ICB financial position that requires robust financial management. The key risks relate to the backlog of CHC assessments and breaches from the continuation of 4-week Hospital Discharge Programme.

Some examples of other risks include:

- Fluctuations in the number of clients eligible for financial support
- Assessments exceeding 28 days
- Unexpected exceptional levels of support required for some clients
- Responsible commissioner cases

The Month 8 forecast position is £1.3m over budget which is an improvement of £1.2m from M7. This is largely a result of mitigating actions on one of the high-cost cases that emerged between months 4 and 5. There is also a £1.5m overspend against FNC budget due to significant increase in client numbers compared to the previous year.

Mitigating actions, including high-cost case reviews, are impacting on the position. The ICB has also commissioned an external provider to conduct reviews of the appropriateness of ongoing packages of care which is expected to reduce costs in January to March.

2.5 Other Programme

All Other Programme area picks up the remaining community based provision of healthcare services including hospice care and other voluntary sector grant based commissioned services. This area also includes the element of our integrated urgent care contract that relates to NHS 111.

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

2.6 Primary Care Services

Primary Care includes expenditure on primary care prescribing, GP Medical Services (delegated from NHSE), enhanced services, Out of Hours and other primary care related expenditure including GP IT.

Prescribing

The prescribing position is being impacted by a cost pressure due to unavailability of the lowest priced stocks of medicines, an issue known as Price Concessions or No Cheaper Stock Obtainable (NCSO). The £4.7m forecast is being driven entirely by this cost pressure having set budgets on a flat cash basis which required savings of £5.7m.

As of month 8 the plan is on track to deliver and the medicines optimisation team have been challenged to go further than the initial plan and increase delivery in order to mitigate the NCSO cost pressure described above. 4 schemes have been

identified targeting £600k and the team have been asked to prioritise their implementation.

Delegated Commissioning

The remaining forecast overspend in primary care is driven by an £7.9m anticipated cost in relation to additional primary care roles which is reimbursed on a retrospective by NHSE.

Other Primary Care

Other primary care services include contracts for enhanced GP services, out of hours GP services, home oxygen services and provision for GP IT costs.

2.7 Running Costs

The pay and associated costs for the ICB are categorised into administrative (running costs) and programme costs according to whether they relate to healthcare services and are solely concerned with management of the organisation.

Each year the ICB receives a specific allocation for its running costs and has an obligation to report against it separately and mustn't overspend against the limit set.

We are expecting to contain our running costs within the specified allocation this year.

2.8 Resource Allocation

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

Allocation Description	Year to date		
	CCG M1-3 £000	ICB M8 £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
New Allocations M7		2,587	2,587
New Allocations M8		5,958	5,958
Non-Recurrent Allocation	**19,798**	**191,577**	**211,375**
Total Allocation	**596,317**	**1,921,129**	**2,517,446**

The new allocations from month 4 to month 8 include £30m relating to the changes in pay inflation and £23.9m demand and capacity funding to increase bed capacity over winter as well other know service development funds.

All allocations are reviewed by the Senior Executive Committee with the review of Month 4 to 7 allocations having been completed in December. A report of that review is attached to this report.

The Month 8 Allocations will be reviewed in early January and comprise:

Month 8 Allocation Description	Total £000
Workforce Planning and Informatics	377
SDF - Innovation: ICS REND Programme -	4
Treating Tobacco Dependency 'topslice' funding	100
CVD Champion - One day per week	67
SW Regional Scaling Programme - Monitoring in 32 Care Homes	42
SW Regional Scaling Programme - Clinical Lead Costs	106
Activity Insourcing	29
PCT GP Fellowships	730
Diabetes SDF: Treatment and care, recovery and implementation	477
Devon - NHS 111 capacity allocations.	366
22/23 ICS Digital Transformation Planning Funding	1,103
Independent Senior Advocate (ISA) Pilot Phase	150
22/23 discharge funding - tranche 1	45
Total	**2,362**

3. Savings And Efficiencies

The delivery of savings and efficiencies as at 30th November 2022 is as follows:

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%	3,800	3,696	(104)	5,704	5,704	0
Running Cost Inflation		R	2.3%	352	352	0	525	525	0
Placements		R	3.7%	2,632	2,364	(268)	3,945	3,945	0
Primary Care Commissioning Review		R	0.8%	1,336	1,336	0	2,000	2,000	0
Commissioning Review		R	0.8%	2,000	2,000	0	3,000	3,000	0
Covid Reduction		NR	78.0%	2,400	2,400	0	3,600	3,600	0
Acute		R	1.4%	520	520	0	784	784	0
Unidentified		NR		1,650	0	(1,650)	2,967	2,546	(421)
SDF		NR	11.1%	3,335	6,421	3,086	6,000	6,421	421
Workstream stretch		NR		4,445	0	(4,445)	8,000	8,000	0
Total				**22,470**	**19,089**	**(3,381)**	**36,525**	**36,525**	**0**
Recurrent				10,640	10,268	(372)	15,958	15,958	0
Non-Recurrent				11,830	8,821	(3,009)	20,567	20,567	0
Total				**22,470**	**19,089**	**(3,381)**	**36,525**	**36,525**	**0**

The majority of identified savings plans are delivering to plan as at Month 8.

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. In addition the ICB is in the process of engaging external assessment resource which is expected to realise further financial benefits.

Savings linked to placements and SDF have seen improved delivery from the previous month. This together with any further financial benefits related to placements will contribute to the unidentified savings within the plan.

The workstream stretch target was linked to the system plan delivery and has no identified opportunities released to date. The forecast delivery recognises that through other non-recurrent means the ICB is able to manage the non-delivery of this target (see risk section 4).

4. Risks

The assessment of financial risk (and mitigations) for the year ended 31 March 2023 as at 30th November 2022, is as follows.

Headline	Description	M7 £000	M8 £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	0		0	2,500
Prescribing prices	Increases in prescription drugs prices	3,900	3,900	0	1,500
Total Risk		**17,867**	**17,867**	**0**	**17,967**
Non-Recurrent flexibility	Release of balance sheet accruals	7,376	7,734	358	7,376
s256 funds	Use of s256 funding held by Local Authorities	2,500	0	(2,500)	2,500
Allocations Review	Hold back further non recurrent allocations		5,921	5,921	0
Non-Recurrent flexibility	Other non-recurrent benefits	7,991	4,212	(3,779)	0
Total Mitigation		**17,867**	**17,867**	**0**	**9,876**
Net Risk		**0**	**0**	**0**	**8,092**

The ICB has identified risk to delivering a breakeven position of £17.8m at 30th November 2022. Risks relate to the delivery of the savings target and increases in prescription drug prices.

Actions including release balance sheet flexibilities and use of non-recurrent funding streams (including reviews of in year allocations) have been identified that fully mitigate the identified risk and preserves s256 funding for use in 23/24.

The balance sheet flexibilities comprise of accruals made in 21/22 that are not required to cover expenditure in 22/23 and include situations where estimates were made at 31st March 2022 due to the timing of delivery of accounts. Budgets have been adjusted to reflect the £7.7m benefit which is currently held in reserve.

Other non-recurrent benefits relate to expected allocations that have yet to be reviewed but where we have a high level of confidence that that they will cover expenditure already incurred or included within the forecast expenditure position.

5. Other Financial Information

5.1 Statement of Financial Position

The statement of financial position (SoFP) provides a snapshot of the ICB's financial position at that date. The SoFP is made of two parts which must always equal each other: the top part (total assets employed) which shows the ICB's assets and liabilities (what the ICB owns and is owed), and the bottom part (total taxpayers' equity) which shows how the ICB has been financed.

The ICB's position at 30th November 2022 is shown in appendix 1.

5.2 Capital

The ICB has spent £120k capital on IT equipment in the period ended 30th November 2022.

5.3 Better Payment Practice Code

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

Better Payment Practice Code	M8	
	Number	£000
Non NHS Creditors - % of bills paid within target	99.71	99.31
NHS Creditors - % of bills paid within target	97.95	99.97

5.4 Cash

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

6. Recommendations

The Finance Committee is requested to:

Consider, review and discuss the ICB's performance and position as at the period ended 30th November 2022.

Appendices

Appendix 1: Statement of Financial Position

Statement of Financial Position	M8 £000
Property Plant & Equipment	2,981
Intangible Assets	193
Non Current Assest	**3,174**
Inventories	896
Trade & Other Receivables - NHS	2,269
Trade & Other Receivables - Non NHS	12,397
Cash & Cash Equivalents	3,672
Current Assets	**19,234**
Total Assests	**22,408**
Trade & Other Payables - NHS	(3,789)
Trade & Other Payables - Non NHS	(155,973)
Other Liabilities	(3,709)
Borrowings / Cash in Transit	(7,916)
Current Liabilities	**(171,387)**
Total Assets Employed	**(148,979)**
General Fund	(148,979)
Total Taxpayers Equity	**(148,979)**

Appendix 2: Cash

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

Measure	Month 8
ICBs must operate within their Cash Drawdown Requirement *The cash drawdown requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,909m for Devon ICB for the period ended 31 March 2023 (excluding the 3 months relating to Devon CCG).*	56.3% of the Cash Drawdown Requirement has been utilised as at month 8 (55.6% is expected based on a straight-line trajectory at month 8). The additional cash required was to cover payments made in April to June 2022 for late allocations received in March 2022.
ICBs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against ICBs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the ICB has not yet been confirmed.	Notional charges amount to £17,737 for November.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The ICB has met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

**Although forecasting is carried out as accurately as possible it sometimes difficult to predict 2 months in advance (the requirement by NHS England) the exact timings and amounts of all income received and all payments made.*

Appendix 3: Operating Expenditure

The detailed financial position as at 30th November 2022

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000
NHS Royal Devon & Exeter Foundation Tru	236,160	236,159	0	355,138	355,138	0
NHS University Hospitals Plymouth NHS Tr	213,555	213,562	(7)	322,608	322,608	(0)
NHS Northern Devon Healthcare Trust	104,846	104,845	1	157,974	157,973	1
NHS South Devon Healthcare Foundation T	170,226	170,222	3	256,483	256,483	0
NHS Taunton and Somerset	6,796	6,795	0	10,193	10,193	0
NHS South Western Ambulance Trust	42,296	42,769	(473)	63,444	64,863	(1,419)
Independent Sector	26,244	26,128	117	39,367	39,176	191
Patient Transport	6,433	7,414	(982)	9,649	11,136	(1,487)
Other Acute	18,250	18,954	(704)	22,877	23,897	(1,020)
Acute	**824,806**	**826,850**	**(2,043)**	**1,237,735**	**1,241,468**	**(3,734)**
Devon Partnership NHS Trust	110,663	110,743	(80)	165,933	166,013	(80)
Livewell MH Services	4,175	4,175	0	6,287	6,287	0
University Hospitals Plymouth MH	27,348	27,348	0	41,040	41,040	(0)
Children and Families Health Devon	10,216	10,196	20	15,373	15,376	(3)
Individual Patient Placements	8,899	9,412	(513)	13,360	14,118	(759)
Section 117	13,855	14,410	(555)	20,855	21,615	(759)
Other Mental Health	5,510	5,278	232	8,224	8,661	(436)
Mental Health	**180,667**	**181,562**	**(895)**	**271,073**	**273,110**	**(2,038)**
Livewell Southwest	(184)	(62)	(123)	(185)	(62)	(123)
Royal Devon and Exeter Community	42,241	42,242	(0)	63,362	63,363	(0)
Northern Devon Healthcare Community	21,768	21,768	0	32,653	32,653	(0)
South Devon Healthcare Community	46,831	46,831	(0)	70,171	70,171	0
University Hospitals Plymouth Community	38,024	38,024	0	57,484	57,484	0
Children and Families Health Devon	8,592	8,569	24	12,925	12,925	0
Individual Patient Placements	567	799	(233)	834	1,199	(365)
Integrated Urgent Care Service	9	8	1	9	8	1
Hospices	5,510	5,445	65	8,264	8,171	94
MIU Contracts	537	493	44	806	757	48
Better Care Fund_Plymouth CC	3,558	3,558	(0)	5,878	5,878	(0)
Better Care Fund_Devon CC	19,480	19,479	1	29,220	29,219	1
VCSE S256	1,749	240	1,509	2,623	2,623	0
Other Community Services	13,825	13,755	70	22,078	22,479	(402)
Community Health	**202,508**	**201,151**	**1,357**	**306,122**	**306,868**	**(746)**
Continuing Healthcare	88,128	86,887	1,241	132,187	131,961	226
Funded Nursing Care	9,651	10,687	(1,036)	14,497	16,030	(1,533)
Continuing Care	**97,779**	**97,574**	**205**	**146,684**	**147,991**	**(1,307)**

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000
Prescribing	139,712	142,340	(2,627)	210,109	214,839	(4,729)
Enhanced Services	6,862	6,736	126	11,081	10,955	126
Delegated Commissioning	132,553	134,061	(1,509)	199,733	207,659	(7,926)
GP Out Of Hours	7,980	8,319	(338)	11,544	11,305	240
GP IT	2,754	2,772	(18)	4,149	4,166	(18)
Other Primary Care	10,530	10,377	153	13,858	13,707	151
Primary Care	**300,392**	**304,605**	**(4,213)**	**450,475**	**462,631**	**(12,156)**
NHS 111	6,512	5,912	600	9,741	9,670	71
Better Care Fund Torbay	2,443	2,443	0	3,665	3,665	0
Chime Audiology	2,578	2,618	(40)	3,867	3,913	(46)
All Other Commisionned Services	13,221	12,194	1,028	20,110	19,333	777
Other Programme	**24,755**	**23,167**	**1,587**	**37,383**	**36,582**	**801**
Total Commissioned Services	**1,630,906**	**1,634,908**	**(4,002)**	**2,449,471**	**2,468,650**	**(19,179)**
Pay	12,144	11,932	211	18,045	18,046	(0)
Non Pay	3,327	3,515	(189)	4,990	4,990	0
Income	(78)	(27)	(51)	(117)	(116)	(0)
Running Costs	**15,392**	**15,421**	**(29)**	**22,919**	**22,919**	**(0)**
Net Expenditure	**1,646,299**	**1,650,329**	**(4,030)**	**2,472,390**	**2,491,569**	**(19,179)**
Reserves/Contingencies	29,716	25,686	4,030	45,056	33,947	11,109
Total Net Expenditure	**1,676,014**	**1,676,015**	**(0)**	**2,517,446**	**2,525,516**	**(8,070)**
Resource Allocation	(1,676,015)	(1,676,015)	0	(2,517,446)	(2,517,446)	0
Additional Roles Reimbursement Scheme	0	0	0	0	(8,070)	8,070
Total Commissioned Services	**(0)**	**0**	**(0)**	**0**	**0**	**(0)**

NHS Devon

NHS Devon Integrated Care Board

NHS Devon (ICS) Finance Report Month 8

Date of committee	Date report produced
18 January 2023	4 January 2023

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	Bill Shields Director of Finance
Phone:	07825 027569	**Date:**	4 January 2023
Email:	kevin.wheller@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)

The presentation of the Integrated Care System's (ICSs) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICS for the year ended 31 March 2023.

The report details the ICS financial position for the period ended 30 November 2022 against the finance plan submitted on 20 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
Finance Committee approved the report on the 11 January

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

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

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 Integrated Care System

Finance Report

Month 8 – 2022/23

Contents

1. Executive Summary

The presentation of the Devon Integrated Care System's (ICS) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICS for the year ended 31 March 2023.

This report details the ICS financial position as at 30 November 2022.

On 20 June 2022, Devon ICS submitted a deficit plan of £18.2m although 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.

As at month 8 the Devon ICS is reporting a year to date £24.1m deficit against a planned deficit of £16.7m – an adverse variance of £7.4m (M7 £5m variance). The reported forecast is a deficit of £18.2m which delivers to plan.

Efficiency savings of £138.9m are required to meet the June plan. As at month 8 the Devon ICS had made efficiency savings £64.4m (M7 £52.5m) This is £19.8m adverse to plan. (M7 £18.3m). Forecast savings are adverse to plan by £30.2m (M7 £33.3m.

At the planning stage net risks of £95.9m were identified to delivery of a break-even plan. The month 8 position identifies risks and issues to be managed totalling £51.8m against an expectation of break-even. (M7 £56.5m).

The above position represents the reported position to NHSE as at Month 8.

2. Financial Performance

The year to date and outturn by organisation as at 30 November 2022 is as follows.

Organisation	Year to date				Forecast			
	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000		Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000	
Devon ICB	0	(0)	(0)	→	0	0	0	→
Royal Devon University NHS FT	(10,805)	(10,805)	0	→	(18,263)	(18,263)	0	→
University Hospitals Plymouth Trust	(3,332)	(3,332)	0	→	0	0	0	→
Torbay and South Devon NHS FT	(1,989)	(9,410)	(7,421)	↓	69	69	0	→
Devon Partnership Trust	(595)	(595)	0	→	0	0	0	→
Total	**(16,721)**	**(24,142)**	**(7,421)**	↓	**(18,194)**	**(18,194)**	**0**	→

As at month 8 the Devon ICS is reporting a year to date £24.1m deficit against a planned deficit of £16.7m – an adverse variance of £7.4m (M7 £5m variance).

As at month 8 we have reported to NHSE that the forecast is a deficit of £18.2m which delivers to plan.

3. Savings And Efficiencies

The delivery of savings and efficiencies as at 30 November 2022 is as follows:

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	22,469	19,089	(3,380)	↑	36,525	36,525	0	→
Royal Devon University NHS FT	21,345	11,250	(10,095)	↓	33,935	16,966	(16,969)	↑
University Hospitals Plymouth Trust	16,274	16,488	214	↓	29,592	29,592	0	→
Torbay and South Devon NHS FT	18,145	13,140	(5,005)	↓	28,452	17,315	(11,137)	↑
Devon Partnership Trust	5,924	4,412	(1,512)	↓	10,358	8,268	(2,090)	↓
Total	**84,157**	**64,379**	**(19,778)**	↓	**138,862**	**108,666**	**(30,196)**	↑

As at month 8 the Devon ICS had made efficiency savings of £64.4m (M7 £52.5m) This is £19.8m adverse to plan. (M7 £18.3m).

Forecast savings are adverse to plan by £30.2m (M7 £33.3m).

4. Risks

The assessment of financial risk (and mitigations) for the year ended 31 March 2023 as at 30 November 2022, is as follows.

Description	Net Weighted Risks & Mitigations						Net Risks at Plan
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000	£000
CIP shortfall	(13,967)	(18,751)	(7,080)	(7,745)	(2,943)	(50,486)	(47,817)
Planned Surplus/(Deficit)		(18,263)		69		(18,194)	(18,194)
Increase in inflation		(2,700)	(2,730)	(1,500)	(874)	(7,804)	(6,950)
Integrated care contract				(7,900)		(7,900)	(6,000)
Hospital discharge	0					0	(2,500)
High cost drugs not met by income		(3,261)	(3,000)	0		(6,261)	(2,314)
Clinical excellence awards			0	(809)		(809)	(1,665)
Pay inflation shortfall		(1,251)	(1,600)			(2,851)	
IFRS 16			(1,200)			(1,200)	
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					(404)	(404)	(1,250)
MHIS and SDF income risk					0	0	(1,200)
ERSF risks			(2,120)			(2,120)	(16,103)
Other		(1,848)	(3,020)	(772)	(1,108)	(6,748)	(5,545)
Total Risk	**(17,867)**	**(46,074)**	**(20,750)**	**(18,657)**	**(5,329)**	**(108,677)**	**(113,838)**
Non-Recurrent flexibility	10,367	24,616	0	0	5,329	40,312	14,076
s256 funds, or exit strategy	7,500					7,500	2,500
Spec com income			3,500			3,500	0
ERSF mitigation	5,000	546				5,546	0
Further Excess inflation funding						0	1,375
Total Mitigation	**22,867**	**25,162**	**3,500**	**0**	**5,329**	**56,858**	**17,951**
Net Risk	**5,000**	**(20,912)**	**(17,250)**	**(18,657)**	**0**	**(51,819)**	**(95,888)**

Month 7	**5,000**	**(24,886)**	**(18,000)**	**(18,623)**	**0**	**(56,509)**

Movement	**0**	**3,974**	**750**	**(34)**	**0**	**4,690**

At the planning stage risks of £113.8m were identified along with £18.0m of mitigations, leaving a net risk of £95.9m to delivery of a break-even plan.

As at Month 8 the net risk has reduced to £51.8m. (M7 £56.5m). This is a risk of £33.6m against planned deficit of £18.2m.

The main risks to be mitigated (in addition to the planned deficit of £18.2m) are:

- Shortfall on planned CIP delivery £50.5m (month 7 £51.5m)
- Excess inflation costs above funded level £7.8m (month 7 £9.1m)
- Integrated care contract increased costs £7.9m (month 7 £7.5m)
- High-cost drugs above funded level £6.3m (month 7 £6.2m)

5. Capital

System capital

Organisation	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Royal Devon University NHS FT	19,307	16,368	2,939	↓	33,306	33,306	0	→
University Hospitals Plymouth Trust	12,261	9,317	2,944	↑	24,080	24,080	0	→
Torbay and South Devon NHS FT	13,844	12,382	1,462	↓	18,371	18,371	0	→
Devon Partnership Trust	4,473	2,551	1,922	↑	7,448	7,448	0	→
Total	**49,885**	**40,618**	**9,267**	↑	**83,205**	**83,205**	**0**	→

System capital spend is under plan at month 8 by £9.3m (M7 £9.0m).

Forecast system capital spend is on plan as at M8.

Total Capital

Organisation	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Royal Devon University NHS FT	29,751	23,853	5,898	↑	50,562	51,952	(1,390)	↑
University Hospitals Plymouth Trust	25,581	13,892	11,689	↑	88,480	82,726	5,754	↑
Torbay and South Devon NHS FT	17,212	17,786	(574)	↓	27,007	40,925	(13,918)	↓
Devon Partnership Trust	4,473	2,619	1,854	↑	7,448	11,893	(4,445)	↓
Total	**77,017**	**58,150**	**18,867**	↑	**173,497**	**187,496**	**(13,999)**	↓

The total capital plan includes impact of IFRS16 on leases.

Total capital spend is under plan by £18.9m as at month 8. (M7 £14.2m) and the forecast spend on capital by end March 2023 is over plan by £14.0m. (M7 £13.2m).

The plan is fixed at submission and not updated as subsequent schemes are approved and PDC awarded so these schemes then show as an overspend.

6. Recommendations

The Finance Committee is requested to:

Consider, review and discuss the ICB financial position as at the period ended 30 November 2022.

NHS Devon

NHS Devon Integrated Care Board Meeting

Change to Devon System Financial Forecast for 22/23

Date of committee	Date report produced
18 January 2023	11 January 2023

Author(s)		Report approved by	
Name and title:	Kirsty Denwood Deputy ICS Finance Lead	**Name and title:**	Bill Shields CFO
Phone:	07779544619	**Date:**	
Email:	Kirsty.denwood@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

On 20 June 2022, Devon ICS submitted a deficit plan of £18.2m although there was a requirement that the system achieved a breakeven outturn by year end. At the planning stage net risks of £95.9m were identified to delivering a break-even plan.

Whilst the level of net risk has decreased throughout the financial year it has not been possible to fully mitigate and the system forecast is now at a £49.5m deficit as opposed to the £18.2m planned deficit, an adverse movement of £31.3m.

To deliver the revised £49.5m deficit the ICB position is also required to improve from a breakeven position to a £4.635m surplus.

The NHSE protocol for change in financial forecast outlines the processes and actions that are required to approve a change in forecast. These are detailed in the body of the report.

Regional finance colleagues have been fully engaged and support the change in financial forecast.

Continued robust management of the financial position will be required during Quarter 4 to ensure that the revised position is delivered.

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

ICB Finance committee received an update with the signal of a change in financial position which was discussed on 7 December 2022.

Organisational Boards/Finance Committees have approved the changes at organisational level (various dates throughout December and January).

ICB Board (Part 2) received a paper on 21 December detailing the request to approve a revised forecast both for the ICB but also for the wider Devon system to be reported in Month 9. This was approved with delegated authority given to the ICB Finance Committee to finalise position for M9 reporting.

ICB Finance Committee on 11 January 2023 approved the change in forecast contained within this paper.

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

1. Note the change in ICB and system forecast at Month 9 to £4.635m surplus for ICB and £49.5m forecast deficit for Devon system as approved by Finance Committee on 11 January 2023
2. Note the need for ongoing management of the system financial position throughout quarter 4

Impact on NHS Devon objectives

Objective	Impact
Commission high-quality and safe services that reduce health inequalities and improve health outcomes	No impact
Improve service performance	No impact
Achieve financial sustainability	Deterioration in financial position which could impact future financial sustainability

Be an effective, well-led organisation with an empowered and inclusive workforce	No impact

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	Maintained
Health inequalities	N/A
Workforce	N/A
Resources and finance	Deterioration in financial position which could impact future financial sustainability
Legal	N/A
Digital and Data	N/A
Engagement and consultation	N/A

NHS Devon (ICS) Proposed Change in Financial Forecast for Month 9

1. Introduction

The ICB Board (part 2) received a paper on 21st December detailing the request to approve a revised forecast both for the ICB but also for the wider Devon system to be reported in Month 9.

The recommendations approved by the Board were:

- Agreement to change the ICB and system forecast at Month 9 to £2.135m surplus for ICB and £52m forecast deficit for Devon system.
- Delegated authority to the ICB Finance Committee for any further changes between then and Month 9 submission resulting from conversations and agreement with region.
- Signed off the ICB and system protocol document on the understanding that all organisation protocols and any outstanding actions would be reviewed by the ICB Finance Committee prior to submission.

2. Proposed Month 9 Forecast

The revised forecast for Month 9 presented to the Board is shown in the bridge below which sets out how the initial risk of delivery to breakeven of £95.9m has been managed down but crystallised at a reported deficit of £52m. This is based on Month 7 risks and mitigations analysis.

	TSD	UHP	DPT	RDUH	ICB	Total
Plan risks and mitigations	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**
Gap to breakeven	69			- 18,263		- 18,194
CIP shortfall including COVID and Workstream stretch	- 19,400	- 8,000	- 3,450	- 3,000	- 10,967	- 44,817
ESRF related	- 2,253	- 1,750	-	- 12,100	-	- 16,103
Increase in inflationary costs forecast above included in plan	-	- 2,750	- 1,000	- 3,200	-	- 6,950
Integrated care contract	- 6,000	-	-	-	-	- 6,000
High cost drugs not met by income	- 1,314	- 1,000	-	-	-	- 2,314
Prescribing Prices	-	-	-	-	- 1,500	- 1,500
Other	- 765	- 900	- 6,095	- 4,700	- 5,500	- 17,960
Balance sheet flexibility/non recurrent actions/funding	-	1,000	2,000	3,700	7,376	14,076
s256 Funds	-	-	-	-	2,500	2,500
Further Excess inflation funding	-	1,375	-	-	-	1,375
Risk to breakeven plan	**- 29,663**	**- 12,025**	**- 8,545**	**- 37,563**	**- 8,092**	**- 95,888**
Improvement / (deterioration) from plan						
CIP improvement	12,159	920	850	631	- 1,050	13,510
ESRF related	2,253	- 370	-	- 2,627	-	- 744
Integrated care contract increased costs	- 4,102	-	-	-	-	- 4,102
High cost drugs increased costs	- 4,636	- 2,000	-	- 3,939	-	- 10,575
Prescribing Prices increases	-	-	-	-	- 2,400	- 2,400
Pay awards not covered by funding	-	- 1,600	- 434	- 1,251	-	- 3,285
Other risk decreases / (increases)	- 7,518	- 3,300	5,338	3,552	5,500	3,572
s256 Funds	-	-	-	-	- 2,500	- 2,500
Underspends / slippage	1,635	-	591	10,344	-	12,570
Additional funding specialist	-	3,500	-	-	-	3,500
Hold back further non recurrent allocations	-	-	-	-	3,000	3,000
Other mitigation	11,250	- 2,375	2,200	12,590	7,677	31,342
Net Improvement	**11,041**	**- 5,225**	**8,545**	**19,300**	**10,227**	**43,888**
Forecast Outturn	**- 18,622**	**- 17,250**	**-**	**- 18,263**	**2,135**	**- 52,000**

The main areas of risk that have not been fully managed and that contribute to the £33.8m deterioration in forecast (£18.2m deficit movement to £52m deficit) are summarised below:

- Shortfall in CIP delivery across all organisations £31.3m
- Elective Services Recovery related across the 3 Acute Trusts £16.8m
- Increased inflationary costs £7.3m
- Integrated Care Contract for TSD £10.1m
- High-Cost Drugs across the 3 Acute Trusts £12.9m
- Prescribing Costs for the ICB £3.9m
- Shortfall on available funding for pay award £3.3m

These have been offset by the following mitigations

- Balance sheet flexibility and non recurrent funding/actions £17.1m
- Underspends and slippage £12.6m
- Additional specialist funding £3.5m
- Other mitigations £18.6m

Since the Board approved the £52m deficit revised position further national support of £2.5m has been notified. This additional support is to help improve the position of systems in deficit. The revised Month 9 forecast now agreed by the Finance Committee is £49.5m with the additional £2.5m currently showing in the ICB position of £4.635m surplus.

The ICB Finance Committee on 11th January 2023 used the authority delegated to it by the ICB Board on 21st December to approve the revised ICB forecast surplus of £4.635m and system forecast deficit of £49.5m

3. Organisational Positions and NHSE protocol

The Finance Committee received a financial recovery progress report on 9th November. This detailed the action taken at both system and organisational level to date to secure the final forecast position for reporting in Month 9. As a re-cap the actions are summarised below:

- A peer review process was carried out on 14th October by CFOs. The review included an organisation-by-organisation review of current financial position, ESRF, risks and mitigations, CIP delivery and recovery actions already being undertaken by organisations.
- The outcome of the peer review was a list of actions that have been taken forward collectively across the system. These actions included further consistency checks on assumptions in areas such as energy inflation, pay award shortfalls and technical accounting treatments as well as further evaluation and sharing of CIP schemes
- The ten system workstreams identified have continued to be monitored by the Operational Planning and Oversight Group (OPOG). The savings on CHC, workforce and high-cost drugs have now been embedded in the revised forecast. The remainder continue to be worked up as part of the 23/24 savings plan.
- A long list of additional recovery actions was produced by the Recovery Support Unit which has been reviewed by all organisations and signed off by CEOs.

NHSE have issued a protocol for changes to in-year revenue financial forecasts that have conditions that apply to the system, ICB and individual providers. Each organisation has carried out an assessment against the protocol compliance as part of the agreed process for making an in-year change to a forecast.

There are 3 organisations that make up the system deficit and therefore need to comply with the protocol at an organisational level. Each organisation has provided evidence of board and committee documents to support their assessment.

RDUH - had an agreed planned deficit of £18.263m. Whilst they are not seeking to change their forecast, they have carried out an assessment against the protocol due to their plan being a deficit position.

UHP – had an original plan of breakeven with a proposed change in forecast of £17.250m deficit.

TSD – had an original plan of breakeven with a proposed change in forecast of £18.622m deficit.

The protocol also includes an assessment at system level. This was shared with and approved by the ICB Board on 21st December 2022.

All other organisations are either in small surplus or breakeven but have signed the NHSE protocol to confirm that they will be complying with the conditions in recognition of the system being in deficit.

4. Financial Reporting Process for Month 9

As part of changing the forecast at month 9 the following actions were required and have been undertaken:

- Signed protocols from Boards/Finance Committees confirming compliance
- Report to NHSE to support the change in forecast – SW regional finance have confirmed that the report to the Finance Committee fulfils this action
- SW Regional Finance colleagues invited to attend Finance Committee – (actioned 11th January 2023).

5. Ongoing Management of Financial Position

The revised position of £49.5m deficit is still exposed to further risk. Careful management of this risk is required during Quarter 4 to ensure that the revised position is delivered. No subsequent deterioration in the position is acceptable and will be deemed as poor financial control.

The current monthly risk and mitigations process will continue until year end and be reported through the ICB Finance Committee. The main residual system risks remaining that are either outside of our control or require careful management are:

- Delivery of remaining CIP included in plans
- Additional costs associated with winter pressures and surges in COVID and flu eg workforce sickness backfill
- Further inflationary increases and increased utility costs if further cold spells.

These risks with be managed throughout the final quarter as follows:

- Liaison with operational colleagues – an assessment of the impact of winter and pressure on urgent care will be provided by the COOs as part of regular operational updates that will be provided to the Executive Finance and Performance Group that meets weekly. A finance cell will be set up to ensure that early indications of operational pressures on the financial forecast are monitored and action taken.
- Executive oversight of the financial position will continue at an organisational level.
- The DOFs will continue to meet weekly where any known variance to forecast will be reviewed and mitigations sought to keep the system position on track.
- The Executive Finance and Performance Group has had its meeting frequency changed from monthly to weekly and membership expanded to include CEOs, CFOs, COOs, and workforce representation. This will enable it to swiftly respond to any intelligence received in terms of workforce/activity/performance and finance.
- The monthly risks and mitigations process will continue as part of monthly financial reporting to the ICB Finance Committee.

6. Recommendations:

The ICB Board is requested to:

- Note the change in ICB and system forecast at Month 9 to £4.635m surplus for ICB and £49.5m forecast deficit for Devon system as approved by Finance Committee on 11th January 2023
- Note the need for ongoing management of the system financial position throughout quarter 4

NHS Devon

NHS Devon Integrated Care Board meeting

Committee chair report – Audit and Risk Committee

Date of board meeting	Dates of committees covered in this report
18 January 2023	14 December 2022

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

Reports discussed and assurances received

- Extension of the Legal services framework report provided assurance that legal services are being provided whilst a procurement process is underway and where exceptions have been identified processes have been put into place.
- Additional to internal audit programme report was presented and discussed. The proposal for two further audits to be included onto the plan were approved. These audits were in relation to the delegation of pharmacy, optometry and dentistry services and declarations of interests of staff who own private businesses.
- Internal Audit progress report– The committee were assured that work is underway on 2022/23 audit plan and this will be reviewed in February 2022.

Reports received and noted

- Risk Management Framework
  The committee felt assured that this piece of work is now moving in the right direction. There remain some concerns around the risks being held and monitored. Further feedback will be provided to enable strengthening of the framework.

- Losses and special payments were noted

Risk register review updates

- This work will continue following the approval of the Board Assurance Framework and risk management process.

Committee decisions

- The committee discussed and made the decision that single action waivers should be being presented to the Audit and Risk Committee and not the Finance committee. A request is made to the board to approve this change to the terms of reference.

Items of concern to be escalated to the board

- External audit contract - There remains a risk that there will not be adequate external audit provision in place for auditing of finances.

- Board Assurance Framework – There is further strengthening required of the BAF and the committee request for this to be discussed further in a development session of the board before being approved.

- Financial and Planning challenges – The board feel there are significant gaps in the ability to be able to undertake adequate financial and planning work required within the organisation.

Recommendations for the board

- N/A

Recommendations for other committees

- N/A

Terms of reference or other committee effectiveness issues

- The committee proposes a change to the terms of reference of the committee to clarify the need for single action waivers to be monitored through the Audit and Risk Committee as part of the governance review.

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.

3

NHS Devon Integrated Care Board meeting

Committee chair report for public meeting of NHS Devon from Primary Care Commissioning Transitional Committee (PCCTC) Private Meeting

Date of board meeting	Dates of committees covered in this report
18 January 2023	22 December 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 NHSE of **Dental, optometry, and community pharmacy services** and were given a presentation by the Head of Primary Care NHSE Lead for Pharmacy & Optometry, on the role of the collaborative Commissioning Hub and the position of the **Optometry services** in Devon.

- PCCTC reviewed and discussed the **Quality Report** which focused on:
  An update on the PITCH report pilot scheme which is encouraging clinicians to report incidents which are then being reviewed and concerns being investigated and resolved.
  A new risk and governance system called 'In Phase' is being used by a PCN in Plymouth.

- PCCTC reviewed and discussed the **Safe delegation checklist** update paper – for information. RAG rating amber overall moving towards green. The area of Quality

is the most challenging in terms of team capacity to do the due diligence work. Everything is currently on track for green status ready for when the responsibilities formally transfer next year

- The PCCTC reviewed the **metrics** for measuring the impact and delivery of the new **Primary Care strategic framework.** It was noted that the Single red item was for practice resilience
  The Amber item is for CQC ratings- there are some positive outcomes which will be updated on the system soon and bring the rating up to green
  Greyed items are work areas which have been put on hold due to some immediate and necessary changes to team, 2 of whom have been seconded to other work areas for 3 months and one of whom has been moved to another team in the directorate.

- A paper on the National **General Practice Access Data** (GPAD), which has recently become available, was scrutinised and ideas for using this data positively within the county were collected from the meeting members. Some overarching issues were highlighted to the meeting. This data is described by NHSE as being experimental and therefore there is a risk of drawing hasty or misleading conclusions from the data; however, it is generally a helpful start point in improving the amount of GP data available. From here we will be able to ask the right questions and refine so that it will be very useful strategically for future models.

Reports received and noted

- PCCTC was updated on **contractual, and resilience matters** in a high-level overview report. This drew the committee's attention to the significant pressures on Primary Care and the whole healthcare system. The need for support has been escalated highlighting high levels of risk in patient safety and provider resilience. The PC and comms teams have issued extra GP bulletins to set out for practices and PCNs the additional support available and enable PC to repurpose capacity more flexibly to urgent demand without financial implications. Conversations continue regionally and nationally to set more risk mitigations and support in place. A PCN in Plymouth, which has previously been a subject of concern, has received positive initial feedback following a recent CQC visit and were praised for the work they have done to improve the practices.
  One branch site in the Plymouth area has been closed for 2 months due to staffing recruitment difficulties which they are working hard to resolve.

- PCCTC received the fourth **finance report** for month 8 highlighted.
  In the Additional Roles Reimbursement Scheme this month £1.2million of bids have been approved.

- The **Deputy Director's Report** highlighted:
  An update on a confidential personnel matter.
  The high percentage of additional patient contacts to general practice has led to urgent requests for extra support and requests to step down less urgent care.
  The Primary Care Team and ICB Executive have been at the national forefront in providing as much support as possible to practices. Giving GP teams the freedom to prioritise work from urgent and clinical need without the impact of financial loss. Extended Access non-mandatory sessions may also be used more flexibly.

- **Workforce update** paper highlighted the decrease in GP partners in Devon and increase in salaried posts as well as the success of investment in recruitment events. The meeting reviewed the information in this paper but were unable to

have a full discussion on it at this time, however, the actions being taken on workforce will be returned to at a later meeting when a member of the strategic workforce team can be present. The item requires further discussion.

Risk register review updates

- Not undertaken at this meeting

Committee decisions

- **Pharmacy, Optometry and Dental commissioning Hub – formal position statement:**
  The Meeting agreed to support the recommendations re direction of travel of the Hub delivery model 1) That the ICB continues to support a 'hub' delivery model during 2022/23. 2) That the ICB works with the SW ICBs to explore an ICB-led hub arrangement from April 2023 at the earliest (there is a recognition this could take longer to establish formally). 3) That the ICB supports during 2023 the commencement of a review of the structure of the 'hub' to ensure it is fit for purpose and offers efficiency and cost effectiveness in line with that expected of an ICB.

- **Options Appraisal**: The meeting carefully considered the options presented as possibilities for a practice in South Devon which is awaiting a CQC contract registration decision. **List dispersal was supported** as the preferred route to take forward if it becomes necessary to terminate this contract (or the ICB receives a contract hand back) at short notice.

Items of concern to be escalated to the board

- None

Recommendations for the board

- None

Recommendations for other committees

- None

Terms of reference or other committee effectiveness issues

None

Management of conflicts of interest:

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
Cornwall and
Isles of Scilly

Chief executive update – NHS Devon ICB

Date of ICB board meeting: 12 January 2023
For: Public meeting - Part 1

Author: Jane Milligan
Presented by: Jane Milligan

1. COVID-19 and vaccination update

The number of people admitted to hospital with flu in England has risen quite sharply as cases in the community rise. Cases of COVID have also risen.

In the South West, there has been a steep rise in the number of adults and children admitted to hospital we are continuing to urge everyone to have the flu jab.

In particular, parents are being encouraged to have their two and three year old children vaccinated when invited by their GP practice.

Unpaid carers, those with low immunity, people with disabilities, frontline health and care staff and those over 50 are also being offered the flu vaccine for free.

Vaccine uptake remains good with 70 per cent uptake across all those who are eligible.

We continue to push vaccine uptake with health and social care staff.

2. Winter Planning

Urgent and Emergency Care (UEC) Performance

The UEC position across Devon continues to be challenging, with bed capacity issues and restricted flow to beds. Some patients are awaiting packages of care or placement to enable discharge, although the situation around discharges is starting to improve.

NHS Devon was awarded £24m of non-recurring funding as part of winter planning. This was split across a number of schemes, creating an equivalent of 310 additional beds across the system. This includes the introduction of virtual ward provision (outlined in last month's report) which is already at the equivalent of 53 beds managed in the community.

Throughout the LCPs there are further plans to increase bed capacity by around 100 beds. An additional 6 mental health beds have been opened with a further adult Place of Safety bed, alongside care home support via a mental health in-reach service.

We now have our system control centre in place. The purpose of this centre is to ensure the safest and highest quality of care possible for the entire population across every area, by balancing the clinical risk within and across all services.

With this additional facility, there will be more visibility around operational pressures and risks, deliver dynamic responses to emerging challenges and efficient flow of information.

Supporting the system

NHS Devon has made some temporary changes to further support our system in Plymouth, which as board members know, is facing a combination of pressures as a result of ambulance delays, discharge challenges and increasing numbers of patients in the emergency department.

As part of this, Simon Tapley, the ICB's Chief Transformation & Strategic Planning Officer, will spend the majority of his time over the next three months alongside colleagues in the Trust, supporting the planning and delivery of actions to deliver urgent and emergency care improvements to Plymouth.

Simon will be based at UHP for the next few months but will continue to liaise closely with his NHS Devon teams.

I would like to express my thanks to Simon for agreeing to temporarily flex his responsibilities.

3. Update from Devon localities facing Cornwall

North Devon

There has been ongoing engagement with Cornwall colleagues in relation to discharge and flow. In particular patients with NCTR within NDDH is improving with good attendance and engagement at the twice-weekly MDT calls. The number of patients is small, approximately five per week, which is good news.

I note that there are gaps in the P2 capacity, and North Devon is keen to explore the opportunity with Cornwall for designated bedded capacity for Cornish patients to provide more options outside of Stratton Hospital.

North Devon would also like to explore creative solutions for P1 to enable more efficient flow.

Plymouth

In Plymouth, the NCTR position remains challenging and despite some progress being made in reducing this in early December and again ahead of the Christmas period, there has been a further increase and the numbers currently stand at 48 across all pathways.

The length of delay for Cornwall residents is an average of 24.4 days. There are weekly complex discharge review meetings which offer check and challenge and escalation.

I am pleased to confirm that demand and capacity investments for Plymouth and Devon are in delivery and bring additional capacity to support local flow. I understand that details of the schemes have been shared with Cornwall colleagues.

Significant progress has been made in utilising the Care Hotel and all 10 Cornwall commissioned beds are now occupied, which is a great achievement. An agreement has

been made that any vacant Devon beds can also be utilised by Cornwall on a spot purchase basis.

4. Key risks for the ICB from an NHS Devon ICB perspective

UEC demand and the potential for elective impact remain a risk as do discharges, particularly over the winter period.

5. Additional comments and/or specific requests of the ICB board

To note the report

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	23.12.22 - Summary report distributed to all board members. Request to close 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.			**Request to close**
24	16.11.22	Investigate the points raised by the patient relating to his experience whilst waiting for treatment of NDHU and follow up with the patient and the Chair	Dec-22	Darryn Allcorn	11.01.23 - Response has been sent to the patient. 08.12.22 - Darryn Allcorn has raised some concerns with NDUH N and had some responses. Darryn will write to the patient and copy in the Chair once a couple of points have been clarified.			**In progress**
26	21.12.22	The Devon Audit Chairs' forum to hold a risk review workshop and feed back to the board, via the Audit committee Chairs report	Feb-23	Graham Clarke	05.01.23 - Dates are being reviewed for the workshop			**In progress**