Integrated Care Board Meeting (Public)

19 October 2022 09:00 - 19 October 2022 12:30

AGENDA

#	Description	Owner	Time
1	Introductory Items		09.00
2	Welcome and Apologies Apologies - Sheena Asthana, Kate Shields, Graham Clarke 01. ICB Board Meeting Action Log (Public) 2022-23... 7	Chair	
3	Declaration of Interest For information 02. Declaration of Interest.pdf 8	Chair	
4	Minutes of the previous meeting 21 September For approval 03. NHS Devon - ICB Board Minutes - Public 21.09.... 12	Chair	
5	Action Log For approval ICB Board Meeting Action Log (Public) 2022-23.pdf 19	Chair	
6	Citizen's Voice		09.05
7	Questions from members of the public	Chair	09.05
8	Citizen involvement story Part of Black History Month: Experience of our international nurses.	Sanita Simadree, Chair of Devon BAME Network	09.30
9	Leadership	Chair	
10	Chairs report For information 05. Chair's report (October 2022) v2.1.docx 20	Chair	09.40
11	Chief Executive report For information 06. CEO and executive report final.docx 28	Chair	09.45

#	Description	Owner	Time
12	Assurance and System oversight	Chair	
13	Integrated quality and performance report For information (including latest update on waiting lists, ambulance and A&E performance, social care issues and access to GP services 07. NHS Devon - IQPR cover sheet template.docx 39 07. NHS Devon Integrated Quality Performance an... 42	Chief Nursing Officer	09.50
14	Performance Recovery For information - Presentation on the impact of urgent care challenges/external factors on cancer and elective performance - what are we doing to recover and what will be the impact of our actions (to be tabled on the day)	Director of Commissioning Urgent and Elective Care	10.00
15	ICB Month 5 Finance Report For discussion 09a. NHS Devon - ICB Finance Report Cover Shee... 102 09a. NHS Devon ICB Finance Report M5 (FINAL).p... 104	Interim Chief Finance Officer	10.15
16	ICS Month 5 Finance Report 09b. NHS Devon - ICS Finance Report Cover Shee... 114 09b. NHS Devon ICS Finance Report M5.pptx 117	Interim Chief Finance Officer	10.30
17	Planning and assurance for Winter For information 10. ICS Winter response presentation v 8 Oct.pptx 132	Chief Medical Officer	10.45
18	BREAK		11.00
19	Workforce challenges For information - including pay, pensions and possible industrial action 08 ICB Board Update re Pay Pensions CoL Strateg... 140	Direct of Workforce	11.05

#	Description	Owner	Time
20	**Better Care Fund** For information 12. NHS Devon - Cover sheet BCF_V0.1.docx 156 HWB BCF (2).docx 159 Torbay HWB (6).docx 180 Plymouth HWB (5).docx 209	Chief Transformation & Strategic Planning Officer	11.20
21	**One Devon Partnership Model** For information 13. NHS Devon - Cover sheet - Devon Operating M... 239 13. Devon Operating Model - Draft Master Version... 242	Chief Transformation & Strategic Planning Officer	11.35
22	**Governance and Risk**		
23	**ICB Priorities and draft Strategic Objectives** For decision 14. NHS Devon - Strategic objectives 2022-23 - DR... 310	Chief Communications and Corporate Affairs Officer	11.40
24	**Audit and Risk Committee, including risk management** For Information NHS Devon - Audit and Risk Committee chair repor... 311 06. Audit Risk Report Sept 2022 (1).docx 314 06. Appendix 1 ARC Risk Report.pdf 320 06. Appendix 2 SWASFT call stacking.pdf 322 06. Appendix 3 Planned care system capacity.pdf 324 06. Appendix 4 Avian Flu.pdf 326 06. Appendix 5 Childrens service review risk.pdf 327 06. Appendix 6 Poor Outcomes for CYP with Neuro... 328 06. Appendix 7 Commissioning of High Quality serv... 330 06. Appendix 8 Risk 38 for closure.pdf 332 06. Appendix 9 Corporate Risk Register.pdf 334		11.45

#	Description	Owner	Time
25	Primary Care Commissioning Transition For Information [P] NHS Devon September PCCTCommittee chair rep... 363	Committee Chair	11.50
26	People and Culture Committee, including workforce strategy For Information [P] NHS Devon PC Committee Report September 202... 366	Committee Chair	11.55
27	Quality and Performance Committee, including ambulance handover delays For Information [P] Chair's report- Quality and Performance committee... 369	Committee Chair	12.00
28	Finance Committee For Information [P] NHS Devon October Finance Committee chair repo... 372	Committee Chair	12.05
29	Remuneration and Internal workforce committee For information [P] NHS Devon - September REMCo Committee chair... 375	Committee Chair	12.10
30	AOB	Chair	12.15
31	Close	Chair	12.30

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**
1	21.09.22	Feedback relating to improving the signage for the Nightingale Hospital to the shared with RUHD	30.09.22	Andrew Millward	12.10.22 - Communications team have fed this back to the RDUH			**Request to close**
2		Provide an update on health inequalities work to the board in October via the Chairs report	Oct-22	Jane Milligan	10.10.22 - Included within the chairs report			**Request to close**
3		Share Dr Hooper's report on long waits during covid	Oct-22	Simon Tapley	12.10.22 - Report is not ready to share yet as it won't be going to the relevant Board meeting in Urgent and Elective Care until November now (17 November) therefore this will be circulated with the minutes of the November ICB meeting.			**In progress**
4		Include an update to the board on how the BCF is being spent and monitored on an ongoing basis via the ICS Executive report	Ongoing	Simon Tapley	10.10.22 - Paper being presented to the board 19.10.22			**Request to close**
5		A forward planner to be developed to ensure a clear understanding of when things will be happening	Oct-22	Andrew Millward	10.10.22 - Under development			**In progress**
6		Work with colleagues to access adult social care data from the local authorities.	Oct-22	Simon Tapley	10.10.22 - Kelvin Grabham is progressing this item and will feed back to the board			**In progress**
7		Trusted resource environment status to be added to a development session for further discussion.	Oct-22	Jodie Howland	22.09.22 - Added to forward planner for development sessions.			**Request to close**
8		Financial review to be added to a development session for further discussion.	Oct-22	Jodie Howland	22.09.22 - Added to forward planner for development sessions.			**Request to close**
9		Strengthen the ICB Strategic objectives following feedback received from board members	Oct-22	Andrew Millward	10.10.22 - Paper being presented to the board 19.10.22 for approval			**Request to close**

Declaration of Interests Register -
Register updated and generated by the Governance Team - 11 October 2022

Register last updated 11 October 2022

Title	Surname	First name	Role or Position held with the ICB	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
Dr	Acheson	Nigel	Chief Medical Officer, Integrated Care Board	ICS Senior leadership team ICB Board Audit and Risk Committee (If Required) NHS Devon Finance Committee Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee Quality and Performance Committee ICS Executive Committee ICB Senior Executive Team	Director of H Smith Safety Associates Patron of the FORCE cancer charity in Exeter	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 Director on the board of the South West Academic Health Science Network	05/10/2018		12/05/2022				NHS Devon ICB
	Allcorn	Darryn	Chief Nurse	Quality and Performance Committee System Quality and Performance Group ICB Board Audit and Risk Committee (If Required) Quality and Risk Group ICS Executive Committee ICB Senior Executive Team	Honorary Associate Professor University of Exeter Seconded to NDHT (to 18 September 2020) Strategic Chief Nurse, Nightingale Hospital Exeter System Chief Nurse, Devon STP		11/05/2020		01/02/2022	Direct	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
Prof	Asthana	Sheena	Independent Non Executive Director of Citizen and Community Involvement	Population Management and Health Inequalities committee ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Committee	Director, Plymouth Institute of Health & Care Research (PIHR). It is likely that members of my institute will undertake funded research for NHS Devon partners Trustee of Change Grow Live (a national charity that provides substance use, CYP, domestic violence, prison etc services. Devon does not currently contract services to CGL Member of the Advisory Committee on Resource Allocation (ACRA) which independently advises on NHS funding formulae Member of the project board of the proposed West End Health and 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 (DCC)	STP Directors ICS Partnership Board ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group ICS Executive Committee	No interests declared		19/11/2020		19/11/2020				Devon County Council
	Clarke	Graham	Independent Non Executive Director of Audit and Risk	ICB Board Audit and Risk Committee NHS Devon Finance Committee Primary Care Commissioning Transitional Committee	Non-Executive Director of Medicine Discovery Catapult Non Execuitve Member at the Deparment of Health & Social Board Chair of HUC (East of England 111 and Urgent Care Provider) Trustee and Treasurer of the Cornwall Community Foundation	Spouse is CEO of Cornwall Partnership Foundation Trust and a Board Member of Cornwall & Isles of Scilly ICB	01/01/2020		04/08/2022				NHS Devon ICB

	Davenport	Liz	Chief Executive Torbay and South Devon Trust	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Integrated Care Partnership Committee ICS Executive Committee ICP	Director of Torbay Pharmaceuticals		24/11/2016	21/06/2022				Torbay and South Devon NHS Foundation Trust
	Dowell	John	Finance Director	Senior Executive Team Meeting Senior Leadership Team (SLT) Primary Care Commissioning Transitional Committee (PCCTC) ICB Board NHS Devon Finance Committee ICS Executive Committee	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	20/10/2020	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	Hara	Thandiwe	Independent Non Executive Director of Inequalities and Population Health	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee People & Culture Committee	Trustee of Plymouth and District Racial Equality Council, a voluntary organisation that work to promote race equality. member on the NIHR SW Clinical Research Network Board.		16/03/2022	16/03/2022			There should be no conflict of interest in current circumstances, but this may arise if, they became a provider during the course of time. I will declare my interest at any meeting that may result in them being considered for service provision and leave the meeting if necessary. This should not raise any conflict, that I can foresee except that it is research related. There is no commissioning involved, but thought to mention it	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 Integrated Care Parernship Committee 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
Milligan	Jane	CEO ICS for Devon	ICB Senior Executive Team Meeting Senior Leadership Team (SLT) Audit and Risk Committee (If required) ICB Board NHS Devon Finance Committee ICS Executive Committee Executive Workforce Committee People & Culture Committee Remuneration & Internal ICB Workforce (If Required)	Member of Cornwall and Isles of Scilly ICB	Partner Trustee for Action for Stammering	31/12/2020	21/06/2022	Personal	indirect	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
Millward	Andrew	Chief Communications and Corporate Affairs Officer	ICB Senior Executive Team Staff Partnership Forum Audit and Risk Committee (If Required) Vacancy Control Panel Equality, Diversity and Inclusion Group ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group ICS Executive Committee Executive Workforce Committee People & Culture Committee	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University Non-Executive Board member of Delt Shared Services		19/06/2018	10/10/2022	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
O'Kelly	Frank	Primary Care Partner for NHS ICB	ICB Board Primary Care Commissioning Transitional Committee Remuneration & Internal ICB Workforce	GP Partner at Amicus Health Blundell's School Lead Doctor Clinical Lead for STEER Education Member of the National Armed Forces Reference Group CQC Manager for Amicus Health Attends Tiverton High School Welfare Meeting fortnightly		01/01/1999	11/07/2022	Financial			NHS Devon ICB
Orford	Kevin	Independent Non Executive Director of Finance and Remuneration	ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Committee Quality and Performance Committee	Non Executive Director on the board of Royal Devon and Exeter NHS FT (Ceased 30.06.22) Non Executive Director on the board of Northern Devon Healthcare NHS Trust (Ceased 30.06.22) Director and Majority Shareholder of Kevin Orford & Associates Ltd, which undertakes consultancy contracts with NHS organisations outside of the South West of England Non-Executive Director on the Board of the Intellectual Property office, a government agency in the Department of BEIS.		01/01/2012	15/07/2022				NHS Devon ICB

	Renshaw	Paul	Director of Workforce Stategy	ICB Board Audit and Risk Committee (If Required) ICS Executive Committee Executive Workforce Committee People & Culture Committee ICB Senior Executive Team	Non-active Consultancy partner for Linea Consulting . No remuneration for this position. No work carried out for Linea to date. Quarterly online meetings take place out of normal business hours.i attend these occasionally		2018	10/10/2022	Partner	Direct	Any Conflicts of interest at meetings will be highlighted and would seek line manager approval for any work to be carried out prior to any taking place	NHS Devon ICB
	Snaith	Ginny	Associate Director of Governance	Senior Executive Team Meeting Working with Industry and Sponsorship Group System Restoration and Transformation Group Audit and Risk Committee ICB Board One Devon Parternship	No interests declared		22/03/2019	25/08/2022				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		Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon ICB Step-son is a Receptionist at Albany Surgery	01/11/2016	04/08/2022	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
Dr	Wollaston	Sarah	Chair for ICS Devon	ICB Board Audit and Risk Committee (If Required) NHS Devon Finance Committee (If Required) Remuneration & Internal ICB Workforce Quality and Performance Committee People and Culture Committee Primary Care Commissioning Transition Committee	Trustee of Landworks, a Dartington based charity that works with ex offenders and people at risk of going to prison to support them into employment and reduce the risk of reoffending	Spouse is president of the Royal College of Psychiatrists and a consultant forensic psychiatrist employed by Devon Partnership Trust Relative is a registrar in Obstetrics and Gynaecology on the South West training scheme (currently on maternity leave) but will be returning to RD&E in late 2022. Relative is a registrar in Anaesthetics on the south West training scheme and currently based at Derriford	26/11/2021	27/06/2022	Non-Financial Personal Interests	Indirect	Where a piece of ICB/ICSD work or an item on a Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB

NHS Devon

INTEGRATED CARE BOARD, BOARD MEETING (Public)
MINUTES

Date: 21 September 2022 Time: 12.30pm – 15.30pm

Location: Via Microsoft Teams

Item	Discussion	*Decision taken by Organisation*
1	**Welcome and Apologies** SW extended a warm welcome to all in attendance and to those members of the public watching via You Tube. Apologies were noted from Sarah-Lou Glover	
2	**Declaration of Interests** No new declarations of interest were offered.	
3	**Minutes of previous meeting and action log** GC requested to update the wording to the audit and risk committee section to read that the committee were delegated authority to appoint the external auditor. No open actions to review.	The board **approved** the minutes with the amendment suggested by GC
4	**Former CCG Annual Report** SW confirmed that the CCG Annual Report has been approved by NHS England and has now been published and is available via the public website.	
5	**Citizen involvement story** Mrs Duran joined the meeting to share her experiences of waiting for a hip replacement. Mrs Duran had waited for over 104 weeks for a hip replacement and following a routine appointment she had a call to be offered a cancellation at the Nightingale Hospital in Exeter. The surgery was undertaken and following just a short overnight stay Mrs Duran could not praise the experience enough highlighting the complete holistic process undertaken by the Nightingale Hospital. Now just 5 weeks post her second hip replacement, again performed at the Nightingale Hospital, and this time being discharged on the same day. Mrs Duran explained that the post operative care and information was excellent. There were no negative comments that Mrs Duran could find to describe her experience and shared she would recommend the Nightingale Hospital to anyone within the system. Mrs Duran was fortunate to work for the NHS so was aware of the pressures facing the acute hospitals and felt that perhaps if the public did have more of an understanding of these pressures it may support patients to understand whilst on the waiting list. There was feedback that the signage for the Nightingale Hospital could be improved on the approach and entrance. **Action 1 – AM to feedback improving the signage for the Nightingale Hospital to be shared with RUHD**	

	SW explained that having touched on health inequalities during the section that this is an area which is very much part of the remit of the organisation and asked how the organisation is ensuring there are not groups of people disadvantaged using our systems. JM shared that through the planned care board there is a focused piece of work with United Hospitals Plymouth (UHP) and the Plymouth System using a framework to drill down that health and inequalities such as learning disability and mental health are being picked up being developed with a view to being rolled out across the County. ST also informed the board of the work one of the local GPs, Clare Hooper, had led coming out of Covid; a comprehensive report on long waits which could also be shared. **Action 2 – JM to provide an update on health inequalities work to the board in October.** **Action 3 – ST to share Dr Hooper's report on long waits during covid.** SW responded to a comment from a member of the public requesting to understand why a positive story had been chosen to share. It was shared that there was a previous story that was a negative experience. There was an acknowledgement that NHS staff are working extremely hard and it shows a balance and acknowledge the positives too.	
6	**Chairs report** SW took the report as read. SW extended her gratitude to all members of staff who had been involved in the appointments of members of the ICB and One Devon Partnership boards and to those members who are giving their time and expertise to the boards. The cost of living crisis was highlighted, and it was shared that there would be a summit bringing together the partners to discuss the impacts, solutions where possible and share best practice. SA felt work around the cost of living crisis should be key. There were discussions around how the cost of living will impact the workforce as well as the public and SB shared some of the ways the cost of living crisis is affecting voluntary organisations such as the Citizens Advice Bureau who are losing volunteers because they need to now work. Further gratitude was expressed to colleagues for the good work happening across the system under extremely challenging circumstances. Devon has a high number of people who are waiting for more than 2 years for care; however, Devon is nationally one of the leading systems in tackling this. JM confirmed there are winter preparations happening alongside the local authorities and voluntary sector organisations within the Integrated Care Partnership (ICP).	
7	**Chief Executive report** JM shared that the winter plan is being worked on including the timelines being worked through the system delivery and improvement group. In October there will be an overarching winter plan on the current key areas. There will also be further information published nationally about the winter approach. This will include community capacity and ensuring workforce is maximised,	

	It was shared that the new 111 provider, Practice Plus Group, starts on 27 September. The organisation has been working with the new provider to ensure a seamless handover. The acute services sustainability programme was shared and there was a signposting to the link to review this. The vaccination programme for flu and covid is well underway.	
8	**ICS Executive report** JM highlighted the purpose of the executive group was to receive updates from the finance, quality, strategy and transformation and system delivery and improvement groups. A strong governance process is being worked on to ensure a good flow of assurance from the different sub groups of work taking place. There was a meeting of the Executives, which took place the previous day which saw the Better Care Fund (BCF) presented and approved. KO asked to understand the board's accountability of the winter plan with the work happening at the system delivery and improvement group and when the plan comes to the board, whether that is for approval alongside the money being spent. This was so it was clear that it is the board accountable for this expenditure rather than an executive group. JM confirmed that the demand and capacity plan has been time limited, so the ICS Executive committee has been utilised to approve this. For the Better Care Fund, the ICS makes the recommendation to the regional team who sign this off. ST felt that the board should have some oversight of the winter plan funding and shared that the providers have their governance route for things such as the Better Care Fund set however there is still work to be done in this regard for the NHS. It was challenged that the organisation should be working within their own standing financial instructions, and this is a piece of work to be undertaken. GC requested to understand how the money is being spent for the Better Care Fund (BCF) to ensure value for money. SW shared that the voluntary sector often feels they could be involved further than they are being. ST confirmed there is communication with the voluntary sector at locality level by groups led by the locality directors. **Action 4 – ST to include an update to the board on how the BCF is being spent and monitored on an ongoing basis.** **Action 5 – ST to gain assurance for the board that the VCSE sector are being involved in service planning.** There was a discussion about governance routes and information reaching the board. JM confirmed there is a plan to have a 6 month review of the governance structure. ST confirmed that going forwards as work develops there will be a greater overarching understanding and suggested if there were elements of the report that were not providing the information required, he would be happy to hear what would be required and the report can be strengthened. There was a suggestion that the regular meetings with the chair and the non-executives could be utilised to gain a deeper understanding of what areas people feel are missing to strengthen knowledge and process. **Action 6 – A forward planner to be developed to ensure a clear understanding of when things will be happening.**	

9	**One Devon Chairs report** JMc took the report as read and provided an update on the strategy development. The work has started and there is a broad spectrum of people on the group, including care providers, voluntary sectors as well as NHS. There is an online summit being planned around the cost of living and to bring this together as a system response. This will enable partners to identify gaps and outline a plan to fill the gaps. TL felt that an understanding of what is happening would be excellent, but the risk of duplication is high as these things are already happening. JMc felt the partnership can bring this together to create an overarching resource. GC felt the changes that have happened with better alignment with local authorities have to create benefits in new ways of working to enable short term delivery and long term sustainable solutions. JMc requested to understand whether adult social care data is made available to the board to ensure oversight. ST confirmed there is access to some data however there is more work to do around this. **Action 7 – ST to work with colleagues to access adult social care data from the local authorities.** SA felt a fast tracking trusted resource environment status would really support with accessing data from our social care partners. **Action 8 – Trusted resource environment status to be added to a development session for further discussion.**	
10	Following a short break there was a question from a member of the public who asked to understand if the cost of living crisis work would include the impact on service users and their access to services. SW responded to confirm that this would be the case.	
11	**Finance report** JD presented the month 4 finance report. It was made clear the report is relating to the Devon ICS which is made up of the ICB and the other NHS providers. A plan of £18.2m deficit was submitted and work is ongoing to deliver this plan. It was highlighted that there will be ongoing impacts on finances year on year. Against the plan ,the organisation is reporting a breakeven position for the year to date of £9.6m and is forecasting to be in line with the set plan. There are significant financial risks and a significant amount of action required to reach this position. The single biggest risk is a shortfall against the Capital Improvement Plan (CIP). There will be wider system work to improve this position. There was a question whether, if you looked at historical finances, would it show a consistency which would indicate there would not be a lot that can be done to come out of deficit. JD agreed that you could look at finances this way and challenged that it wouldn't show that nothing could be done. There was an acknowledgement that any deficit is carried over and would have to be paid at some point in time. The financial recovery plan was highlighted consisting of 14 workstreams. The intention of these programmes requires cross system working and will enhance areas of system work.	

	There was an understanding that the long term direction and sustainability of the system had been highlighted during the day and questions of how housekeeping can support with financial management. LD brought the board back to the other drivers for the system which are not always financial. GC felt revenue and expenditure and investment should be reviewed for future. **Action 9 – Financial review to be added to a development session for further discussion.**	
11	**ICB Priorities/strategic objectives** AW presented the proposed strategic objectives which have been worked up with a working group. It was felt the objectives were very clear and well written. TL requested to understand how these fit into the bigger picture. It was confirmed these objectives will give the ICB board an in-year focus and further work on some of the language attributed to these would be useful. **Action 10 – AM to strengthen the objectives following feedback received**	The board **approved** the objectives in principle once the work is strengthened.
12	**Assurance Committee updates and escalations** *Audit and Risk Committee* GC raised the capacity within the governance team which consequently has impacted the risk management work being undertaken. It was also raised that the organisation remains without an external auditor. There are 16 other trusts who are in the same situation. JD shared that in the South West there is a joint conversation with the audit market to see what the best way forward ia. SW confirmed the ARC had delegated authority to approve. *Primary Care Transition Committee* JH reiterated that the PCTC is in place as there will shortly be further delegated primary care services. The framework for ensuring primary care is developed for the out of hospital care vision, has been socialised and it had gained feedback on how and where this can be strengthened. It was felt that the strategy gives primary care providers the opportunity to get on board. There will be an in-depth review of the new primary care services within the next 3 meetings of the committee. NA confirmed CFOs have raised the dental issues with NHSE. *People and Culture Committee* TH shared that the committee had met for the first time in August and informed the board that the committee will be an evolving committee as it crosses all areas within the organisation. It was shared that the workforce strategy has been drafted within includes learning and development and building workforce capacity; which will require some system redesign that will feed into upcoming meetings. PR shared that a set of principles have been agreed and work has been happening in terms of getting agreement of the size and shape of the workforce in 5 years time. There will need to be an understanding of where skill mixes can be utilised. It is acknowledged that there will need to be an investment in workforce which will include training and development. It was suggested there	

	could be further working with education to shape learning before people come into the system, as well as digital and perhaps broadcasting to involve the public. *Quality and Performance Committee* Report was taken as read. DA raised the concerns of ambulance handovers and the unmitigated risk. The results of the summit will come back to the quality group. There have been a number of never events which have been discussed. The IQPR will also be appended to the chairs' reports monthly. SW asked to understand what is happening to address the never events. DA confirmed the providers are being worked closely with and it looks as though there are links between wrong site surgery and xxx there have been some immediate actions taken. NHSE are working with the organisation on this as it is nationwide issue. NA shared that, when servicemen returned from service, mistakes happened and highlighted that following pressures during the pandemic this would not be uncommon to expect mistakes. *Finance Committee* KO took the report as read and raised that the Plymouth Cavell Centre business case has been submitted to NHSE which has undertaken a review. There has been feedback across 35 categories and 16 green 18 amber, 1 red. The red related to capital affordability. The next steps will be to explore alternative sources of capital and looking at the amber and green scores which include detailed actions, feedback from the Executives should be useful so that the finance committee can oversee the changes to the business case. The meeting closed at 15.05. The next meeting of the board will be 19 October.	

Minutes approved	Date:	Signed by chair:

Members (attended** / apologies [A])	
Name and initials	*Title and organisation*
Andrew Millward (AM)**	Chief Communications and Corporate Affairs Officer, NHS Devon
Darryn Allcorn (DA)**	Chief Nursing Officer, NHS Devon
Frank O'Kelly (FOK)**	Primary Care Representative, NHS Devon
Hisham Khalil (HK)**	Non-Executive Director, Quality and Performance, NHS Devon
Cllr James McInnes (JMc)**	Co-Chair Devon Integrated Care Partnership
Jane Milligan (JM)**	Chief Executive Officer and Accountable Officer, NHS Devon
John Dowell (JD) **	Chief Finance Officer, NHS Devon
Judy Hargadon (JH)**	Non-Executive Director, Primary Care, NHS Devon
Kate Shields (KS)	Chief Executive Officer, Cornwall and Isles of Scilly ICB
Kevin Orford (KO)**	Non-Executive Director, Finance and Remuneration, NHS Devon
Liz Davenport (LD)**	Chief Executive Officer, Torbay and South Devon NHS Trust
Nigel Acheson (NA)**	Chief Medical Officer, NHS Devon
Paul Renshaw (PR)**	Director of Strategic Workforce, NHS Devon
Sarah-Lou Glover (SLG)	Mental Health Representative, NHS Devon
Dr Sarah Wollaston (SW) Chair**	Independent Chair, NHS Devon
Sheena Asthana (SA)**	Non-Executive Director,
Simon Tapley (ST) **	Chief Transformation & Strategic Planning Officer, NHS Devon

Steve Brown (SB)**		Director of Public Health, Devon County Council
Thandiwe Hara (TH)**		Non-Executive Director, People and Culture, NHS Devon
Tracey Lee (TL)**		Director of Public Health, Plymouth City Council
Attendees		
Ginny Snaith (GS) **		Board Secretary, NHS Devon
Jodie Howland (JH)** Minutes		Governance and Facilities Business Manager, NHS Devon
Minutes approved	Date:	Signed by chair:

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**
1	21.09.22	Feedback relating to improving the signage for the Nightingale Hospital to the shared with RUHD	30.09.22	Andrew Millward	12.10.22 - Communications team have fed this back to the RDUH			**Request to close**
2		Provide an update on health inequalities work to the board in October via the Chairs report	Oct-22	Jane Milligan	10.10.22 - Included within the chairs report			**Request to close**
3		Share Dr Hooper's report on long waits during covid	Oct-22	Simon Tapley				
4		Include an update to the board on how the BCF is being spent and monitored on an ongoing basis via the ICS Executive report	Ongoing	Simon Tapley	10.10.22 - Paper being presented to the board 19.10.22			**Request to close**
5		A forward planner to be developed to ensure a clear understanding of when things will be happening	Oct-22	Andrew Millward	10.10.22 - Under development			**In progress**
6		Work with colleagues to access adult social care data from the local authorities.	Oct-22	Simon Tapley	10.10.22 - Kelvin Grabham is progressing this item and will feed back to the board			**In progress**
7		Trusted resource environment status to be added to a development session for further discussion.	Oct-22	Jodie Howland	22.09.22 - Added to forward planner for development sessions.			**Request to close**
8		Financial review to be added to a development session for further discussion.	Oct-22	Jodie Howland	22.09.22 - Added to forward planner for development sessions.			**Request to close**
9		Strengthen the ICB Strategic objectives following feedback received from board members	Oct-22	Andrew Millward	10.10.22 - Paper being presented to the board 19.10.22 for approval			**Request to close**

Report of the ICB chair

Integrated Care Board

Date of committee	Date report produced
October 19, 2022	October 10, 2022

Author(s)		Report approved by	
Name and title:	Nick Pearson, chair and chief executive's office	**Name and title:**	Dr Sarah Wollaston, ICB chair
Phone:	-	**Date:**	October 10, 2022
Email:	Nick.pearson@nhs.net		

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

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

The document represents the chair's report and includes updates on the latest developments in quality and performance, reference to the health inequalities and prevention plan, governance and brief details of recent 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
Involvement, Engagement and consultation	Engaging communities and stakeholders in our work

Report of the NHS Devon chair

Integrated Care Board

10 October

Quality and performance

I have been asked to update the board on which directors are responsible for providing assurance around quality and performance but wanted to set this in the context of the current oversight of our system and the future policy direction.

NHS Devon remains in Segment 4 of the System Oversight Framework (SOF) and subject to the support regime from NHS England. The criteria to move from segment 4 to segment 3 have been set and require robust recovery plans to be in place as well as improvement from across our system on our performance standards as well as our financial position. We remain challenged on both, and I know the whole board is focused on the impact that has on those who rely on services as well as our workforce and wider system partners.

The policy direction for integrated systems is that increasingly the responsibility and accountability for the use of resources, performance reporting and management and key decision-making will be at place. This means that the Local Care Partnerships will have a significant role in future performance management and oversight. However, it is recognised that these groups are still in their formative phase and currently lack the capacity and capability to undertake this role. We cannot in any case make this change in Devon until we are in financial balance as a system and out of the current oversight process. Devolving powers to LCPs would allow a greater focus on prevention, tackling health inequality, service redesign and integration at local level.

It is deeply concerning that many aspects of performance are worsening. The executive team are applying a matrix approach to managing this involving triangulation of operational, financial, and quality metrics as the basis for an integrated performance framework.

The lead for quality and performance will continue to be with the Chief Nursing Officer, finance with the Chief Finance Officer, and operational delivery with the new post of Chief Delivery Officer.

The director with responsibility for the integrated oversight of performance is proposed to be the Chief Finance Officer. Both the Chief Delivery Officer and the Chief Nursing Officer will be present in the performance management meetings to ensure that operational performance and quality are the key considerations for decision making.

The framework will provide specific scrutiny of performance including but not limited to; Referral to Treatment Time (RTT), Cancer, Diagnostics, Urgent Care including ambulance handover, Criteria to Reside, Elective Recovery Fund (ERF) activity and further metrics related to SOF exit. This process will recognise the accountability of individual providers to achieving performance and will be focussed on future improvements against agreed performance standards and include rigorous review of trajectories and action plans for areas of performance not meeting agreed standards.

To ensure the matrix approach between performance and quality, further scrutiny will be given to the impacts on patient safety, risk and experience by the relevant committee structures.

As a newly constituted board, we now need to review our committee structures, support and governance to ensure that we can be as effective as possible in our role.

Governance review

We will shortly be undertaking an ICB governance review.

The new ICB system architecture has been in place now for a little over three months and it seems right that we take a look at it at this early stage to ensure it is fit for purpose.

It had always been our intention to review the governance structures of the ICB, and indeed NHS England has requested that all systems do this.

The review will also help us to ensure that our structures are as efficient as possible, reducing any duplication.

I am grateful to colleagues who have been assisting with this.

Update on our health inequalities work

Working to prevent ill health and reduce health inequalities are key ambitions of the One Devon partnership.

In early 2022 we established a health inequalities and prevention team to take this forward across health, care and other services tackling the causes of poor outcomes in disadvantaged communities.

The following provides context for their work, its governance, and an update on progress and plans for the future.

Context

The pandemic has further widened health inequality across Devon. Michael Marmot in his 10 year follow up to *Health Equity in England: The Marmot Review 10 Years On – The Health Foundation* (Feb 2020) found improvements to life expectancy has stalled and declined for the poorest 10 per cent of women.

The gap between wealthy and disadvantaged areas is becoming wider and concerns not just the years lived but the years spent living in poor health.

In April 2022 we established a Health Inequalities and Prevention Team with a broad mandate to work across and beyond the health system, connecting closely to people and places.

Shared purpose

The Health Inequalities Team drafted *Our Shared Purpose* which describes:

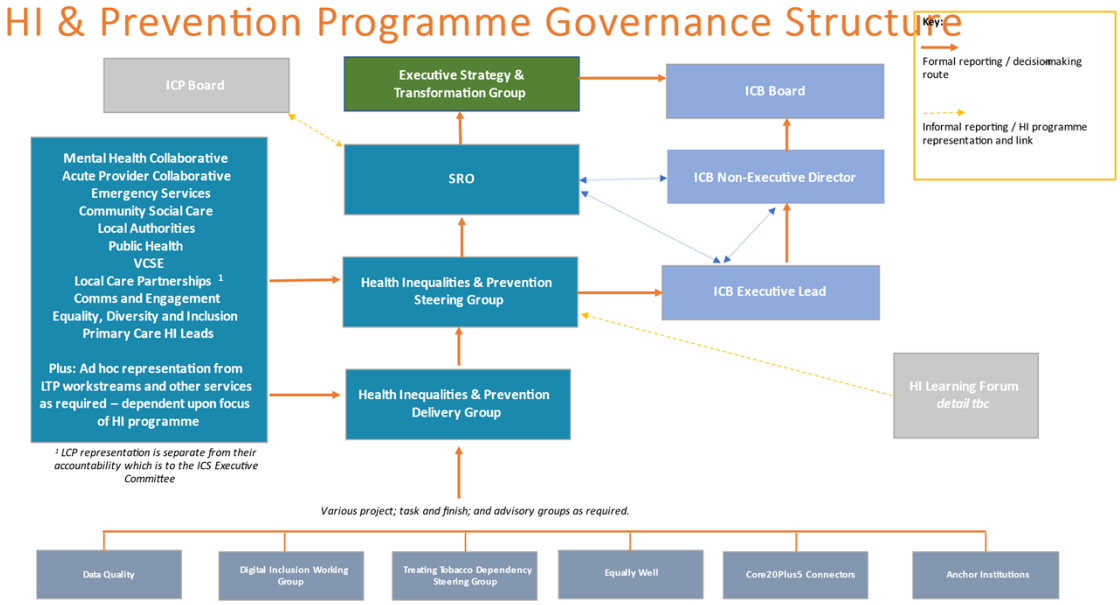
- An accountability to citizens and a principle of subsidiarity. Developing understanding of people's lives and a commitment to devolve power and resources close to people, families, and communities as possible, in a belief that people know the best solutions to the issues they are facing

- An ambition to think and act beyond current thinking and ways of operating. Building a capability to imagine a different relationship between the local state and citizens and to work creatively and collaboratively to achieve that relationship

- A commitment to learning from working with people in places and identifying opportunities to repurpose resources where we find more effective ways of working

Governance

The programme is delivered through the following architecture, in the process of being implemented.



Health Inequalities and Prevention Plan –

A broad and ambitious programme of activity is being driven by the team.

The programme has an annual budget of £2million. This is invested in a number of activities aimed at addressing health inequalities, preventing ill health, and creating the conditions for change.

The following five workstreams give an overview of our work but are not exhaustive.

1) **Delivering on commitments**

- Supporting developments to build 'Complex Needs Alliances' to improve outcomes for people with multiple disadvantage who's needs our siloed services struggle to meet – people with drug and / or alcohol issues, homelessness, mental ill health, domestic and / or sexual violence and abuse.

- Treating Tobacco Dependency Programme - we have been invited to take up project manager funding for 2022/23 to accelerate planned efforts to expand community based mental health support in 23/24.
-

2) **Accelerating whole system efforts**

- Establishment of a Poverty Truth Commission as a means of learning with and from people living precarious lives.
- Developing a whole system understanding of obesity and a proposal to develop a more coherent, citizen led, 'whole system, whole person' response. This work is also about develop capability to build understand from a citizen's perspective and to think and work as 'actors' in complex systems.

- Develop the Plymouth, Devon, and Torbay Trauma Informed networks. Trauma and shame are bad for health, deter people from seeking help. Trauma and shame can also be reinforced by encounters with services.

- People-led Change – working with people in places to develop responses to the challenges they face. We are working to develop a network of 'changemakers' involved in building responses to the things that matter to them. An example is the community-led adolescent mental health work in Northern Devon – Kailo – a partnership with Newham and chaired by Sir Michael Marmot.

- CORE20+5 – focussed efforts in the areas and with population groups whose health experience and outcomes are worse

- Equally well – creating adaptations to care pathways to improve sensitivity to people with mental ill health, learning disabilities and autism

3) **Enabling actions**

- The Clinical Fellows programme which supports GPs and practice nurses to develop approaches to addressing health inequalities, such as the bi-monthly health outreach clinic based out of Brixham Harbour.

- Supporting development and delivery of a Health Inequalities Symposium

- Support for NHS Devon fora/stakeholders seeking to address health inequalities including Planned Care, Maternity, Learning Disability and Autism, Cancer, Mental Health

- Establishment of new Devon-wide stakeholder fora (CVD prevention)

4) **Building the conditions to make Health Inequalities and Prevention everyone's business**

- Revising the Equality, Impact Assessment template, in partnership with the VCSE to support service and system developments
- Working with, supporting and learning from our LCP colleagues, including Northern Devon work to identify people living with fuel poverty.

5) **Strengthening our evidence base / continuous learning and development**
   - Key role in establishing the Strategic Intelligence, Evidence and Outcomes Group

The team was set up in April 2022 and impact on public health and inequality takes time. That said there has already been some notable recognition:

- Shortlisted for Health Service Journal Award for our 'Whole Systems for Whole People' work, October 24, 2022. This is the overarching project for a number of pieces of exciting work, including 'Trauma informed primary care', Sexual Violence NHS England Pathfinder (1st in the Country) and High Flow.
- Devon is one of 5 ICSs nationally to pilot Health Inequalities eLearning package with NHSE England –with national programme expected Spring 2023
- Devon is also one of 8 ICSs nationally to be successful in the Kings Fund Inclusion Health Learning and Development Programme.

The team look forward to providing updates as the programme develops.

My visits and speaking engagements

I had the pleasure this month of addressing an audience of NHS England staff from across the region to reflect on our system challenges and aspirations and to thank colleagues for their work.

Alongside my role as chair of NHS Devon, I am the co-chair of the One Devon Partnership and keen to establish connections and hear views from across VCSE partners. One of those visits was to Wellmoor, a community health and wellbeing initiative based in Moretonhampstead and set up in 2017 to support and empower a network of local Dartmoor communities.

Wellmoor played an important role during the pandemic offering both practical and emotional support as well as helping to set up the vaccination programme. That role continues but they are also demonstrating how working in partnership with local organisations is crucial to achieving our aims as an Integrated Care System. As well as providing accessible and valued local services (such as falls prevention, digital befriending and support for those who would otherwise be excluded from using digital services) they are co-ordinating a local response to the cost of living crisis based on views from the community as well as partners who are already providing support with food, providing a community larder and reducing isolation.
My thanks to Chair Richard Foxwell and all the volunteers.

It was a pleasure to visit the Intercom Trust on their 25th anniversary to thank their staff and volunteers for their work supporting LGBT+ communities as well as listen to views on the experience of services.

I am also grateful to Active Devon for inviting me to join Lincoln Sargeant and Sir Muir Gray as part of their conference on the evidence for and need to promote and facilitate physical activity in later life.

I would like to thank the councillors I met at the Devon Association of Local Councils event earlier this month.

Parish and town councillors undertake outstanding work for their communities and are an important link between NHS Devon, the One Devon Partnership and local communities.

We discussed how we could build mutually convenient relationships, particularly at Local Care Partnership level, ensuring that their constituents receive better targeted care.

I also meet regularly with other elected representatives including MPs, county and district councillors. This month our regular MP briefing focused on the impact of housing costs, shortfalls and homelessness on local residents and the related effect on recruitment and retention of the NHS and care workforce.

Report of the chief executive

ICB report

Date of committee	Date report produced
October 19, 2022	October 10, 2022

Author(s)		Report approved by	
Name and title:	Nick Pearson, chair and chief executive's office	**Name and title:**	Jane Milligan, Chief Executive
Phone:	-	**Date:**	October 10, 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

The document includes summary updates on COVID-19 and vaccinations, the target investment fund, winter planning, NHS annual objectives, children's surgery and Black History Month.

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
Involvement, Engagement and consultation	Engaging communities and stakeholders in our work

Report of the chief executive

Integrated Care Board

10 September

COVID-19 and vaccination update

The number of patients in Devon's hospitals with Covid-19 has risen substantially over the last month. Around 250 people in hospital have tested positive for the virus, roughly five times the number in early September.

Obviously, higher covid rates add to the pressures that already exist in our local health and care system.

The most vulnerable people to both Covid-19 and flu have been encouraged since late September to book their autumn booster.

The autumn booster and seasonal flu vaccines will help to protect people from becoming seriously ill this winter, which in turn will reduce pressure on the NHS during, what is expected to be, a very challenging winter.

Clinics offering the latest vaccine are being held at supermarkets, sports grounds, pharmacies and places of worship.

Our teams have given more than three million doses of the Covid-19 vaccine to people in Devon since the programme began back in December 2020 and well over four in five eligible people received a spring booster earlier this year.

As with previous doses, those most at risk from serious illness are being called forward first, with people able to book in online or through 119 as long as it has been three months since their last dose.

Care home residents and staff have been among the first to receive the Covid-19 autumn vaccine in Devon and hundreds more people have already been vaccinated in their own homes.

Immunosuppressed people and people aged over 65, can currently book in for the first ever variant-targeted Covid-19 vaccine on the NHS using the National Booking service.

Frontline health and care workers are also eligible for the vaccination through their employer. People need to leave at least three months from their last booster.

The good news is that as of 6th October, we had administered 161,623 vaccines and 50 per cent of care home residents have had their booster in the first 3 weeks.

In addition to this, I include the latest percentage rate by age group.

- 44 per cent over 80's
- 39 per cent 75-79 year olds
- 38 per cent 70-74 year olds
- 22 per cent 60-69 year olds

In total, 28 per cent of all those eligible have received their booster in the first three weeks.

We are also rolling out the seasonal flu vaccine and encouraging eligible people to take up the offer where possible.

The flu vaccine is offered free to frontline health or social care workers and to those who are: 50 and over, have certain health conditions, pregnant, are in long-stay residential care or the main carer for an older or disabled person.

People who are eligible for both the flu and COVID vaccines may be offered both jabs at the same time subject to supply.

Clearly, as we head towards winter it is vitally important that eligible people take up the opportunity to get their latest vaccinations.

We know that many people are well aware of the pressures on NHS services and will want to do their bit to help by taking up the vaccine.

The ICB's communications department has been busy promoting the vaccine and there has been good coverage in local media, and social media more generally.

Targeted Investment Fund

Members may recall that late last year NHS England announced that there would be £700 million national available through the Targeted Investment Fund.

This was national investment in local schemes to promote recovery from the Covid-19 pandemic.

Systems were asked to work with NHS England on proposals.

We put in three proposals and I am pleased to say that following several months of regional and national probing of our providers as to the feasibility, we have been given informal approval and guidance to proceed.

This is obviously excellent news for Devon.

Governance processes for the schemes will be agreed over the next few weeks with progress reports via the Planned Care Board.

The total value of the three schemes is almost £37.6 million, brief details of which I include below:

1) **Orthopaedic theatre development at University Hospitals Plymouth NHS Trust (UHP) - £14.8 million.**

The creation of three additional elective theatres aim to resolve the long-term problem of limited elective orthopaedic capacity at UHP.
It will provide ring-fenced elective capacity to ensure the delivery of uninterrupted orthopaedic activity throughout the year at a significantly improved rate; a rapid reduction then elimination of 104 and 52 week waits; sufficient capacity for the longer term to meet not only the ongoing demand for the Trust, but also to help meet complex orthopaedic demand from across the Devon System.
Construction of the theatres due to be completed February 2023.

2) **Improvement to Cardiology Day Case Unit by Royal Devon University NHS Foundation Trust (RDUH) at the RD&E site - £8 million.**

Providing 12 protected elective capacity beds and 3 additional non-elective beds to address elective recovery for cardiology. The growth in emergency admissions for Cardiac patients has resulted in elective and non-elective exceeding capacity for this service, resulted in a backlog and high volume of long waiters. The additional beds will provide additional capacity for elective day case patients; improve total RTT incomplete position for Cardiology and significantly reduce long waits (including 104ww); provide ringfenced, dedicated elective capacity, which will improve productivity and cases per list.
Construction due to be completed December 2023.

3) **Improvement to protected elective care day surgery capacity by Torbay and South Devon NHS Foundation Trust (TSDFT) - £14.7 million**.

Two new elective theatres to provide support for all specialities to reduce backlogs and improve efficiency.
The theatres will deliver significant levels of protection of elective care, by enhancing existing facilities within Hospital. They will also provide additional sustained capacity and productivity improvements in Day Surgical activity across all specialties which will have a significant and long-term impact on reduction in waiting lists. This will also enable the hospital to provide wider Devon support for Day-Surgical activity for all specialities to reduce backlog and contribute to improved efficiency.
Construction due to be completed by March 2024.

Winter planning

I provided a broad overview of planning for winter in September. Such is the importance of our preparations, I'd like to provide little more detail for the board.

Each year health and care work together on winter planning. But this year they are doing so against the backdrop of delays to urgent care, a backlog in elective care and the ongoing COVID pandemic.

Additional support is going into our hospitals from national funds with Devon having been provisionally allocated almost £24 million to help reduce the pressures in urgent and emergency care services to create additional bed capacity.

As I reported last month a total of £5 million of this funding has been ringfenced to tackle ambulance handover delays at Derriford Hospital in Plymouth from September 2022, including new ways of working and additional hospital and community bed capacity.

The remaining funding, in the region of £19 million - is focused on high impact services across Devon to provide additional capacity over winter with Local Care Partnerships taking the lead on plans for their local populations.

There are an additional 54 acute hospital beds or bed equivalents in the community funded in the Derriford Ambulance Improvement Plan.

Each of our other acute hospitals will also receive funding for additional temporary acute hospital beds and support staff to support winter pressures at a cost of close to £6 million.

Torbay Hospital will have an additional 37 beds/spaces and the Royal Devon and Exeter Hospital, 18 new beds. North Devon District Hospital will receive 11 additional beds.

We will also be developing ‘virtual wards’ which allow patients to receive acute/inpatient-level care at home safely and conveniently, rather than in hospital.

A total of £9.85 million will be spent on enhancing discharge capacity from hospitals, with schemes across the system including care hotels, additional community-based rehabilitation care and support and measures to help people who have complex dementia leave hospital safely.

This includes additional capacity for mental health and is in addition to the NHS mental health allocation of £219,000 for winter pressures.

Devon’s integrated community urgent care services, which include NHS 111 and GP out-of-hours, will be delivered by a new provider, Practice Plus Group, in October 2022.

Ahead of, and as part of this, several initiatives are taking place to improve services to support the transition.

Partners from across the Devon system recently met to agree priorities and next steps for Urgent and Emergency Care (UEC). An UEC Strategic Oversight Group will be established shortly, providing leadership within a clear governance structure.

Regular progress reviews and reporting across the UEC delivery workstreams will take place to ensure streamlined reporting against existing plans and wider stakeholder requirements.

Dr Amanda Doyle, NHS England's director for primary care and community services, wrote recently to us to recognise the importance of primary care in underpinning NHS services.

The letter requested that we increase capacity outside of acute trusts, including scaling up of additional roles in primary care, increasing the flexibility for primary care networks to do this, and taking further action to support general practice. We are, of course, doing this and will put in place the further measures outlined in the letter so that primary care is supported.

Finally, many commentators have observed that this year is likely to be extremely tough for the NHS and social care – as if it somehow hasn't already been hard enough over the last few years.

If this is the case, I know that our clinicians, managers and staff will continue to give their all for patients. And that this hard work - when backed by the additional investment outlined above and the preparations we are making, will put our system on a good footing as we deal with the additional demands of winter and the challenge it offers.

My heartfelt thanks to everyone involved.

NHS Devon annual objectives

The 2022/23 objectives are now available.

They were co-created by executives in the Integrated Care System and Integrated Care Board.

There are four main headline objectives; Improving our services, rebalancing our priorities, making more efficient use of our resources and developing our culture and how we operate. These are supported by 12 deliverables.

Alongside the objectives, an operating model for how the various parts of the system work with each other, is being developed – again co-produced.

They are due to be discussed at an event for system leaders next month to ensure alignment with the future ICS strategy, being produced by the One Devon Partnership (ICP) later this year.

Children's surgery in Devon

NHS partners in the region are working together to support more children to have their surgery closer to home.

Up to 100 children are expected to benefit in the first year of the initiative which could also see waiting times fall.

University Hospitals Plymouth NHS Trust (UHP) is working with the region's specialist hospital for children, Bristol Royal Hospital for Children (BRHC), to reduce the number of children who need to go there for treatment.

UHP already hosts a dedicated Children's Surgical Centre and I am pleased to say that it has been designated as an Interim Sub-specialty Centre for Surgery in Children for Devon and Cornwall.

Under the first phase of the new arrangements, in November 2021 a visiting surgeon from BRHC began leading UHP's children's surgical centre team to carry out cleft lip and palate surgery on young patients from Devon and neighbouring counties at Derriford.

Other Devon trusts will continue to provide children's surgery; currently around 6,000 surgical procedures a year. The impact on waiting times will vary but it could mean some children receive surgery more than a year earlier than they would have done without this arrangement.

This is excellent news for the children and their families and demonstrates how partnership with our colleagues is making a real difference to people.

Latest appointments to NHS Devon

The two newest recruits to the NHS Devon executive team are to start work next month.

Chief finance director Bill Shields and chief delivery officer Anthony Fitzgerald take up their positions with us in November.

The pair joined an executive away day earlier this month with colleagues in Exeter.

Bill and Anthony complete the NHS Devon executive team line-up and we very much looking forward to welcoming them full-time next month.

Black History

October is Black History Month.

The NHS in Devon is celebrating with awareness raising events across the county. Much of what is planned was informed by learning from cultural programmes and staff listening events.

NHS Devon staff are also being encouraged to pledge their support and action for ethically diverse colleagues, patients and communities in Devon.

My personal pledge is to champion diversity in all its forms in everything I do,

Inclusion is vitally important, and if anyone was in any doubt then I would urge them to take a moment to reflect on the proud impact that generations since Windrush have had both on the NHS – and the wider country.

Visits and speaking engagements

As a trained physiotherapist I maintain good links with my former profession, and I am an occasional speaker (and listener) at the Devon Allied Health Professional group.

As the third largest workforce in the NHS, they are, of course, central to improving outcomes for people and I was lucky enough to spend time with the group earlier this month with the director of in hospital commissioning John Finn.

It was good to talk through our strategies in person and listen to where they think they can add further value in patient pathways. My thanks to them all for their input.

Simon Tapley, our chief transformation and strategic planning officer, and I also had the pleasure of meeting chief executives of the four excellent adult hospices in Devon this month.

We have both met them individually on a number of occasions before but it was the first time that they had come together as one to meet us.

It almost goes without saying that the work they do is extremely valued - not only by us but by also by the many patients and carers up and down the county, who they support.

We talked about the great work they are currently doing, their expansion plans and how we see the relationship developing in the future. All in all a very positive meeting.

I thank them all for being so welcoming but particularly to Rowcroft in Torquay, who hosted us.

Integrated Care System (ICS) executive committee updates

The following are key updates from the ICS executive committee

Winter planning and discharge plans

Following discussions around discharge plans, 'no criteria to reside' and preparing for Winter, progress is being made on our demand and capacity schemes and the Winter Assurance submission was finalised and submitted to the region on 26 September 2022.

We currently have a 100-day challenge in place focusing on 8 priority areas as well as action plan and the outputs from this work will identify the areas that will have the biggest impact.

Executive Finance Group – Terms of Reference (ToR) agreed

The ToR for the Executive Finance Group, who met for the first time in the week commencing 12 September, were approved by the ICS Executive Committee.

The Executive Finance Group will support the Devon ICS Partnership to achieve financial sustainability and balance, and will adopt a short-, medium- and long-term focus.

This group will also provide a mechanism for the system to agree the overarching NHS financial plan and monitor delivery against that plan.

The Executive Finance Group does not have decision making powers but is able to approve and recommend on key decisions related to financial matters.

2022/23 Financial position and recovery plan

The ICS is committed to delivering to the Financial Plan it set for the year. As noted in the finance report, we are off target for the year to date but are working hard on a plan to recover this by the year end.

The Financial Recovery Plan (FRP) focusses on our workstreams such as workforce, procurement and estates, where collaborative work across organisations can supplement and enhance local Cost improvement plans (CIP).

A small team is in place to apply traction to the FRP to improve the in-year financial benefit and we continue to report delivery of the plan by year end.

Peninsula Acute Provider Collaborative

Since the July meeting of the Peninsula Acute Provider Collaborative, there have been several sessions to engage with key colleagues.

These sessions include workshops with medical directors to agree methodology as well as a ‘check and challenge’ session with a wider group of directors from across the provider trusts.

A draft process is being developed to focus on “fragile services”.

It is recognised there are a number of generic considerations that will be common to all services and the mechanism for addressing these will need to be worked through in more detail by the Programme Board.

The intention is to confirm a set of recommendations to progress this in October/November.

ICB Board

Integrated Quality, Performance and Finance Report

Date of committee	Date report produced
19th October	29th September

Author(s)		Report approved by	
Name and title:	Performance Team	**Name and title:**	Sam Wadham-Sharpe Director of Performance and Assurance
Phone:		**Date:**	29th September 22
Email:			

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

Executive summary (250 words max)
This report provides a consolidated update on key strategic issues and measures of outcomes, performance, quality, finance and activity to provide the necessary assurance to the ICS, at both place and system level that issues are being identified and addressed. The One Devon system has submitted its 2022/23 Operating Plan which will include plans to work towards delivery of key elective care targets and address underlying issues that restrict ability to deliver elective activity. However, the financial forecast currently sits at an £18.2m deficit. Operationally the ICS remains under extreme pressure and although Covid inpatient numbers are declining, the summer surge of visitors, elective backlogs and staffing

challenges has meant that services continue to compete for resources. This has resulted in a sustained position of increased risk, including delays in urgent care and delayed discharges due to poor community capacity. Emergency Departments (ED) performance and ambulance conveyancing targets have continued to decline impacting on operational performance against both urgent and elective care standards across the system.

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

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

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

Key recommendations and actions requested
The board are asked to note performance against key metrics

Impact on NHS Devon objectives	
Objective	**Impact**

Does this report have implications in any of the areas highlighted below?		
Area	**Yes (summarise implications)**	**No**
Quality of services		
Health inequalities		

Workforce

Resources and finance		

Legal

Involvement. Engagement and consultation		

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

Integrated Quality, Performance and Finance Report (IQPR)

Table of contents

Executive Summary

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Key to Variance & Assurance Icons

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

Performance

Urgent and Emergency Care – System Overview

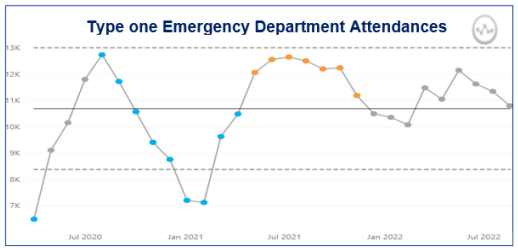
				System			Royal Devon University NHS Foundation Trust			Torbay and South Devon NHS Foundation Trust			University Hospitals Plymouth NHS Trust		
	Metric	Target	Latest Date	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance
UEC	A&E all types seen within 4 hours	95%	2022-08	58.3%			57.6%			59.2%					
	A&E Type 1 seen within 4 hours	95%	2022-08	44.4%			47.8%			37.8%					
	Attendances Type 1		2022-08	24,081			10,795			5,813			7,473		
	Type 1 Admissions (conversion rate)		2022-08	30.1%			27.5%			21.0%			41.1%		
	Emergency Admissions via A&E		2022-08	7,237			2,966			1,206			3,065		
	ambulance arrivals delayed over 30 mi...		2022-08	43.4%			25.9%			60.4%			70.1%		
	12 hr trolley waits	0	2022-08	1,314			425			152			737		
	Time lost to Ambulance Handover Del...		2022-08	9,134			1,333			2,503			5,299		
	Mean ambulance response times cat 1	7	2022-08	12											
	Mean ambulance response times cat 2	18	2022-08	61											

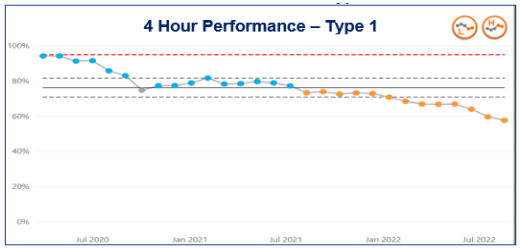
Analytical Summary: This month has seen a deteriorating position against most metrics across the system, with assurance indicating a failing position. TSD have seen an improvement in emergency admissions via the emergency department, however continued improvement is needed to provide assurance of an improved process/system.

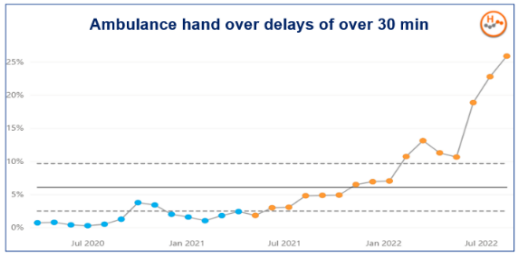
The next slides focus on Trusts' performance against the following metrics: type one emergency department attendances, four-hour performance, ambulance handover delays of +30 minutes and total time lost to ambulance handover delays.

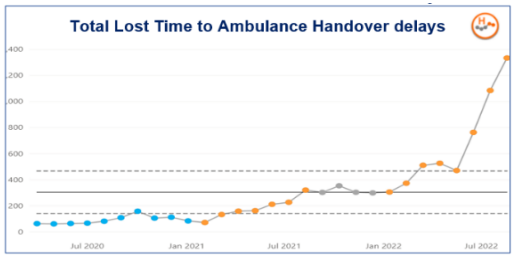
Urgent and Emergency Care – Royal Devon University Healthcare

Data









Analytical Summary

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

Operational Summary

Causes (**Eastern** area):

- 111 call abandonment rate 31% of and lack of primary care streaming
- Bed capacity pressure and restricted flow to beds in the hospital, numbers of patients, for August the average number of patients with no criteria to reside was 171
- Early closures at Sidwell Street MIU due to lack of trained staff
- Current vacancies and sickness in Medical and Nursing teams at end of September there were 77 covid related Absences

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

- Nursing –Band 3 fully recruited, 9 whole time equivalent (wte) Band 5 vacancy
- Nurse Practitioners –6 wte vacancy to be recruited by August 2022, trained, and working independently by August 2023.
- All 8 Consultants recruited, 4 are in post, 3 are starting in September 2022 and one in March 2023

Causes (**Northern** area):

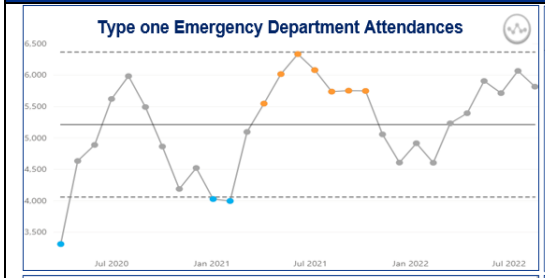
- Poor flow with 65-70 patients with no criteria to reside resulting in a reduced active bed base
- Impact of Covid on bed occupancy and workforce, covid numbers in hospital rose to 17 in September. Covid related staff sickness

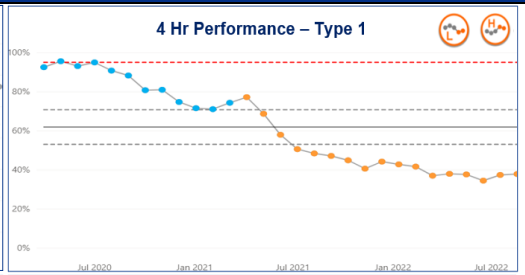
Actions:

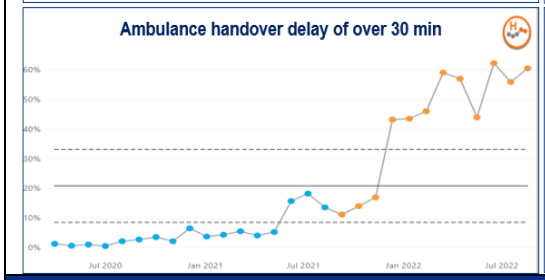
- Re-set week planned for 3rd October
- Scoping for Emergency Department based pharmacist – to support fast turn-around where medication/prescription required.
- Additional porter services for winter surge to support flow efficiencies at time of increased demand.
- Recruitment for permanent discharge lounge staffing.
- Maintaining communication and working with partners

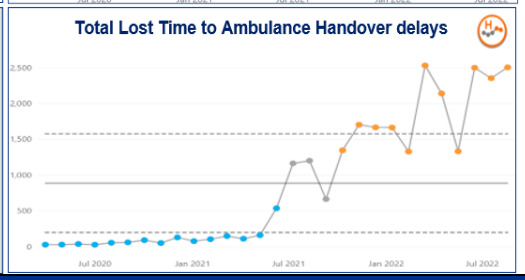
Urgent and Emergency Care – Torbay & South Devon

Data









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- There is a statistically significant upward shift in the number of ambulance arrivals delayed for over 30 minutes
- There is a statistically significant upward shift in the total hours lost to ambulance handover delays.

Operational Summary

Causes:

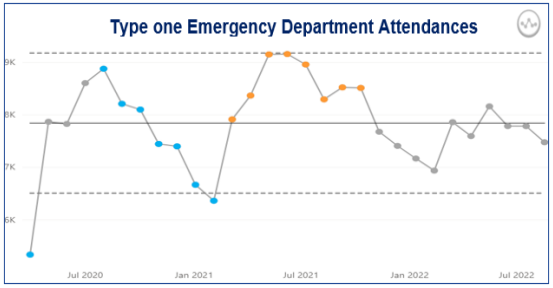
- 111 call abandonment rates of 31% and lack of primary care streaming
- Bed capacity pressure and restricted flow to beds in the hospital an august average of 72 beds occupied by patients with no criteria to reside.
- High numbers of Pathway 0 patients with a length of stay >7 days within the general and acute bed base, bed occupancy of 99%
- Current vacancies and sickness in Medical and Nursing teams

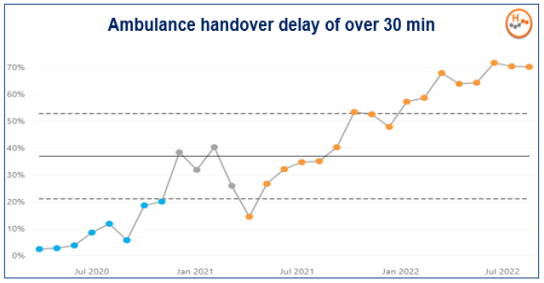
Actions:

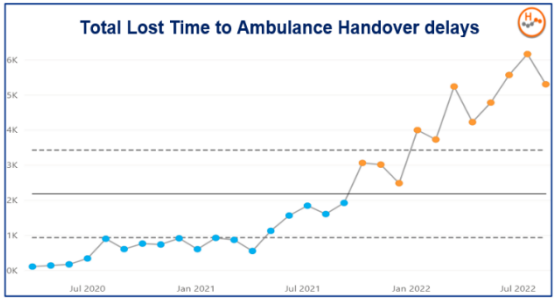
- Support of direct off-load of Pathway 2 and above ambulance patients into the clinical footprint (utilisation of a “red” trolley)
- Clinical review for all those awaiting handover by an appropriate ED clinician, and a brief handover accepted by the nursing staff.
- Joint Emergency Team patients within the ED being on-boarded to the Discharge Lounge for review and onward treatment plans, to open capacity within the ED.
- Embedded escalation process of utilisation of the Discharge Lounge and Cardiac Catheter Lab overnight to enable flow at the beginning of each day.
- 6 x a day command meeting with organisation wide visibility and support, includes: infection protection control/nursing/operations.
- Daily review of all complex patients through the Discharge Hub.
- Weekly review and ownership by the bed management team of all Pathway 0 >7day length of stay patients.
- Recruited 4 x Discharge Co-ordinators so that every appropriate ward has a designated co-ordinator to support flow and discharge.
- Interview for a second trusted assessor to support relationship/comms with residential care providers and increase confidence in facilitating return of existing residents and new residents

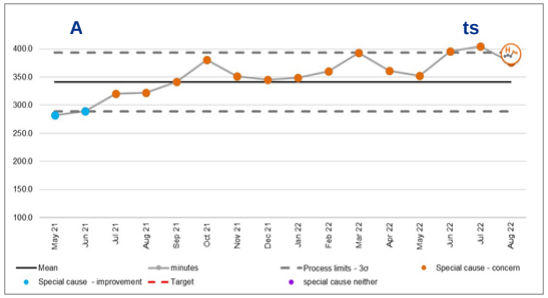
Urgent and Emergency Care – University Hospitals Plymouth

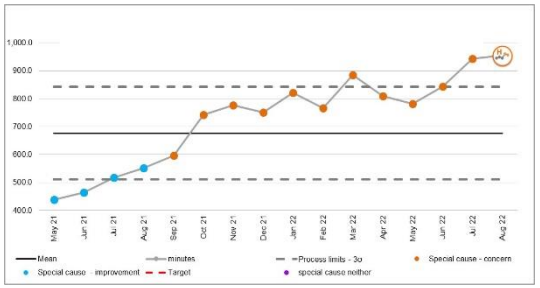
Data











Analytical Summary

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

Operational Summary

Causes:

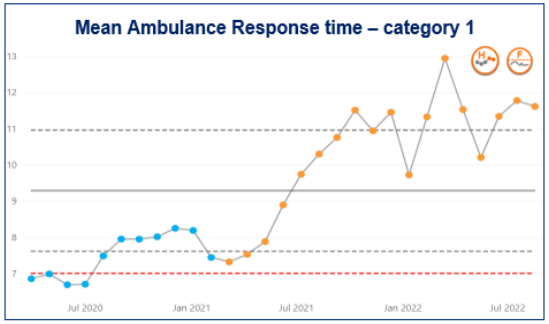
- Flow through the hospital being compromised due to delays to discharge. For august there was a daily average of 235 patients without the criteria to reside
- 111 call abandonment rates of 31% and lack of primary care streaming
- Higher number of ambulatory patients that previously seen with an average of 184 in August which is higher than the levels seen in August 2018 and 20019

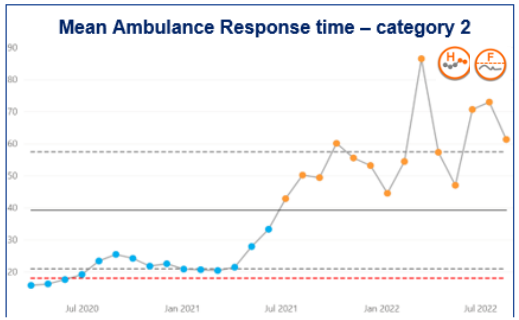
Actions:

- The creation of additional surge capacity within the ED with additional space and staffing.
- An increased Same Day Emergency Care (SDEC) offer with additional 6 spaces from 15th September to increase to 10 in line with recruitment.
- A new Acute Medicine Model to Improve flow in ED to enable an increase in Same SDEC overall by 10%.
- Increased Surgical SDEC and a restart of GP take through Medical Admissions Unit/Acute Ambulatory Unit.
- Increased falls provision from Urgent Care Response and Out of Hours nursing services.
- Increased resource for the Hospital to Home pathway 1 service, enhanced clinical support to care homes with high admission rates and targeted support to the top 7 high referring practices across the city with a Multi-Disciplinary Team approach.

Ambulance response times (Cat 1 and Cat 2)

Data





Analytical Summary

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

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

Call answering times in July dropped from the previous few months down to 36% of calls answered in 5 seconds (target 95%). Mean call answering time, also increased to 96 seconds. This is due to difficulties recruiting and retaining emergency medical dispatchers (EMDs).

Operational Summary

Cause:

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

Actions:

- All systems have submitted trajectories to reduce hours lost; however, the trajectory is not yet being met. Handover improvement plans are in place for Derriford and Torbay, monitored fortnightly through the Devon ambulance cell.
- Through August, a “pathway to paramedic” role was advertised, where recruits start as an EMD. There has been significant interest in the role, and it is anticipated this will enhance the numbers of EMDs to meet the trajectory of 250 EMDs by end March 2023.
- To mitigate the effect of handover delays on response times, SWASFT routinely putting on 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. Going into winter, a “risk share” has been agreed across all the south-west systems. If hours lost to handover across the south-west increase above 3900 hours per week, additional payments are made to SWASFT against the system trajectory and SW position. The funding will purchase additional response resource, including third-party provider.

Planned Care: System Overview

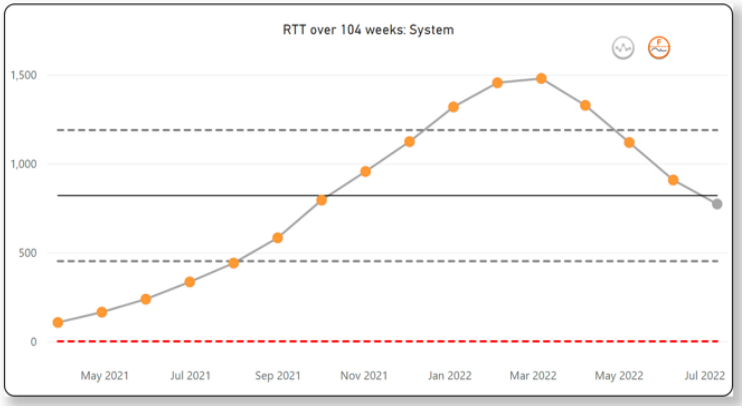
	Metric	Target	Latest Date	System Value	Variation	Assurance
RTT	RTT Incomplete Waiting list		2022-07	178,885		
	RTT 18 weeks	92%	2022-07	54.3%		
	RTT over 104 weeks	0	2022-07	772		
	RTT over 78 weeks		2022-07	3,361		
	RTT over 52 weeks		2022-07	16,129		
Diagnostics	Diagnostics within 6 weeks	99%	2022-07	66.5%		
	Diagnostic Total activity		2022-07	38,299		
Cancer	Cancer 2 week wait	93%	2022-07	72.9%		
	Breast Symptomatic 2 week wait	93%	2022-07	36.7%		
	Cancer 31 day First	96%	2022-07	92.4%		
	Cancer 31 day follow-up drug	98%	2022-07	99.3%		
	Cancer 31 day follow-up sugery	94%	2022-07	84.0%		
	Cancer 31 day follow-up radiotherapy	94%	2022-07	98.4%		
	Cancer 62 day urgent	85%	2022-07	61.0%		
	Cancer 62 day screening	90%	2022-07	60%		
	Cancer 62 day Upgrade	85%	2022-07	67.3%		
	Cancer Faster diagnosis	75%	2022-07	75.5%		

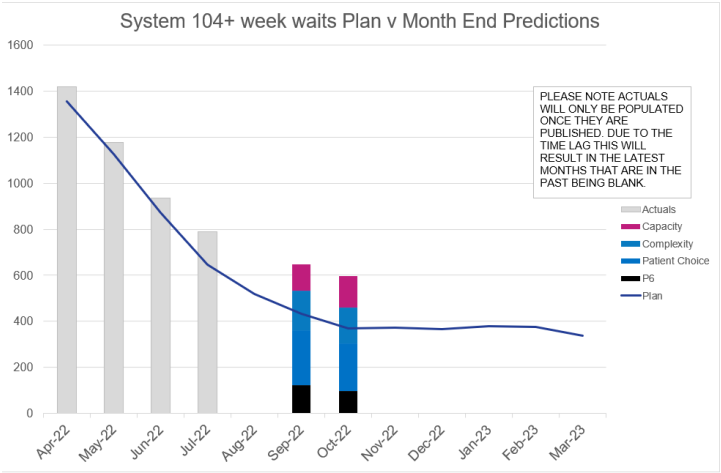
The majority of system performance for the month has been within normal common cause variation indicating no significant change. However, a significant number of the metrics are failing to achieve the national targets and will continue to do so without process intervention.

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

Planned Care: System 104 Week Wait

Data





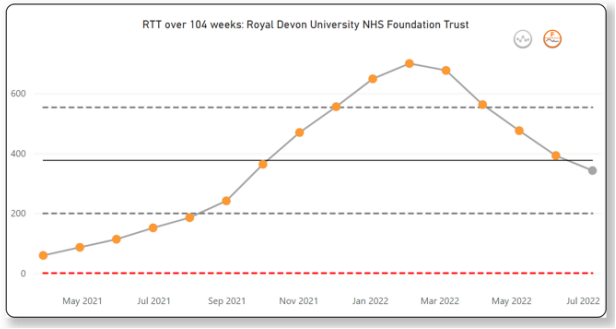
Analytical Summary

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

Operational Summary

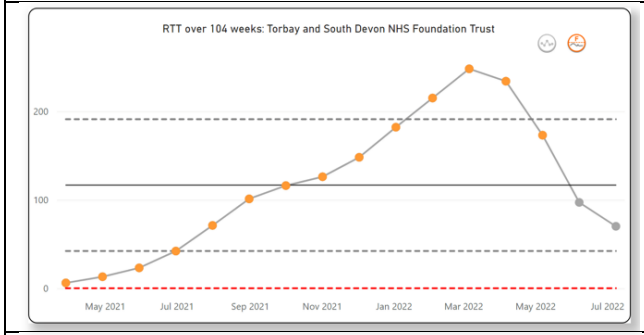
- Progress continues to be made across the system to reduce the number of long waiting patients, making use of protected capacity (there are 73 “ring fenced beds” now in the system to minimise cancellations).
- As reported at the System Tier 1 meeting Friday 16th the September month end position showed a total 104ww breaches of 652, including independent sector partners. This is behind plan of 433, giving a negative position of 219 patients.
- Weekly meetings continue with regional and national colleagues for Tier 1 oversight. Weekly template submissions are provided by all providers to the Friday meetings for discussion and challenge with future forecasting included. The ICB is also monitoring trajectory to ensure a system oversight is in place and ensure consistent contemporary single reference for the metric.
- Waiting Well workstream - to quantify experience of adult patients on the waiting list.
- Clinical Validation in undertaken to quantify deterioration of patients on the waiting list & suitability to receive treatment out of area.
- The scrutiny and resource applied to the 104 week waits is now being extended to the 78 week waits and then to the 52 week waits.
- Engaging with national work such as Mutual Aid Offer and High-Volume Low Complexity pathway reviews.
- Action to offer support to patients whilst they are on the waiting list - Better Lives Initiative.
- Understanding patient experience when planned care moved ‘out of area’ – patient surveys.
- System Governance in place to mitigate risk (25)- Clinical Risk & Harm Group, reporting to Planned Care Programme Board.

Planned Care: Trusts 104 Week Wait



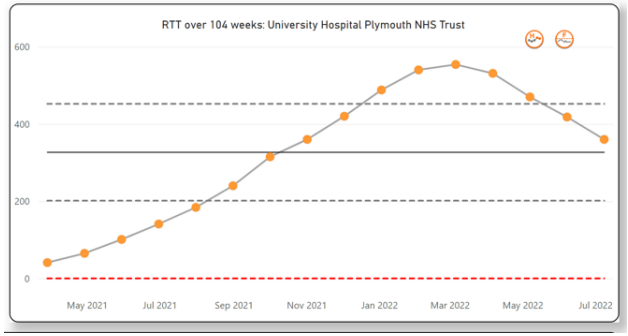
RDUH Operational Summary

- Improvements at RDU around insourcing solutions are being progressed (across colorectal, general surgery and T&O specialties) which will improve their month end position from 265 ahead of schedule, through increased activity, and staffing levels.
- RDUH East's Dyball elective orthopaedic ward has provided 26 ringfenced beds since February.
- Challenges remain for specialist surgeon capacity for complex colorectal patients (specifically complex abdominal wall surgery) and trying to balance this with urgent cancer demand.
- Further challenges in soft tissue knee and spinal surgery caused by small teams and staffing issues.
- Ongoing risks related to UEC/bed capacity will continue into winter
- Insourcing solutions being progressed for Colorectal, General Surgery and T&O to bolster staffing and increase activity



TSD Operational Summary

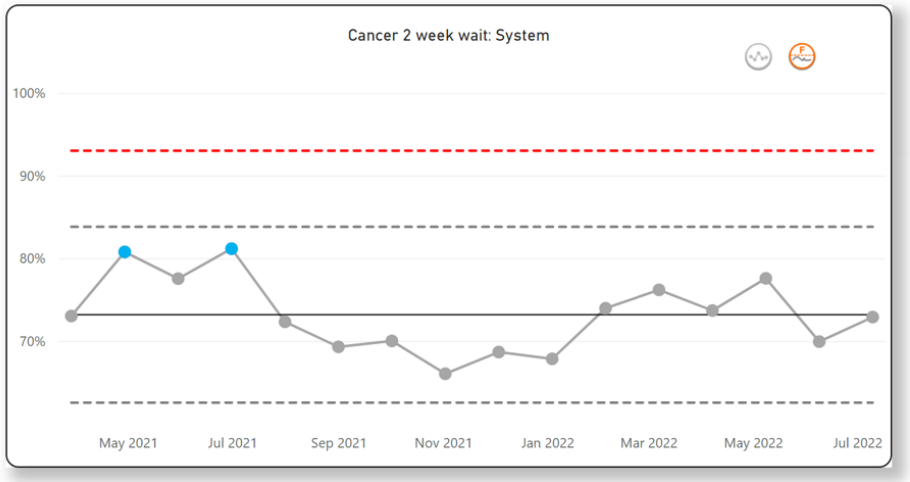
- Activity has begun to recover activity lost to recent cancellations (lost due to bed pressure, Covid and Patient choice).
- Protected elective capacity of Torbay's Ella Rowcroft ward (reinstated on 25 April) provides 11 beds (plus 2 high care beds).
- Patients continue to be booked to mitigate against capacity lost to cancellations.



UHP Operational Summary

- Progress continues to reduce the number of long waiting patients.
- Patients continue to be booked to mitigate against activity lost to cancellations.
- Protected elective beds number increased to 12 from 16 May 2022. Providing robust additional orthopaedic capacity
- Recovery of wait times impacted by critical operations taking priority, for example a recent surge in Trauma. Also staffing challenges in terms of unplanned Consultant absences and ODP vacancies are limiting ability to put on additional sessions
- Other barriers to achieving the zero patients waiting 104 weeks have been:
  - Lack of theatres, beds & workforce for Orthopaedics & Neurosurgery
  - Patient choice delays
  - Low volume of patients treated via national mutual process
  - Consultant ability to undertake additional work due to tax implications

Cancer 2 Week Wait: System

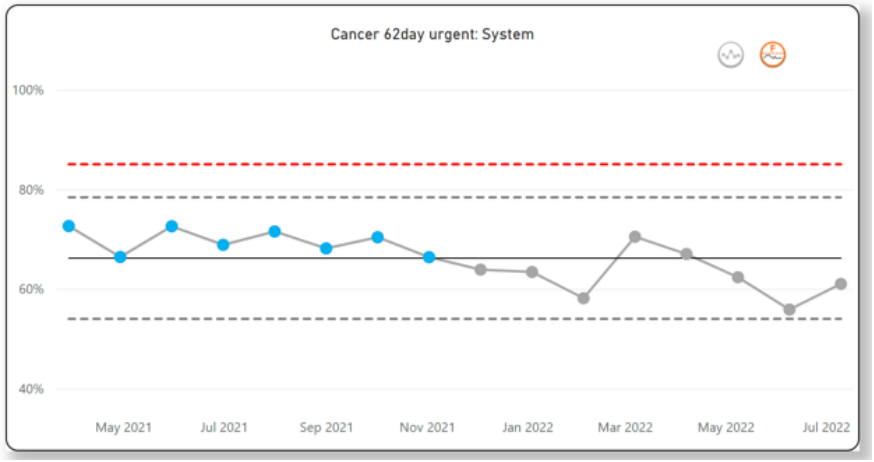
Data	Analytical Summary
	The Cancer 2ww metric is consistently failing the target, it displays common cause variation, there is no significant change nor indication of improvement in this system wide metric Position – July performance 72.9% against an 93% standard.

Operational Summary

- The three most challenged tumour sites for 2ww across the system are Lower GI, Breast and Skin.
- Increased 2ww demand persists (139%) post Covid. Increase due to latent demand, public health awareness campaigns and restoration of screening services. Service capacity unable to meet the requirement to see patients within 2 weeks. Staff vacancy factors and ongoing difficulties with recruitment and retention directly impacting on capacity.
- Actions –
  - All Trusts being monitored in delivering imaging within the standard and are all achieving within 14 days and performance against the 28-day cancer diagnosis standard is 75.5% against the national standard of 75%.
  - All Trusts have a cancer recovery action plan in place. Trusts, ICS, and Cancer Alliance meet weekly to actively monitor and mitigate issues as they arise.
  - UHP and RDUH have completed pathway mapping to identify any areas where process efficiencies can be identified.
  - TSDFT have support from the NHSE Intensive Support Team in place.

Cancer 62 day Urgent: System

Data



Analytical Summary

The Cancer 62day metric is consistently failing the target, it displays common cause variation, there is no significant change or indication of improvement in this system wide metric.

July performance 61% 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.
- Service capacity, particularly within diagnostic elements of pathways delays pathways meeting the standard.
- Staff vacancy rates and ongoing difficulties with recruitment and retention directly impacting on capacity.

Actions:

- Mitigating the impacts of biopsy and diagnostic capacity within both pathways within prostate and lower GI pathways.
- All Trusts have a cancer recovery action plan in place. Trusts, ICS, and Cancer Alliance meet weekly to actively monitor and mitigate issues as they arise.
- From the weekly meeting mutual aid is provided where possible, additional capacity is being commissioned where possible and business cases are being developed for funding to bring in additional temporary capacity to support recovery in 22/23.
- Additional prostate biopsy capacity has been approved for UHP. Start date likely November 22 pending confirmation of equipment delivery. Will deliver an additional 50 biopsies per month.
- Additional prostate biopsy, cystoscopy, hysteroscopy, and endoscopy capacity is being secured. Pending confirmation of funding (due end September)
- UHP and RDUH have completed pathway mapping to identify any areas where process efficiencies can be identified.
- TSDFT have support from the NHSE Intensive Support Team in place
- TSDFT have a mobile endoscopy unit on site providing a fourth room.
- A bid for funding to place a staffed mobile endoscopy unit at Tiverton has been submitted.
- Once the funding has been confirmed a delivery plan will be developed and the trajectories for improvement in the 62-day pathway will be developed.

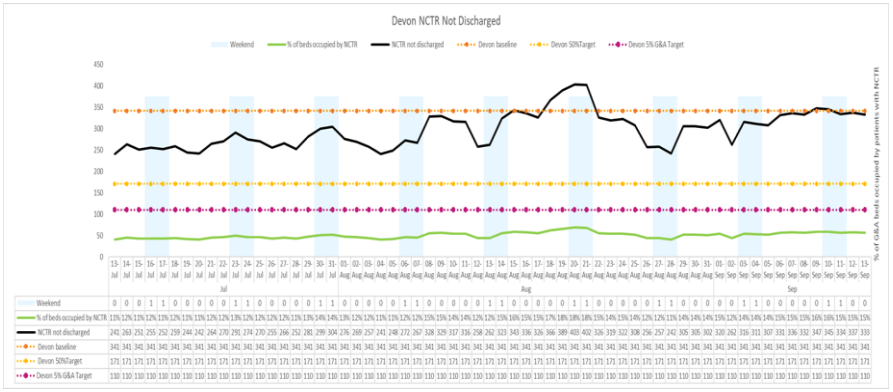
Hospital Discharge

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

KPI Description

% beds occupied by patients with no criteria to reside

Trend Chart



Analytical Commentary: Devon has agreed a target of no more than 5% (110) beds occupied by patients with no criteria to reside. As at 13th September there were 15% (333) beds occupied across the acute trusts in Devon.

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

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

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

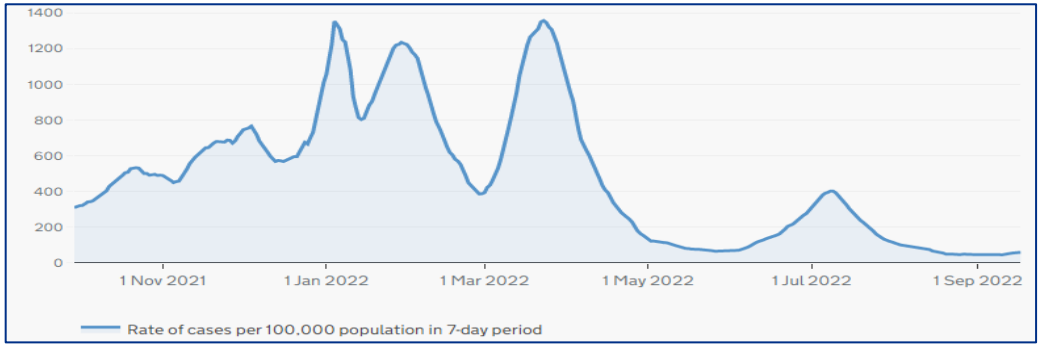
Delivery of these vary by trust, but trajectories show October delivery in most areas

Pathway 1-3 Complex Discharges

- Demand & Capacity (community capacity creation) – investment of c.£9m in schemes to create beds ahead of winter. Locality level plans are in delivery/development. This additional capacity will support reduction of delays due to available social care market capacity, Delivery varies by scheme and area, but incremental mobilisation is November/December
- National Hospital Discharge Plan 100 Day Challenge – implementation of 10 initiatives proven to improve hospital discharge. Progress has been made across schemes, including the 4 areas previously scored red (now amber), but further progress to ensure delivery (or clear plan for delivery) required by 30/09/2022

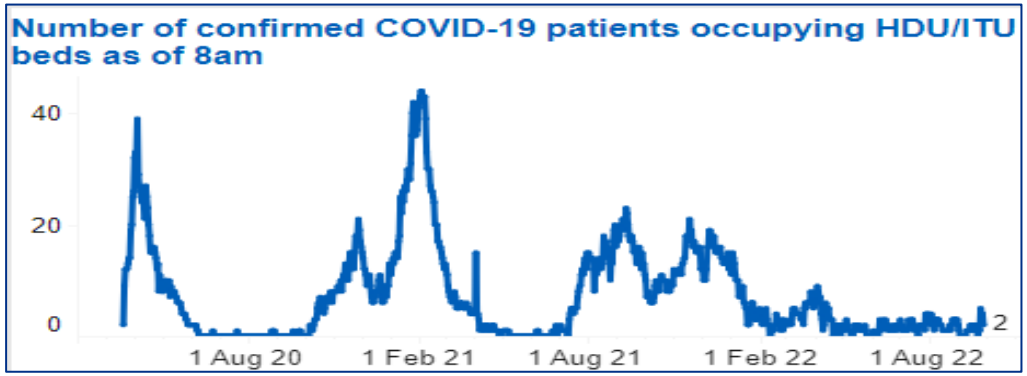
Covid Update

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



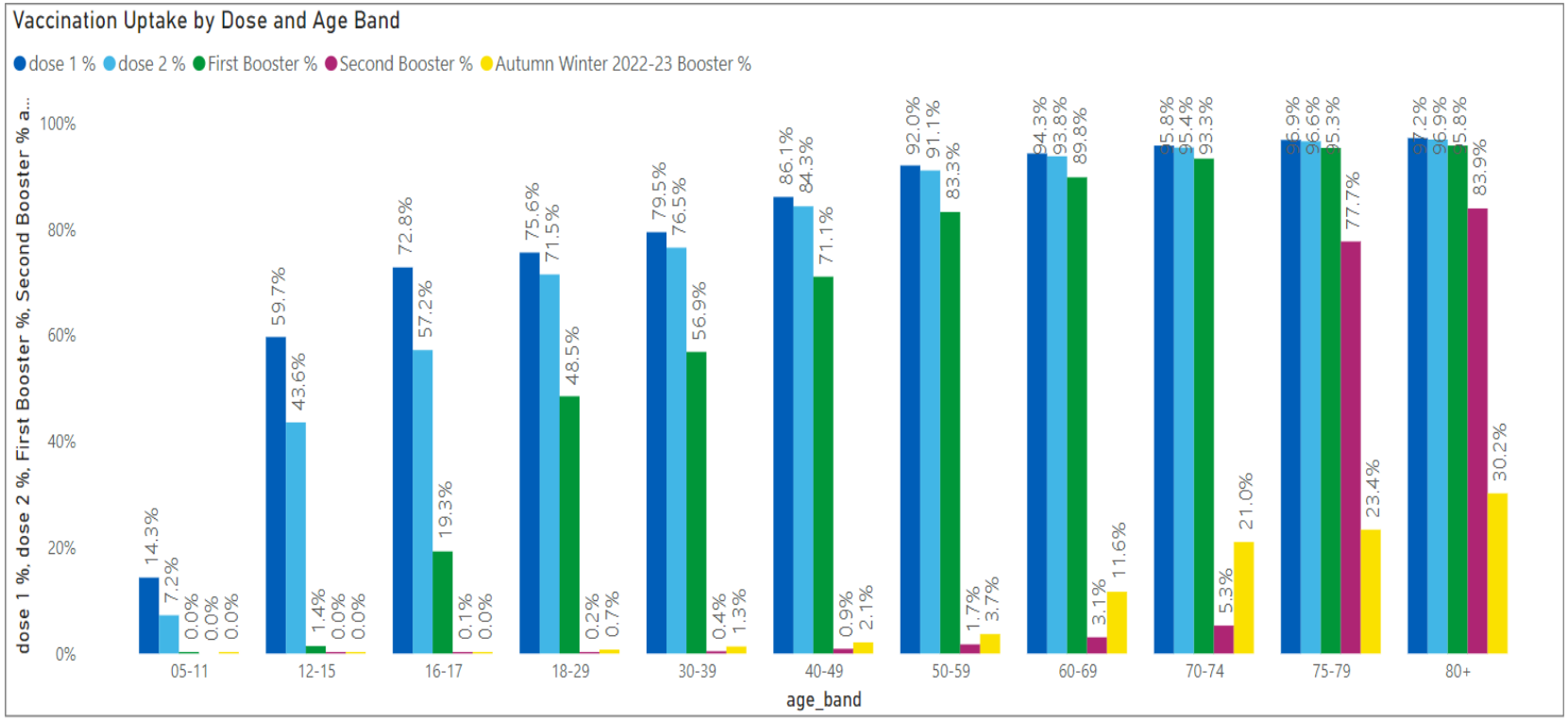
The number of Covid patients in hospital beds quickly reduced since the peak of 353 at the beginning of July down to a low of around 50 in early September. However, numbers have risen quickly to 189 as of 28th September.

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



Covid Update: Vaccinations

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

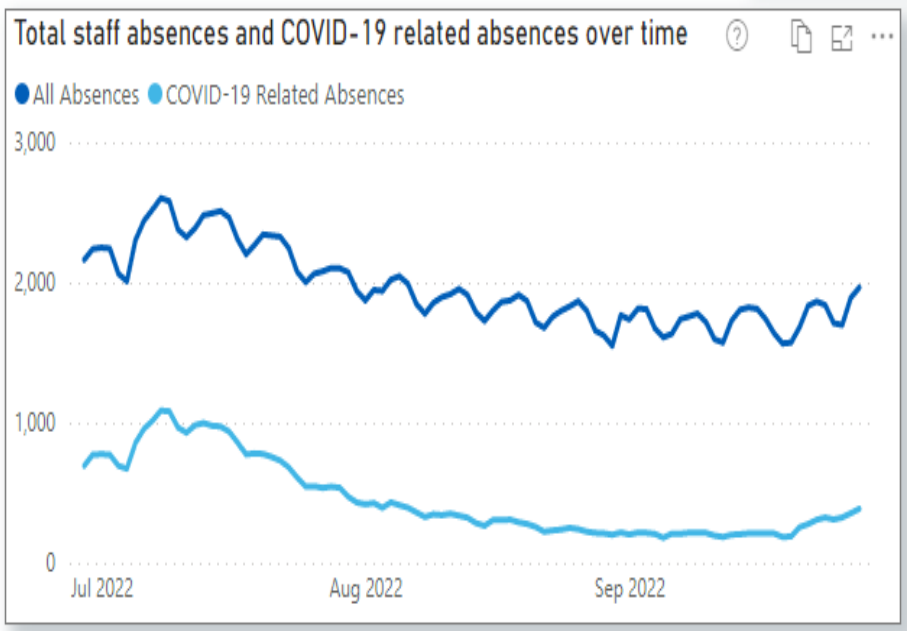


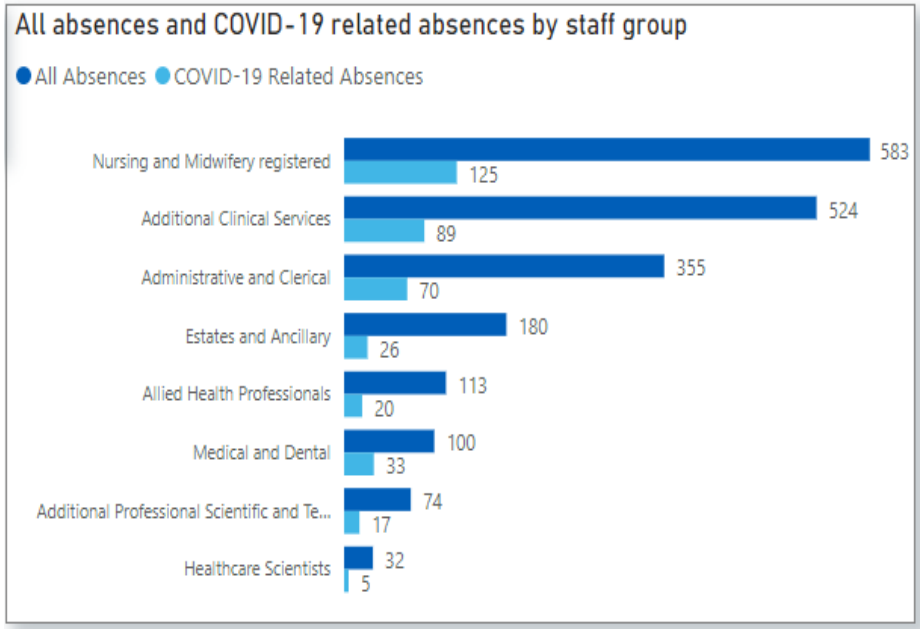
Covid Update (workforce absence)

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

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

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





Primary Care: Clinical Activity

Theme: General Practice Clinical Activity Backlog

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

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

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

Primary Care: Clinical Activity

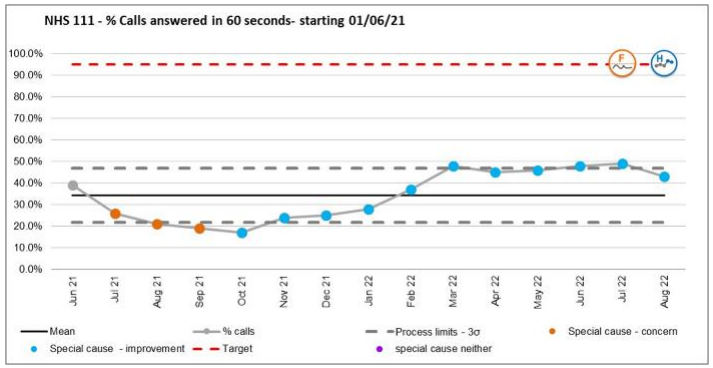
Actions undertaken in last month:	Impact:
Primary Care completed action to access BI Team to review quantification of activity data that could be utilised to monitor accumulation of delayed work, for example QOF, Public Health screening metrics, immunisation rates and referral activity. Further work to develop and present this data is planned.	Potential data sources identified to help identify backlogs. Once available, this data will be used to assess the extent of delayed services and plan improvement.
Following release of the initial tranche of Devon Spring Action Fund (DSAF) funding in May (£641,000) each practice has now been sent a template to complete and return with supporting evidence. Once all information has been received the Primary Care Team will be in a position to provide detail on the number and type of additional sessions that have been provided under this fund.	Additional financial support will enable practices to secure extra clinical sessions, from both existing staff providing additional sessions and locum practitioners. In comparing data provided by BI regarding the number of available appointments, most recent data from July 2022 shows an increase in appointments compared to pre-pandemic levels of 2.12% per working day, which is likely partially attributable to DSAF

Actions for next month/s:	Intended impact:	Date impact will be realised:
Continued work with BI to quantify outstanding practice and provision of services.	Will support a system-wide understanding of the impact of COVID on clinical backlog in partner organisations; and identify the interdependencies and potential impact of system wide provision on other partners.	Ongoing, work will continue

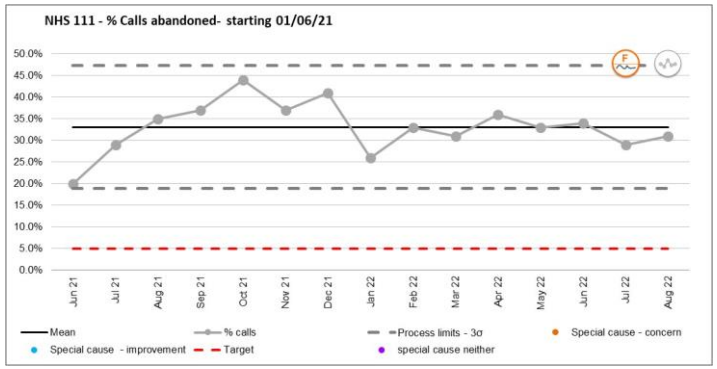
Integrated Urgent Care Service: NHS 111

Data

NHS 111 - calls answered in 60 seconds



NHS 111 – calls abandoned



Analytical Summary

- % of calls answered in 60s has seen an upward shift in performance. However, the target of 95% will not be met without system change
- % of calls abandoned is variable with no statistically significant change. The target of 5% will not be met without system change
- % of call backs within 20 minutes is variable. The target of 90% will not be met without system change.

Operational Summary

Causes

Poor 111 performance is due to low call answering capacity because of unplanned absence and insufficient staffing. Attrition rates are high and while recruitment is ongoing, all 111 providers are experiencing difficulties in recruiting staff.

Actions

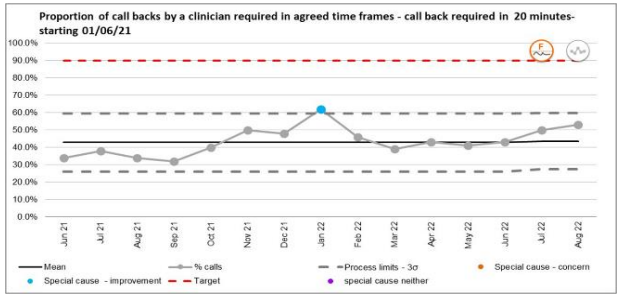
Additional capacity from Vocare commenced on 15th July with support starting immediately to provide cover for evenings, overnight and at weekends. Since 8th August all calls have been diverted from Devon Doctors to Vocare between 7pm - 8am each day with additional support provided through national contingency at weekends during the day to protect Devon Doctors from 50% of calls all day. As a result, the graphs above only show the proportion of Devon's that is handled by Devon Doctors. Call answering performance by Vocare is significantly better.

To secure a long-term solution, Devon commissioners undertook a comprehensive procurement exercise for provision of the service from 27th September 2022 onwards resulting in the appointment of Practice Plus Urgent Care Group Ltd. (PPG) to provide both 111 and GP Out of Hours service.

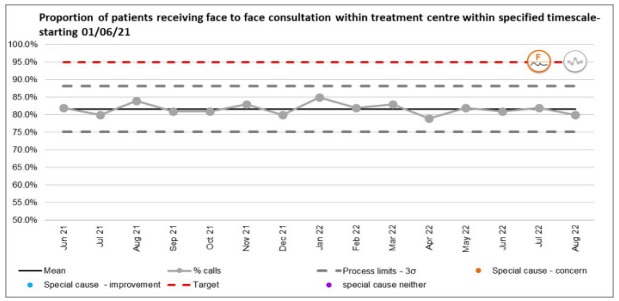
Integrated Urgent Care Service: GP Out of Hours

Data

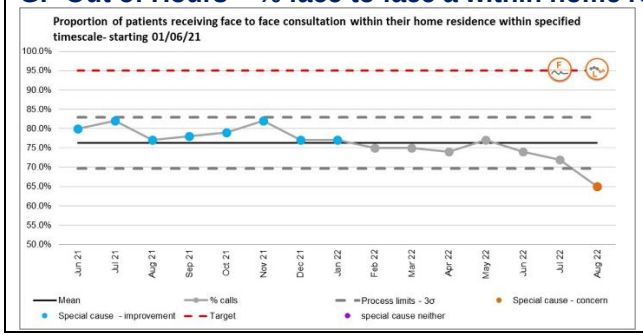
GP Out of Hours - % call backs within 20 minutes



GP Out of Hours – % face to face within a treatment centre withing timescales



GP Out of Hours – % face to face a within home residence within timescales



Analytical Summary

- % of face to face consultations within a treatment centre within the timescales is variable with no statistically significant change. The target of 95% will not be met without system change.
- % of face to face consultations within a home residence within the timescales is variable with no statistically significant change. The target of 95% will not be met without system change

Operational Summary

Causes

Poor GP Out of Hours performance is due to low rota fill. A key reason for this is competing demand on limited GP workforce.

Actions

Going forward, 80 of the required 108 GPs for the service have approached PPG and been onboarded. As yet, a much smaller number have signed up for shifts. The onboarding of so many GPs is positive and whilst the number of shifts filled is concerning, it is likely to change. In looking at rota fill figures it is important to note that Clinical Assessment Service and out of hours have significant input from clinicians who are self-employed and sign up for shifts, of their choosing, at their time of choosing. In many cases this means that clinicians will pick up shifts at the last moment.

Mental Health: System Overview

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

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

The next slides focus on providers performance against the following metrics: IAPT 6-week access, CYP eating disorders and inappropriate out of area placements.

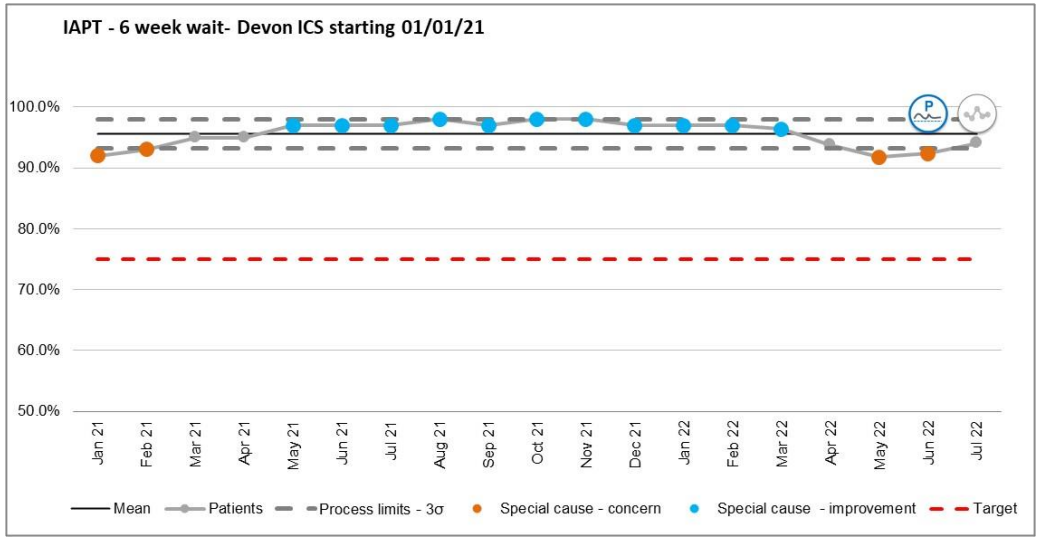
Mental Health: IAPT

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
IAPT – first appointment within 6 weeks	75%	Jul-22	94.13%		

KPI Description

The proportion of people who had their first treatment appointment within 6 weeks of referral in the reporting period.

Statistical Process Chart



DPT = 90.6%
Livewell SW = 96.8%

Analytical Commentary

Variation indicates that the measure is consistently passing the target. There are two points of special cause concern in recent months which fall outside of the process limits, however this is well above the target rate of 75%.

Operational Summary

It is expected to continue to meet this standard.

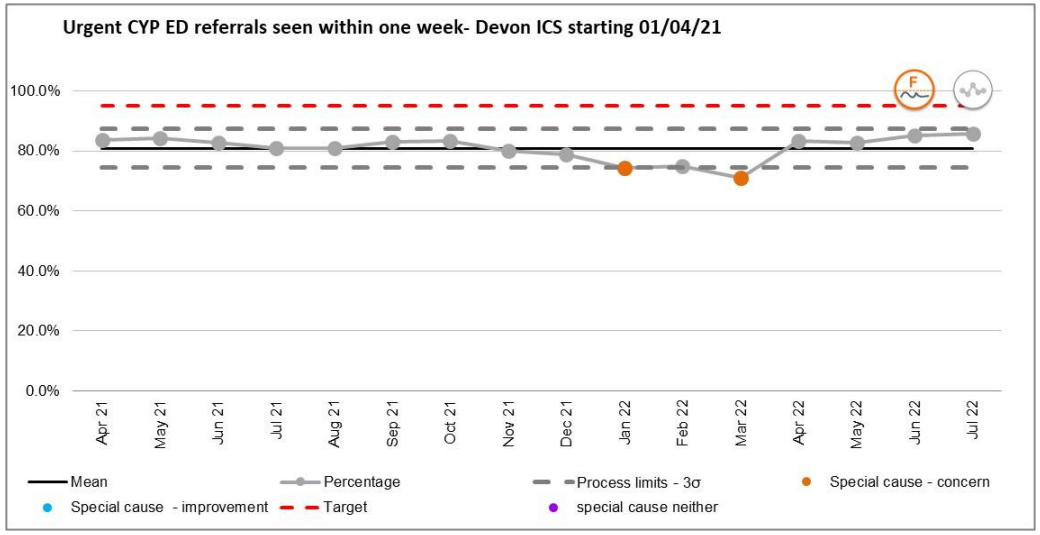
Mental Health: CYP Eating Disorders Urgent

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

KPI Description

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

Statistical Process Chart



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

Analytical Commentary

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

Operational Summary

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

Actions and Assurance

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

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

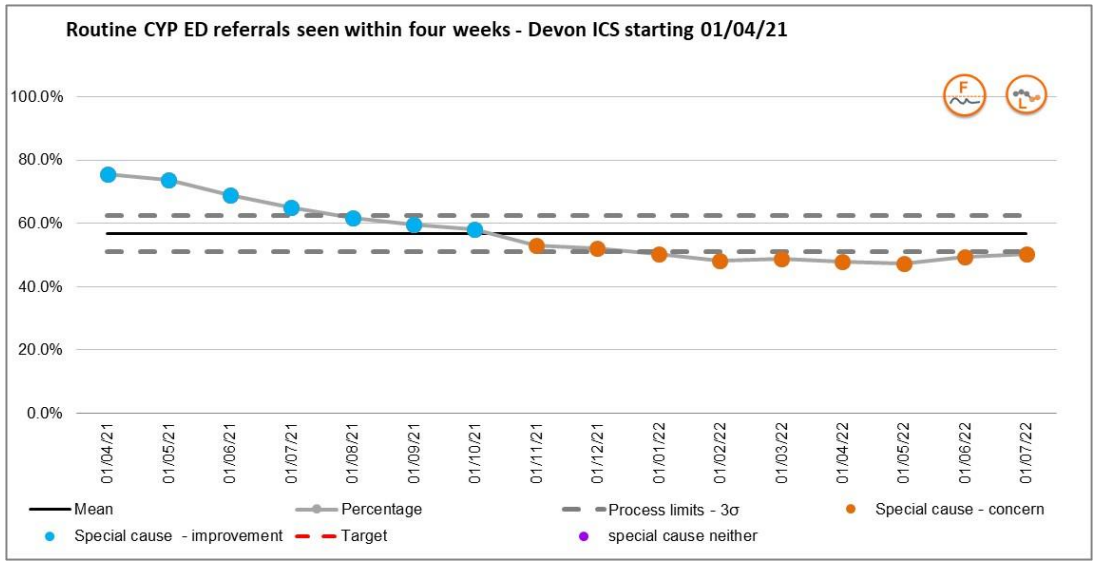
Mental Health: CYP Eating Disorders (ED) Routine

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

KPI Description

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

Statistical Process Chart



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

Analytical Commentary

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

Operational Summary

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

Actions and Assurance

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

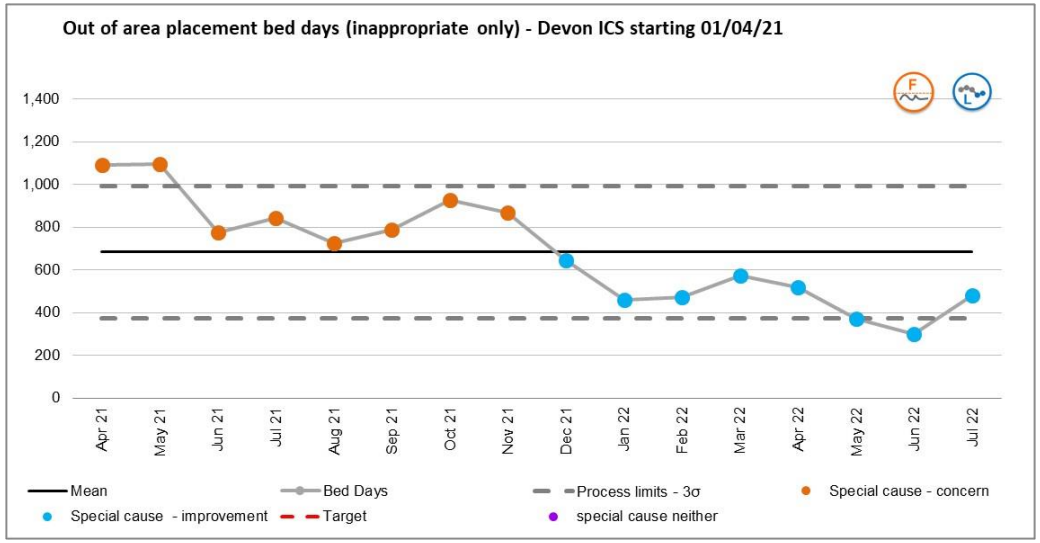
Mental Health: Out of Area Placements/Bed days

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

KPI Description

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

Statistical Process Chart



DPT = 235 bed days
Livewell SW = 244 bed days

Analytical Commentary

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

Operational Summary

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

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

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

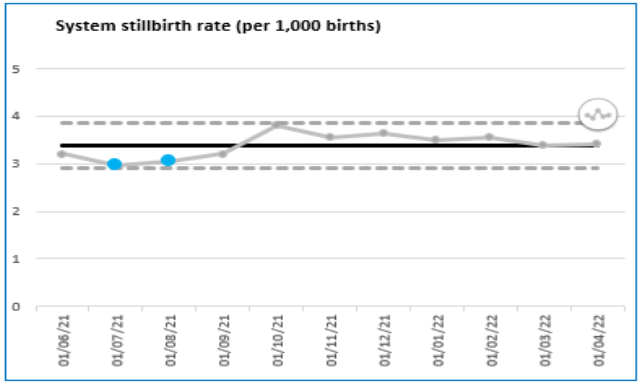
LMNS (Local Maternity and Neonatal System) update

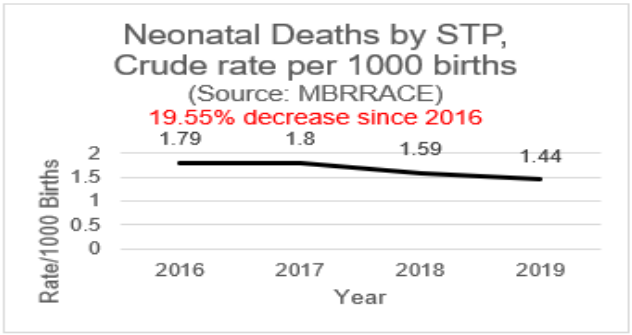
Key Performance Indicator	Target/Plan	Actual	Variation	Assurance
Stillbirth & Neonatal Death	Stillbirth: 1.38/1000 births by 2025 Neonatal Death: 0.89/1000	3.2/1000 stillbirths 1.44/1000 neonatal deaths	-	NA

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

Statistical Process Chart

Stillbirth ratio (SUS) June 2021-April 2022.





Latest Period: Stillbirth: 2021/22. Neonatal Death: 2019

Analytical Summary

System still birth rates are within common cause variation. However, process change may be required to meet the target should future progress continue at the current rate.

Operational Summary

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

Smoking cessation: Delayed. Implementation across Devon, prioritising the areas of greatest deprivation. Torbay has begun implementation, however other Trusts have postponed until October 2022 due to workforce constraints.

Saving Babies Lives Care Bundles: On track. All Trusts have implemented the care bundle, but face challenges in sonography capacity. This is a national issue.

Ockenden Report: On track. All Trusts have implemented the recommendations of the interim Ockenden report. Compliance is noted against most immediate and essential actions. Paritially compliant areas have appropriate action plans in place.

Perinatal Quality Surveillance Model: On Track. Implementation of this model supports Trusts and the LMNS to review and share learning from incidents and complaints.

Continuity of Carer: Delayed. An increased risk of stillbirth and neonatal death is associated with preterm birth, especially with vulnerable families. The main challenge to implementation is ensuring that Trusts have safe staffing levels. System increase in staffing levels, anticipated in October 2022.

Inequalities. Smoking, obesity and lack of access to consistent evidence based information increases the risk of poor outcomes, especially for deprived and minority ethnic groups. We are currently developing a LMNS Equity & Equality Strategy, outlining the high level actions needed over the next 5 years to address the impact of inequalities on maternity and neonatal care.

Children & Young People (CYP): Special Educational Needs and Disabilities (SEND) Written Statement of Action (WSoA)

Key Performance Indicator	Target/Plan	Latest Period
SEND WSOA – Torbay and Devon. SEND Plymouth anticipating their inspection	WSOA	Sept 22

KPI Description:
Complete Department for Education & CQC (Care Quality Commission) approved WSoA

Themes:
National SEND review identified key themes, aligned across Devon ICP:

- Strengthen culture of working together.
- Change the narrative about SEND, SEND is everyone's business.
- Co-production and use of common language
- Graduated Offer must feel real to families
- More focus on outcomes and how are we making a difference.
- Improve experience at points of transition into adulthood.

Operational Summary:
Torbay and Devon have a WSOA to address areas of weakness, the Devon ICP have identified common themes to share learning, best practice and collaborative approaches.

DEVON Local Area:

- Devon re-inspection by Ofsted and CQC in May 2022.
- Inspection found, none of significant weaknesses identified in 2018 had improved.
- Level of intervention being discussed with DfE and NHS England.

TORBAY Local Area:

- The Torbay inspection was undertaken in October 2021.
- 8 areas of weakness were identified in the inspection.
- The WSoA has been developed by the Local Area.

PLYMOUTH Local Area:

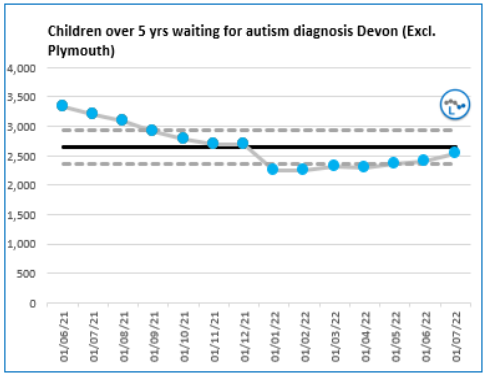
- Plymouth was inspected in 2016 they were not issued with a WSOA.
- An inspection, under the new framework, is anticipated for the autumn 22.
- In anticipation of the inspection there are plans to learn from Devon and Torbay

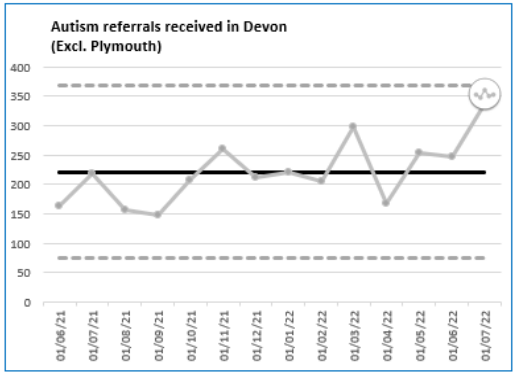
Children & Young People (CYP): Autism Diagnosis waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Autism waiting times	< 18 wks.	July 22	84.3 wks.		
Autism referrals	NA	July 22	NA		NA

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

Statistical Process Charts – Devon & Torbay





Average wait = 84.3 weeks
Longest wait = 176 weeks

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

Operational Summary – Devon & Torbay

What are the causes?
- Insufficient capacity to process referrals and assess CYP.
- Historical backlog and increase in number of referrals.
- A complex pathway delivered by multiple services; bottlenecks arise with children awaiting diagnoses.

What are we doing/what are the challenges?
- Reach agreement with CFHD to increase & recruit keyworkers
- A prioritisation case for investment is being completed.
- Plans to assess long waiters jointly with TSDFT.
- Vacancies and recruitment challenges for key clinical roles.
- Access unavailable to electronic patient records.

Is there any risk/harm caused to children by waiting longer?
- CYP are not able to access support and achieve their full potential.
- Potential for increase emotional distress and crisis.
- Increased risk of family breakdown.

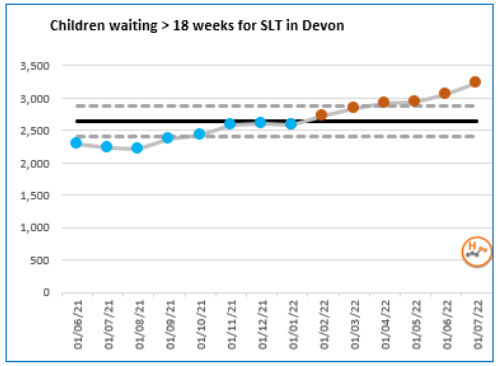
<u>When will we see an improvement?</u>
Improvement on long waiters within 6 month.
Strategic long term Neuro Diversity improvement plan over 5 years.

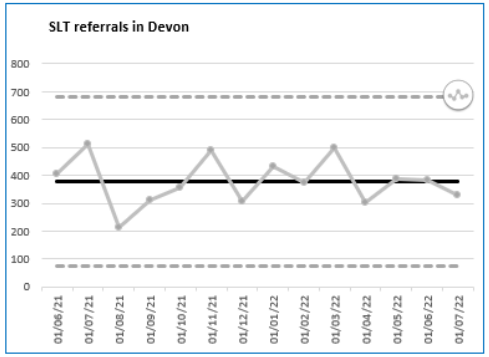
Children & Young People (CYP): Speech & Language waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Speech and Language waiting times	< 18 wks	July 22	33.5 weeks	H	F
Speech and Language referrals	NA	July 22	NA		NA

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

Statistical Process Control Charts – Devon, Torbay and Plymouth





Average wait: 33.5 weeks
Longest wait = 101 weeks

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

Operational Summary – Devon, Torbay and Plymouth

What are the causes?
Insufficient capacity to process referrals and assess CYP.
Increased number of referrals during covid.
Continued fluctuation in referrals, causing bottlenecks on pathway.

What are we doing/what are the challenges?
Recruitment to vacancies, managing (long term) sickness.
Challenged co-ordination across multiple services/organisations.

Is there any risk/harm caused to children by waiting longer?
Delays in specialist assessment affects CYP support.
Potential for poor development of language and communication skill.
Delays can further impact provision of support for CYP with SEND.

When will we see an improvement?
Improvement on long waiters by August 2023 in Devon. Provider trajectories being drafted for Devon, Torbay and Plymouth.

Children & Young People (CYP): Elective Recovery

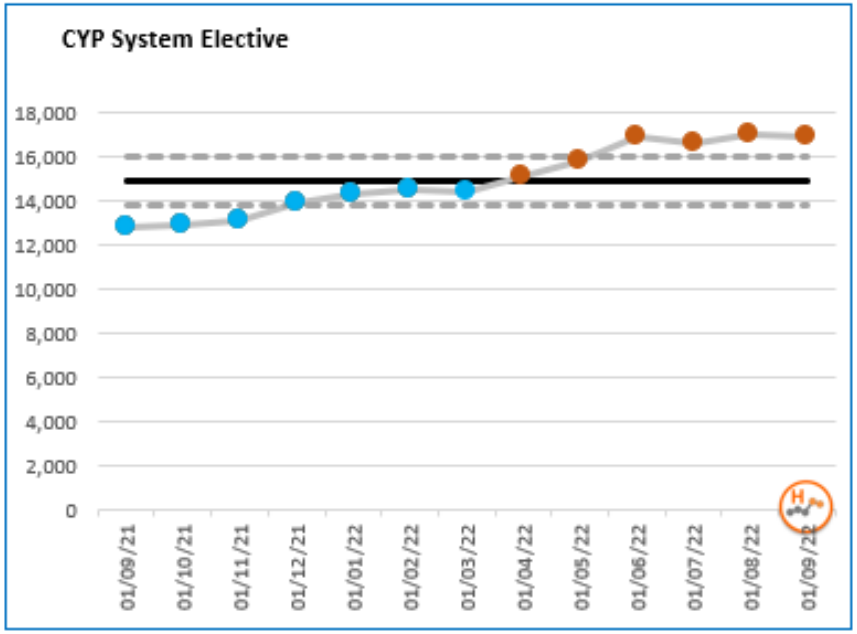
Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
CYP long waiters – Specialty services	Operating plan	Sep 22	As of 14th Sept -	H	F

KPI Description

National RTT standards of 92% seen within 18 weeks.
Operating plan - eliminate 104 week waits and reduce waits of 78+ weeks.

Statistical Process Chart

Figure 1: Devon system CYP waiters for Paediatric and Specialty services



Analytical Commentary

Metric is currently experiencing Special Cause Variation of a concerning nature and the position is deteriorating.

Operational Summary

What are the causes?

Impact Covid pandemic and disruption to Specialty services. CYP elective recovery slower pace that adult services and has not had the National, Regional or ICS focus to date.

Nationally and Locally significantly slower pace CYP elective recovery compared with adults. Waiting Lists under 18s increasing at faster rate than adults. Prioritisation considers mortality and time waited - not elements of harm and impact on child's development, future life and outcomes. CYP must have appropriate care (not inappropriate prioritisation)

What are we doing/what are the challenges?

Aligned to National and Regional Elective Recovery establish a CYP steering group and ensure 'whole system all age' ER approach across Devon ICB. Developed CYP dashboard to monitor waiting times and performance.

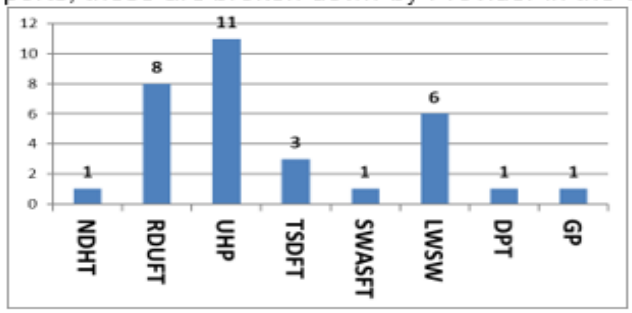
Is there any risk/harm caused to children by waiting longer?

Assessment not completed yet, there is no recommended CYP framework/tool for this risk assessment.

Quality

Serious Incidents

During August 2022 there have been **32 serious incidents** reports, these are broken down by Provider in the chart below:



increase of 1 more than last month (31)

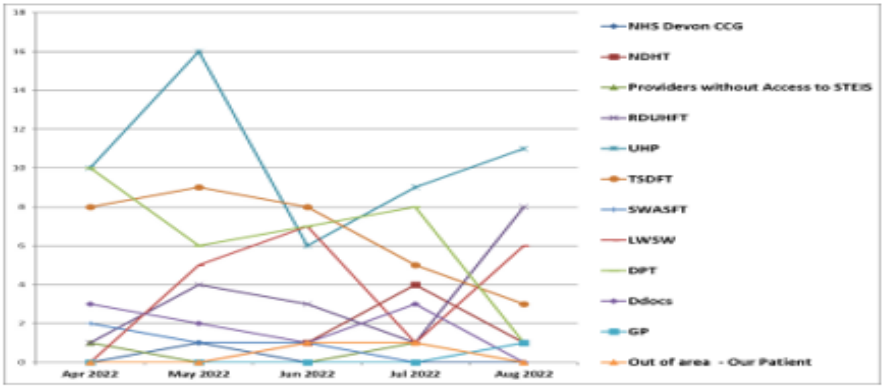
One never event (wrong site surgery) was **reported** by **RDUFT** during August. Initial report is being completed and full investigations will follow to identify any learning. Since April 2022 there have been **11 never events reported**, which is a significant increase compared to the same period last year (3).

The **top five Serious incident** types reported in August were:

- Diagnostic Incident incl delay (7) ↑
- Treatment Delay (4) →
- Slips trips Falls (3) ↓
- Maternity / Obstetric (3) ↑
- Medication (3) ↑

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

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



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

The **SWASFT System SI** recommendations are being mapped against Devon UEC system improvement plans. Summaries and presentations of the report are being shared with the SQPG and the QPC this month.

306 open serious incidents

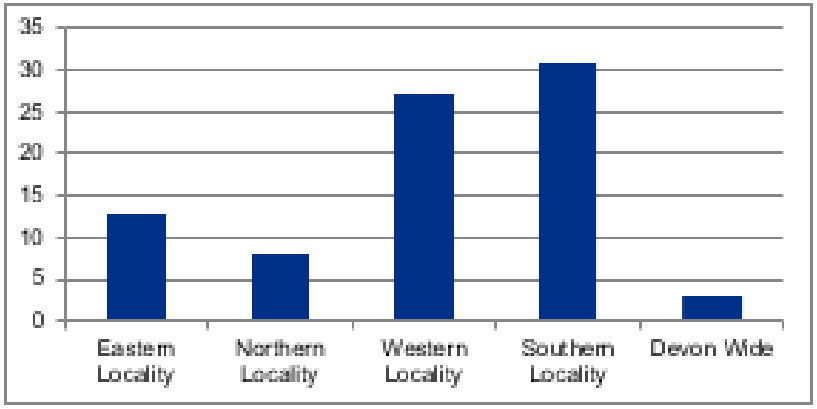
124 overdue investigation reports

15 serious incidents being reviewed

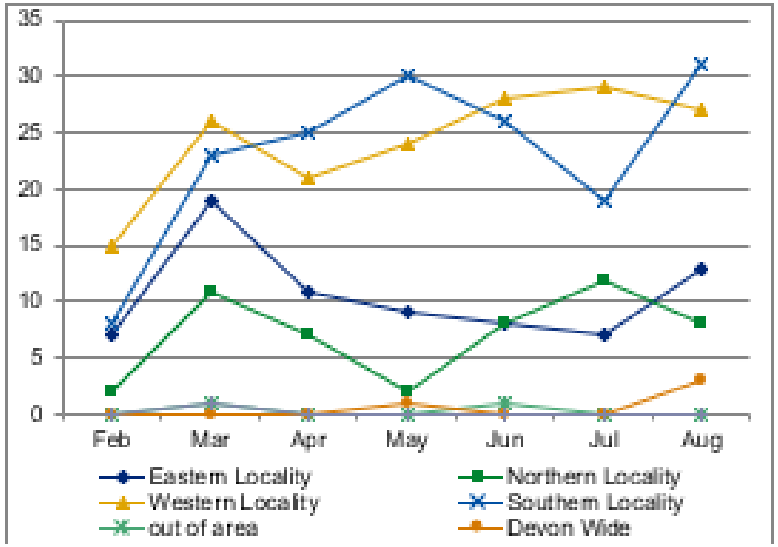
35 serious incidents closed in August

Peer Improvement Tips for Care and Health (PITCH)

During August there have been 82 PITCHs reported, these are broken down by locality in the chart below:



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

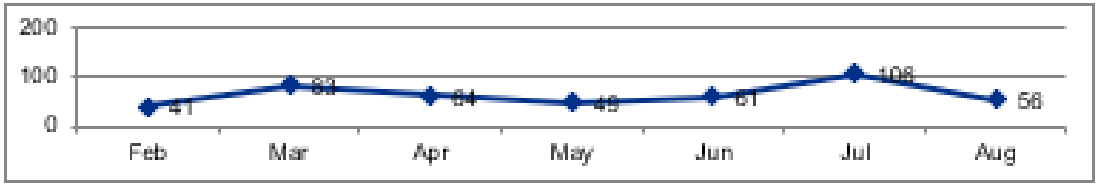


The top three PITCH concerns received in July were:

- Procedure or process (14)
- Access to services (12)
- Prescribing (11)

The team review all PITCHs, escalating to the potential serious incident panel or safeguarding teams if required. During August 3 reported PITCHs were referred to the Safety Systems Team for review if they meet the criteria of a serious incident. Additionally, they are reviewed for themes and trends across specialities and localities.

During August 56 PITCHs were closed compared to 91 last month. The below chart, illustrates the number of closed PITCHs per month since February 2022:

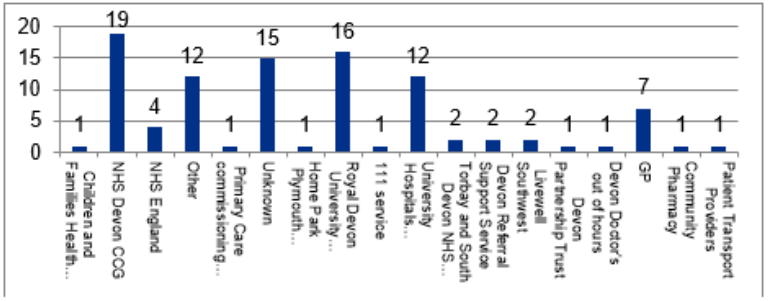


60 open PITCHs remain open

Priority next month – Focus on PITCH reporting

Patient Experience (NHS Devon): Patient Contacts

During August there were **99 new patient experience** feedback and concerns to manage, these are broken down by Provider in the graph below:



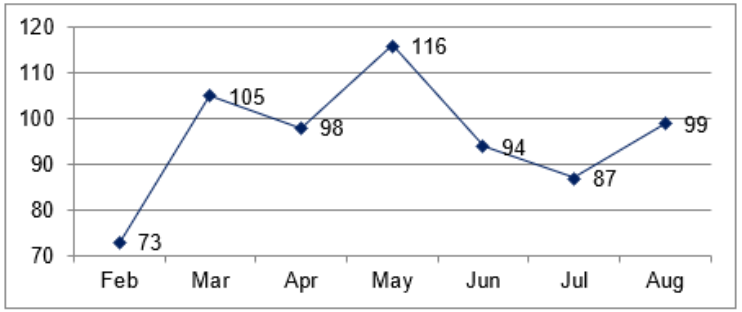
The **top three patient experience concerns received in** in August were:

- Process and Procedure (10)
- Quality of Care (8)
- Other (8), varying subjects from vaccines to commissioning services

A particular subject of focus in recent months relates to ADHD/Autism services and the ability for patients to enact their 'right to choose' due to the significant delays in referrals for diagnosis

- There have been 7 **new formal complaint** raised during August for the CCG.
- There have been **4 contractual reviews received** and in progress, which are required and form part of Primary Care complaints which are managed by NHS England.
- There are **2 requests for information** from the **Parliamentary Health Care Ombudsman (PHSO)**

July saw a slight reduction in contacts compared to the last 3 months, however in August the numbers of **patient experience concerns** reported have increased to that of previous months. The increased demand is expected during the coming months.



The team continue to **close** patient experience concerns this month, **closing 88 in August**, as illustrated in the graph below:

Safeguarding: Adult Enquiries

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

Data	Underlying cause

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

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

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

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

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

Safeguarding: Children in Care (CIC)

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

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

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

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

Safeguarding: Child Protection

Issue: A section 47 enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare if a child who is suspected of or likely to be suffering significant harm. Following section 47 enquiries an initial child protection conference brings together family members and practitioners most involved with the child and family to determine whether a child protection plan is required.

Children subject to child protection plans: August 2022

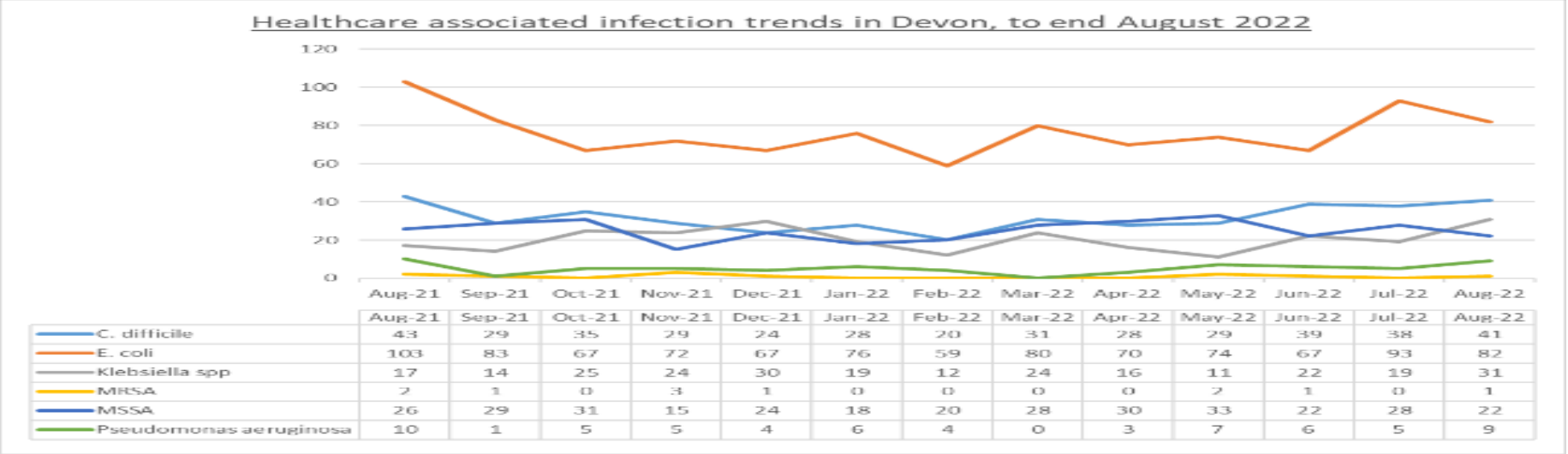
Data	Underlying cause
<table><tr><th>Local Authority</th><th>Number of children on a plan (% per 10,000 children)</th><th>Neglect</th><th>Physical</th><th>Emotional</th><th>Sexual</th></tr><tr><td>Torbay</td><td>211 (82.8 %)</td><td>111</td><td>11</td><td>71</td><td>5</td></tr><tr><td>Devon</td><td>579 (39%)</td><td>236</td><td>46</td><td>276</td><td>21</td></tr><tr><td>Plymouth</td><td>216 (40.5%)</td><td>97</td><td>15</td><td>93</td><td>12</td></tr></table>	Children are subject to child protection plans because of physical, sexual or emotional abuse, or neglect.

Actions undertaken in last month	Impact
As part of local safeguarding children's partnerships, NHS Devon is working with multiagency partners to identify harm, and work with families to improve the safety, health and wellbeing of children.	Improving the health, well-being and safety of children.

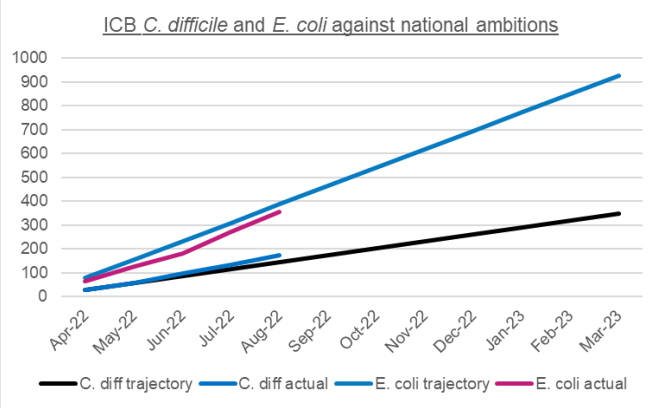
Actions for next month/s	Intended impact	Date impact will be realised
Work with multiagency partners through the local child safeguarding partnerships.	improved multiagency working, early identification of harm, learning from incidents of harm.	Ongoing

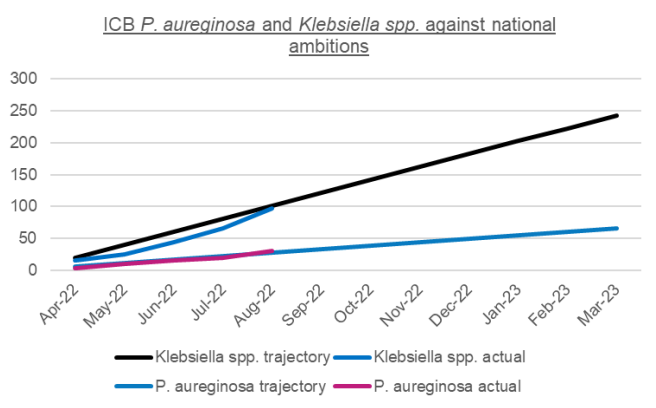
Infection Prevention and Control

Theme: Healthcare associated infections trends and national ambitions



	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
C. difficile	43	29	35	29	24	28	20	31	28	29	39	38	41
E. coli	103	83	67	72	67	76	59	80	70	74	67	93	82
Klebsiella spp	17	14	25	24	30	19	12	24	16	11	22	19	31
MRSA	2	1	0	3	1	0	0	0	0	2	1	0	1
MSSA	26	29	31	15	24	18	20	28	30	33	22	28	22
Pseudomonas aeruginosa	10	1	5	5	4	6	4	0	3	7	6	5	9





Infection highlights

- University Hospitals Plymouth have seen an increased number of hospital onset *C. difficile* cases and have convened an IPC summit with a focus on the 10 infection control standard precautions, and 5 specific priorities for the Trust to implement.

Influenza (seasonal and avian)

- The vaccination programme for seasonal flu is under way, and weekly monitoring meetings have been set up to identify emerging issues with the vaccine rollout.
- A change of provider for antiviral prophylaxis in flu outbreak situations is currently in progress and is being taken forward by the commissioning team.

Actions undertaken in last month	Impact
Initial reset meeting of community infection management service to plan new community reduction projects	Community infection management service proactive work enhanced
Setting up and chairing of community flu group	Monitoring of primary care and pharmacy vaccine rollout

Actions for next month/s	Intended impact	Date impact will be realised
Antimicrobial resistance group to restart, with potential joint working with Cornwall	System antimicrobial resistance workstreams, sharing of good practice	November 2022
Antiviral prophylaxis recommissioning	Continuation or transfer of existing antiviral prophylaxis service ahead of the 2022/23 flu season	October 2022

Workforce

Workforce: Metrics

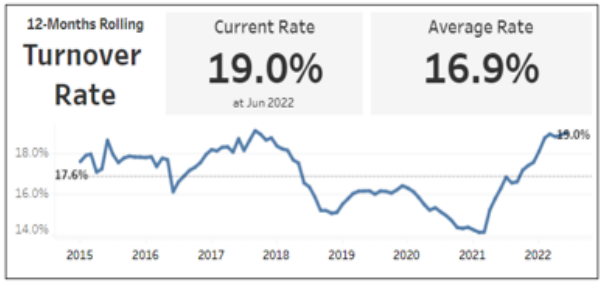
Leaver rate (leavers outside the NHS)

Devon – June 22 (HEE data – inc LSW)

South-West – June 22 (HEE data)

Turnover rate (leavers including to other Trusts)

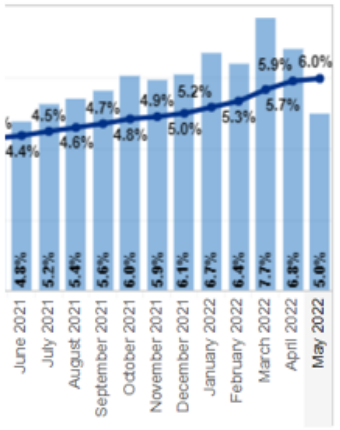
Devon – June 22 (HEE data – inc LSW)



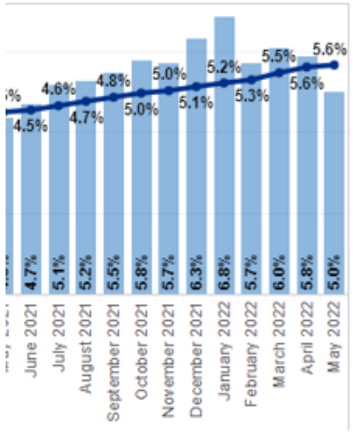
South-West – June 22 (HEE data)

Absence

Devon (HEE data)



National (HEE data)



Sickness Absence Rate by Month and 12 Monthly Rolling Rate

Vacancies

July 22 (inc LSW) – local data

Total vacancies for ICS - Jul 2022				
This month vacancies	Previous month vacancies	This month previous year vacancies	Vacancies as % of funded establishment	Substantive WTE
2,502.46	2,591.02	1,651.01	7.38%	31,393.97

Consultant: 116 wte -

Nursing 770 wte ↓

AHP 329 wte ↓

HCA 338 wte ↓

Trust data (not inc Primary or Social Care)

Spend £ against operational plan 22/23

April 22 – July 22 – local data

	Plan YTD	Actual YTD	Variance
Agency	£9,657M	£16,378M	(6,721)
Substantive	£458,838	464,411	(5,573)
Bank	£26,527	£28,279	(1,752)

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

WTE against operational plan 22/23

July 22 – local data

	Plan M4	Actual M4	Variance
Substantive	29,882 wte	29,145 wte	737
Bank	1,550 wte	1,537 wte	13
Agency	382 wte	561 wte	(179)

Workforce: Workforce Strategy

Strategic Workforce Planning

- The development of a standardised and systemised approach to Strategic Workforce Planning is on-ongoing and work continues on an MVP (Minimum Viable Product) to enable the system to 'build our own' Strategic Workforce Planning tool.
- Measures of success have been collated.
- Requirements workshops held on 8th and 14th September with SMEs (Subject Matter Experts) from providers and HEE (Health Education England).
- Data mapping workshops planned over 3 dates in September and early October.
- Workforce Planner interviews held on 4th August but unable to appoint.

Workforce Strategy

- Ontrack for deliver by the end of March 2023.
- **Two 'future facing scenario workshops'** have been held to date and 24th August was cancelled due to low attendance.
- A **further 5 virtual events** have been planned between September and October 2022.
- **C.250 delegates** have been invited to attend the workshops across Health and Care.
- Mid-point review scheduled for 20th September.
- **10 '7 questions for the future' have been planned** with senior executive directors across the Devon System. Using 7 Questions Futures Technique - Futures, Foresight and Horizon Scanning. 70% complete
- **First draft of Workforce Strategy chapter written** pending review and templates.

Workforce: Learning, Education and Strategy

- **Placement expansion:** With collaboration of the group a template has been devised to collect data from providers on Student Placements for last year and capacity for the upcoming academic year. This will allow us to identify gaps and pressure points. Data has been received on 31 August 2022 and is being consolidated into one report by end of September 2022.

- **ICS Learning Academy:** Devon proposal for the ICS Learning Academy is being socialised, aiming for operationalisation in November.

- **Community Upskilling Funding:** Following the successful System bid for Community Upskilling funding a new group will be established for Upskilling, to ensure the priority areas are delivered and appropriately represented from across the system.

Workforce: Best Place to Work (BPTW)

- **Inclusive Health and Wellbeing (HWB) Strategies:** Health and Wellbeing Working Group established, first meeting 21.09.22 to further develop and inform inclusive HWB Strategies across the Devon System, considering HWB offers available to staff.
- **HWB bid**: 'Wellbeing Support Buddies and Champions Programme' to support and equip 300 staff to create peer networks to enable sustainable longer term health improvement and increased resilience across the system is being implemented. Links to onboarding have been communicated across the Devon System.
- **Cultural and wellbeing dashboard**: Wellbeing and Culture **Dashboard** designed and in place with licences for provider organisations obtained to enable organisation and system intelligence to be utilised by individuals, teams and Committees. Working group now in place to develop further the KPIs (Key Performance Indicators), narrative, reporting and users.
- **Absence management:** The ICS partners across the Devon System completed a review and implementing actions using the NHSE/I publication 'Deep dive into factors affecting non covid sickness absence North West NHS Trusts 2020' (NW Tool) to focus within their organisation on addressing and improving Sickness Absence. System discussion on managing sickness and absence aligned to just and learning culture with update on implementing the North West Tool to take place 16.09.22 at BPTW Group.

Workforce: Workforce Capacity

- **Livewell /Social care recruitment pilot:** Project will now transfer across into Proud to Care portfolio (with expansion into Social Care and AHP (Allied Health Professionals) roles).
- **Collaboration of banks**: Plans are being formulated to commence a sharing collaborative of nursing banks across the system to add to the already established medical collaborative bank. This programme of work will be in place by end March 2023.
- **Bank and agency spend**: New HTE (Health Trust Europe) agency framework for nursing, medics' and AHP has been tendered for and will be awarded and live in September. This will help standardise agency rates for the remainder of 2022/23 and formalise the approach to the agency tiering and cascade process.
- **Overhaul of recruitment & promotion practices to reduce/eliminate diversity gaps**: EDI (Equality Diversity Inclusion) leads continue to progress local action plans. Some detail still to be agreed in the overarching system action plan. Agreed to report by exception. First draft of metrics are now within Cultural dashboard.
- **International recruitment (IR):** Paper to be received at CEO (Chief Executive Officer) meeting in September outlining a proposal to extend the IR programme into Social Care. Recruitment into NHS remains on track.
- **Attraction**:
    - Attraction Strategy and Plan of events discussed at August Steering Group and time set aside to draft at end September.
    - ICS Virtual Fair deferred to Oct due to capacity challenges.
    - Medical Recruitment Campaign – website live. First video produced, some edits required. Remainder of videos booked in for filming by Whitespace + market research being undertaken. Videos will be added to website from September.

Finance

Financial Summary

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

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

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

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

- As at month 4 the Devon ICS is reporting break even against a planned deficit of £9.6m (M3 £0m)

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

- As at month 4 the Devon ICS had made efficiency savings of £23.8m (M3 £16.0m) This is £6.8m adverse to plan (M3 £6.5m).

- Forecast savings are averse to plan by £12.5m. (M3 £0m)

- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of the deficit plan.

- As at Month 4 the net risk has remained at £79.8m. (M3 £78.2m)
- Although no data is available from central sources to confirm performance against ESRF, systems have been informed to assume no clawback for month 4 reporting.

- April and May internal ESRF data shows that although the system is not reaching the required 104% of 19/20 activity, ICB commissioned activity is ahead of plan as of May 2022 by £2.2m but NHSE commissioned activity is behind plan by £2.8m leaving a potential shortfall from plan of £0.6m. We have not received M3 data as yet.

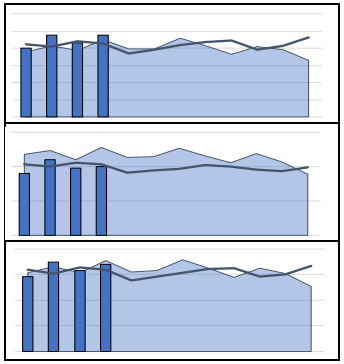
- The month 4 position identifies risks and issues to be managed totalling £90.7m against an expectation of break-even. (M3 £94.3m)

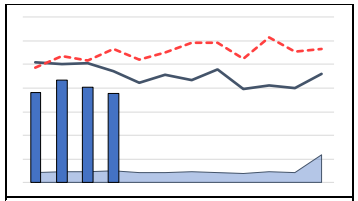
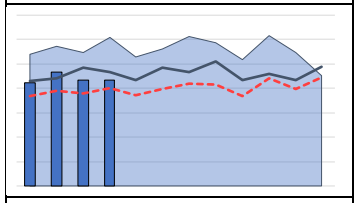
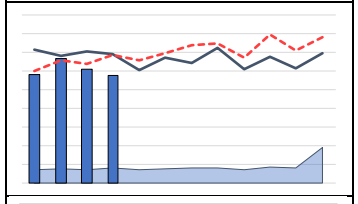
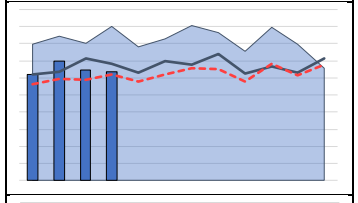
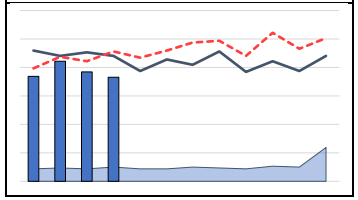
Organisation	Year to date			Forecast		
	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000
Devon CCG	0	0	0	0	0	0
Royal Devon University NHS FT	(1,960)	(1,958)	2	(18,263)	(18,263)	0
University Hospitals Plymouth Trust	(3,864)	(3,864)	0	0	0	0
Torbay and South Devon NHS FT	(2,884)	(2,884)	0	69	69	0
Devon Partnership Trust	(648)	(648)	0	0	0	0
Total	**(9,356)**	**(9,354)**	**2**	**(18,194)**	**(18,194)**	**0**

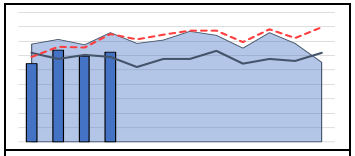
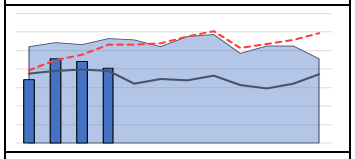
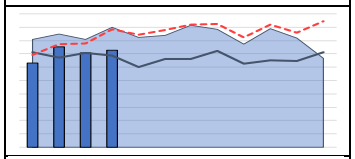
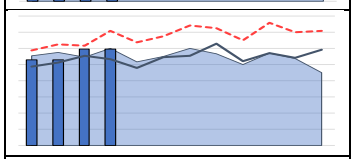
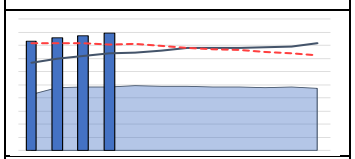
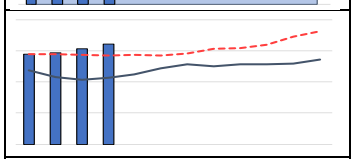
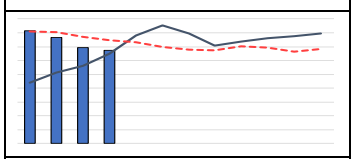
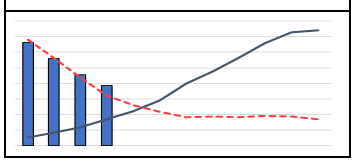
- As at month 4 the Devon ICS is reporting break even against a planned deficit of £9.4m
- The reported forecast is a deficit of £18.2m which delivers to plan.
- The system however is required to deliver a breakeven position by the year end.

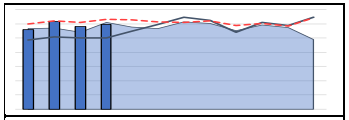
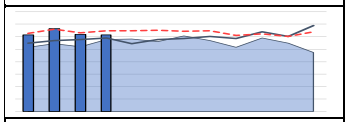
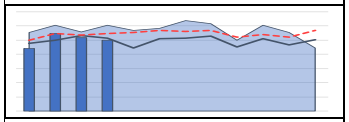
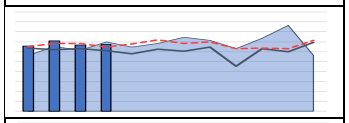
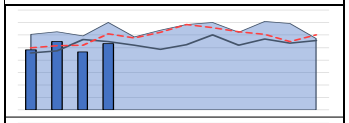
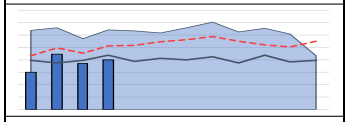
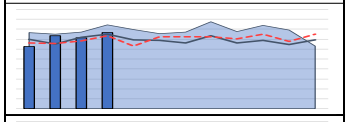
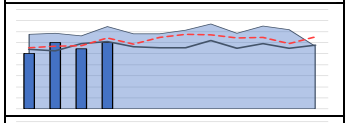
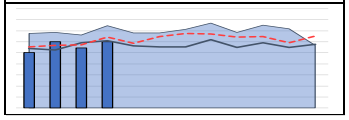
Appendix 1: Activity Vs. Plan

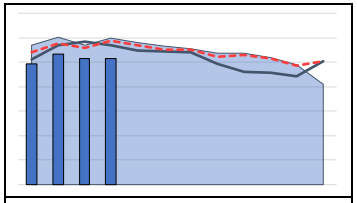
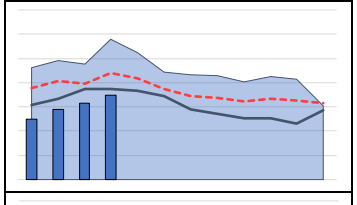
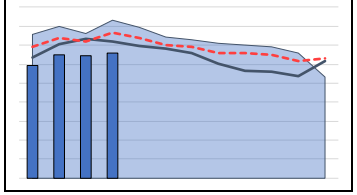
			April	May	June	July	August	September	October	November	December	January	February	March	Previous	Latest	
DEMAND	GP REFERRALS	2019/20	18,912	20,629	19,450	22,588	19,776	19,901	22,943	20,686	18,248	20,411	19,719	16,384	19,450	22,588	▲
		2020/21	8,601	9,461	13,879	17,890	16,960	18,685	18,689	17,602	17,731	16,405	16,512	23,269	13,879	17,890	▲
		2021/22	21,279	20,421	22,128	21,342	18,483	19,684	20,882	21,922	22,327	19,586	20,791	23,253	22,128	21,342	▼
		2022/23	20,164	23,880	21,686	23,841									21,686	23,841	▲
		Growth vs 19/20	7%	16%	11%	6%									11%	6%	▼
	OTHER REFERRALS	2019/20	11,851	12,348	11,071	12,844	11,319	11,511	12,703	11,643	10,617	11,900	10,753	8,927	11,071	12,844	▲
		2020/21	4,920	5,951	8,843	9,644	8,592	10,298	9,104	8,352	7,947	8,696	8,456	11,508	8,843	9,644	▲
		2021/22	10,421	10,026	10,623	10,402	9,171	9,420	9,651	10,298	10,067	9,633	9,307	9,964	10,623	10,402	▼
		2022/23	9,028	11,024	9,829	10,018									9,829	10,018	▲
		Growth vs 19/20	-24%	-11%	-11%	-22%									-11%	-22%	▼
	TOTAL REFERRALS	2019/20	30,763	32,977	30,521	35,432	31,095	31,412	35,646	32,329	28,865	32,311	30,472	25,311	30,521	35,432	▲
		2020/21	13,521	15,412	22,722	27,534	25,552	28,983	27,793	25,954	25,678	25,101	24,968	34,777	22,722	27,534	▲
		2021/22	31,700	30,447	32,751	31,744	27,654	29,104	30,533	32,220	32,394	29,219	30,098	33,217	32,751	31,744	▼
		2022/23	29,192	34,904	31,515	33,859									31,515	33,859	▲
		Growth vs 19/20	-5%	6%	3%	-4%									3%	-4%	▼
OUTPATIENTS	Consultant-led first outpatient attendances	2019/20	36,441	38,338	36,220	41,053	35,114	37,152	40,388	38,015	33,381	38,546	34,540	29,527	36,220	41,053	▲
		2020/21	18,043	20,615	25,240	27,697	24,669	29,860	28,582	28,788	28,594	28,899	28,251	33,559	25,240	27,697	▲
		2021/22	32,495	32,710	35,064	32,610	30,037	34,603	33,622	37,545	31,023	33,990	32,019	36,943	35,064	32,610	▼
		Plan	33,439	35,700	35,241	39,234	36,016	39,084	40,585	40,763	36,494	41,563	38,204	42,026	35,241	39,234	▲
		2022/23	31,606	36,182	34,789	34,695									34,789	34,695	▼
		Plan vs 19/20	92%	93%	97%	96%	103%	105%	100%	107%	109%	108%	111%	142%	97%	96%	▼
		Actual vs 19/20	87%	94%	96%	85%									96%	85%	▼
	Consultant-led follow-up outpatient attendances	2019/20	75,101	79,912	76,409	84,799	73,215	79,443	86,264	82,621	73,308	87,171	77,107	68,822	76,409	84,799	▲
		2020/21	50,139	56,322	70,452	72,988	63,558	75,018	71,318	74,071	70,146	71,860	70,324	82,120	70,452	72,988	▲
		2021/22	75,227	75,258	81,320	77,753	70,021	79,151	76,101	84,892	70,555	77,197	72,486	80,619	81,320	77,753	▼
		Plan	67,267	72,132	70,589	75,418	69,336	76,378	77,986	78,346	69,576	82,733	73,831	82,546	70,589	75,418	▲
		2022/23	66,909	76,747	72,143	73,724									72,143	73,724	▲
		Plan vs 19/20	90%	90%	92%	89%	95%	96%	90%	95%	95%	95%	96%	120%	92%	89%	▼
		Actual vs 19/20	89%	96%	94%	87%									94%	87%	▼
	Total Consultant-led Outpatient attendance	2019/20	111,542	118,250	112,629	125,852	108,329	116,595	126,652	120,636	106,689	125,717	111,647	98,349	112,629	125,852	▲
		2020/21	68,182	76,937	95,692	100,685	88,227	104,878	99,900	102,859	98,740	100,759	98,575	115,679	95,692	100,685	▲
		2021/22	107,722	107,968	116,384	110,363	100,058	113,754	109,723	122,437	101,578	111,187	104,505	117,562	116,384	110,363	▼
		Plan	100,706	107,832	105,830	114,652	105,352	115,462	118,571	119,109	106,070	124,296	112,035	124,572	105,830	114,652	▲
		2022/23	98,515	112,929	106,932	108,419									106,932	108,419	▲
		Plan vs 19/20	90%	91%	94%	91%	97%	99%	94%	99%	99%	99%	100%	127%	94%	91%	▼
		Actual vs 19/20	88%	96%	95%	86%									95%	86%	▼
	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance face to face	2019/20	51,475	54,896	51,896	58,785	50,590	53,547	59,012	55,351	47,696	56,151	50,485	41,422	51,896	58,785	▲
		2020/21	16,867	20,837	27,666	33,524	31,916	39,323	35,522	32,841	31,511	31,286	30,983	38,088	27,666	33,524	▲
		2021/22	37,558	38,554	45,507	43,126	39,488	42,997	42,093	45,919	38,752	42,336	39,574	44,748	45,507	43,126	▼
		Plan	38,673	41,386	41,511	44,067	41,413	44,502	47,680	47,174	41,579	48,111	44,105	46,627	41,511	44,067	▲
		2022/23	39,196	45,796	42,137	39,847									42,137	39,847	▼
		Plan vs 19/20	75%	75%	80%	75%	82%	83%	81%	85%	87%	86%	87%	113%	80%	75%	▼
		Actual vs 19/20	76%	83%	81%	68%									81%	68%	▼



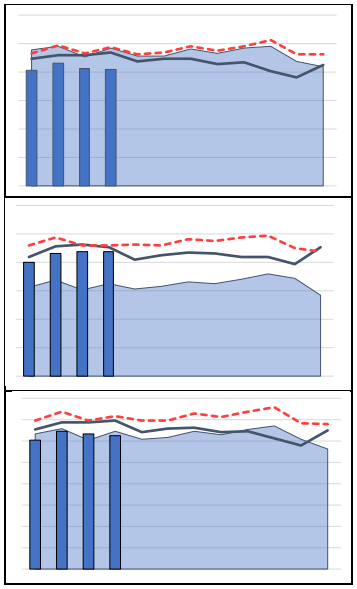
OUTPATIENTS	Outpatient attendances (all TFC; consultant and non consultant led) - First telephone or telemedicine consultation	2019/20	884	934	946	1,019	880	864	936	865	765	937	878	2,356	946	1,019	▲	
		2020/21	9,320	9,497	10,536	9,422	7,101	7,466	8,616	11,106	9,405	10,333	9,402	10,285	10,536	9,422	▼	
		2021/22	10,160	10,022	10,112	9,431	8,434	9,123	8,666	9,549	7,966	8,252	7,987	9,179	10,112	9,431	▼	
		Plan	9,757	10,751	10,312	11,304	10,419	11,048	11,807	11,815	10,475	12,292	11,079	11,281	10,312	11,304	▲	
		2022/23	7,661	8,673	8,072	7,516									8,072	7,516	▼	
		Plan vs 19/20	**1104%**	**1151%**	**1090%**	**1109%**	**1184%**	**1279%**	**1261%**	**1366%**	**1369%**	**1312%**	**1262%**	**479%**	**1090%**	**1109%**	▲	
		Actual vs 19/20	**867%**	**929%**	**853%**	**738%**									**853%**	**738%**	▼	
	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance face to face	2019/20	107,833	114,053	108,967	121,755	105,987	112,094	122,681	117,308	103,605	122,760	109,018	90,300	108,967	121,755	▲	
		2020/21	40,354	44,467	60,868	71,409	66,904	80,517	77,558	76,850	73,994	73,452	72,963	88,327	60,868	71,409	▲	
		2021/22	86,140	88,166	97,055	93,600	86,755	96,576	93,306	101,854	86,635	91,476	86,548	97,683	97,055	93,600	▼	
		Plan	73,508	77,759	75,999	80,413	74,688	79,826	84,015	83,425	73,853	87,962	79,275	88,930	75,999	80,413	▲	
		2022/23	84,509	93,590	87,081	86,858									87,081	86,858	▼	
		Plan vs 19/20	**68%**	**68%**	**70%**	**66%**	**70%**	**71%**	**68%**	**71%**	**71%**	**72%**	**73%**	**98%**	**70%**	**66%**	▼	
		Actual vs 19/20	**78%**	**82%**	**80%**	**71%**									**80%**	**71%**	▼	
	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up telephone or telemedicine consultation	2019/20	3,583	3,954	3,506	4,009	3,614	3,723	4,065	4,018	3,677	4,407	4,108	9,503	3,506	4,009	▲	
		2020/21	31,546	34,906	36,729	32,833	24,117	26,392	27,995	34,618	31,837	34,724	32,467	36,819	36,729	32,833	▼	
		2021/22	35,685	34,111	35,221	34,576	30,279	33,624	32,267	36,181	30,459	33,841	30,862	34,881	35,221	34,576	▼	
		Plan	30,105	32,879	32,050	34,454	32,972	34,787	36,960	37,411	33,736	39,902	35,501	39,108	32,050	34,454	▲	
		2022/23	29,182	33,452	30,442	28,989									30,442	28,989	▼	
		Plan vs 19/20	**840%**	**832%**	**914%**	**859%**	**912%**	**934%**	**909%**	**931%**	**917%**	**905%**	**864%**	**412%**	**914%**	**859%**	▼	
		Actual vs 19/20	**814%**	**846%**	**868%**	**723%**									**868%**	**723%**	▼	
	Total Outpatient attendances (all TFC; consultant and non consultant led) - Face to face	2019/20	159,308	168,949	160,863	180,540	156,577	165,641	181,693	172,659	151,301	178,911	159,503	131,722	160,863	180,540	▲	
		2020/21	57,221	65,304	88,534	104,933	98,820	119,840	113,080	109,691	105,505	104,738	103,946	126,415	88,534	104,933	▲	
		2021/22	123,698	126,720	142,562	136,726	126,243	139,573	135,399	147,773	125,387	133,812	126,122	142,431	142,562	136,726	▼	
		Plan	112,181	119,145	117,510	124,480	116,101	124,328	131,695	130,599	115,432	136,073	123,380	135,557	117,510	124,480	▲	
		2022/23	123,705	139,386	129,218	126,705									129,218	126,705	▼	
		Plan vs 19/20	**70%**	**71%**	**73%**	**69%**	**74%**	**75%**	**72%**	**76%**	**76%**	**76%**	**77%**	**103%**	**73%**	**69%**	▼	
		Actual vs 19/20	**78%**	**83%**	**80%**	**70%**									**80%**	**70%**	▼	
	Total outpatient attendances (all TFC; consultant and non consultant led) - Telephone/virtual	2019/20	4,467	4,888	4,452	5,028	4,494	4,587	5,001	4,883	4,442	5,344	4,986	11,859	4,452	5,028	▲	
		2020/21	40,866	44,403	47,265	42,255	31,218	33,858	36,611	45,724	41,242	45,057	41,869	47,104	47,265	42,255	▼	
		2021/22	45,845	44,133	45,333	44,007	38,713	42,747	40,933	45,730	38,425	42,093	38,849	44,060	45,333	44,007	▼	
		Plan	39,862	43,630	42,362	45,758	43,391	45,835	48,767	49,226	44,211	52,194	46,580	50,389	42,362	45,758	▲	
		2022/23	36,843	42,125	38,514	36,505									38,514	36,505	▼	
		Plan vs 19/20	**892%**	**893%**	**952%**	**910%**	**966%**	**999%**	**975%**	**1008%**	**995%**	**977%**	**934%**	**425%**	**952%**	**910%**	▼	
		Actual vs 19/20	**825%**	**862%**	**865%**	**726%**									**865%**	**726%**	▼	

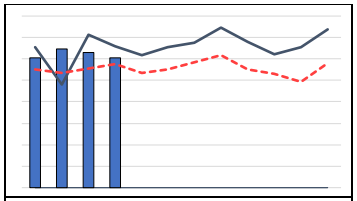
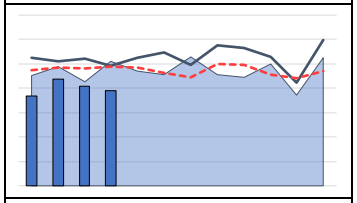
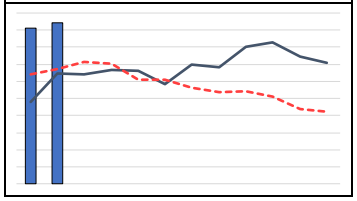
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				
ELECTIVES	DE - Day Case Elective	2019/20	13,574	14,274	13,446	15,181	13,640	14,177	15,353	14,796	13,024	15,202	13,710	11,028	13,446	15,181	▲	
		2020/21	4,125	5,601	8,296	10,726	10,293	11,976	12,084	12,507	12,468	11,268	11,595	13,502	8,296	10,726	▲	
		2021/22	12,379	11,494	12,125	11,782	10,415	11,528	11,531	12,607	10,905	11,554	11,284	12,378	12,125	11,782	▼	
		Plan	11,822	13,172	13,137	14,986	14,218	14,890	15,480	15,471	13,867	15,670	14,409	15,935	13,137	14,986	▲	
		2022/23	10,872	12,727	11,942	12,497									11,942	12,497	▲	
		Plan vs 19/20	87%	92%	98%	99%	104%	105%	101%	105%	106%	103%	105%	144%	98%	99%	▲	
		Actual vs 19/20	80%	89%	89%	82%									89%	82%	▼	
	IE - Inpatient Elective	2019/20	2,611	2,723	2,665	2,827	2,791	2,608	2,881	2,926	2,431	2,623	2,622	2,285	2,665	2,827	▲	
		2020/21	801	1,290	1,664	2,054	2,007	2,136	2,032	1,596	1,582	1,361	1,371	1,801	1,664	2,054	▲	
		2021/22	1,873	1,958	1,979	1,955	1,614	1,729	1,691	1,825	1,576	1,476	1,602	1,865	1,979	1,955	▼	
		Plan	1,971	2,235	2,388	2,666	2,657	2,704	2,883	3,032	2,573	2,671	2,779	2,976	2,388	2,666	▲	
		2022/23	1,715	2,280	2,198	2,019									2,198	2,019	▼	
		Plan vs 19/20	75%	82%	90%	94%	95%	104%	100%	104%	106%	102%	106%	130%	90%	94%	▲	
		Actual vs 19/20	66%	84%	82%	71%									82%	71%	▼	
	Total Elective Admissions	2019/20	16,185	16,997	16,111	18,008	16,431	16,785	18,234	17,722	15,455	17,825	16,332	13,313	16,111	18,008	▲	
		2020/21	4,926	6,891	9,960	12,780	12,300	14,112	14,116	14,103	14,050	12,629	12,966	15,303	9,960	12,780	▲	
		2021/22	14,252	13,452	14,104	13,737	12,029	13,257	13,222	14,432	12,481	13,030	12,886	14,243	14,104	13,737	▼	
		Plan	13,793	15,407	15,525	17,652	16,875	17,594	18,363	18,503	16,440	18,341	17,188	18,911	15,525	17,652	▲	
		2022/23	12,587	15,007	14,140	14,516	0	0	0	0	0	0	0	0	14,140	14,516	▲	
		Plan vs 19/20	85%	91%	96%	98%	103%	105%	101%	104%	106%	103%	105%	142%	96%	98%	▲	
		Actual vs 19/20	78%	88%	88%	81%	0%	0%	0%	0%	0%	0%	0%	0%	88%	81%	▼	
	RTT - Clock stops	2019/20	27,642	28,829	27,282	30,093	25,765	27,442	30,035	28,347	25,004	28,514	26,809	22,469	27,282	30,093	▲	
		2020/21	12,638	14,580	18,090	20,192	19,141	22,714	23,082	22,653	20,915	21,422	21,104	25,537	18,090	20,192	▲	
		2021/22	24,456	25,673	27,780	26,725	24,024	27,288	27,769	31,437	26,071	28,606	27,091	29,693	27,780	26,725	▼	
		Plan	29,357	31,242	30,939	35,494	31,850	33,653	37,093	36,293	32,557	37,814	35,069	35,389	30,939	35,494	▲	
		2022/23	26,519	26,519	29,825	29,825									29,825	29,825	▼▲	
		Plan vs 19/20	106%	108%	113%	118%	124%	123%	123%	128%	130%	133%	131%	158%	113%	118%	▲	
		Actual vs 19/20	96%	92%	109%	99%									109%	99%	▼	
	RTT Incomplete pathways	2019/20	85,565	95,238	96,319	96,979	98,176	97,636	97,368	96,283	96,899	95,777	96,157	94,760	96,319	96,979	▲	
		2020/21	90,579	88,030	90,090	94,617	99,428	103,521	108,999	114,168	120,683	121,377	122,332	128,734	90,090	94,617	▲	
		2021/22	133,890	139,801	143,499	147,480	149,026	151,724	155,745	155,489	155,766	156,866	158,188	162,678	143,499	147,480	▲	
		Plan	163,085	163,494	163,258	161,461	161,945	159,492	156,453	154,145	153,011	150,242	147,599	144,889	163,258	161,461	▼	
		2022/23	166,330	171,009	174,161	178,885									174,161	178,885	▲	
		Plan vs 19/20	191%	172%	169%	166%	165%	163%	161%	160%	158%	157%	153%	153%	169%	166%	▼	
		Actual vs 19/20	194%	180%	181%	184%									181%	184%	▲	
	RTT 52 Week wait	2019/20	203	195	227	268	368	349	345	328	281	301	237	288	227	268	▲	
		2020/21	618	1,228	2,166	3,124	3,942	4,796	5,972	7,413	8,626	9,856	11,665	12,916	2,166	3,124	▲	
		2021/22	11,918	10,809	10,378	10,705	11,256	12,140	12,829	12,524	12,807	12,808	12,939	13,650	10,378	10,705	▲	
		Plan	14,455	14,422	14,327	14,262	14,353	14,301	14,555	15,288	15,456	15,988	17,241	18,104	14,327	14,262	▼	
		2022/23	14,500	14,713	15,278	16,129									15,278	16,129	▲	
		Plan vs 19/20	7121%	7396%	6311%	5322%	3900%	4098%	4219%	4661%	5500%	5312%	7275%	6286%	6311%	5322%	▼	
		Actual vs 19/20	7143%	7545%	6730%	6018%									6730%	6018%	▼	
	RTT 78 Week wait	2019/20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2020/21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2021/22	2,191	2,570	2,811	3,246	3,912	4,274	3,971	3,540	3,680	3,794	3,876	3,976	2,811	3,246	▲	
		Plan	4,060	4,013	3,859	3,736	3,666	3,494	3,384	3,378	3,510	3,473	3,323	3,410	3,859	3,736	▼	
		2022/23	4,065	3,839	3,453	3,361									3,453	3,361	▼	
		Plan vs 19/20																
		Actual vs 19/20																
	RTT 104 Week wait	2019/20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2020/21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2021/22	106	164	237	334	440	582	794	955	1,123	1,318	1,454	1,478	237	334	▲	
		Plan	1,356	1,127	871	645	518	433	368	373	366	380	377	336	871	645	▼	
		2022/23	1,327	1,118	907	772									907	772	▼	
		Plan vs 19/20																
		Actual vs 19/20																

			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				
DIAGNOSTIC TESTS	MAGNETIC RESONANCE IMAGING	2019/20	5,655	5,705	5,423	6,099	5,773	5,682	6,128	6,040	5,517	5,939	5,755	4,902	5,423	6,099	▲	
		2020/21	2,281	3,112	4,389	5,491	4,864	4,848	4,982	4,784	4,947	4,701	4,794	5,607	4,389	5,491	▲	
		2021/22	4,856	5,069	5,006	5,010	5,498	5,959	6,475	6,232	5,424	6,103	5,889	6,478	5,006	5,010	▲	
		Plan	5,984	6,218	6,085	6,317	6,278	6,148	6,102	6,200	5,873	6,034	5,862	6,434	6,085	6,317	▲	
		2022/23	5,593	6,192	5,806	5,941									5,806	5,941	▲	
		Plan vs 19/20	106%	109%	112%	104%	109%	108%	100%	103%	106%	102%	102%	131%	112%	104%	▼	
		Actual vs 19/20	99%	109%	107%	97%									107%	97%	▼	
	COMPUTED TOMOGRAPHY	2019/20	10,297	10,870	10,368	11,555	11,583	11,179	12,081	11,368	10,281	11,782	10,974	9,500	10,368	11,555	▲	
		2020/21	6,511	9,060	10,047	11,175	10,729	11,008	11,533	10,498	10,238	10,930	10,398	11,643	10,047	11,175	▲	
		2021/22	10,996	11,366	11,526	11,794	10,868	11,528	11,667	12,074	11,721	12,754	12,041	13,770	11,526	11,794	▲	
		Plan	12,528	13,173	12,590	12,934	12,974	13,036	12,903	12,949	12,175	12,422	12,071	12,805	12,590	12,934	▲	
		2022/23	12,281	13,296	12,397	12,271									12,397	12,271	▼	
		Plan vs 19/20	122%	121%	121%	112%	112%	117%	107%	114%	118%	105%	110%	135%	121%	112%	▼	
		Actual vs 19/20	119%	122%	120%	106%									120%	106%	▼	
	NON-OBSTETRIC ULTRASOUND	2019/20	11,040	12,078	11,148	12,063	11,398	11,659	12,760	12,334	10,009	12,071	11,095	8,920	11,148	12,063	▲	
		2020/21	4,357	6,111	8,783	9,794	8,249	9,271	9,153	9,005	8,414	8,458	8,314	9,906	8,783	9,794	▲	
		2021/22	9,521	10,006	10,662	10,274	8,883	10,196	10,279	10,592	9,053	10,230	9,353	10,033	10,662	10,274	▼	
		Plan	9,982	10,954	10,684	10,944	11,092	11,347	11,186	11,368	10,407	10,808	10,432	11,398	10,684	10,944	▲	
		2022/23	8,789	10,920	10,363	9,993									10,363	9,993	▼	
		Plan vs 19/20	90%	91%	96%	91%	97%	97%	88%	92%	104%	90%	94%	128%	96%	91%	▼	
		Actual vs 19/20	80%	90%	93%	83%									93%	83%	▼	
	CARDIOLOGY - ECHOCARDIOGRAPHY	2019/20	2,818	3,264	3,079	3,480	3,220	3,421	3,727	3,562	3,150	3,675	4,314	2,803	3,079	3,480	▲	
		2020/21	1,075	1,949	2,565	2,987	2,716	2,890	2,482	2,454	3,159	2,810	2,889	3,180	2,565	2,987	▲	
		2021/22	3,181	3,090	3,156	3,057	2,884	3,116	3,025	3,226	2,259	3,148	2,989	3,464	3,156	3,057	▼	
		Plan	3,246	3,422	3,417	3,226	3,395	3,582	3,412	3,481	3,157	3,171	3,158	3,569	3,417	3,226	▼	
		2022/23	3,280	3,545	3,338	3,365									3,338	3,365	▲	
		Plan vs 19/20	115%	105%	111%	93%	105%	105%	92%	98%	100%	86%	73%	127%	111%	93%	▼	
		Actual vs 19/20	116%	109%	108%	97%									108%	97%	▼	
	COLONOSCOPY	2019/20	1,215	1,253	1,191	1,400	1,172	1,281	1,372	1,402	1,243	1,423	1,387	1,144	1,191	1,400	▲	
		2020/21	100	138	524	838	757	826	892	903	854	888	1,036	1,158	524	838	▲	
		2021/22	917	945	1,128	1,093	1,037	975	1,047	1,200	1,035	1,137	1,067	1,113	1,128	1,093	▼	
		Plan	997	1,029	1,035	1,218	1,154	1,242	1,367	1,323	1,253	1,215	1,099	1,201	1,035	1,218	▲	
		2022/23	961	1,096	928	1,063									928	1,063	▲	
		Plan vs 19/20	82%	82%	87%	87%	98%	97%	100%	94%	101%	85%	79%	105%	87%	87%	▲	
		Actual vs 19/20	79%	87%	78%	76%									78%	76%	▼	
	FLEXI SIGMOIDOSCOPY	2019/20	635	656	570	642	634	615	656	703	626	653	609	433	570	642	▲	
		2020/21	42	116	281	391	379	361	356	404	381	308	386	483	281	391	▲	
		2021/22	395	377	396	439	386	413	402	423	374	439	385	395	396	439	▲	
		Plan	435	494	454	512	516	544	564	589	548	522	506	548	454	512	▲	
		2022/23	301	446	371	402									371	402	▲	
		Plan vs 19/20	69%	75%	80%	80%	81%	88%	86%	84%	88%	80%	83%	127%	80%	80%	▲	
		Actual vs 19/20	47%	68%	65%	63%									65%	63%	▼	
	GASTROSCOPY	2019/20	1,534	1,503	1,536	1,688	1,588	1,507	1,539	1,746	1,555	1,680	1,583	1,257	1,536	1,688	▲	
		2020/21	156	257	915	1,044	1,010	1,277	1,166	1,178	1,185	1,129	1,188	1,465	915	1,044	▲	
		2021/22	1,394	1,298	1,436	1,503	1,383	1,376	1,322	1,465	1,326	1,376	1,286	1,382	1,436	1,503	▲	
		Plan	1,327	1,314	1,369	1,468	1,265	1,444	1,442	1,448	1,410	1,496	1,353	1,503	1,369	1,468	▲	
		2022/23	1,252	1,463	1,423	1,525									1,423	1,525	▲	
		Plan vs 19/20	87%	87%	89%	87%	80%	96%	94%	83%	91%	89%	85%	120%	89%	87%	▼	
		Actual vs 19/20	82%	97%	93%	90%									93%	90%	▼	
	TOTAL SCOPES	2019/20	3,384	3,412	3,297	3,730	3,394	3,403	3,567	3,851	3,424	3,756	3,579	2,834	3,297	3,730	▲	
		2020/21	298	511	1,720	2,273	2,146	2,464	2,414	2,485	2,420	2,325	2,610	3,106	1,720	2,273	▲	
		2021/22	2,706	2,620	2,960	3,035	2,806	2,764	2,771	3,088	2,735	2,952	2,738	2,890	2,960	3,035	▲	
		Plan	2,759	2,837	2,858	3,198	2,935	3,230	3,373	3,360	3,211	3,233	2,958	3,252	2,858	3,198	▲	
		2022/23	2,514	3,005	2,722	2,990									2,722	2,990	▲	
		Plan vs 19/20	82%	83%	87%	86%	86%	95%	95%	87%	94%	86%	83%	115%	87%	86%	▼	
		Actual vs 19/20	74%	88%	83%	80%									83%	80%	▼	
	TOTAL DIAGNOSTICS	2019/20	33,194	35,329	33,315	36,927	35,368	35,344	38,263	37,155	32,381	37,223	35,717	28,959	33,315	36,927	▲	
		2020/21	14,522	20,743	27,504	31,720	28,704	30,481	30,564	29,226	29,178	29,224	29,005	33,442	27,504	31,720	▲	
		2021/22	31,260	32,151	33,310	33,170	30,939	33,563	34,217	35,212	31,192	35,187	33,010	36,635	33,310	33,170	▼	
		Plan	34,499	36,604	35,634	36,619	36,674	37,343	36,976	37,358	34,823	35,668	34,481	37,458	35,634	36,619	▲	
		2022/23	32,457	36,958	34,626	34,560									34,626	34,560	▼	
		Plan vs 19/20	104%	104%	107%	99%	104%	106%	97%	101%	108%	96%	97%	129%	107%	99%	▼	
		Actual vs 19/20	98%	105%	104%	94%									104%	94%	▼	

			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				
A&E	TYPE 1 & 2	2019/20	28,522	30,086	28,559	29,922	29,139	28,329	27,862	26,878	26,935	26,021	24,551	20,546	28,559	29,922	▲	
		2020/21	14,502	20,922	22,659	26,096	27,714	25,599	23,510	21,040	21,257	18,958	18,367	23,647	22,659	26,096	▲	
		2021/22	25,613	28,472	29,187	28,481	27,375	27,163	27,059	24,630	23,143	22,929	22,158	25,177	29,187	28,481	▼	
		Plan	27,063	28,885	28,014	29,471	28,476	27,655	27,614	26,239	26,524	25,872	24,375	25,180	28,014	29,471	▲	
		2022/23	24,641	26,756	25,790	25,874									25,790	25,874	▲	
		Plan vs 19/20	**95%**	**96%**	**98%**	**98%**	**98%**	**98%**	**99%**	**98%**	**98%**	**99%**	**99%**	**123%**	**98%**	**98%**	▲	
		Actual vs 19/20	**86%**	**89%**	**90%**	**86%**									**90%**	**86%**	▼	
	TYPE 3 & 4	2019/20	9,256	9,832	9,552	11,599	10,485	8,873	8,681	8,554	8,041	8,524	8,265	6,118	9,552	11,599	▲	
		2020/21	2,865	3,958	2,469	6,265	7,230	6,638	6,410	3,504	3,057	2,494	2,431	3,434	2,469	6,265	▲	
		2021/22	6,183	6,687	7,451	7,461	7,329	6,864	5,765	5,449	5,044	5,036	4,658	5,714	7,451	7,461	▲	
		Plan	7,558	8,119	7,962	8,841	8,382	7,485	6,915	6,784	6,438	6,649	6,514	6,282	7,962	8,841	▲	
		2022/23	4,996	5,810	6,332	6,980									6,332	6,980	▲	
		Plan vs 19/20	**82%**	**83%**	**83%**	**76%**	**80%**	**84%**	**80%**	**79%**	**80%**	**78%**	**79%**	**103%**	**83%**	**76%**	▼	
		Actual vs 19/20	**54%**	**59%**	**66%**	**60%**									**66%**	**60%**	▼	
	TOTAL A&E ATTENDANCES	2019/20	37,778	39,918	38,111	41,521	39,624	37,202	36,543	35,432	34,976	34,545	32,816	26,664	38,111	41,521	▲	
		2020/21	17,367	24,880	25,128	32,361	34,944	32,237	29,920	24,544	24,314	21,452	20,798	27,081	25,128	32,361	▲	
		2021/22	31,796	35,159	36,638	35,942	34,704	34,027	32,824	30,079	28,187	27,965	26,816	30,891	36,638	35,942	▼	
		Plan	34,621	37,004	35,976	38,312	36,858	35,140	34,529	33,023	32,962	32,521	30,889	31,462	35,976	38,312	▲	
		2022/23	29,637	32,566	32,122	32,854									32,122	32,854	▲	
		Plan vs 19/20	**92%**	**93%**	**94%**	**92%**	**93%**	**94%**	**94%**	**93%**	**94%**	**94%**	**94%**	**118%**	**94%**	**92%**	▼	
		Actual vs 19/20	**78%**	**82%**	**84%**	**79%**									**84%**	**79%**	▼	

NON ELECTIVE	+1 LENGTH OF STAY	2019/20	9,562	9,786	9,029	9,693	9,112	9,129	9,602	9,321	9,680	9,820	8,752	8,377	9,029	9,693	▲
		2020/21	5,932	7,400	7,910	8,511	8,620	8,761	9,058	8,153	8,471	8,252	7,853	9,008	7,910	8,511	▲
		2021/22	8,911	9,160	9,168	9,382	8,766	8,956	8,951	8,563	8,691	8,043	7,652	8,491	9,168	9,382	▲
		Plan	9,333	9,872	9,309	9,731	9,270	9,339	9,774	9,513	9,822	10,211	9,213	9,216	9,309	9,731	▲
		2022/23	8,111	8,606	8,253	8,165									8,253	8,165	▼
		Plan vs 19/20	**98%**	**101%**	**103%**	**100%**	**102%**	**102%**	**102%**	**102%**	**101%**	**104%**	**105%**	**110%**	**103%**	**100%**	▼
		Actual vs 19/20	**85%**	**88%**	**91%**	**84%**									**91%**	**84%**	▼
	ZERO DAY LENGTH OF STAY	2019/20	3,129	3,373	3,032	3,257	3,065	3,167	3,314	3,244	3,421	3,593	3,431	2,865	3,032	3,257	▲
		2020/21	2,087	2,875	3,070	3,537	3,497	3,804	3,546	3,223	3,297	3,008	3,087	3,983	3,070	3,537	▲
		2021/22	4,177	4,563	4,615	4,531	4,109	4,242	4,339	4,305	4,199	4,191	3,930	4,530	4,615	4,531	▼
		Plan	4,610	4,866	4,592	4,588	4,622	4,596	4,806	4,750	4,883	4,923	4,491	4,381	4,592	4,588	▼
		2022/23	4,006	4,311	4,380	4,365									4,380	4,365	▼
		Plan vs 19/20	**147%**	**144%**	**151%**	**141%**	**151%**	**145%**	**145%**	**146%**	**143%**	**137%**	**131%**	**153%**	**151%**	**141%**	▼
		Actual vs 19/20	**128%**	**128%**	**144%**	**134%**									**144%**	**134%**	▼
	TOTAL NON ELECTIVES	2019/20	12,691	13,159	12,061	12,950	12,177	12,296	12,916	12,565	13,101	13,413	12,183	11,242	12,061	12,950	▲
		2020/21	8,019	10,275	10,980	12,048	12,117	12,565	12,604	11,376	11,768	11,260	10,940	12,991	10,980	12,048	▲
		2021/22	13,088	13,723	13,783	13,913	12,875	13,198	13,290	12,868	12,890	12,234	11,582	13,021	13,783	13,913	▲
		Plan	13,943	14,738	13,901	14,319	13,892	13,935	14,580	14,263	14,705	15,134	13,704	13,597	13,901	14,319	▲
		2022/23	12,117	12,917	12,633	12,530									12,633	12,530	▼
		Plan vs 19/20	**110%**	**112%**	**115%**	**111%**	**114%**	**113%**	**113%**	**114%**	**112%**	**113%**	**112%**	**121%**	**115%**	**111%**	▼
		Actual vs 19/20	**95%**	**98%**	**105%**	**97%**									**105%**	**97%**	▼



CANCER	CANCER 28 DAY FASTER DIAGNOSIS	2019/20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2020/21	0	0	0	5,286	5,054	5,739	5,344	5,524	4,993	4,965	5,109	6,647	0	5,286	▲	
		2021/22	6,566	4,822	7,125	6,614	6,188	6,562	6,751	7,477	6,803	6,207	6,539	7,403	7,125	6,614	▼	
		Plan	5,521	5,342	5,566	5,757	5,348	5,516	5,861	6,169	5,498	5,300	4,949	5,795	5,566	5,757	▲	
		2022/23	6,035	6,475	6,312	6,054									6,312	6,054	▼	
		Plan vs 19/20																
		Actual vs 19/20																
	CANCER TREATEMENT VOLUMES (31 DAY FIRST)	2019/20	903	973	855	1,018	937	914	1,059	912	886	1,000	746	1,052	855	1,018	▲	
		2020/21	710	614	731	737	807	921	714	752	792	720	719	859	731	737	▲	
		2021/22	1,047	1,020	1,044	987	1,047	1,092	993	1,149	1,128	1,056	843	1,197	1,044	987	▼	
		Plan	944	968	961	975	970	924	886	999	989	910	883	940	961	975	▲	
		2022/23	733	876	818	778									818	778	▼	
		Plan vs 19/20	**105%**	**99%**	**112%**	**96%**	**104%**	**101%**	**84%**	**110%**	**112%**	**91%**	**118%**	**89%**	**112%**	**96%**	▼	
		Actual vs 19/20	**81%**	**90%**	**96%**	**76%**									**96%**	**76%**	▼	
	PATIENTS WAITING 63+DAYS AFTER REFERRAL (62 DAY URGENT)	2019/20													0	0	▼▲	
		2020/21													0	0	▼▲	
		2021/22	479	645	642	665	659	582	697	684	801	826	745	709	642	665	▲	
		Plan	639	674	713	704	608	611	563	534	544	513	437	422	713	704	▼	
		2022/23	910	940														
		Plan vs 19/20																
		Actual vs 19/20																

Board Meeting

NHS Devon (ICB) Finance Report Month 5

Date of committee	Date report produced
19th October 2022	10th October 2022

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	John Dowell Director of Finance
Phone:	07825 027569	**Date:**	10th October 2022
Email:	kevin.wheller@nhs.net		John.dowell@nhs.net

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

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

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

The report details the ICB financial position for the period ended 31st August 2022, setting out the year to date and forecast financial position as well as the risks to deliver a break-even plan.

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

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
The Board is requested to: Consider, review and discuss the ICB financial position as at the period ended 31st August 2022.

Impact on NHS Devon objectives	
Objective	**Impact**

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

NHS Devon ICB Finance Report

Month 5 – 31st August 2022

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

Executive Summary

- The position to Month 5 includes the final reported position of the NHS Devon CCG to the 30th June 2022.
- Based on the year to date position the ICB is expecting to meet its target of break even for the year.
- The delivery of savings and efficiencies is off plan at month 5 by £3.2m, driven by a slower than expected delivery of savings linked to placements and targets associated with the recovery programme that has yet to take shape.
- Savings plans are forecast to deliver to target by 31st March 2023 and actions are being taken to improve the delivery going forward.
- The ICB risk profile has changed from month 4 due to expected non-recurrent flexibilities resulting in net risks to delivery totalling £3m.

Summary Financial Performance

Service	Year to date				Forecast			M4 YTD Variance £000
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000		Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	
Acute	497,802	497,201	600	↑	1,194,778	1,194,596	182	138
Mental Health	111,212	109,614	1,599	↓	266,960	267,308	(348)	2,034
Community Health	128,115	124,110	4,005	↓	308,042	304,232	3,811	4,229
Continuing Care	60,411	60,820	(410)	↓	145,063	145,063	(0)	765
Primary Care	190,066	187,346	2,719	↑	454,457	451,282	3,175	2,189
Other Programme	17,823	17,733	91	↓	42,248	43,229	(981)	166
Total Commissioned Services	**1,005,429**	**996,825**	**8,604**	↓	**2,411,548**	**2,405,710**	**5,838**	**9,519**
Running Costs	9,748	9,418	329	↑	22,919	23,976	(1,057)	219
Net Expenditure	**1,015,177**	**1,006,243**	**8,934**	↓	**2,434,467**	**2,429,686**	**4,781**	**9,739**
Reserves/Contingencies	1,700	10,634	(8,934)	↓	25,870	30,652	(4,781)	1,688
Tptal Net Expenditure	**1,016,877**	**1,016,877**	**(0)**	↓	**2,460,337**	**2,460,337**	**(0)**	**11,427**
Resource Allocation	(1,016,877)	(1,016,877)	0	→	(2,460,337)	(2,460,337)	0	0
CCG/ICB Transitional Budget Profiling		0	0	↑	0	0		(11,427)
Total Commissioned Services	**(0)**	**0**	**(0)**	↑	**(0)**	**0**	**(0)**	**(0)**

Summary Financial Performance

- The position to Month 5 and for the year ending 31st March 2023 includes the final reported position of NHS Devon CCG to the 30th June 2022.
- The over and underspends by service are as a result of the requirement to produce a 3 month set of accounts for the CCG against a budget that was not profiled to reflect the actual expenditure incurred in that period.
- The budget profile will be reviewed and finalised in month 6, providing a clearer picture of the ICB variances.
- Despite this based on the year to date position the ICB is expecting to meet its target of break even for the year.

Savings and Efficiencies

Scheme	RAG Status	Rec/ Non-Rec	% of Budget	Year to date				Forecast			
				Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable/ (Adverse) £000		Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable/ (Adverse) £000	
Prescribing		R	2.7%	2,375	2,375	0	→	5,704	5,704	0	
Running Cost Inflation		R	2.3%	220	220	0	→	525	525	0	
Placements		R	3.7%	1,645	918	(727)	↑	3,945	3,945	0	
Primary Care Commissioning Review		R	0.8%	835	835	0	→	2,000	2,000	0	
Commissioning Review		R	0.8%	1,250	1,250	0	→	3,000	3,000	0	
Covid Reduction		NR	78.0%	1,500	1,500	0	→	3,600	3,600	0	
Acute		R	1.4%	325	325	0	→	784	784	0	
Unidentified		NR		660	0	(660)	↓	2,967	2,967	0	
SDF		NR	11.1%	1,334	1,250	(84)	↓	6,000	6,000	0	
Workstream stretch		NR		1,778		(1,778)	↓	8,000	8,000	0	
Total				**11,922**	**8,673**	**(3,249)**	↓	**36,525**	**36,525**	**0**	
Recurrent				6,650	5,923	(727)		15,958	15,958	0	
Non-Recurrent				5,272	2,750	(2,522)		20,567	20,567	0	
Total				**11,922**	**8,673**	**(3,249)**		**36,525**	**36,525**	**0**	

Savings and Efficiencies

- The majority of savings plans are delivering to plan as at Month 5.
- The Placements savings plan are currently reported as being off plan. The savings plan in this area focuses on reviews of high cost placements, timely post discharge assessments and reviews of personal health budgets. Currently actions taken to date are forecast to deliver £1.9m of the £3.9m target. Whilst savings in this area diminish as the year progresses, the team are confident that the planned actions will deliver the target.
- The ICB is in the process of engaging external assessment resource which is expected to realise financial benefits.
- The unidentified savings and workstream stretch target are linked to the recovery plan actions.
- The ICB has recently appointed a small team (funded by the Recovery Support Team) to instil pace and traction to the recovery plan and improve on the in-year financial benefit.

Risks and Mitigations

Headline	Description	M4 £000	M5 £000	Movement £000	Risk at Plan £000
CIP shortfall	Non-delivery of workstream stretch efficiency	8,000	8,000	0	8,000
CIP shortfall	Non-delivery of unidentified CIP	2,967	2,967	0	2,967
CIP shortfall	Partial delivery of SDF Review efficiency	3,000	3,000	0	3,000
Hospital discharge	Unable to manage costs of hospital discharge within budgets set	2,500	2,500	0	2,500
Prescribing prices	Increases in prescription drugs prices	1,500	1,500	0	1,500
Total Risk		**17,967**	**17,967**	**0**	**17,967**
Non-Recurrent flexibility	Release of balance sheet accruals	7,376	7,376	0	7,376
s256 funds	Use of s256 funding held by Local Authorities	2,500	2,500	0	2,500
Non-Recurrent flexibility	Other non-recurrent benefits		5,000	(5,000)	0
Total Mitigation		**9,876**	**14,876**	**(5,000)**	**9,876**
Net Risk		**8,092**	**3,092**	**5,000**	**8,092**

- The ICB risk profile has changed from month 4 due to expected non-recurrent flexibilities resulting in net risks to delivery totalling £3m.

Resource Allocation

Allocation Description	Year to date		
	CCG M1-3 £000	ICB M5 £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
Non-Recurrent Allocation	**19,798**	**134,468**	**154,266**
Total Allocation	**596,317**	**1,864,020**	**2,460,337**

Conclusion

- The ICB is expecting to deliver its target of break even for the year.
- The budget profile will be reviewed and finalised in month 6, providing a clearer picture of the ICB variances.

Other Financial Information

Statement of Financial Position	M5 £000
Property Plant Equipment	2,757
Intangible Assets	212
Non Current Assest	**2,969**
Inventories	896
Trade & Other Receivables - NHS	561
Trade & Other Receivables - Non NHS	7,242
Cash & Cash Equivalents	11,673
Current Assets	**20,373**
Total Assests	**23,343**
Trade & Other Payables - NHS	(2,778)
Trade & Other Payables - Non NHS	(132,539)
Other Liabilities	(3,505)
Borrowings / Cash in Transit	(4,985)
Current Liabilities	**(143,808)**
Total Assets Employed	**(120,465)**
General Fund	(120,465)
Total Taxpayers Equity	**(120,465)**

Better Payment Practice Code	M5	
	Number	£000
Non NHS Creditors - % of bills paid within target	99.71	99.51
NHS Creditors - % of bills paid within target	96.74	99.97

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

ICB Board

NHS Devon (ICS) Finance Report Month 5

Date of committee	Date report produced
19th October 2022	31st August 2022

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	John Dowell Director of Finance
Phone:	07825 027569	**Date:**	23rd September 2022
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 (ICS) financial position in this report seeks to provide the necessary assurance to the Integrated Care Board. The report details the ICS financial position for the period ended 31st August 2022 against the finance plan submitted on 20th June 2022, setting out the year to date and forecast financial position as well as the risks to delivery of an expected break-even position at system level.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Finance Committee on 5th October 2022 reviewed and approved the report. It identifies adverse variance to plan at end August of £3m. Year-end forecast is that the financial plan target will be met, but this requires mitigation of identified risk to delivery. Further assurance required on the mitigation which will be reported to the next meeting.

Key recommendations and actions requested
The ICB Board is requested to: Consider, review and discuss the ICS financial position as at the period ended 31st August 2022.

Impact on NHS Devon objectives	
Objective	**Impact**

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

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

NHS Devon ICS Finance Report

Month 5 – 31st August 2022

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

Executive Summary

- On 20th June 2022, Devon ICS submitted a deficit plan of £18.2m. There is a requirement that the system achieves a breakeven outturn by year end.
- For 22/23 the system has received a reduced COVID envelope from 21/22. Some COVID funding will be reimbursed on top of the system envelope, this includes spend on testing and vaccinations.
- Efficiency savings of £138.9m are required to meet the June plan.
- Elective Services Recovery Fund (ESRF) funding has been received by the system to deliver 104% of 19/20 elective activity. Delivering more / less than 104% will result in additional funding / clawback at 75% PBR value. (Outsourced activity is reimbursed at 100% subject to meeting 104% target).
- As at month 5 the Devon ICS is reporting year to date £14.6m deficit against a planned deficit of £11.6m – an adverse variance of £3m (M4 £0m).
- The reported forecast is a deficit of £18.2m which delivers to plan.

Executive Summary

- As at month 5 the Devon ICS had made efficiency savings of £35.3m (M4 £23.8m) This is £10.4m adverse to plan (M4 £6.8m).
- Forecast savings are adverse to plan by £16.7m. (M4 £12.5m)
- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of the deficit plan.
- As at Month 5 the net risk (excluding ESRF) has reduced to £66.8m. (M4 £79.8m)
- Limited data is available from central sources to confirm performance against ESRF, systems have been informed to assume no clawback for month 5 reporting.
- Internal ESRF data to July shows that although the system is not reaching the required 104% of 19/20 activity, ICB commissioned activity is ahead of plan as at July 2022 by £2.1m but NHSE commissioned activity is behind plan by £6.5m leaving a potential shortfall from plan of £4.4m.
- The month 5 position identifies risks and issues to be managed totalling £77.7m against an expectation of break-even. (M4 £90.7m)

Summary Financial Performance

Organisation	Year to date			Forecast		
	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000
Devon ICB	0	0	0	0	0	0
Royal Devon University NHS FT	(3,880)	(3,883)	(3)	(18,263)	(18,266)	(3)
University Hospitals Plymouth Trust	(4,077)	(4,077)	0	0	0	0
Torbay and South Devon NHS FT	(3,037)	(6,015)	(2,978)	69	69	0
Devon Partnership Trust	(582)	(583)	(1)	0	0	0
Total	**(11,576)**	**(14,558)**	**(2,982)**	**(18,194)**	**(18,197)**	**(3)**

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

Efficiency Plan 22/23

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

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

Efficiency Plan 22/23

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

Efficiency Plan 22/23

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

Efficiency Savings Delivery

Organisation	Year to date			Forecast		
	Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000	Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000
Devon ICB	11,922	8,673	(3,249)	36,525	36,525	0
Royal Devon University NHS FT	12,791	8,426	(4,365)	33,935	33,935	0
University Hospitals Plymouth Trust	7,507	9,538	2,031	29,592	29,592	0
Torbay and South Devon NHS FT	10,494	6,636	(3,858)	28,452	11,798	(16,654)
Devon Partnership Trust	3,045	2,067	(978)	10,358	10,358	0
Total	**45,759**	**35,340**	**(10,419)**	**138,862**	**122,208**	**(16,654)**

- As at month 5 the Devon ICS had made efficiency savings of £35.3m (M4 £25.4m) This is £10.4m adverse to plan. (M4 £8.6m).
- Forecast savings are adverse to plan by £16.7m (M4 £12.5m).

Summary financial risks against break-even requirement

Organisation	Summary Of Risks To Breakeven						
	Reported Surplus/ Deficit £000	CIP Risk £000	Other Risks £000	Mitigation £000	Variance Pre ESRF Favourable / (Adverse) £000	ESRF Risk £000	Variance Favourable/ (Adverse) £000	
Devon ICB	0	(13,967)	(4,000)	14,876	(3,092)	5,000	1,909	
Royal Devon University NHS FT	(18,263)	(2,725)	(8,067)	12,200	(16,855)	(9,733)	(26,588)	
University Hospitals Plymouth Trust	0	(12,500)	(6,400)	750	(18,150)	(5,000)	(23,150)	
Torbay and South Devon NHS FT	69	(14,700)	(7,265)	2,000	(19,896)	(1,136)	(21,032)	
Devon Partnership Trust	0	(5,360)	(5,930)	2,500	(8,790)	0	(8,790)	
Total	**(18,194)**	**(49,252)**	**(31,662)**	**32,326**	**(66,783)**	**(10,869)**	**(77,652)**	

- The month 5 position identifies risks and issues to be managed totalling £77.7m against an expectation of break-even. (M4 £90.7m).
- This is a risk of £59.5m against planned deficit of £18.2m.
- The £13m improvement from M4 is a result of a reduction of assessed unmitigated risk at TSD and the ICB.

Risks & Mitigations (Excluding ESRF)

Description	Net Weighted Risks & Mitigations						Net Risks at Plan £000
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000	
CIP shortfall	(13,967)	(2,725)	(12,500)	(14,700)	(5,360)	(49,252)	(47,817)
Planned Surplus/(Deficit)		(18,263)		69		(18,194)	(18,194)
Increase in inflation		(2,800)	(4,000)	(2,500)	(1,000)	(10,300)	(6,950)
Integrated care contract				(2,500)		(2,500)	(6,000)
Hospital discharge	(2,500)					(2,500)	(2,500)
High cost drugs not met by income		(2,900)	(1,500)	0		(4,400)	(2,314)
Clinical excellence awards			(900)	0		(900)	(1,665)
Specialist commisioning rebase					0	0	(1,500)
Prescribing prices	(1,500)					(1,500)	(1,500)
OOA and staffing support					(1,300)	(1,300)	(1,300)
IPP service growth					(1,250)	(1,250)	(1,250)
MHIS and SDF income risk					(1,200)	(1,200)	(1,200)
Other		(2,367)		(2,265)	(1,180)	(5,812)	(5,545)
Total Risk	**(17,967)**	**(29,055)**	**(18,900)**	**(21,896)**	**(11,290)**	**(99,108)**	**(97,735)**
Non-Recurrent flexibility	7,376	12,200	750	2,000	2,500	24,826	14,076
s256 funds/Other	7,500					7,500	2,500
Further Excess inflation funding						0	1,375
Total Mitigation	**14,876**	**12,200**	**750**	**2,000**	**2,500**	**32,326**	**17,951**
Net Risk	**(3,092)**	**(16,855)**	**(18,150)**	**(19,896)**	**(8,790)**	**(66,783)**	**(79,785)**

Risks & Mitigations (Excluding ESRF)

- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of the deficit plan.
- As at Month 5 the net risk has reduced to £66.8m. (M4 £79.8m)
- The main risks to be mitigated (in addition to the planned deficit of £18.2m) are
  - Shortfall on planned CIP delivery £49.3m (month 4 £52.4m)
  - Excess inflation costs above funded level £10.3m (month 4 £10.3m)
  - High cost drugs above funded level £4.4m (month 4 £5.1m)
- ESRF risk remains volatile, with confirmation that the clawback has been suspended for the first 6 months and ongoing discussion at national level regarding the remainder of the year. Assessed ESRF related risk is described in the next slide.

ESRF Performance/Risk

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

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

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

- Limited data is available from central sources to confirm performance against ESRF, systems have been informed to assume no clawback for month 5 reporting.
- Internal ESRF data to July shows that although the system is not reaching the required 104% of 19/20 activity, ICB commissioned activity is ahead of plan as at July 2022 by £2.1m but NHSE commissioned activity is behind plan by £6.5m leaving a potential shortfall from plan of £4.4m.
- The differential earning potential in the plan by provider is why the risk appears skewed.

Capital (CDEL)

Organisation	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Royal Devon University NHS FT	13,158	10,257	2,901	33,306	33,306	0
University Hospitals Plymouth Trust	5,640	2,119	3,521	24,080	24,080	0
Torbay and South Devon NHS FT	11,745	8,297	3,448	18,371	18,371	0
Devon Partnership Trust	2,742	1,626	1,116	7,448	7,448	0
Total	**33,285**	**22,299**	**10,986**	**83,205**	**83,205**	**0**

- System Capital spend is under plan at month 5 by £11.0m (M4 £9.7m)
- Forecast system capital spend is on plan as at M5.

Capital (Total)

Organisation	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Royal Devon University NHS FT	20,732	16,571	4,161	↑	50,562	51,133	(571)	↓
University Hospitals Plymouth Trust	10,099	3,368	6,731	↑	88,480	89,313	(833)	→
Torbay and South Devon NHS FT	12,323	11,736	587	↓	27,007	33,505	(6,498)	↑
Devon Partnership Trust	2,742	1,626	1,116	↓	7,448	8,073	(625)	↑
Total	**45,896**	**33,301**	**12,595**	↑	**173,497**	**182,024**	**(8,527)**	↓

- Total capital plan includes impact of IFRS16 - leases
- Total capital spend is under plan by £10.0m as at month 5. (M4 £10.0m)
- The forecast spend on capital by end March 2023 is over plan by £8.5m. (M4 £8.0m)
- The plan is fixed at submission and not updated as subsequent schemes are approved and PDC awarded. These schemes then show as an overspend.

Conclusion and Next Steps

- The operational financial plan submitted on 20th June 2022 recognised a significant delivery risk against the NHSE break-even expectation, valued at £95.9m (£77.7m against plan).
- At the end of month 5, this has improved by £18.2m and stands at £77.7m (£59.5m against plan)
- The most material items are shortfall against required CIP (£49.3m), eliminating the residual deficit at plan (£18.3m), excess inflation costs (£10.3m) and shortfall against ESRF required earnings (£10.9m)
- In addition to continuous drive to reduced CIP shortfall and ESRF related risks, the ICS is committed to delivering further mitigation through a Financial Recovery Plan, consisting of 14 workstreams.
- The ICB has recently appointed a small team (funded by the Recovery Support Team) to instil pace and traction to the recovery plan and improve on the in-year financial benefit.
- Whilst work continues to deliver recurrent financial improvement and to identify further non-recurrent mitigation, the system should continue to report delivery of the plan by year end.

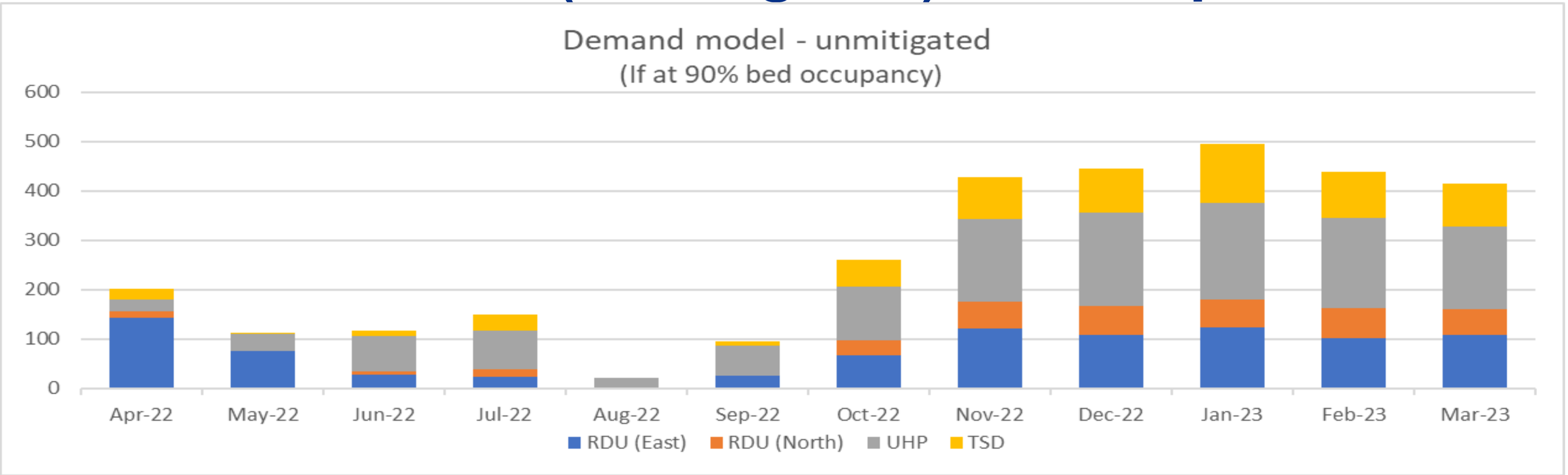
Winter Planning and Assurance

The Challenge Going into Winter

- **Covid surge – 3 weeks earlier than prediction (253 in Devon Hospitals @ 4/10)**
  - UHP 92 including 5 in Community Hospitals
  - TSD 78 including 7 in Community Hospitals
  - RDE 59 including 8 in Community Hospitals
  - ND 24

- **High Number of Patients with No Continuing Right to Reside in Hospital (237 @ 4/10)**
  - UHP 84 (10% of G&A beds) of which 41 are Cornwall residents
  - TSD 42 (12% of G&A beds)
  - RDE 87 (12% of G&A beds)
  - ND 42 (15% of G&A beds) and of which 6 are Cornwall residents
  - Target is to get down to at least 5% of G&A beds in each hospital
- 38% of Devon patients with no criteria to reside were discharged per day compared to 29% for the South West region

Modelled demand (unmitigated) – bed equivalents



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
UHP	26	34	71	79	21	60	108	167	188	195	184	166
TSD	21	2	11	32	-2	9	55	87	91	118	92	88
RDE	143	74	28	24	-8	25	66	121	108	122	102	107
NDHT	11	1	6	14	-6	1	31	54	58	59	60	54
Trust total	201	112	117	148	4	94	260	428	445	494	438	415

- The chart shows the expected level of demand in excess of the 90% bed occupancy level if there is no additional mitigation. Revised (27th Sept) to take into account latest covid predictions
- The level of demand is expected to increase as we enter the winter period linked to covid/ flu etc

Mitigation Action: Expanding Capacity for Winter

- Devon's Funding Allocation for 310 beds/equivalents £23.919m NRR

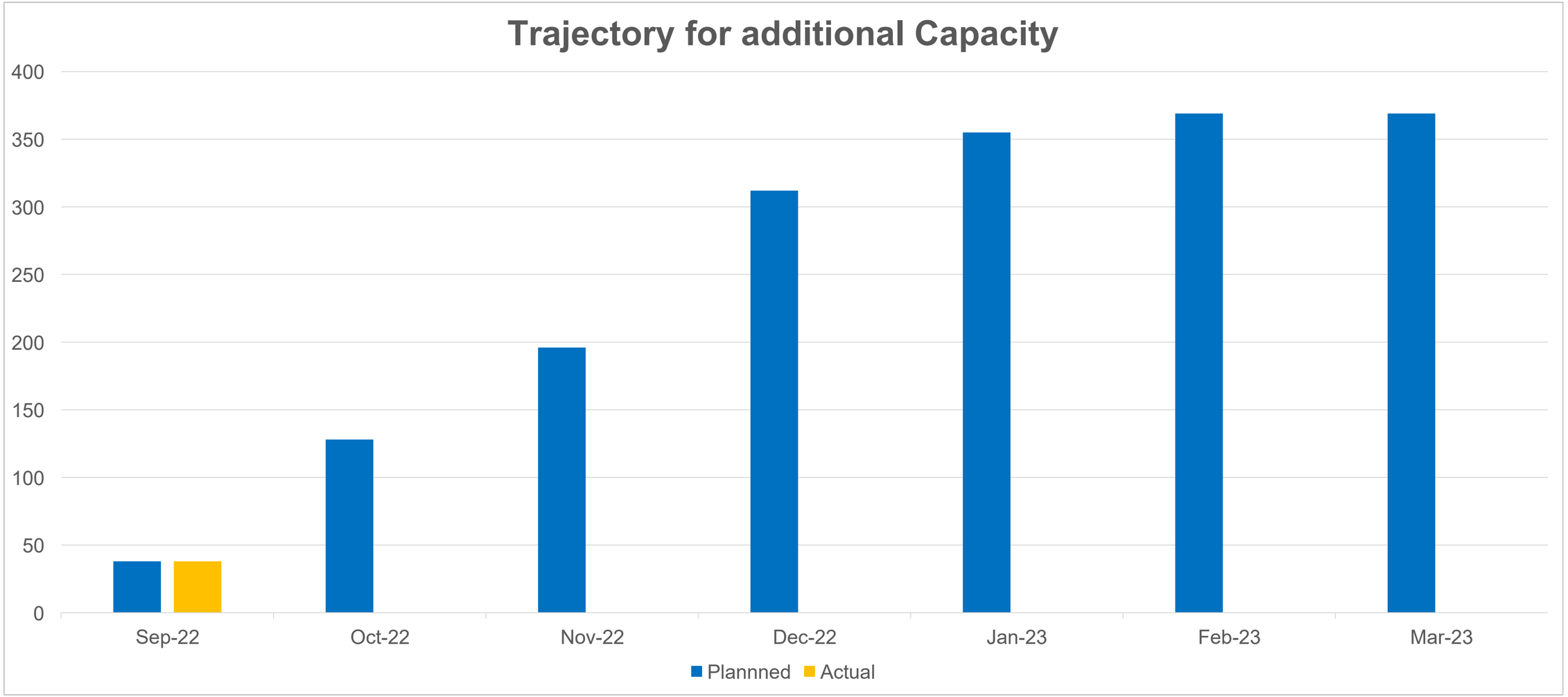
  105 beds less than the modelled capacity gap of 415 bed

- *Less Ringfenced Funding*
  - Western/UHP Ambulance Improvement Plan £ 5.069m

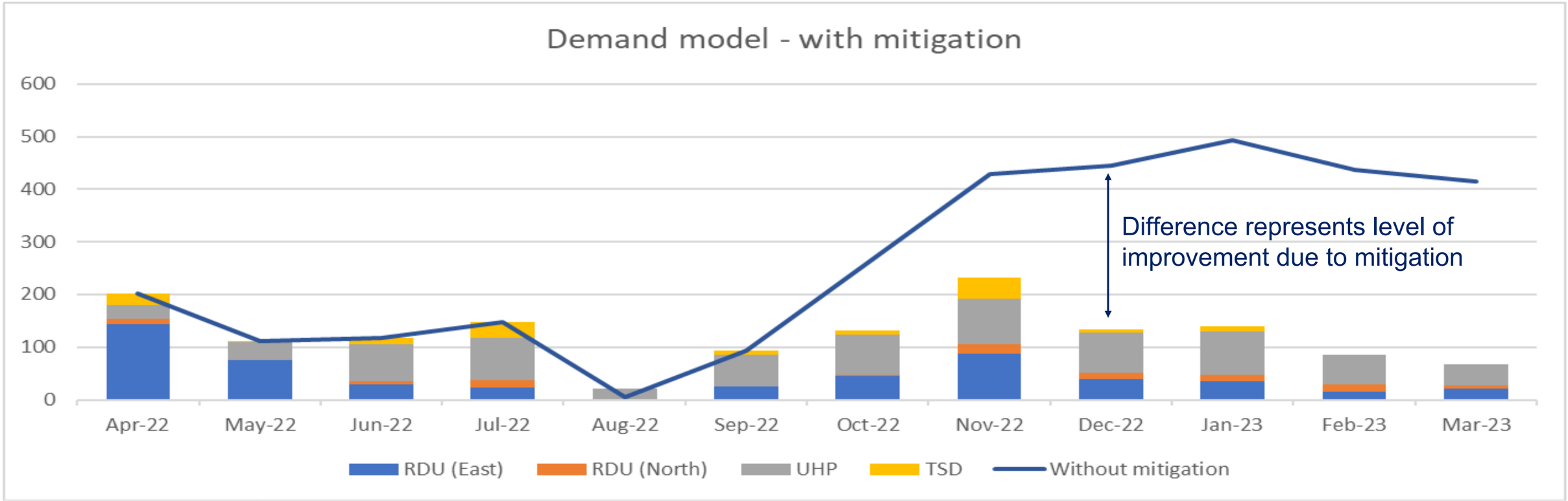
- Balance for Devon-wide Capacity Priorities **£18.85m**

  - Acute Escalation Beds + Flow capacity £6m
  - Extended Virtual Ward £2m
  - Enhanced Discharge capacity £8.85m
  - Mental Health Capacity £1m
  - IUCS/Vocare £0.916m

Trajectory for additional capacity



Modelled demand bed gap with mitigation



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RDU (East)	143	74	28	24	0	25	46	88	39	36	16	21
RDU (North)	11	1	6	14	0	1	1	18	11	12	13	7
UHP	26	34	71	79	21	60	76	85	77	82	57	40
TSD	21	2	11	32	0	9	9	41	5	9	0	0
Trust total	201	112	117	148	21	94	132	232	133	139	86	68

- The planned mitigation is expected to reduce the bed gap to relatively low levels by March 23
- The peak bed gap is expected in November when demand is high but not all mitigation is in place

Other Actions Agreed and Underway

Immediate:

- ✓ Ongoing System-wide Communications to the public (completed and ongoing)
- ✓ Short-term expansion of Ambulance catchment for RDUH (starting 10/10/022 to 7/11/2022)
  - Risk: Will reduce elective capacity to treat 104/78ww and Cancer
- Consistent Infection Protection and Control approach for Covid and Flu
- Locality/LA led deep dives to reduce No Criteria to Reside within each Hospital (already done for UHP) + system-level discussions with Cornwall system about No Criteria to Reside at UHP
- Development of an enhanced protocol for forecourt ambulance diverts
- Brought forward 8 of the additional Northern P2 Winter capacity beds into September

In Next 2 weeks

- Agreement of comparable measure of ED/Hospital Risk to support decisions on balancing risk across System, launching ‘Real Time’ UEC Dashboard, pre-agreed risk thresholds for action
- Acute Care Collaborative-led diagnostic to analyse the root cause of current performance
- Develop current ‘Tactical Team’ into ‘System Control Centre’ with Senior Clinical leadership for ‘least worst’ decisions

‘Battle Rhythm’ through Tactical Control Team

- Tactical Team co-ordinates data, assesses system risk and initiates mitigation actions and acts as single point of contract for escalation for Devon system - operates 8am to 6pm Mon-Friday and ICS on call rota for ICS Director and Manager so 24/7 ICS
- Daily meetings including:
  - Daily handovers to/from on call team
  - 8.20 Chief Operating Office Call
  - 11am Devon System Calls (7 days per week)
  - Further scheduled system calls as needed to manage risks
- Weekly System Flow meeting focused on hospital discharge
- Weekly Ambulance Cell Meetings to focus on handover improvement
- Fortnightly System Delivery and Improvement Group Meetings to oversee progress on improvement actions, winter planning/delivery and management of system-level operational risk.

Workforce Update for ICB Board

Paul Renshaw
Director of Strategic Workforce
October 2022

#OneDevon

Contents

- Industrial action update
- NHS pay & pensions update
- Cost of living update
- Workforce Strategy development update

Industrial Action Plans – Devon Approach Briefing

Introduction

- All of the main Trade Unions/Staff Side Organisations have indicated their intention to ballot their members with a view to taking industrial action (IA) in dispute of the pay award for 2022/23 agreed by the Government.

- This briefing provides an overview of the key points and considerations at the time of writing. It should be noted that further information and guidance is being prepared nationally.

Current Position

- RCN – Formal notification that their ballot will run from 06/10 - 02/11 they have identified in the ballot paper that they are balloting for ‘strike action’ and ‘not action short of a strike’ Should the RCN receive a mandate to take strike action they are proposing "to take discontinuous industrial action in the form of strike action on dates to be announced over the period from 17 November 2022 to 11 May 2023”.

- RCM, GMB, Unite and Societies of Radiographers and Physiotherapists - Consultative ballots expected late September (Trade unions sometimes hold 'consultative' or ' indicative' ballots asking members whether they might be prepared to take industrial action about a particular issue)

- Unison - planning ballot no date stated as yet

- BMA - likely to move to ballot no date stated as yet

National Coordination

- All of the above issues/considerations are being considered nationally DHSC, NHSE and NHS Employers working closely to develop with guidance, templates and documentation.
- They are working up operational plans which will flow through emergency planning/incident management response processes.
- Operational service guidance and checklists to be provided by October.
- Sitrep processes will be established, published in September.
- They are modelling impacts on outpatient, elective and A&E etc and impacts on service delivery.
- They are to establish communication channels.

Devon Position

- All trusts working with their EPPR teams to review operational impact and update will be provided towards end of October.
- TSDFT, UHP, Livewell have briefed their executives, DPT and RDU are about to brief their executives
- National list of exemptions – likely to be ED's and ITUs
- Current proposed position for EPPR is consideration of a 'Christmas day' service across all sectors within the system (NHS, Primary care and social care nursing) this is to be explored further as we gain more intelligence

Areas to consider

- Covid and flu impact on staff and operationally - need to be monitored and realised following ballot closure
- Bank and agency staffing shifts – cancellation rate and impact on trusts
- Impact on operational national targets such as elective recovery
- Impact on cost of living as strike is unpaid, therefore this may reduce number of people who undertake strike action

Next Steps

- Need to understand position for primary care and social care in more detail
- Await national templates and guidance before progressing Devon approach
- understand the impact on elective care - ie timeline to calculate once ballot results and action is confirmed, we will understand impact by xxxxx
- Develop a communication strategy to inform that strike pay is unpaid and provide an FAQ
- Agree a Devon approach to the unpaid element of strike and the impact on pay over a 24 hour period i.e someone works a night shift and at midnight goes on strike this would require payroll to adapt the pay
- Agree an approach regarding the impact of strike action on number of temporary staff and incentive pay current filled shifts
- Understand the impact on elective care - ie timeline to calculate once ballot results and action is confirmed, we will understand impact by first week of November following announcement of strike action and date of strike.

NHS Pay & Pension Update

NHS Pay & Pensions Update

- **NHS Pay Award – Key headlines**

- AfC pay award of minimum £1400 back-dated to April 22 (back -dated payments made in September salary-runs).
- Specific value of AfC pay award dependant upon AfC Banding - see table on next slide for detail.
- Qualified Doctors & Dentists pay award of 4.5% back dated to April 22.
- Recommended VSM pay award of 3.5% back-dated to April 22

- **Pension – Key headlines**

- Employee contributions for some bandings to increase wef October 22
- The NHS pension scheme continues to be one of the most comprehensive and generous schemes in the UK. The main features of the scheme are:
  - Contributions to the scheme are tax free, bringing down the cost of membership
  - Employers contribute 20.68% of your salary towards the cost of your pension
  - Pension benefits increase each year during retirement to help keep up with the rising cost of living
  - Options are available to increase your benefits and to retire flexibly, to suit your plans
  - Life Assurance providing a lump sum to nominated beneficiaries

Agenda for Change Pay Scales & Award

AfC Band	2021/22 Pay Scale £	2022/23 Pay Scale £	Pay Award % (Bottom of Band / Top of Band)
Band 2	18,546 – 19,918	20,270 – 21,318	9.3% / 7%
Band 3	20,330 – 21,777	21,730 – 23,177	6.9% / 6.4%
Band 4	22,549 – 24,882	23,949 – 26,282	6.2% / 5.6%
Band 5	25,655 – 31,534	27,055 – 32,934	5.5% / 4.4%
Band 6	32,306 – 39,027	33,706 – 40,588	4.3% / 4%
Band 7	40,057 – 45,839	41,659 – 47,672	4% / 4%
Band 8a	47,126 – 53,219	48,526 – 54,619	3% / 2.6%
Band 8b	54,764 – 63,862	56,164 – 65,262	2.6% / 2.2%
Band 8c	65,664 – 75,874	67,064 – 77,274	2.1% / 1.8%
Band 8d	78,192 – 90,387	79,592 – 91,787	1.8% / 1.6%
Band 9	93,735 – 108,075	95,135 – 109,475	1.5% / 1.3%

Pension Contribution Increases

- Pension Contributions up to 1st Oct 22

Tier	Pensionable pay (whole time equivalent) / earnings used to assess contribution rate	Contribution rate from 1st April 2015 – 30th September 2022
1	Up to £15,431.99	5.0%
2	£15,432 - £21,477.99	5.6%
3	£21,478 - £26,823.99	7.1%
4	£26,824 - £47,845.99	9.3%
5	£47,846 - £70,630.99	12.5%
6	£70,631 - £111,376.99	13.5%
7	£111,377 and over	14.5%

- Pension Contributions from 1st Oct 22

Salary Range	Contribution rate from 1st October 2022	Future Planned contribution rate (from 2023 tbc)
Up to £13,246	5.1%	5.2%
£13,247 - £16,831	5.7%	6.5%
£16,832 - £22,878	6.1%	6.5%
£22,879 - £23,948	6.8%	6.5%
£23,949 - £28,223	7.7%	8.3%
£28,224 - £29,179	8.8%	8.3%
£29,180 - £43,805	9.8%	9.8%
£43,806 - £49,245	10%	10.7%
£49,246 - £56,163	11.6%	10.7%
£56,164 - £72,030	12.5%	12.5%
£71,031 and above	13.5%	12.5%

Pension Changes Colleague Communication

- https://www.nhsbsa.nhs.uk/sites/default/files/2022-09/NHSPension_MemberContributions_ActiveLetter_0822.pdf
- https://youtu.be/0UoMVsDcajw

Cost of Living Summary

- Discussions with HRDs and Deputy HRDs are on-going to explore what can be considered to support staff
- Cost of travel to work can continue to be looked at
- Providers are planning for more staff choosing to come into the office this winter to reduce their heating costs at home – no agreement planned to pay for home working

Support in place

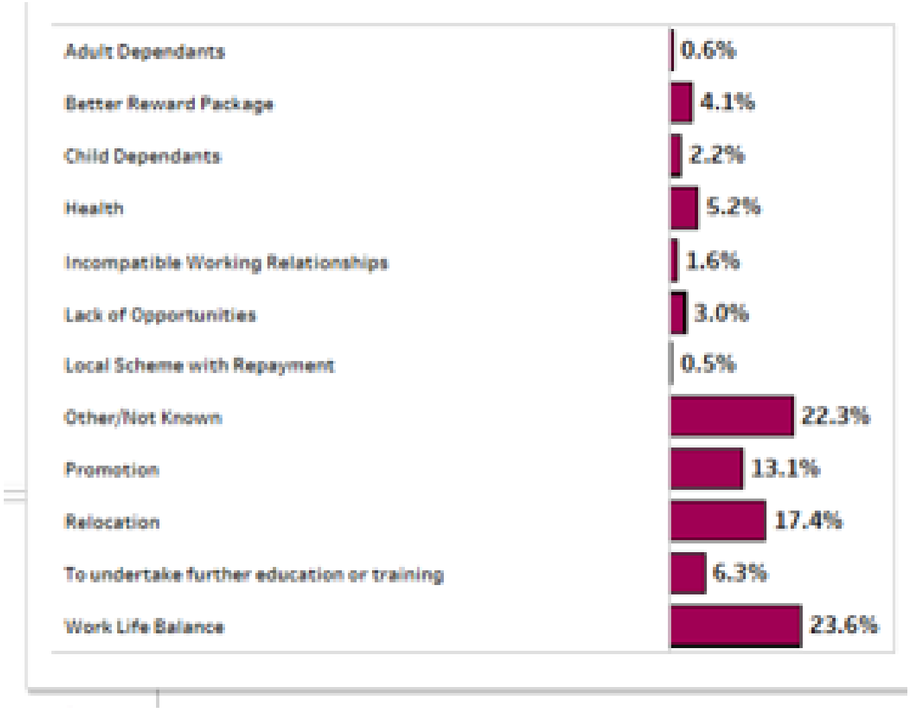
- Mileage rates – increased for the rest of the FY to ensure people aren't subsidising any business travel
- TSD has negotiated a higher discount rate on Stagecoach for travel to work – this has been shared with other providers with request for their rates to see if system can harmonise – UHP are also negotiating to match the rate
- Resources shared with staff on intranet sites – credit unions, free financial advice/seminars, guidance taken from NHS Employers, signposting to HWB support
- Promoted staff discounts using NHS 'Health Services Discounts'
- Providers have charities using food banks
- Single benefits platform showing all benefits in one place

Further support for staff

- Deputy HRDs group looking at travel to work options – Stagecoach
- Car parking – currently inconsistency around re-introduction of fees
- NHS discounts – blue light discounts extend to social care and ongoing work at national level

Leaver data – are staff leaving due to COL?

- NHS Devon staff survey on COL (1/3 completed it) with 71% saying COL was having a negative impact on them
- Reasons for leaving (HEE data for ICB) includes 70% due to resignation and 20% due to retirement (slide 4)
- From those who resign 4.1% are citing ‘Better Reward Package’ as a reason – this is an increase from 2.3% in the previous 12 months.
- Exit interview return rates are low which means we have limited reliable information for analysis
- From Retention project work at the start of the year primary data showed that pay began to appear as a reason why nursing staff leave – specifically for early stage career support to nursing and staff under aged 30.



NHS Devon Integrated Care Board (ICB) meeting

Better Care Fund (BCF)

Date of committee	Date report produced
19 October 2022	04 October 2022

Author(s)		Report approved by	
Name and title:	Dilek Hill Head of Strategic Planning	**Name and title:**	Simon Tapley, Chief Transformation & Strategic Planning Officer
Phone:		**Date:**	
Email:	Dilek.hill3@nhs.net		simon.tapley@nhs.net

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

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

The purpose of this report is to ask NHS Devon Integrated Care Board to note and endorse the three local Better Care Fund (BCF) annual plans for 2022/23.

BCF is the only mandatory policy to facilitate integration between Health and Social Care, providing a framework for joint planning and commissioning. The BCF brings together ring-fenced budgets from NHS allocations, ring-fenced BCF grants from Government, the Disabled Facilities Grant, and voluntary contributions from local government budgets. The Health and Wellbeing Board has oversight of the BCF and is accountable for its delivery.

National planning requirements for the BCF were published on 19 July 2022 by NHS England. The core requirements for this were:

- Submission of annual plan documents by 26 September 2022. NHS England will assure and approve the plans, writing to areas to confirm that the NHS minimum funding can be released. These letters are expected from 30 November 2022.
- A s.75 (NHS Act 2006) agreement between each HWB Board and NHS Devon (Integrated Care Board) to be completed by 31 December 2022. This agreement cannot be finalised until the annual BCF plan has been approved by NHS England.

In total, there are three BCF Plans submitted for Devon, one for each local area and as per the national planning requirements each plan includes:

- A narrative plan (headings as recommended by the planning requirements)
- A template spreadsheet plan
- A template spreadsheet plan for Capacity and Demand for Intermediate Care (new requirement for 2022/23)

These are embedded below. These plans will be monitored through the Local Care Partnerships and through System Delivery and Improvement Group (SDIG).

Committees that have previously discussed/agreed the report, and outcomes of that discussion
SET System Flow Meeting System Development and Improvement Group ICS Executive Committee

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. NHS Devon Integrated Care Board is asked to note and endorse the three local Better Care Fund (BCF) annual plans for 2022/23
2. NHS Devon Integrated Care Board are asked to note that NHS England will assure and approve the plans, writing to areas to confirm that the NHS minimum funding can be released by 30 November 2022.
3. NHS Devon Integrated Care Board are asked to note that a s.75 (NHS Act 2006) agreement between each HWB Board and NHS Devon (Integrated Care Board) to be completed by 31 December 2022 and that this is dependant upon plan approvals by NHS England.
4.

Impact on NHS Devon objectives	
Objective	**Impact**
Objective 1	

Objective 2	
Objective 3	
Objective 4	

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	Yes - A jointly agreed plan between local health and social care commissioners and signed off by the HWB, to include arrangements for joint commissioning, and an agreed approach for making progress towards the 2 policy objectives: - Enable people to stay well, safe and independent at home for longer. - Provide the right care in the right place at the right time. BCF plans should include stretching ambitions for improving outcomes against the national metrics. Plans will be developed locally in HWB areas by the relevant local authority and health commissioners
Health inequalities	
Workforce	
Resources and finance	Yes - NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Cover

Health and Wellbeing Board(s)

Devon County Council footprint, Devon Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

The basis of our strategic plan is our Devon ICS Community First Strategy, to which the BCF is an enabler. Bodies involved in the development of our strategic plan:

Devon County Council (DCC)

Torbay Council

Plymouth City Council (PCC)

NHS Devon

Royal Devon University Healthcare NHS Foundation Trust (RDU)

Torbay and South Devon NHS Foundation Trust (TSDFT)

Livewell Southwest (LWSW)

The Devon Primary Care Committee

Devon Partnership Trust (DPT)

University Hospitals Plymouth (UHP)

Devon Voluntary Community Social Enterprise (VCSE) Reference Group

The Mental Health and Learning Disability and Autism Provider Collaborative

North Devon Local Care Partnership Delivery group and Executive group

East Devon Local Care Partnership Delivery group and Executive group

South Devon Local Care Partnership Delivery group and Executive group

West Devon Local Care Partnership Delivery group and Executive group

Plymouth Devon Local Care Partnership Delivery group and Executive group

The Devon Virtual Voices Panel

University of Plymouth

How have you gone about involving these stakeholders?

Stakeholders have been involved in the development and adoption of the ICS Community First Strategy. They have been engaged through a series of meetings developing the draft plan and final adoption of the plan. Engagement meetings in each locality via the Local Care Partnership structure have taken place with representation from primary, community, acute, mental health, local authority and VCSE organisations; and focus groups have taken place to ensure public representation. The feedback from the engagement meetings has been reviewed and considered for inclusion within the strategy.

Through the weekly ICS System discharge and flow meetings we have engaged with acute and community colleagues in the design of our BCF planning metrics and at the bi-monthly System Delivery and Improvements Group where Trusts are represented at COO level.

The Devon Health and Wellbeing Board receive quarterly reports regarding the BCF including performance against the national metrics, rationale for planned spend; and examples of BCF investment and the impact that has had at service level.

Executive summary

This should include:

- *Priorities for 2022-23*
- *Key changes since previous BCF plan*

Since the previous BCF plan NHS Devon has become an Integrated Care System (ICS) which is a partnership of health and social care organisations who come together to improve the health, wellbeing, and care of people who live and work in Devon. This change took place on the 1st July 2022, whereby NHS Devon statutory body took on the commissioning functions that resided with NHS Devon CCG. As part of the Devon-wide system sign-off for the under the new Integrated Care System (ICS) governance framework, the BCF plans for each of the three Health and Wellbeing Boards will be reviewed and signed off by the NHS Devon ICB Executive Board.

One of the key system priorities for 2022/2023 remains urgent care and system flow given the current challenges being experienced within the urgent care system and the impact discharge has on wider system flow. The Devon BCF plan 2022/2023 responds to this with schemes that support targeted long-term investments to build sustainable community services for individuals on discharge across all care pathways with the aim to reduce pressure on urgent care through services that enable people to stay well, safe and independent at home for longer.

The Devon ICS Community First Strategy sets out our vision and direction of travel for community services over the next five years (2022 to 2027). It aims to define how community services will look different in the future in comparison to the current landscape across Devon today.

Community services play an important role in keeping people well and managing acute, physical, and mental health and long-term illness. The key focus of the Community First Strategy is on preventative, proactive and personalised care to support people to live as independently as possible with greater connection to their local community ensuring people spend more time at home, wherever their home may be, rather than in a hospital bed.

We want community services, including the voluntary sector, to be far more prominent in our system with well thought out planning regarding the steps we need to take to achieve the vision, co-production of services with our system stakeholders and the public, and in ensuring that they are adequately funded to sustain delivery and outcomes in the longer term.

Devon has a strong history of integrated working, and today several community services are now being provided by, or in partnership with, local acute trusts bringing many benefits to people, services, and the system. The recent procurement of an Integrated Care Partnership in Western Devon is an excellent example of the move towards organisations working in more and more integrated ways towards common goals. Our work towards integration thus far has improved collaboration between services, the opportunity for the standardisation of pathways which cuts across different sectors, and potential to use the workforce in a different way, providing better continuity of care for people. Future developments are likely to include extension of traditionally acute based specialists out into the community, bringing more of the medical expertise to support people in their own homes and out of a hospital setting.

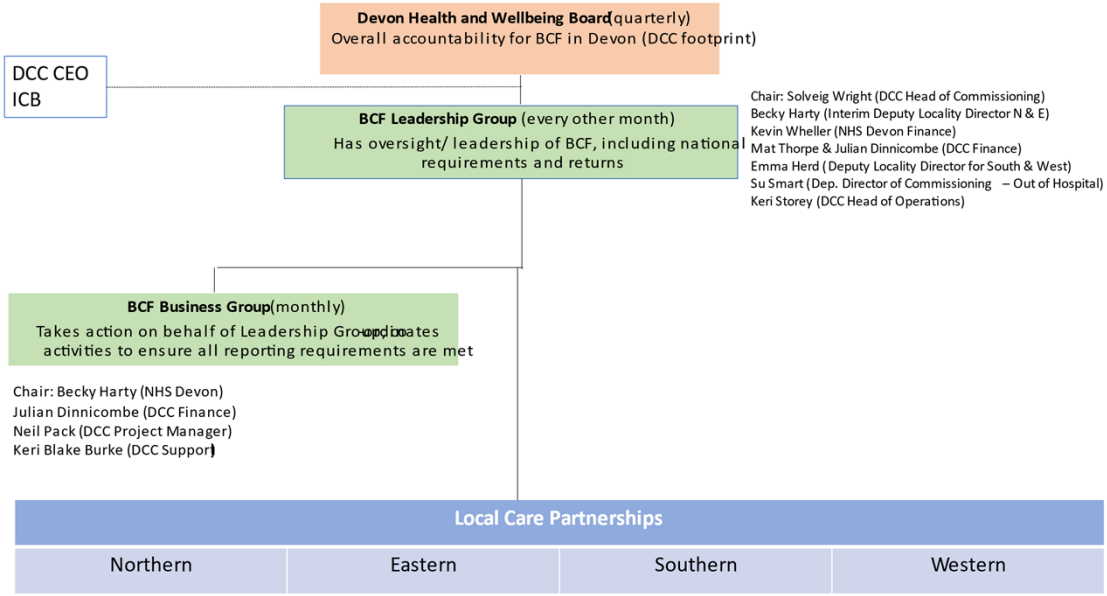
Whilst our history for integration is strong, is has not been delivered consistently across the county. This strategy describes our ambitions and visions at a system level in order that we can increase the consistency and equity of access, experience and outcomes for people using community services. Those ambitions will then be necessarily operationalised at a local level, such that they truly service their local population and make the best use of existing and future community assets (see 'next steps').

Integration is widely accepted and promoted as the methodology to move health and care services forwards, including within the most recent NHS white paper 'Health and Social Care Integration' (February 2022). We are now in a unique position to be able to understand and evaluate the different models of integration and to share learning about what works well in being able to meet the needs of the local population by focussing on care outside of the hospital setting. As the ICS evolves further it will be important for us to be able to demonstrate the financial benefits of integrated working and how this model supports the flow of activity away from the hospital and crisis-management services, and supports funding out into the community, to create a more robust and resilient offer.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Five localities have been established for the footprint of Devon ICS, four of these are within the DCC footprint. The governance of the DCC Better Care Fund is through the following structure:



Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- *Joint priorities for 2022-23*
- *Approaches to joint/collaborative commissioning*
- *How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.*

The BCF in 2022-2023 will continue to facilitate jointly commissioned arrangements in the DCC footprint:

- Carers; mental health; older people with mental health needs; learning disabilities; children and young people; older people with physical disabilities - mostly supported by joint teams and joint strategies.
- Joint delivery arrangements between the local authority and health providers with services focused on complex care teams to support people when they are most vulnerable, working closely with primary care using a strength-based approach. These are multi-disciplinary teams that focus on the frailest and most vulnerable, identified by risk stratification, with care coordinated around the individual. These services have been developed in local place and are designed to support people to remain safe, well and independent at home, as part of our collective home first approach.
- Tangible examples of jointly commissioned services, for example Integrated Children's Services; the Community Equipment Service; personal care; dementia support workers; rapid response; and social care reablement.
- Engagement between Devon County Council and eight district councils, for example in relation to Extra Care Housing, Disabled Facilities Grants and planning

Our aim in our Community First Strategy is that by 2027 we will be commissioning and delivering community services that:

1. Have adequate investment and are commissioned for outcomes that are important to the people using our services utilising data to build a deeper understanding of the value being delivered rather than solely guiding the decision making.
2. Encourage and enable people to be an active participant in their health and care when they are well, and equipping them with the skills, knowledge, technology, and confidence to better self-manage when they are unwell, so they can live well for as long as possible on their own terms, promoting People Led Change.
3. Deliver person-centred, coordinated care that focuses on people strengths and what matters to people.

4. Improve integration of workforce to enable greater collaborative working across organisational boundaries and the sharing of data across multiple systems via linked records, moving towards single records and plans of care that people can access and contribute to.

5. Build community capacity at neighbourhood level, informed by local needs so people have better access to the responsive services they require closer to home and at the time they need them.

6. Provide proactive, reliable, resilient, safe, and sustainable community services that support people to stay in their usual place of residence or stay there for as long as possible, avoiding unnecessary hospital admissions and accelerating discharges after an acute stay.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- ***Enable people to stay well, safe and independent at home for longer***
- ***Provide the right care in the right place at the right time***

Please use this section to outline, for each objective:

- *The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care*
- *How BCF funded services will support delivery of the objective*

  Plans for supporting people to remain independent at home for longer should reference
- *steps to personalise care and deliver asset-based approaches*
- *implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches*
- *multidisciplinary teams at place or neighbourhood level.*

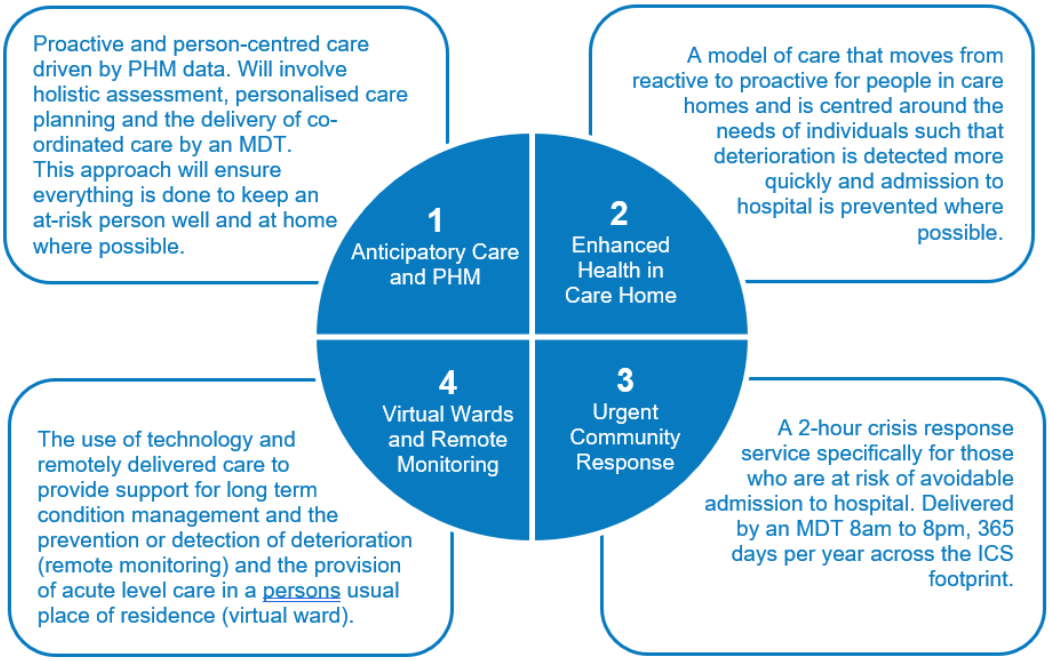
  Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:
- *Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.*
- *Carry out collaborative commissioning of discharge services to support this.*

  Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

The ten components of our Community First strategy follows the ten areas of our Integrated Care framework which describes our approach in Devon to deliver truly integrated care in community services. The strategy itself forms the first component, being the map by which we will realise our vision and deliver integrated care across Devon ICS. As BCF is an enabler to this vision, investment will be particularly focused in 2022/2023 on the discharge to assess model and more appropriate use of capacity for integrated community-based health, social care, and mental health services, with a greater focus on care closer to home, supported by timely discharge and virtual wards.

Our community approach to keeping people at home

The diagram below highlights four key areas which directly seek to keep people at home (in their usual place of residence) when it is safe to do so. This strategy aims to move us to a place where we can increasingly have the resource, infrastructure, and clinical skill to support people with higher acuity needs in the community. In addition to the programmes below, there are several more specific services areas that support the avoidance of unnecessary admissions for people. A good example of this currently is the Devon ICS End of Life review, of which a focus is on giving people the increased ability to die in their preferred place and reducing avoidable admissions.



The table below outlines our system approach to improving timely and safe discharges.

We know that every part of our community work must further the ambition of keeping people as home wherever possible and returning people to their homes following an inpatient stay as quickly as is safe to do so.

The table shows the different overarching elements of this work, the actions we will take to achieve them, and the related programmes and projects which will enable them to become a reality.

Element	Actions	Enablers
Understanding demand and supply	• Understanding projected need • Market availability, supply of care home support and care home beds • Admission avoidance • Community reablement • Capacity and case management	• Population health management • UCR 2-hour and 2-day • Anticipatory care • Virtual wards
Improvements to discharge practice	• Transfer of Care Quality Improvement Group • Trusted assessors • Locality improvement plans	• Population health management • UCR 2-hour and 2-day • Anticipatory care • Virtual wards
Capacity creation	• Market engagement and development • Market rates • Block purchase/ commissioning arrangements	• Personal health budgets • Complex care market development • Enhanced health in care homes • P2/short term bed configuration
Discharge to assess (DTA)	• Clear performance measures • Consistent process application across the ICS	• Strategic DTA review

Our priorities in 2022/23 align with the High Impact Change Model for which we have completed a self-assessment. We have adopted the national discharge to assess model across Devon and are monitoring the delivery of the time to transfer standards on a daily basis and working as a Devon system to share learning and make improvements where required through our System Flow programme. Through detailed analysis of daily performance, we recognise that our main challenges are with pathway 1- 3 discharges. Care market business continuity, workforce and market sufficiency are the key issues that we are grappling with. We are currently undertaking a piece of work, as one of the 10 points of the national 100 day challenge, to understand our discharge demand and capacity and are modelling this for each of our five localities. From this modelling work we are developing local plans for each area addressing; demand reduction for pathways 1-3, efficiencies within each pathway; and capacity creation for each discharge pathway.

We have engaged with the care market to listen to their experience of discharge and to act on these by co-producing a Transfers of Care Quality Improvement programme to improve discharge to care homes. We are utilising the learning from patient experience and PITCH reports received through the Patient Safety and Quality Teams to shape our improvement actions.

Through co-production with the Devon Care Home Collaborative, we are developing a shared workforce plan. Key projects include 'Proud to Care- shop-front for the sector in Devon, recruitment portal and information hub, 'LoveCare'- the purpose of this work is to build the case for improved investment in adult social care to reward and value the workforce, securing parity with the NHS and achieving sufficiency in the market. This will include consideration of potential for a minimum pay level for care workers, ESP-HASSP and Clinical Skills Expansion Programme.

We continue to focus on supporting early discharge planning by expanding the reach of the discharge hubs and proactively supporting people home from hospital, improving patient flow through the hospital, further developing a 'one team' approach, driving forward our plans for integration including the voluntary sector, mental health services and the independent sector and further developing the home first approach and maximising impact from the enhanced health in care homes workstream. This can be seen in our continued investments in such areas as:

- multi-agency discharge teams
- enhancing our urgent and intermediate care / reablement services to build both capacity and skills
- extending hours of service across the system but particularly in community teams to move towards embedding a 7-day service and avoid peak admission and discharge times,
- increasing the scope and availability of residential and nursing care placements through discretional purchase of beds to increase capacity
- building on the skills of staff within care homes but also investing in the support we wrap around through such things as enhanced therapy support and proactively targeting primary care support to the sector
- extending the capacity of trusted assessors
- building the scope and reach of our community equipment and telecare and assistive technology opportunities.
- Partnership and investment in the VCSE to support admission avoidance and also to facilitate discharge.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

BCF Carers funding is pooled with the Devon County Council's contribution to provide a Carers Strategic Budget. This pooled budget is £3.886 million and is held within the Better Care Fund.

The largest item of expenditure is the Caring Well in Devon (CWiD) contract at £2.25846 million (including an 88k inflation uplift in 2022/23).

The core contract covers information, advice, awareness work, the development of Peer and community support for carers, delivery of direct support, training, and the delivery of "Carer Support Management" (CSM), the Care Act statutory duties delegated to "Devon Carers" through the contract.

Carer Direct Payments are generated through CSM service and administered by Devon County Council (estimated at £220k in 2022/3).

The CWiD contract has also been varied to provide:

- administration of an enhanced Breaks fund which last year (2021-2022) provided targeted Breaks payments in excess of £300k, carers, recognising the impact of Covid 19 on Carers. (Likely to be 200k+ in 2022/3);
- testing of a volunteer provided sitting scheme to extend opportunities for carers to take short breaks from caring
- the delivery of our HSJ Award-winning Carers Hospital scheme, preventing admissions at the Hospital front door and facilitating discharges in all four Acute Hospitals and related Community Hospitals. This is the subject of an additional allocation from BCF of £820,750 in 2022/3. The evidence submitted for the Award is available in evidence of effectiveness and impact – a few key points from our main study period:
- Between April 2020 and December 2021 over 4,000 carers would simply not have been recognised, and would have gone without support, maybe until another crisis
- The service identifies carers early in their caring journey, protects their health and wellbeing and effectively meets and de-escalates needs.
- Without this service around 1,000 carers a year would be facing a discharge on Pathway 0 with no support, and at the point of or in actual crisis, including suicide attempts.
- The Scheme now has capacity of 450 cases per month.

In addition to the CWiD contract the pooled budget provides funds to Children and Families Commissioning for a support service to Young Carers (£250k, with an agreed uplift of £12k this year)), transfers to Adult Care and Health in respect of Care Act Duties (£537k), a Carers

Employment Advice and Support service (£46.7k) and smaller items such as Carer access to the HOPE scheme (Help Overcoming Problems Effectively), access to IT for Carers and Carer Passports (NHS LTP).

Impact in 2021/22 (data lag means that 2022/23 data not yet available)

The Carers' Service ("Devon Carers")

- Supported 26,700 carers
- Assisted over 1,900 carers through facilitation of Peer Support
- Administered breaks for 1794 carers
- Answered 13,691 calls from carers, handled 1,300 email contacts and 1,560 webchats.
- Provided training to 286 carers
- Issued 7,789 Carer Passports (In addition to the 19,823 sent out in the initial issue in 2020/21)
- Completed 3201 carer assessments/reviews, of which 2011 were new assessments.
- Generated 121 on-going (whole or part year) Direct Payments to Carers, and 365 one-off Direct Payments (of the one-off payment recipients, 31 also received an ongoing payment).

This is only a snapshot of the service which provides a very rich mix of service including training to professionals, Carer Alert Cards, Contingency Planning and support to locality integrated planning.

The pooled budget also supports the recruitment support and facilitation of our Carer Ambassador Scheme. Carer Ambassadors are our strategic volunteers who facilitate two-way communication with wider groups of carers and are active collaborators in co-production, including co-production of the CA scheme. There are currently 71 active Carer Ambassadors.

The impact of this service for carers is regularly monitored, including through movement on a locally co-produced Carer Outcomes Wheel which has been in use for some years and is a core part of the local Protocol for Carer Assessments (Carer Health and Wellbeing Checks).

Our latest report on impact on Outcomes of Carer Support Management shows consistent improvements when measured against the Carer Outcomes Wheel. The service is also monitored for inclusion, and for reach into the most deprived and most isolated areas, which are positive and generally improving on all measures.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The approach of Devon's key public sector partners (Health, Social Care and Housing) is set out within DCC's Housing Strategy at https://www.devon.gov.uk/care-and-health/document/a-joint-strategic-approach-to-supporting-people-to-live-independently-in-devon-2020-to-2025/

This strategy sets out how we will work in partnership to drive the delivery of care, and health and wellbeing in communities across Devon so that people feel safe, healthy, connected and able to help themselves and each other. The strategy is based around the understanding that people's care and support needs change over time and so might the housing and accommodation that they choose to support them to live as independently as possible. The Housing Assistance Policy for the Better Care Fund https://www.middevon.gov.uk/media/347132/adopted-housing-assistance-policy-2019-22-with-agreed-amends.pdf is an important delivery tool for this strategy. This policy sets out the areas on which Devon's partners will focus the available resources in order to improve housing conditions, and how the different grants available will be fairly and efficiently managed to mitigate hazards in the home and avoid unnecessary injuries, episodes of ill-health, and harm to mental health. The policy reflects the Better Care Fund priorities that aim to achieve the following outcomes:

- Reduced admissions to residential and nursing care homes
- Reduce delayed transfers of care
- Reduce avoidable emergency admissions
- Increase dementia diagnosis rates

The Devon County Council's 'Promoting Independence policy' is built upon four key aspects that promote independence; one of which is 'resilient and independent people and communities'. This recognises the importance of a person's own home, community, social relationships, and networks and how these can shape a person's identity and contribute to their independence. The policy states that, where appropriate, the Council will work with our partners to provide support to people so they can gain and remain in employment and live-in housing that enables maximum independence. To achieve this, the Council has published a joint Housing and Accommodation Strategy – 'Healthy Lives, Vibrant Communities and Housing Choices 2020-2025' with NHS Devon CCG. We have developed local, placed based networks, facilitating our work with the 8 district councils to deliver the joint Strategy, and we continue to utilise the BCF DFG funding allocation as key mechanism to deliver major adaptations, modular ramps and a range of wider Housing Assistance Grants aimed at older and disabled people to enable them to live as independently as possible within their homes in the community. Building upon the good working practices established over the past 5 years, the County Council has reached the following agreement with the 8 district councils in Devon with regards to the BCF DFG allocation for 2022/23, the DFG funding pot will continue to prioritise delivery of major adaptations across Devon first and foremost.

New DFG guidance has been issued - [Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England - GOV.UK (www.gov.uk)]

Devon is a strong position in relation to the guidance already with our joint work with the district councils.

More government changes are coming soon in 2022. Consultations on upper limit, means testing, allocations and common parts coming later in the year, along with funding for minor repairs services to deliver the promises set out below in the White Paper on Adult Social Care reform.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- *Changes from previous BCF plan*
- *How these inequalities are being addressed through the BCF plan and BCF funded services*
- *Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered*
- *Any actions moving forward that can contribute to reducing these differences in outcomes*

ICSs have a leading role in tackling health inequalities, through building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level. CORE20Plus5 remains the focus of NHS Devon's combined HI and prevention plan, with plans to strengthen leadership and system-wide awareness of health inequalities through a range of activities, including the participation in the national piloting of both the CORE20PLUS5 Connectors model; the support and investment we continue to make in the work of our Local Care Partnerships (LCP's); and our ambition to be a pilot area for the HEE Health Inequalities eLearning programme.

Embedding Health Inequalities across the Devon system is being delivered through a number of actions, including:

- Working closely with our workforce programme, NHS Devon will aspire to deploy Health Inequalities awareness to all staff. This will ensure the workforce:
  - Have a common understanding of what health inequalities are, and how they can affect the population of Devon;
  - Are more confident in asking patients to share personal information about themselves that will assist us in ensuring that factors such as where they live, their ethnic background and other characteristics are not resulting in unacceptable differences in access; experience and outcome;
  - Are confident in identifying health inequalities;
  - Are confident in taking positive action to tackle any identified health inequalities experienced by the people they come into contact with.
- Working closely with our colleagues in Communications & Engagement NHS Devon will aim to raise awareness of health inequalities within our population. This will support patients in being confident in why it is safe and relevant to share information about themselves.
- In 2022/23 NHS Devon revised the Quality and Equality Impact Assessment (QEIA) which will be launched across Devon to ensure HI is fully considered in all change. A "soft launch" within NHS Devon in Q3 will inform final revisions prior to a phased, wider rollout for completion by Q4 2022/23. This refreshed tool will view inequalities from the perspectives of those affected by them through co-design with the relevant inclusion health groups. Importantly, not only will this tool make it easier to identify potential inequalities brought about by change, it will connect those completing the assessment with best practice and easy to understand, tangible examples of how to mitigate against possible inequalities.

- Revisions to our governance structure for health inequalities will give increased focus supporting the Health Inequality priorities our LCP's, and the PCN's within them, have described, alongside the delivery of whole-Devon improvements.
- Establish even stronger links with our network of Health Education England HI Fellows.
- Build upon the work of Devon Communities Together cultural awareness programme that describes a common understanding of why tackling health inequalities is important to our communities, to influence both public health & VCSE sector workforce and our population.

By November 2022, NHS Devon will have completed a homeless health needs assessment within each locality to give both a local, and aggregated whole-Devon, view. The homeless HNA will also be used to inform future commissioning requirements of Primary Care services to support the homeless population and ensure inequalities that may exist in the current provision are addressed across Devon.

Currently work is being undertaken on Devon's overarching primary care and Community First strategies, People Led Change and the expectation is that addressing health inequalities will be a prominent feature of that work (strategy production July 2022).

Investment in prevention priorities continues both in whole-Devon workstreams, and in interventions at place via our £2m annual prevention fund.

Devon approaches 22/23 having made significant improvements in the capacity and leadership of the Health Inequalities programme. Through:

- The appointment of a Non-Executive Director with the responsibility for Health Inequalities
- Alignment of the HI, Prevention and Health Inequalities agendas under the portfolio of the Deputy Director of Commissioning of Out of Hospital.
- Identification of a whole-Devon SRO for Digital Inequalities
- Appointment of a Head of Health Inequalities and Prevention
- Appointment of an Acting Public Health Consultant for Health Inequalities, providing dedicated time to support the programme and interface more closely with the work of our three public health teams;
- Increased support to, and engagement with, the HEE funded Health Inequalities Fellows network in Devon;
- Dedicated project management capacity in place to support localities in taking action to deliver the priorities they will define to achieve the aims of our Equally Well aspirations.

Data and insight relating to the characteristics of the population who are, and importantly, are not, accessing our support and services remains a challenge for Devon. Our Elective Recovery plans will give focus to actions to addressing the quality, completeness and availability of data within the Hip and Knee subset of Orthopaedics.

NHS Devon's Population Health Management programme is closely linked with the Health Inequalities team. The Population Health Management Programme has the overall aim of having a systematic population health analysis at system, place and neighbourhood level, by 2023/24 enabling LCPs, PCNs and partners including mental health and local authority, to understand their population's needs, including the wider determinants of health, and design interventions to meet them. As an end state, all LCPs and PCNs should be routinely utilising PHM to develop targeted interventions for identified 'at risk' cohorts. The One Devon Dataset (ODD) is in the process of being developed. The dataset will allow all data to be accessible in one place, with various organisations able to access the data.

Using the data made easily accessible by the One Devon dataset will enable us to inform the use of the Better Care Fund, ensuring better outcomes for the population as well those facing inequalities in accessing services.

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Better Care Fund

Draft Narrative Plan 2022-3

Torbay Health and Wellbeing Board

Cover

Health and Wellbeing Board(s)

Torbay

Introduction

The Better Care Fund brings together health and social care funding to support organisations across the One Devon Integrated Care System (ICS) in building toward a sustainable health and care system which will improve the health and wellbeing of the population, with the Better Care Fund a mechanism to assist in achieving this aim.

This document is the draft plan for which Torbay Health & Well-being Board are accountable within the new One Devon, Integrated Care System architecture. This plan has been developed for Torbay but sits in the context of and contributes toward delivery against the Devon system Integrated Care Strategy through the integrated approach and joint commissioning arrangements in the South Local Care Partnership.

The intention being that a more place-based approach continues to develop with partners which includes influencing and shaping the further development of system-wide strategies and delivering improved outcomes for our local communities. Learning from good practice which already exists and further developing models which have been developed with much work with voluntary and community organisations to respond to the needs of our communities through a different 'front door' for Adult Social Care and support Torbay's vision to deliver a more strengths-based approach, promoting maximum independence and wellbeing.

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

This narrative plan, together with the BCF Planning and Capacity and Demand templates have been drafted by local system partners, overseen by the newly created Adult Social Care Continuous Improvement Board, feeding through the Health & Wellbeing Executive to the Health & Wellbeing Board, and supported by the main statutory organisations as in previous years. These being Torbay Council, NHS Devon Integrated Care Board and Torbay and South Devon NHS Foundation Trust.

Key stakeholders involved in the emerging Local Care Partnership include those organisations highlighted above as well as Devon County Council, the Southern Primary Care Collaborative Board, Devon Partnership Trust, Voluntary & Community sector leads for Torbay & South Devon, Directors of Public Health/Consultants (Devon County Council & Torbay Council), Devon Local Pharmaceutical Committee and Devon Local Optical Committee.

How have you gone about involving these stakeholders?

For this submission, the BCF Leads have engaged with a range of key stakeholders including local authority and NHS colleagues specifically to develop the narrative and supporting templates.

The initial delegated sign off for the draft submission was from the Director of Adult & Community Services for Torbay Council on behalf of the Health and Wellbeing Board for Torbay, with this submission being approved through the Chief Executive, Torbay Council. The Health and Wellbeing Board will then oversee the development of the BCF Plan 2022-23 and approve any subsequent BCF Planning submission (dependent on timescales). As part of the Devon-wide system sign-off process, the BCF plans for each of the three Health and Wellbeing Boards has been reviewed and signed off by the NHS Devon Integrated Care Board Executive.

The continuation of the Better Care Fund arrangements requires effective partnership working to ensure the delivery of these schemes and associated outcomes using an integrated local system approach which will be facilitated through the emerging South Local Care Partnership which covers the Torbay & South Devon footprint. This plan will be shared with this group in October.

The approach to integrated commissioning at 'place' is developing and the development of the Local Care Partnership arrangements will support as a key driver of local strategy and agreeing and delivering against key local priorities. The local Integrated Care Organisation (NHS Provider) already delivering services across acute and community health and social care.

This development of even closer alignment and approaches to joint working and the existing governance architecture ensures system wide support and oversight of their delivery, across statutory partners and all key local stakeholders.

The development of the Community First Strategy for the Devon Integrated Care System has also supported this approach with consultation and engagement across each of the five Local Care Partnership areas and with representation from primary, community, acute, mental health, Local Authority, VCSE organisations and small groups to represent the public.

In Torbay, the Better Care Fund and Improved Better Care Fund resources are delegated to Torbay and South Devon NHS Foundation Trust as an integrated care organisation responsible for the delivery of health and social care services in Torbay. The Adult Care Strategic Agreement between Torbay Council and Torbay and South Devon NHS Foundation Trust governs the delivery of Adult Social Care, April 2020 to March 2023 and includes delivery of services and outcomes agreed through the Better Care Fund.

Executive summary

The most significant development since the previous plans were developed and submitted has seen the inception of the NHS Devon Integrated Care Board following in the footsteps of NHS Devon Clinical Commissioning Group and the wider partnership arrangements for the system known as One Devon, which came into being with effect from 1st July 2022.

The five local care partnership geographical arrangements sit as part of this system architecture along with Provider Collaboratives for Acute and for Mental Health, Learning Disability and Neurodiversity and Collaborative Board arrangements for Primary care in each local system.

The local system has been under increased pressure during the last couple of years and a key priority focus remains in relation to urgent care and system flow. The BCF plan is a key contributor responding to this with schemes that support targeted long-term investments to build sustainable community services for individuals on discharge across all care pathways with the aim to reduce pressure on urgent care through services that enable people to stay well, safe, and independent at home for longer.

The local system is developing its approach to a small number of priorities through the Local Care Partnership (LCP), with the BCF plan being key to enabling across many of these and with further work to develop a proposal for supporting further local system integration particularly in relation to community services.

These are set in the context of:

- Further development of Local care partnerships.
- PCN/Community services at “place” alongside Health and wellbeing centres
- ICS strategy for community first / community urgent care / Primary Care (GP)
- National developments, inc. Fuller report and national model of rehabilitation
- EPR convergence, wider digital technology adoption e.g., remote monitoring

And include:

- Establishing an integrated approach to responding to urgent care needs in Torbay - primary care, minor injury, social care, 0-19, drugs and alcohol, mental health and CFHD.
- Develop approach to integrated health and wellbeing services in South Devon
- Transformation and continuous improvement in delivery of Adult Social Care Services.

The Devon ICS Community First Strategy sets out our vision and direction of travel for community services over the next five years (2022 to 2027). Community services play an important role in keeping people well and managing acute, physical, and mental health and long-term illness. The key focus of this strategy is on preventative, proactive and personalised care to support people to live as independently as possible with greater connection to their local community ensuring people spend more time at home rather than in a hospital bed and at the same time avoid or at the very least delay the need for long-term residential care.

We want community services, including the voluntary sector, to be far more prominent in our system with well thought out planning regarding the steps we need to take to achieve the vision, co-production of services with our system stakeholders and the public, and in ensuring that they are adequately funded to sustain delivery and outcomes in the longer term.

Devon has a strong history of integrated working, and today several community services are now being provided by, or in partnership with, local acute trusts bringing many benefits to people, services, and the system. Our work towards integration thus far has improved collaboration between services, the opportunity for the standardisation of pathways which cuts across different sectors, and potential to use the workforce in a different way, providing better continuity of care for people. Future developments are likely to include extension of traditionally acute based specialists out into the community, bringing more of the medical expertise to support people in their own homes and out of a hospital setting.

Whilst our history for integration is strong, is has not been delivered consistently across the county. This strategy describes our ambitions and visions at a system level in order that we can increase the consistency and equity of access, experience and outcomes for people using community services. Those ambitions will develop and be implemented at a local level, such that they truly serve their local population and make the best use of existing and future community assets.

The high-level draft Income & Expenditure summary is set out below:

Selected Health and Wellbeing Board:	Torbay

Income & Expenditure

Funding Sources	Income	Expenditure	Difference
DFG	£2,128,689	£2,128,689	£0
Minimum NHS Contribution	£13,119,732	£13,119,732	£0
iBCF	£8,837,572	£8,837,572	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£24,085,993**	**£24,085,993**	**£0**

The templates completed in support of this narrative document and Better Care Fund plans for 2022-23 appear at the end of this document and set out in further detail the expenditure and associated metrics toward submission.

The refreshed Torbay Joint Strategic Needs Assessment has also just been published and is available here: http://www.southdevonandtorbay.info/media/1285/2022-2023-torbay-jsna.pdf

The Joint Strategic Needs Assessment describes the health and wellbeing needs of our population, and the drivers that influence health and wellbeing, like housing, employment, and education. The draft Health and Wellbeing Strategy seeks to tackle these difficult issues through agencies working together to bring about real, sustainable change.

It has been prepared in collaboration with Health and Wellbeing Board partners over the last nine months and identifies 5 priorities areas, and 6 cross-cutting areas,

which all member organisations feel are critically important for improving the health and wellbeing of Torbay residents. Importantly, this year working closely with colleagues in the new Integrated Care System, and especially those in the South Local Care Partnership, to make sure our priorities are clearly aligned.

The Health and Wellbeing Strategy responds to the areas of greatest need given the levels of deprivation and poorer outcomes in some parts of Torbay:

- children living in challenging circumstances and losing out on educational opportunities
- lack of high-quality housing with secure tenure
- people living with poor mental health
- older people experiencing loneliness and isolation.

All these needs have been exacerbated by the pandemic, and all of them hit our most disadvantaged communities the most.

During this last period teams across the Local Authority and NHS have devoted significant capacity to supporting providers in the Torbay Care Market. This included timely and flexible use of government support funding, within the prescribed grant conditions, across a range of COVID funding such as the Infection Control, Testing and Workforce Grants. Without this support we would not have maintained market capacity during this time. The Better Care Fund has supported this Integrated approach and way of working with the market and work continues to further improve these arrangements.

The local Market Position Statement and Blueprint is the local source document for market strategy. The document aims for enhanced capacity via additional Supported Living and Extra Care capacity using Housing based care models. Also, the document has a strong focused on quality Nursing Care and Dementia which reflects system priorities and is evidenced by demographic data in the Joint Strategy needs Assessment (JSNA).

Despite the challenging backdrop, looking ahead to plans during the current financial year which are proceeding with Extra Care Housing Schemes at Torre Marine, Torquay, and Crossway in Paignton. We are working with providers as well to bring forward new Supported Living capacity in the community for people with Learning Disabilities or Mental Health conditions as an alternative to bed-based care.

The Trust and Council also commence work with two providers in relation to two potential schemes one for Rehabilitation capacity and one for Dementia beds across the footprint of the local Integrated Care system. This local system is the Local Care Partnership which includes NHS, VCSE, Primary Care Networks, Mental Health providers and two Local Authorities (Torbay & Devon County Council).

The Better Care Fund has and continues to along with our approach support focus on priority areas through the application of the funding available. These are in 3 broad areas which are developed further throughout the document, but seek to

- Promote independence (Alternative ‘front door’ with VCS, use of DFGs and assistive tech etc, and reablement).
- Through our approach to joint commissioning, develop strong and sustainable care markets which meet the needs of those in our communities.
- Supporting carers and their families.

Governance

NHS Devon is one of 42 integrated care boards across the county and took over the statutory functions of clinical commissioning groups (CCGs) on 1 July 2022. It is the organisation responsible for the majority of county's NHS budget, and for developing a plan to improve people's health, deliver high-quality care and better value for money. Our aim is to improve people's lives in Devon – wherever they live – to reduce health inequalities and make sure we can deliver these services for the long term.

Diagram 1.1

The local system for Devon is comprised of NHS Devon, responsible for commissioning NHS services and joining up care and the One Devon Partnership developing the strategy and working together as NHS, local councils, voluntary sector, and many other stakeholders as per the diagram (1.2) below:

Diagram 1.2

Within the One Devon Partnership there is a representative from each of the five Local Care Partnerships, with our Local Care Partnership being the South LCP. This is where most of the service changes will happen and covers around 300,000 people.

As part of the Devon-wide system sign-off for the under the new Integrated Care System (ICS) governance framework the BCF plans for each of the three Health and Wellbeing Boards will be reviewed and signed off by the NHS Devon ICB Executive Board.

The Local Care Partnership is developing to provide system leadership and clinical oversight to the integrated commissioning arrangements. It provides focus and direction for integrated commissioning, ensuring collaborative planning and performance monitoring. It also provides assurance to the governance arrangements of both NHS Devon and Torbay Council. To ensure collaboration in our local system, much of the development work will take place through the Local Care Partnership with stakeholders and partners represented and co-ordination toward sign off by the Torbay Health and Wellbeing Board through the Adult Social Care Continuous Improvement Board.

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

This section will also include

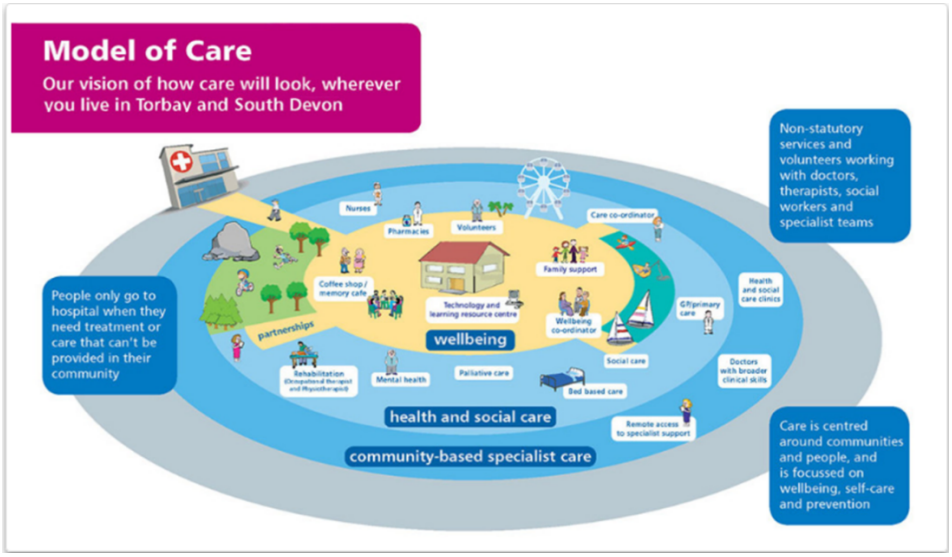
Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe, and independent at home for longer
- Provide the right care in the right place at the right time

The One Devon Integrated Care Partnership will lead the development of the strategy which builds upon existing foundations and supports more integrated approaches to delivering health and care. This will help to provide focus on and drive the change required to tackle the challenges the system faces such as reducing disparities in health and social care; improving quality and performance; preventing mental and physical ill health; maximising independence and preventing care needs.

Within Torbay, there has been ongoing work to implement an integrated care model that puts a strengths-based approach at its heart. This model provides a fully integrated health and social care system involving joined-up services which deliver education and advice about how to maintain independence and stay well, with mental health and wellbeing as high a priority as physical health and wellbeing. It also aims to take a person-centred approach and build wider support around people, through making the best use of what is already available to them at home and in the community. A significant programme of work with our VCSE partners has delivered a new 'front door' to adult social care with an emphasis on making the most of individual and community resources as part of our strengths-based approach.



The creation of the Integrated Care Organisation in October 2015 - Torbay and South Devon NHS Foundation Trust, was strongly supported and encouraged by both the Clinical Commissioning Group and the local authorities and this has resulted in a more effective patient journey where fewer people in Torbay experience delays in moving between hospital and home and waits for care at home remain short - in stark comparison to many other areas in the current year.

Our vision is to have excellent, joined up care for all. Torbay already has a model of integrated health and social care teams built around geographical clusters and primary care practices, with a single point of access. These teams provide functions to enable:

- Proactive identification of people at risk and admission to hospital or inappropriate care settings.
- Integrated assessment and personalised support planning for people with long-term conditions and/or complex care needs.
- Urgent reactive care to people in crisis to avoid immediate risk of admission.

South Devon and Torbay has a respected reputation for partnership working and for innovating to find more effective ways of delivering quality care. Relationships between statutory and voluntary sector organisations are well founded and there is a shared ambition to tackle problems. This extends to positive working with provider organisations whose reach is broader than South Devon and Torbay. This is well supported by the framework the Better Care Fund has provided but is also being taken forward through the approach to creating Local Care Partnerships which seek to cement some of this working and further enhance what we can deliver together.

The Better Care Fund sits within this longstanding programme of integration through the creation of the ICO and the continued development of a new model of care.

Joined up approach to integrated, person-centred services across health, care, housing, and public sector services locally

Adult Social Care:

Torbay and South Devon NHS Foundation Trust and Torbay Council are working together on an Improvement Plan with partners to progress Adult Social Care delivery and opportunities for transformation using a strengths-based approach in Torbay. Much has been learnt from the Covid Pandemic and new ways of working with our community have developed as a result. Members of staff alongside service providers from the private and voluntary sector as well as people who have lived experience and their carers were invited to join us in several facilitated conversations focused on creating a shared Vision of the future for Adult Social Services

Our shared vision is: **Thriving communities where people can prosper**
Our mission statement is: **Our residents can have a place to call home in a community they can be part of, while being empowered to achieve what matters most to them, through the best care and support available.**

We know that the demand on the adult care system in Torbay is high and it will only continue to increase due to our aging population and areas of social deprivation. This is one of the reasons why we need to change the way we currently deliver our social care and work towards fully adopting a community led approach where our communities can be supported to flourish. Our commitment to engage with and work with our voluntary and community partners as well as people who use services to co-design the plan will enable us to develop a robust service delivery that is fit for the future and for the people of Torbay. We are also

encouraging a culture within teams of embedding continual improvement. We are focussing on achieving positive shared outcomes for people receiving Social Care support and reflecting this via monitoring our own performance and seeking feedback from all involved so we can learn from experience.

We are reminding people of the core values of social care, including:

- being part of the community,
- supporting people to build their own capability,
- enabling people to live their lives as independent as possible.

The Adult Social Care Improvement plan (ASCiP) seeks to support the vision of developing thriving communities in Torbay by delivering the strategic priorities, deepening integration with partners and promoting a strength-based approach throughout all conversations. This will be achieved by working in collaboration with partner agencies and by valuing skills, knowledge and potential in all individuals and their communities.

Providing Safe Quality Care and Best Experience:

Working across our system with partners to deliver high quality care that meets best practice standards, is timely, accessible, personalised, and compassionate. It will be planned and delivered in partnership with those who need our support and care to maximise their independence and choice.

Focus on Mental Health

In under 65 MH we have been working with providers to ensure that all clients live in the least restrictive environments that promote their independence. We have been working to develop the local supported living framework and to identify ways to support people in their own homes. Torbay Public Health have engaged with local voluntary sector providers to help improve access to voluntary sector and community assets to support people to achieve positive mental wellbeing. We continue to work with partners and our communities to ensure that the people of Torbay receive a good offer in terms of mental health support both through the Community Mental Health Framework and more broadly.

Focus on the Transition team

We have developed a specialist team to work with young people who are being referred through to our service from our colleagues in Children's services. This team has developed from having two skilled and un-registered practitioners to include a Social Work Lead and two additional experienced Social Workers. Close links have been developed with Children's services, Education and Mental Health services. There are now regular review meetings to consider a young person's aims, hopes and aspirations when they reach 14 and 16 years old. The transition teamwork within a strengths-based approach aligning their assessments and support with the preparing for adulthood guidelines promoting health, education, employment, independence, and community inclusion. The team work flexibly to ensure their care plans are outcome based which includes reviewing a situation when it is right for the young person rather than on an annual basis.

Focus on Learning Disability

Much of 2020/21 was spent evaluating and preparing for the launch of Torbay's Market Position Statement to achieve the following outcomes:

- An increase of 50 units of self-contained supported living, sheltered housing and/or Extra Care for people with learning disabilities, in line with the Housing Strategy 2017. One

third of people over 45 with a moderate or severe learning disability, and one third younger adults (under 35 years) are living with parents. We want to ensure there is appropriate accommodation and choice, so people can have planned transitions towards independent living, and avoid unnecessary entry into residential care wherever possible.
- Increased Quality Assurance support for supported living providers and the consequent improvement and monitoring of the quality of support and tenancies.
- A reduction in the number of working age adults with LDs in long-term residential settings (currently just over 70 adults). Residential settings by their nature, do not usually maintain or increase self-determination, control, citizenship, or enable community inclusion and natural circles of support.
- The development of an outcomes commissioning framework for the development of Daytime activities/services which offer more choice, develop community inclusion, and deliver more aspirational outcomes. Greater housing choice - particularly self-contained Supported Living, sheltered housing, Extra Care, and access to general needs housing.

The Torbay Learning Disability Partnership Board (LDPB), which was launched in December 2019 will continue to be supported by 8 Ambassadors who act as Learning Disability self-advocates. The Ambassadors ensure that people with learning disabilities are involved in decisions about all new services, strategies, and policies.

Focus on Autistic Spectrum Conditions and Neurodiversity

During 2019, in recognition of the need to focus on post-diagnostic support in Torbay for people with Autistic Spectrum Condition (ASC), a multi-stranded ASC post-diagnostic project was launched, which included the following:
- A new accessible information and advice service, to help improve access to employment, education, and welfare benefits.
- The development of Peer Support for people with ASC through seed funding of small groups (one for adolescents and one for adults)
- Employment of a 0.4FTE specialist ASC Social Worker

Focus on Dementia

- The Care Home Education and Support Team (CHEST) continues to form an integral part of the Older People Mental Health service in Torbay despite the enormous challenges that the ongoing Covid pandemic has brought upon Health and Social Care services. Although CHEST core business needed to be suspended in the initial months of the pandemic it soon became apparent that people with Dementia both in Care Homes and in the Community still required the specialist input provided by the team. The CHEST method focusses on a strengths-based, holistic, person-centred, and collaborative non-pharmacological approach to look at the person and how they are trying to communicate their needs. Medication although helpful can never be the only solution and we work with providers and people's loved ones and formal carers to adapt interventions thus easing a person's distress.
- CHEST colleagues focused on re-building and strengthening relationships with Care Homes, which in turn boosted staff morale. Although there has been no official survey undertaken this year, there has been some informal feed-back from different homes stating that they find the CHEST involvement to be invaluable, particularly in terms of the quick response it provides. Many homes appreciate the ability to refer to CHEST directly.
- As previously referenced, are proceeding with Extra Care Housing Schemes at Torre Marine, Torquay, and Crossway in Paignton, and working with providers to bring forward new Supported Living capacity in the community for people with Learning Disabilities or Mental Health conditions as an alternative to bed-based care and a potential scheme to realise additional dementia capacity.

Focus on Homelessness

An integrated team consisting of a social worker, drug and alcohol treatment worker, housing staff, outreach team and the new Housing First team have worked to remove barriers for people who are homeless to access housing, health, and care services. The Housing First teamwork with those whose needs have not been previously met; housing people straight from the streets into the community and providing intensive support to help people maintain their accommodation. The Housing First team is working well with the Homeless and Vulnerability locality team with good effect. The teamwork across 7 days a week and have a case load of only 5 people to ensure that they can provide the levels of support that people need.

Focus on carers

The BCF contributes towards payment of staffing to deliver service and towards the carer's personal budgets such as a break from caring to improve their health and wellbeing. There are statutory duties for both LAs and the NHS to ensure that services are provided for family and friend carers, via Care Act 2014 and recently passed Health and Care Bill 2022. Every year, more and more people take on a caring role. The enormous contribution of the country's carers not only makes an invaluable difference to the people they support, but it is also an integral part of our health and social care system, and it deserves to be better recognised. The economic value of their contribution is huge – and the UK's health and social care system is heavily and increasingly reliant on it. An impact assessment published by the Department of Health (October 2014) estimated that each £1.00 spent on supporting carers would save councils £1.47 on replacement care costs and benefit the wider health system; Carers UK estimate that care provided by friends and family saves the state £132 billion each year.

We know that people do not always see that they are a Carer, so we try to make it as easy as possible for Carers to be identified, whether at GP surgeries, through other professionals that may work with Carers, and through our campaigns such as Carers' week and Carers' Rights Day. In 2021-22, 1,930 Carers of Adults received a Carers' assessment / health and wellbeing check, which is 52% of people receiving Adult Social Care services against an annual target of 36%.

In 21-22, 704 carers received support to have a Carers Break, and the positive impact on their Health and Wellbeing was significant. Link to Carers Personal Budgets evaluation.. This has been especially important at a time when Replacement Care (Respite) Services have been limited.

Improved wellbeing through partnership:

We will work with our local partners in the public, private, voluntary and community sectors to tackle the issues that affect the health and wellbeing of our population. We will work in partnership with individuals and communities to support them to take responsibility for their own health and wellbeing.

Supported Living Provision

Supported housing provides crucial help to some of our most vulnerable people. It can have an enormous positive impact on an individual's quality of life: from their physical and mental health to their engagement with the community and reducing social isolation.

The Supported Living framework introduced in April 2018 provides a greater focus on assisting improvement alongside our statutory assessment function. The framework is intended as a focal point for joint working between partnership organisations and reflects

Torbay's integrated health and care service delivery model. The framework supports Torbay in moving towards a more enabling environment with measurable outcomes in promoting people's independence, quality of life and health and well-being.

During the year we identified significant gaps in the market for people with a mental health diagnosis resulting in a tender, specifically for this client group, being published in the summer of 2020. As a result, we have increased the number of Supported Living Providers on our framework and are working with them to increase capacity and develop services.

Enhanced Intermediate Care

We have invested in Enhanced Intermediate Care services to help people stay independent at home longer. Intermediate care also aims to avoid hospital admission if possible and delay people being admitted to residential care until they absolutely need to. Intermediate Care is a key requirement in facilitating early discharges from hospital.

We work to ensure Enhanced Intermediate Care is fully embedded working with GPs and Pharmacists as part of the health and wellbeing teams within Torquay, Paignton and Brixham. We also have a dietician in the Torquay locality who has been invaluable during any Covid Care Home Outbreaks

We have developed stronger links with the ambulance service and the acute hospital which means that the person experiences a more seamless service between settings.

We work with the Joint Emergency Team in the Emergency Department (ED) to prevent an unnecessary admission into the hospital. The Frailty Team are also based in the T&SD ED working alongside JETS to identify and support the Health of the Older Person (HOP) clients through to outpatient, acute HOP in-patient or IMC beds as appropriate. This links into the agreed Frailty Virtual Ward arrangements, with recruitment underway. There is also an In-reach B7 Occupational Therapist from the T&SD Complex Discharge Team, with those above enabling/supporting safe discharges and collaboration with the VCSE discharge teams.

We have recently started doing a virtual multi-disciplinary team meeting with the Care Home Visiting Service, Older Mental Health Services, dietician, pharmacist, and Health Care for the Older Person Consultants. This happens weekly and we refer any people in our Intermediate Care service who we feel may benefit from this specialised group of clinicians. This results in the person receiving care without having to attend an appointment. This service has been extended so that the localities can discuss any people who are either in their own home or a care home placement, promoting proactive treatment.

The average age of people benefitting from this service is 83 years old. The deeper integration of these services, supported by investment through the Better Care Fund has helped ensure people have shorter stays in hospital. The implementation of a 'discharge to assess at home' pathway has further developed the ability of the organisation to care for people at home and we always work towards the ethos that 'the best bed is your own bed'.

Extra Care Housing

Extra Care housing combines care and support to maximise the independence of Torbay's population whose Long-Term Condition or diagnosis means they require ongoing care and / or support to maintain independent living, for as long as possible, in their own community-based home. Our Extra Care service is multi-generational supported living benefitting from 24/7 on-site staffing.

Demand for Extra Care Housing continues to outstrip supply. To address this the Council has purchased a site in Torquay to increase capacity. A dedicated Capital housing officer has been recruited by the Council to work in partnership with TDA and Torbay and South Devon NHS Foundation Trust in developing these sites. The Extra Care project group membership includes multi-disciplinary representation and the voluntary sector whose aim is to develop housing which:

- Promotes independence, quality of life, health and well-being and offers choice and diversity.
- Creates mixed communities which integrate well.
- Supports people in their own home.
- Build homes which adapt to individuals' changing needs.
- Diverts people from more institutionalised care.

The Extra Care Scheme is in Torre Marine, but we have a second one planned for Crossways. a scheme in Torquay which is in the planning system and a second plan for central Paignton as part of a regeneration scheme.

Wellbeing services with the Voluntary Sector

During 20/21 the statutory sector in Torbay further developed its well-being offer by working more closely in an enduring partnership with the Community and Voluntary Sector in Torbay. Jointly with the Voluntary Sector we have responded to the challenges of the pandemic:

- By Facilitating/supporting alliances/partnerships within the community to improve resilience
- By working more openly and collaboratively with the Voluntary sector on an equal footing via forums such as the Voluntary Sector Steering group and via the use of the Adult Social Care precept previously.

During the pandemic Voluntary Sector partner organisations responded flexibly and used resources in a creative fashion. Their added value to the social care offer was noted and their place and benefit to the Health & Social Care system, and Adult Social Care can only build in strength as we move forward with the Adult Social Care Improvement Plan.

The development and implementation of the Adult Social Care Three Year Plan has been very much informed by our "Community Led Support" work in Adult Social Care, which preceded it. This focused on working in a different way with the community, and a more person-centred approach to wellbeing. This work has been further developed and reinforced through the pandemic, with a more open, collaborative approach being taken to joint working, improving relationships, and understanding between the sectors. Initiatives have been truly community-led and asset-based, with statutory services taking a more facilitative, supporting role.

The VCSE sector has been agile, creative, and person-centred in its response to community need, which has positively influenced culture within Adult Social Care and the way in which we are improving our services. For example, as part of the Three-Year Plan, we are redesigning our "Front Door" (the way in which people access our services) in Adult Social Care. This is not only being informed by the development of the Community Helpline, but VCSE partners are actively involved in the redesign work. This approach is fully aligned to the Care Act (2014), which recommends greater integration and collaboration with local partners, for the benefit of community wellbeing.

Building upon this ethos, there is now an extension of this work to be piloted within the Emergency Department, with a VCSE model at the front door to support the clients who

have attended, with a community-based connector to facilitate and signpost other pathways of support. This could be both for this attendance but also to support with advice/appointment booking/connection to other services to reduce or mitigate the need for attendance for that issue in the future or support another part/area of their lives (mental health and well-being/social/carers issues/non-acute health related problems).

A new Steering Group has been created with representatives from across the VCSE and statutory sectors, which will help to guide and shape developments. A VCSE Forum has also been set up, to make it easier for organisations within the sector to connect with a common purpose, providing greater opportunities for collaboration, and a stronger voice in the local system. The VS in conjunction with the Council are planning a community response to the Cost-of-Living crisis via a procured Alliance approach.

Technology Enabled Care Services (TECS)

A Technology Enabled Care Service (TECS) is available across Torbay. Commissioned in 2018 by Torbay and South Devon NHS Foundation Trust, the service is provided by NRS Healthcare located in Paignton. TECS provides solutions to individuals to keep them safe and independent in their own homes for longer, potentially delaying any need for formal service interventions. NRS Healthcare offer a private purchase option so that people can choose different ways to support how they access the community and live as independently or care for loved ones. For those who are eligible following a Care Act Assessment, TECS will be considered before other packages of care are put in place.

This contract has supported people from managing medications independently through to allowing people to access their community with TEC phones linked to 24/7 care for emergencies. The provider NRS have been developing a new system to support people being discharged from hospital through until their assessment has been completed in their home while having access to a care line. Work has started with public health to use TEC to support people with diabetes and mental health so that they are able to manage and live full lives.

The Hope Programme

The HOPE (Help to Overcome Problems Effectively) Programme is an evidence based 6-week self-management course based on positive psychology, mindfulness, and cognitive behavioural therapy, built on 20 years of research from Coventry University.
It brings together people with similar needs and experiences in a safe space across 6 weeks. Participants are given the tools to build their knowledge, skills and confidence whilst helping each other. The groups are run by trained facilitators – professionals or volunteers. Across Torbay and extending into wider Devon, the HOPE programme continues to go from strength to strength with over 1,400 participating in the programme to date. We celebrated our 4th Birthday on 13th November 2021

As we continue to adapt our day to day lives towards a new normal amidst the Covid-19 pandemic, the HOPE programme has had to evolve as well. Since April, facilitators have been delivering the HOPE programme using Microsoft Teams and finding out the best ways to modify the face-to-face programme to an online one. This meant a two-month hiatus from April – June 2020, but since then we have been delivering 'Virtual HOPE'. This has increased our spread and reach, with people not having to travel to a HOPE venue but can access in the comfort of their own homes. We have also been able to offer more evening courses to support people who have working responsibilities.

Health and wellbeing coordinators and PCN link workers

Provide effective links into the voluntary and community sector- both these roles base their approach on discussions focussing on what matters to each person. Making Every Contact Count is more established and provides support to people around behaviour change related to tobacco, hypertension, alcohol, being overweight or physically inactive.

Falls and frailty prevention work

Is being driven by the locality Ageing Well and Frailty Partnership working across the system.

a) Approach to Collaborative Commissioning

Torbay has had integrated services since 2005 which were extended in 2015 to encompass a whole system integration with the creation of the Integrated Care Organisation (ICO) Torbay and South Devon NHSFT. Arrangements include aligned commissioning posts across the local authority and NHS Devon, pooled funding arrangements which are managed through agreed collaboration as to how these are spent. We have developed a Local Care Partnership Delivery Group which brings together operational and commissioning leaders across our system including the local authority, NHS Devon, public health, Primary Care Networks, and the voluntary sector. This group is responsible for aligning system plans and evolving strategy into operational plans. The Integrated Care Model sets out our system wide ambition to have a maturing integrated offer at neighbourhood and place, bringing together primary care networks, mental health, social care, and hospital services to meet population needs.

b) Overarching Approach to support people to remain independent at home

The key elements of our plans to support people to remain independent at home are connecting people with things that help them to lead healthy lives, supporting people to stay well and independent at home, proactively working to avoid dependency and escalation of illness, connecting people with expert knowledge and clinical investigation, providing easy access to urgent and crisis care and embedding end of life care at all levels.

The key priorities are population health management through data driven planning and delivery of care to achieve maximum impact, social prescribing, and community asset-based approaches. There is an Integrated Care Model Programme aiming to deliver these ambitions by bringing together several projects which aim to bring greater integration of health and social care provision. These include workstreams on: Enhanced Health provision in Care Homes, Ageing Well and Frailty, Community Urgent Response, transforming the delivery of social care, enhanced discharge, and our community mental health framework. The aim is to work as a system to meet the health and wellbeing needs of the population.

The programme includes working in partnership with primary care services and our voluntary and community sector.

The process for developing PCNs in Torbay is being supported by the local care partnership delivery group. There are 3 PCNs in Torbay and these are co-terminus with the council boundary. We have worked in partnership with PCNs to support the development of their pharmacists and social prescribing link workers.

A VCSE strategy has been developed across Torbay. It contains a mix of place-based agencies and those that operate across a wider theme and area due to their specialist nature. The VCSE is a key part of the integrated model of care and will help to deliver the

BCF priorities in the following ways: social prescribing, self-care, building resilient communities, by helping with transport, enabling hospital discharge to take place by supporting people with volunteers or befriending, looking after pets whilst people are in hospital, and wellbeing co-ordinators will be linking to community assets.

c) Reducing health inequalities and inequalities for people with protected characteristics

Learning from the pandemic has highlighted an increase nationally in health inequalities. The Devon ICS has responded by creating a health inequalities group focused on understanding and developing plans to reduced health inequalities. Responses and plans to this challenge are Devon-wide e.g., Disability strategy, Carers Strategy, Promoting Independence Policy as well as local LCP place as well specific plans at local place-based LCP level utilising PHM approaches.

Quality is the golden thread that runs through all aspects of our integrated commissioning and service delivery. We have created a system-wide quality, equality, and performance group to ensure that QEIAs are undertaken for all services to understand impact on all sectors of society but with reference to those with protected characteristics. All QEIAs will subsequently be subject to a system scrutiny panel to provide assurance that all elements of quality impact are understood, and risk assessed. All commissioning-led decisions in respect of service redesign are robustly and openly challenged and must be able to demonstrate that key impacts on quality of care have been appropriately considered through use of the agreed QEIA assessment process. Our Quality and Equality Impact Assessment (QEIA) tool aims to review impact through both an evidence/narrative account and a guided rating scale: measurable outcome scores of impacts on safety, treatment quality and experience.

The approach in Torbay is to work closely with public health colleagues to reduce health inequalities and inequalities for people with protected characteristics. As part of the development of plans we have assessed the areas where there are greatest health inequalities, and the Adult Social Care Transformation Plan includes approaches to reduce these. Areas of particular focus include suicide prevention, looked after children and older people's mental health.

Strategic, joined up approach for DFG spending

Approach to integration with wider services – using DFG to support housing needs of people with disabilities or care needs and arrangements for strategic planning for the use of adaptations and technologies.

The approach to using the DFG to support the housing needs of people with disabilities or care needs is supported by the Torbay Council Housing Strategy 2020-25 https://www.torbay.gov.uk/council/policies/community-safety/housing-strategy/, which recognises the need for its Strategy to support the Community and Corporate Plan and recognises the significance of housing within the wider determinants of health, particularly in helping to alleviate the pressure on Adult Social Care and Health services. The strategy enables the co-ordination several housing and health related priorities including, aids and adaptations for disabled people, home improvements; access to community equipment and assistive technology to enable independence at home, speed up hospital discharge/reduce readmission, prevent escalation of need e.g., accidents and falls and support maintenance of physical and mental well-being.

As part of this year's Better Care Fund, we have set aside a small amount to invest in a Strategic Review of our approach in relation to DFGs.

Torbay's housing strategy aims to deliver homes fit for the future at each stage of life to meet the needs of an increasing aging population; higher proportion of older people; higher proportion of population with disability; increased referrals for Disabled Facilities Grants; higher proportion of one person households; higher proportion of households aged over 65 living alone (from Housing and Health Needs Assessment). As part of improving quality of homes and providing homes fit for the future, there will be the development of additional extra care housing units. The local partnership arrangements including, an integrated ASC and housing strategy team, ensure effective partnership with local housing providers, local communities; large and small private sector bodies, the broader public sector; and our local community and voluntary sector.

Agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach

Planning for a patient's discharge from hospital is a key aspect of effective care and some will have ongoing care needs that must be met in the community. Meeting the ongoing care may involve specialised equipment at home or daily support from carers to complete the activities of daily living. Planned of the patient's return home, to ensure that there is no gap in the provision of care between the discharge from hospital and the initiation of community services is widely recognised. The flow of information about the patient must also be handed over from the hospital team to the community team so an informed plan of care can be put into place. Discharge planning is vital: poor discharge planning may lead to reduced quality of patient outcomes and delayed discharge planning can cause patients to remain in hospital longer than necessary.

The Complex Discharge Hub with a single system co-ordinator supports the discharge of patients on Pathways 1-3 from the acute hospital and decides the pathway, destination and level of care required to support the appropriate prescription of care from acute settings. The approach uses triage and liaison with Short Term Services (STS) and independent providers. The hub works across 7 days with an MDT workforce with the aim that the level of support provided enhances patients' independence utilising digital technology where possible. A recruitment programme is in place to increase workforce for STS.

The new Trusted Assessor roles at T&SD working from within the hospital on behalf of care providers to support appropriately assessed and supported discharges to those environments, facilitating and supporting close working relationships and collaboration with them, but also the primary link for P0 clients to support a smooth discharge back to their usual place of residence if it is a care environment. The control team also undertake a daily review of all P0 patients with a LoS >7 days to ensure that if they require any help or support from the Discharge Hub, that this is escalated and reviewed.

There is a complex discharge daily sit rep meeting to check and challenge the approach towards complex discharges which maintains oversight of actions to be completed to facilitate discharge. This meeting includes voluntary sector colleagues to increase understanding of voluntary sector services and ensure appropriate input to support discharge. Increased collaboration between therapy and discharge teams is aiming to create a team ethos and improve everyone's understanding of each other's challenges and pressure. Aiming for a Joint therapy team being established across acute, community and social care – sharing the assessment burden.

The team are working with hospital wards to develop ways of managing people's care within the hospital that avoids multiple moves across in-patient wards and embeds the ethos of home first.

a) Avoidable admissions: overall plan for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive admissions.

The indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, convulsions and epilepsy and high blood pressure. The rate is the standardised rate per 100,000 population of emergency admissions for chronic ambulatory care sensitive conditions.

Plans include extending urgent community response offer, the use of surgical and medical receiving units 24/7 and extending the enhanced health in care homes offer.

In terms of frailty - in response to Torbay and South Devon NHS FT joining the Acute Frailty Network programme for a year, greater Healthcare of the Older Person clinical presence has been embedded at the Front Door. The workforce currently consists of a Consultant and Registrar with a Frailty Advanced Nurse Practitioner starting in January and a Frailty Discharge Coordinator out to advert. This team is working closely with the already established Joint Emergency Team. The emphasis is on Same Day Emergency Care and admission avoidance. Other focuses include system wide frailty identification and the roll out of a Comprehensive Geriatric Assessment.

We also have plans in place covering admission avoidance for people with Long Term Conditions, specifically respiratory and diabetes:

- **Respiratory**
  PCN's piloting a COPD pathway by working with community teams and referring into intermediate care. Weekly MDTs with specialist nurses available to support. Successfully seen as an enabler to support discharge.
  Respiratory 'hot' clinics in place by December 2021, to avoid unnecessary admissions by allowing rapid access to respiratory physicians and specialist nurses, enabling stable patients to be managed in the community.

- **Diabetes**
  Following results from an audit in September 2021, where 100% of required acute diabetic foot referrals were made, a B3 podiatry post is in place providing education, foot touch tests and next steps to all wards within TSDFT.
  Individuals can still self-refer to the National Diabetes Prevention Programme (NDPP) until March 2022. 92% of PCN referrals, for the period April 2020 to October 2021, are for NDPP.

  TSDFT continuing the roll out of CONNECT Plus app which has been co-designed with NHS clinicians and patients to make it easier to manage multiple conditions together and in one place. Its range of features provides 24/7 access to clinically assured information that helps patients to be better educated about their conditions. CONNECT Plus empowers patients by enabling them to monitor progress, manage their medication, handle numerous appointments, and better care for themselves from the comfort of their own homes. This means that patients will need fewer appointments, make fewer calls to the department, and it becomes much easier to run patient-initiated follow-up programmes.

b) Length of Stay: plan for reducing the percentage of hospital patients with a length of stay over 14 days and 21 days.

Percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days

- Model for Winter to include forensic review completed on all patients with a LOS greater than 10 days by the Clinical site Manager with a physical presence on wards to discuss patients with MDT workforce. The aim is to support a reduction in patients moving to >14 days with a focus on the patients with a criteria to reside and what needs to happen to bring care decisions forward.

- Weekly MDT meeting including mental health teams, complex Discharge. Reviewing all patients with no CTR and LOS > 14 days. Supported shared understanding of each other's challenges and pressures.

c) Discharge to normal place of residence: plan for improving the percentage of people who return to their normal place of residence in discharge from acute hospital.

Percentage of hospital inpatients who have been discharged to their usual place of residence.

Home First strategy throughout the hospital. Plans include that any patient not on Pathway 0 or not returning to their usual place of residence with usual package of care is assessed by ward staff and then referred into discharge hub.

The discharge hub undertakes multidisciplinary triage and decides the pathway, destination, and level of care. Return to usual place of residence is supported by multi-agency intermediate care teams and short-term services.

d) **Admissions to residential and nursing homes: plan for reducing rates of admissions to residential and nursing homes for people over the age of 65.**

Adult Social Care Improvement Plan is engaged with improving ASC, focussing on strength-based approach, efficiency, effectiveness, innovation, and cashable savings. This plan includes ambitions to reduce admissions to residential and nursing care, increase the use of extra care housing and increase the number of people supported to stay in their own home.

Torbay Council and Torbay & South Devon NHS Foundation Trust has jointly commissioned two new extra-care housing schemes with the express outcome of reducing admissions for older people to general residential care (we have projected a reduction of 200 commissioned residential care beds by 2030) in Torbay and extending the length of time older people can remain independent before requiring residential care with nursing. The first scheme of 80 units is at the design stage and has involved the University of Stirling's Dementia Design Centre to ensure that our admission reduction approach includes maximising independence at home for people with varying degrees of dementia. Start on site is scheduled for June 2022, with completion and mobilisation in December 2023. The second scheme of 100 units has a more complex development schedule due to the nature of the site but will be completed and mobilised in late 2024.

Further to this, we are respecifying our existing extra-care schemes (108) to increase the capability of the service to divert older people with care needs away from residential care; this will be mobilised in 2022 and is expected to a further reduction of 12 admissions a year.

e) **Effectiveness of reablement: plan for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation**

Our plans include using our multi-agency Intermediate Care Teams and enabling short term services to support people after discharge from hospital. These teams have close links with social prescribers and our voluntary sector partners so that people continue to be supported after initial, intensive short-term intervention.

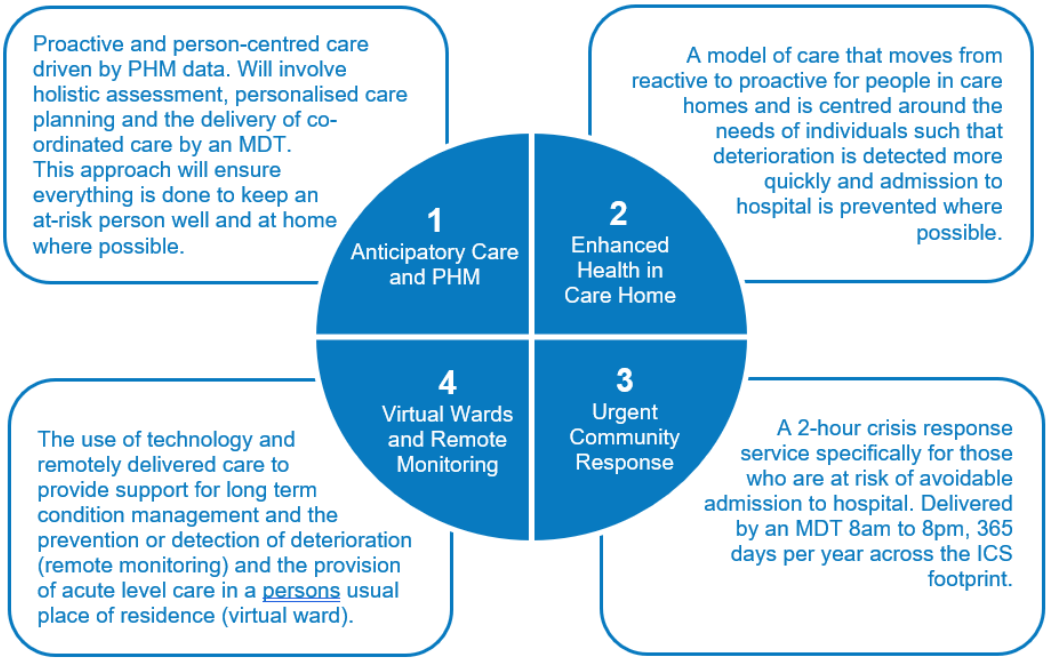
Torbay Council and Torbay & South Devon NHS Foundation Trust are at the early stages of jointly commissioning a 20-24-bed residential hospital step-down and reablement service, working in partnership with an existing Torbay care home provider alongside an embedded NHS multidisciplinary therapy team in the same building. Mobilisation of this service would be late 2022 and it is anticipated that 96-124 older people would go through the service annually, improving flow through the integrated health and care system and significantly improving post-discharge outcomes, including a reduction in unplanned hospital readmissions.

Community First Strategy

The ten components of our Community First strategy follows the ten areas of our Integrated Care framework which describes our approach in Devon to deliver truly integrated care in community services. The strategy itself forms the first component, being the map by which we will realise our vision and deliver integrated care across Devon ICS. As BCF is an enabler to this vision, investment will be particularly focused in 2022/2023 on the discharge to assess model and more appropriate use of capacity for integrated community-based health, social care, and mental health services, with a greater focus on care closer to home, supported by timely discharge and virtual wards.

Our community approach to keeping people at home

The diagram below highlights four key areas which directly seek to keep people at home (in their usual place of residence) when it is safe to do so. This strategy aims to move us to a place where we can increasingly have the resource, infrastructure, and clinical skill to support people with higher acuity needs in the community. In addition to the programmes below, there are several more specific services areas that support the avoidance of unnecessary admissions for people. A good example of this currently is the Devon ICS End of Life review, of which a focus is on giving people the increased ability to die in their preferred place and reducing avoidable admissions.



Our priorities align with the High Impact Change Model (have completed a self-assessment on managing transfers of care), and we have adopted the national discharge to assess model across Devon and are monitoring the delivery of the time to transfer standards daily and working as a Devon system to share learning and make improvements where required through our System Flow programme. It is important here that existing good practice in Torbay and indeed other parts of the system are considered as such as part of the approach in the wider system and we don't impact good progress.

Through detailed analysis of daily performance, we recognise that our main challenges are with pathway 2 and 3 discharges. Care market business continuity, workforce and market sufficiency are the key issues that we are grappling with. We are currently undertaking a piece of work, as one of the 10 points of the national 100-day challenge, to understand our discharge demand and capacity and are modelling this for each of our five localities. From this modelling work we will then draft a local plan for each area addressing; demand reduction for pathways 1-3, efficiencies within each pathway and capacity creation for each discharge pathway.

We continue to focus on supporting early discharge planning by expanding the reach of the discharge hubs and proactively supporting people home from hospital, improving patient flow through the hospital, further developing a 'one team' approach, driving forward our plans for integration including the voluntary sector, mental health services and the independent sector

and further developing the home first approach and maximising impact from the enhanced health in care homes workstream. This can be seen in our continued/new investments including through the Better Care Fund in such areas as:

- In-reaching B7 into ED to collaborate and link with JETS/Frailty/acute teams
- new Trusted Assessor / Admiral nurses working directly with the private care providers for transfers of care but also focussing Pathway 0 patients that are resident within a care environment to ensure they return to their usual place of residence
- Assistant Practitioners review all Pathway 1 from the Rapid Team, and they re-triage the Pathway 2 to ensure their prescription of care is correct and if it can be de-escalated
- multi-agency discharge teams
- enhancing our urgent and intermediate care / reablement services to build both capacity and skills
- extending hours of service across the system but particularly in community teams to move towards embedding a 7-day service and avoid peak admission and discharge times,
- increasing the scope and availability of residential and nursing care placements through discretional purchase of beds to increase capacity
- building on the skills of staff within care homes but also investing in the support we wrap around through such things as enhanced therapy support and proactively targeting primary care support to the sector
- building the scope and reach of our community equipment and telecare and assistive technology opportunities.

The Better Care Funding and our approach to integrated working are contributing to a number of existing schemes and supporting the development of others which are helping to address our local pressures, including capacity in the community, pressure of the complex caseload and the use of bed-based care.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Healthy people are at the core of healthy societies. Yet health is more than just the absence of disease. The World Health Organisation defines health as “a state of complete physical, mental and social well-being”. When it comes to health, accessible and high-quality health care is important, but as little as 10% of a population’s health and wellbeing is linked to access to health care. Many other factors, such as the home and the community we live in, our environment,
work, education and money, influence whether we are healthy and happy. It is therefore crucial to address these and create an environment that enables people to be as healthy as they can.

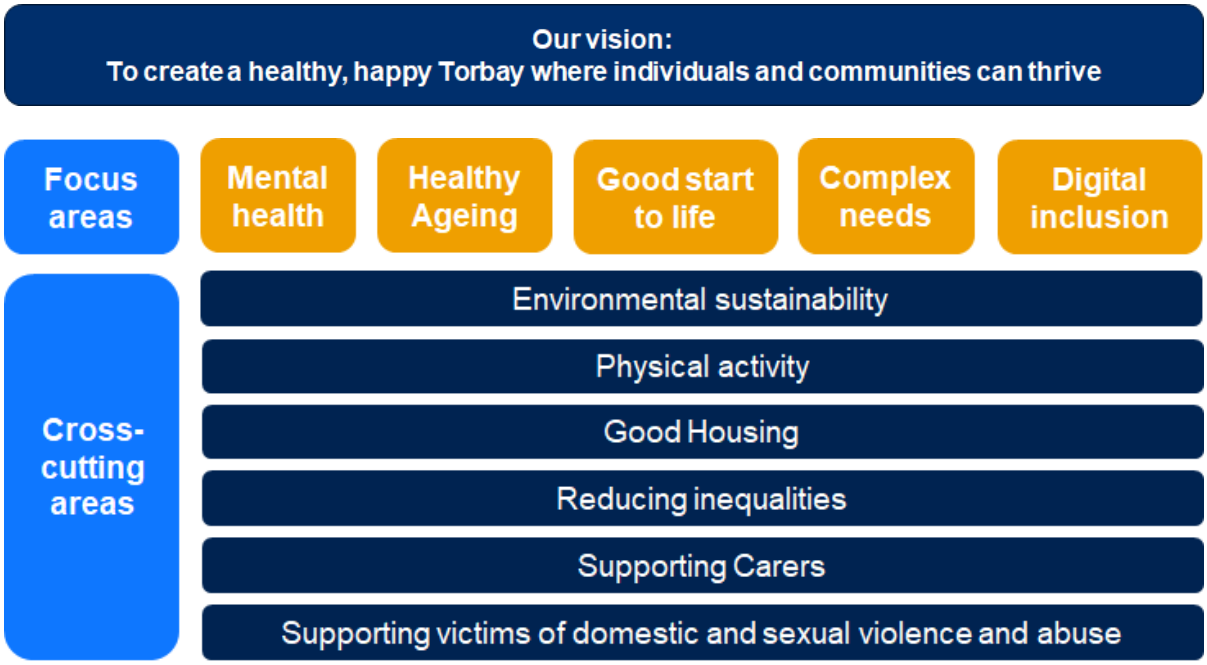
The circumstances in which we live, our daily activities and our social lives affect our physical and mental health and wellbeing. At the same time, having a physical illness or mental health problem can have a significant impact on our social and working lives and our wellbeing. Everyone in our community should have the opportunity for good health and wellbeing. To increase the health and wellbeing of the people in Torbay we need to work across all sectors and organisations to address the factors that influence these. This Joint Health and Wellbeing Strategy sets out our focus areas and key actions to improve lives in Torbay over the next four years.

Torbay offers a great quality of life for individuals and families, with a great natural environment on the English Riviera, a wide range of outdoor activities, excellent schools and a growing arts and cultural sector. But in common with other coastal communities, Torbay faces major challenges. Some of these are listed below. For more detail consult Torbay Council’s Joint Strategic Needs Assessment.

The Strategy in summary

The Joint Health and Wellbeing Strategy lays out the plan to improve the health and wellbeing of the population in Torbay between 2022 – 2026. Five focus areas and six cross cutting areas identify priorities for collective system action over the next four years.
The Health and Wellbeing Board has selected priority areas that relate to all aspects of health and wellbeing, without duplicating existing work or losing focus by spreading efforts too widely.

The Joint Health and Wellbeing Strategy provides a framework for the Health and Wellbeing Board to promote and monitor progress in the areas identified to be most important. It also provides a direction for the commissioning of services in other areas and identifies medium and long-term goals. The goals outlined in the following sections of the strategy will provide a basis for the Health and Wellbeing Board to monitor progress on each priority area.



The goals and actions laid out in Torbay's Health and Wellbeing strategy will be delivered by Torbay Council, constituent members of the Joint Health and Wellbeing Board and partners, in accordance with the table below.

The Health and Wellbeing Board has agreed 'areas of focus', 'areas to sponsor' and 'areas to watch'. Areas of focus match the focus areas of the Strategy. These are where the Board will take a more active direction and oversight of delivery. Areas to sponsor and watch are the underpinning areas where the Board is not the lead for delivery but requires assurance from partners that progress is on track.

For each area of focus there is a lead strategic group who will oversee delivery. There will also be an annual delivery plan sitting beneath the Strategy, defining actions year on year.

To ensure we achieve our aims in the agreed priority areas, an outcomes framework sets out the indicators and measures against which progress will be measured. Progress reports will be presented at the quarterly Health and Wellbeing Board meetings. In addition to this, the Health and Wellbeing Board will hold a spotlight session on each work area to examine progress in more detail through the year.

Devon Integrated Care System

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities, and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation.

The key headlines from the developing Equality, Diversity and Inclusion strategy are that One Devon is moving towards a new approach to inclusion that prioritises co-production and working with community partners to understand the needs of our diverse communities in Devon. Inclusion should be at the heart of our organisational culture and is set to be the foundation of joint working within the One Devon and NHS Devon. Since the last BCF Plan, NHS Devon implemented a new Equality, Diversity, and Inclusion Team, which includes an Equality, Diversity and Inclusion Project Manager and System Equality, Diversity, and Inclusion Lead.

ICSs have a leading role in tackling health inequalities, through building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level. CORE20Plus5 remains the focus of NHS Devon's combined HI and prevention plan, with plans to strengthen leadership and system-wide awareness of health inequalities through a range of activities, including the participation in the national piloting of both the CORE20PLUS5 Connectors model; the support and investment we continue to make in the work of our Local Care Partnerships (LCP's); and our ambition to be a pilot area for the HEE Health Inequalities eLearning programme.

Embedding Health Inequalities across the Devon system is being delivered through a number of actions, including:

- Working closely with our workforce programme, NHS Devon will aspire to deploy Health Inequalities awareness to all staff. This will ensure the workforce:
    - Have a common understanding of what health inequalities are, and how they can affect the population of Devon.
    - Are more confident in asking patients to share personal information about themselves that will assist us in ensuring that factors such as where they live, their ethnic background and other characteristics are not resulting in unacceptable differences in access, experience, and outcome.
    - Are confident in identifying health inequalities.
    - Are confident in taking positive action to tackle any identified health inequalities experienced by the people they meet.
- Working closely with our colleagues in Communications & Engagement NHS Devon will aim to raise awareness of health inequalities within our population. This will support patients in being confident in why it is safe and relevant to share information about themselves.
- In 2022/23 NHS Devon revised the Quality and Equality Impact Assessment (QEIA) which will be launched across Devon to ensure HI is fully considered in all change. A "soft launch" within NHS Devon in Q3 will inform final revisions prior to a phased, wider rollout for completion by Q4 2022/23. This refreshed tool will view inequalities from the perspectives of those affected by them through co-design with the relevant inclusion health groups. Importantly, not only will this tool make it easier to identify potential inequalities brought about by change, but it will also connect those completing the assessment with best practice and easy to understand, tangible examples of how to mitigate against possible inequalities.
- Revisions to our governance structure for health inequalities will give increased focus supporting the Health Inequality priorities our LCP's, and the PCN's within them, have described, alongside the delivery of whole-Devon improvements.
- Establish even stronger links with our network of Health Education England HI Fellows.

- Build upon the work of Devon Communities Together cultural awareness programme that describes a common understanding of why tackling health inequalities is important to our communities, to influence both public health & VCSE sector workforce and our population.

By November 2022, NHS Devon will have completed a homeless health needs assessment within each locality to give both a local, and aggregated whole-Devon, view. The homeless HNA will also be used to inform future commissioning requirements of Primary Care services to support the homeless population and ensure inequalities that may exist in the current provision are addressed across Devon. From a study undertaken in 2020 to understand attendance and discharge experiences of no fixed abode and addiction patients at local hospitals.

Currently work is being undertaken on Devon's overarching primary care and Community First strategies, People Led Change and the expectation is that addressing health inequalities will be a prominent feature of that work (strategy production July 2022).

Investment in prevention priorities continues both in whole-Devon workstreams, and in interventions at place via our £2m annual prevention fund.

Devon approaches 22/23 having made significant improvements in the capacity and leadership of the Health Inequalities programme. Through:

- The appointment of a Non-Executive Director with the responsibility for Health Inequalities
- Alignment of the HI, Prevention and Health Inequalities agendas under the portfolio of the Deputy Director of Commissioning of Out of Hospital.
- Identification of a whole-Devon SRO for Digital Inequalities
- Appointment of a Head of Health Inequalities and Prevention
- Increased support to, and engagement with, the HEE funded Health Inequalities Fellows network in Devon.
- Dedicated project management capacity in place to support localities in taking action to deliver the priorities they will define to achieve the aims of our Equally Well aspirations.

NHS Devon's Population Health Management programme is closely linked with the Health Inequalities team. The Population Health Management Programme has the overall aim of having a systematic population health analysis at system, place, and neighbourhood level, by 2023/24 enabling LCPs, PCNs and partners including mental health and local authority, to understand their population's needs, including the wider determinants of health, and design interventions to meet them. As an end state, all LCPs and PCNs should be routinely utilising PHM to develop targeted interventions for identified 'at risk' cohorts. The One Devon Dataset (ODD) is in the process of being developed. The dataset will allow all data to be accessible in one place, with various organisations able to access the data.

Using the data made easily accessible by the One Devon dataset will enable us to inform the Better Care Fund schemes, ensuring better outcomes for the population as well those facing inequalities in accessing services.

Better Care Fund Submission Templates:

N.B. Awaiting further information in support to complete some components in the attached templates.

BCF Template 2022-23 Torbay v2.4

BCF Demand & Capacity Template -

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Plymouth Better Care Fund

Narrative Plan

Plymouth Health and Wellbeing Board

Karlina Hall (Plymouth City Council)
James Glanville (NHS Devon)

NHS Devon

PLYMOUTH CITY COUNCIL

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

BCF (Better Care Fund) narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as the excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board(s)

Plymouth.

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

The BCF Plan 2022-23 has been written jointly between Plymouth City Council (PCC) and NHS Devon through their respective BCF Leads based within Commissioning. The BCF Leads have engaged with a range of key stakeholders including local authority and NHS Devon finance teams, local authority housing, Carers Commissioning lead, University Hospitals Plymouth, PCC Reablement Service manager and local authority and NHS Devon performance teams specifically to create the narrative and/or the BCF Planning template.

The individual scheme leads have completed online evaluation forms that have helped to shape the BCF Plan and the upcoming visit from the National BCF Team and partners.

The initial delegated sign off is from the Chair of the Health and Wellbeing Board for Plymouth via the Service Director for Integrated Commissioning. The Health and Wellbeing Board will then oversee the progress of the BCF Plan 2022-23 and the development of any subsequent BCF Plan (dependent on timescales).

As part of the Devon-wide system sign-off process the BCF plans for each of the three Health and Wellbeing Boards will be reviewed and signed off by the NHS Devon ICB Executive Board.

How have you gone about involving these stakeholders?

The role of integrated commissioning at ‘place’ is well established within Plymouth, with joint commissioning functions and the development of the Integrated Care Partnership supporting vertical integration across acute, community and mental health provision, and with a community provider delivering services across both health and social care. Underpinning this is Plymouth Local Care Partnership which is a key driver for local strategy and agreeing and delivering against key local priorities. This foundation of a clear system wide set of priorities (as described later within this narrative) agreed by partners across the local system underpins the BCF plan with investments that are a key enabler of many of the LCP (Local Care Partnership) priority areas. This close alignment and existing governance approaches ensures system wide support of these schemes, and oversight of their delivery, across partners and all key stakeholders.

At place, the Western Urgent Care Board is an integrated governance arrangement including NHS Devon, UHP NHS Trust, Livewell Southwest, Plymouth City Council and other health and care organisations from Devon and Cornwall.

The continuation of the BCF schemes delivered through the associated funding requires effective partnership working to ensure the delivery of these schemes using an integrated partnership system approach. The Plymouth partners include the acute hospital (University Hospitals Plymouth NHS Trust), Local Authority Reablement Service, community health and adult social care provider (Livewell Southwest), Primary Care, Care Providers and Voluntary and Community Sector Organisations.

University Hospitals Plymouth NHS Trust clinical strategy's overarching principles align with the priorities and objectives of the Better Care Fund. UHP continue to play a proactive leadership role in shaping Devon ICS direction to maintaining services and patient access. More detail on the clinical strategy can be found in the approach to integration section.

Executive summary

This should include:

- *Priorities for 2022-23*
- *Key changes since previous BCF plan*

Since the previous BCF plan NHS Devon CCG (Clinical Commissioning Group), has moved to an Integrated Care System known as NHS Devon. This change took place on the 1st July 2022, whereby NHS Devon statutory body took on the commissioning functions that resided with NHS Devon CCG. As part of the Devon-wide system sign-off for the under the new Integrated Care System (ICS) governance framework, the BCF plans for each of the three Health and Wellbeing Boards will be reviewed and signed off by the NHS Devon ICB (Integrated Care Board) Executive Board.

One of the key system priorities remains urgent care and system flow given the current challenges being experienced within the urgent care system and the impact discharge has on wider system flow. University Hospitals Plymouth is a national outlier in terms of ambulance handover delays and has been supported through the National Hospital Discharge Programme. The Plymouth BCF plan responds to this with schemes that support targeted long-term investments to build sustainable community services for individuals on discharge across all care pathways with the aim to reduce pressure on urgent care. This will be achieved by working in partnership to deliver joined-up integrated, person-centred care in the community using the new ICP and LCP arrangements as a driver for change between partner organisations that enable people to stay well, safe, and independent at home for longer.

The local Plymouth system has shaped a number of priorities of the Plymouth Local Care Partnership (LCP), with the System Plan adopted in autumn 2021. These priorities underpin local system work and the BCF plan is a key enable across many of these.

1. Building a Compassionate and Caring City
2. Developing a Sustainable system of Primary Care
3. Empowering Communities to help themselves and each other
4. Ensuring the Best Start to Life through “A Bright Future”
5. Relentless focusing on Homelessness Prevention
6. Integrating Care to deliver “the right care, at the right time, in the right place” to promote home first, prevent unnecessary admissions, facilitate timely discharges, enable people to die in a place of their choice and that delivers Equally Well.

As the Plymouth LCP continues to develop, there remains an opportunity to review existing s.75 joint funding arrangements and seek to enhance these further by building on the joint funding arrangements currently set out under the BCF plan. As a local area this is work that we will be progressing in the coming months to develop a proposal for supporting further local system integration.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

From 1st July 2022, the Devon NHS ICS statutory body took on the commissioning functions that resided with NHS Devon CCG. Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area. They exist to achieve four aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

Diagram 1.1

The local system for Devon has key elements, as demonstrated by the diagram (1.1) above. NHS Devon is responsible for commissioning NHS services and joining up care. One Devon is a committee of local organisations and groups who work together on a strategy to join-up services. The committee includes NHS, local councils, voluntary sector, and many other representations, as per the diagram (1.2) below.

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Diagram 1.2

As part of the Devon-wide system sign-off for the under the new Integrated Care System (ICS) governance framework the BCF plans for each of the three Health and Wellbeing Boards will be reviewed and signed off by the NHS Devon ICB Executive Board.

In 2016, NHS Devon CCG and Plymouth City Council formed an integrated commissioning function as part of their single commissioning approach, with an integrated fund, risk and benefit sharing agreements. The Local Care Partnership and approaches to integrated commissioning have developed this further. Central to this approach are the integrated governance arrangements as shown in the diagram (1.3) below:

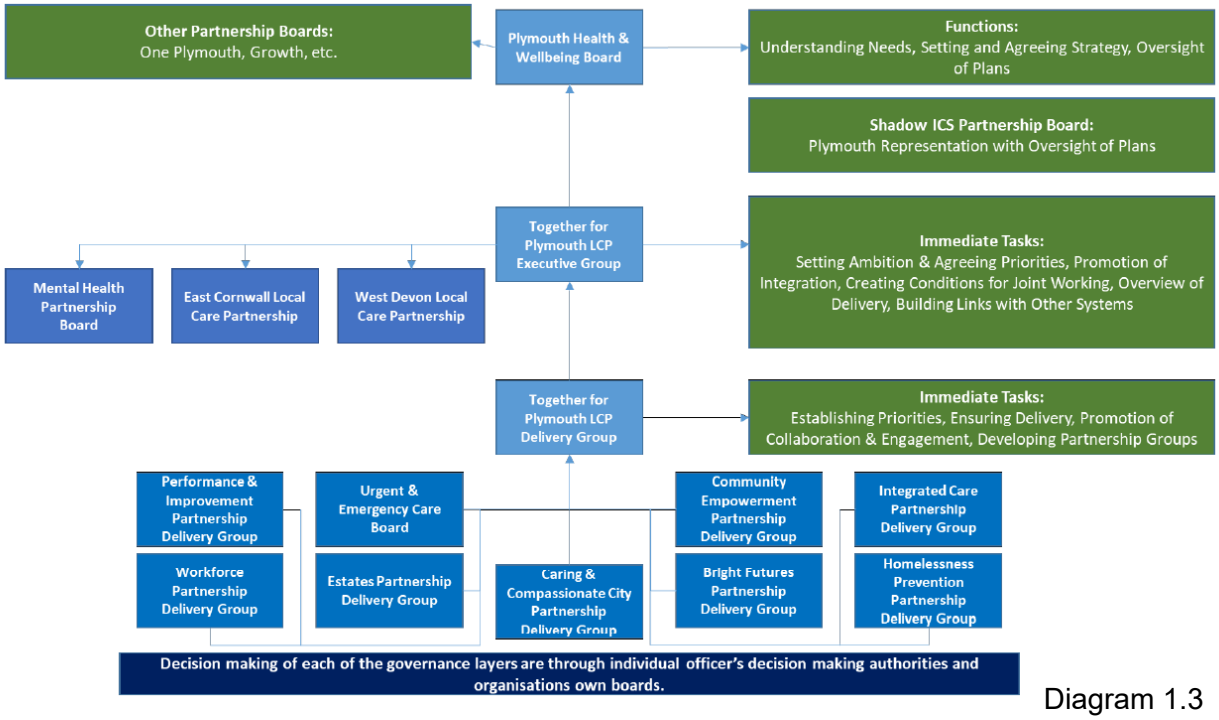


Diagram 1.3

The Plymouth Local Care Partnership provides system leadership and clinical oversight to the integrated commissioning arrangements. It provides focus and direction for integrated commissioning, ensuring collaborative planning and performance monitoring. It also provides assurance to the governance bodies of both NHS Devon and Plymouth City Council. To ensure entire system collaboration, the following organisations are members of the Local Care Partnership:

- Age UK Plymouth
- Colebrook
- Community Connections
- Devon Local Optical Committee
- Devon Local Pharmacy Committee
- Elder Tree
- Healthwatch
- Improving Lives Plymouth
- Livewell Southwest
- NHS Devon
- Plymouth City Council
- Plymouth Octopus Project
- St Luke's Hospice
- University Hospitals Plymouth

In terms of governance of the Better Care Fund, the Plymouth Health and Wellbeing Board sign off the plan, whilst monitoring is undertaken by the Plymouth Local Care Partnership.

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- *Joint priorities for 2022-23*
- *Approaches to joint/collaborative commissioning*
- *How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.*

As a newly formed Integrated Care System, using published guidance, an Integrated Care strategy is being developed. The strategy will be developed with the members of the One Devon Partnership. The strategy will build upon existing integration work that has taken place to develop strategies that support more integrated approaches to delivering health and care. This will help to provide focus on and drive the change required to tackle the challenges the system faces such as reducing disparities in health and social care; improving quality and performance; preventing mental and physical ill health; maximising independence and preventing care needs.
Plymouth Local Care Partnership priorities have been informed by our Joint Strategic Needs Assessment (Plymouth Report) and Locality Profile. The priorities have also been shaped by our experiences and learning from COVID, and the sustained pressure on our urgent care system. The priorities of the Plymouth Local Care Partnership are:

a) Building a Compassionate and Caring City
b) Developing a Sustainable system of Primary Care
c) Empowering Communities to help themselves and each other
d) Ensuring the Best Start to Life through “A Bright Future”
e) Relentless focusing on Homelessness Prevention
f) Integrating Care to deliver “the right care, at the right time, in the right place” to promote home first, prevent unnecessary admissions, facilitate timely discharges, enable people to die in a place of their choice and that delivers Equally Well.

The LCP (“Together for Plymouth”) has 6 key programmes and workstreams including Urgent and Emergency Care recovery, Integrated Care Partnership Transformation Plan, Ageing Well Programme, Community Mental Health Framework, Caring for Plymouth, and End of Life Action Plan.

Through this work we continue to aim to reduce the number of Emergency Department attendances, increase the number of people discharged to home first, reduce the number of people entering long term care, increase the utilisation of alternative to admission and crisis response, increased number of mental health clients being supported in the community and increase the number of people able to die in their place of choice.

The recently produced Devon ICS Community First Strategy sets out a vision at a Devon System level for shaping the direction of community services over the next 5 years, underpinned by integrated care, and seeking to enhance community resources through the delivery of preventative, proactive and personalised care. Local delivery of this strategy aligns to Plymouth LCP priorities, and the BCF plan supports this with a clear focus on the BCF policy objectives.

University Hospitals Plymouth NHS Trust have developed a ten-year overarching clinical strategy providing the framework for the 50 individual clinical strategies for each service line.

The strategy defines the basis for collaboration- putting the needs of the patients and population at the heart of integration. The clinical strategy outlines the vision and ambition for system collaboration and support for future care models to deliver, at local and regional level. This has been described in the strategy as a need to collaborate with partners to deliver streamlined end-to-end patient pathways which ensure patients get the right interventions first time, share information seamlessly, focus on prevention, and deliver care as close to home as possible.

Work is underway across Health and Care in the Peninsula to define and embed new integrated clinical models of care. This clinical strategy helps us define the basis for collaboration – putting the needs of patients and our population at the heart of our integration work. Work to date has had input and co-development from our partners in the ICP, but we need to further test, iterate, and refine our clinical models and service-level strategies with our partners across the region. Specifically:

- Integrated Care Partnership: For the first time, our organisations have more visibility over end-to-end pathways and capacity for our local population. As we mature as an integrated partnership, we should be prioritising changes in allocation and delivery of resources, aligned to colleagues in Primary and Social Care.
- Local Care Partnership: Working with primary care, local authority and VSCE organisations, we have an opportunity to change how we meet needs of our local population, and play a proactive role in supporting LCP delivery - for both health and social care
- Integrated Care System: Our Devon ICS is maturing, and work is underway to develop the Devon ICS clinical strategy – we need to be proactive and play a leadership role in shaping the direction to maintain access specialist services within the local region and ensure patients have access to high-quality, innovative, and emerging care regardless of geography. We must also continue to foster closer collaboration with the Cornwall and Isles of Scilly ICS.
- Peninsula and SW region: Our catchment extends across two ICSs (Devon and Cornwall & IOS) – we need to work with and align with emerging plans in Cornwall or there is a risk of East Cornwall population being underserved. Additionally, many of our specialist network discussions will need to happen at a Peninsula or Southwest regional level.

Source: UHP NHS Trust Clinical Strategy.

Our local approach to integration is demonstrated through the recent joint procurement undertaken by Plymouth City Council and Torbay Council in partnership with NHS Devon, to procure Community Equipment Services within each local authority area. The opportunity was split into two Lots with a separate contract to be awarded for each local authority area. Plymouth's Community Equipment Service (CES) is for adults and children within the Plymouth City Council area or those on the outskirts if registered with a GP in Plymouth. The current Plymouth contract has been in place since 1st April 2015 and between 16,000 and 18,000 people are supported by the service every year.

There were several strategic and operational drivers to review the community equipment service, including the increase in demand on services with Devon's growing and aging population and the increase in number of young people with complex disabilities reaching adulthood and living in the community. In the future more people with increasingly complex needs are likely to need to be enabled to live in their own homes for a longer period. The joint exercise enables the alignment of products, practice and quality requirements across Plymouth and Torbay Councils, to develop and shape the market, ensure sustainability of

provision across the geographical area and to ensure suitable funding arrangements and mechanisms to manage the spend against the contract.
This service provides equipment relating to a prescribed, clinical need to support a person in their own home. This includes equipment such as beds, mattresses, and mobility aids. Equipment may be provided to support someone with a short-term need, while they recover from illness, or longer term or permanent ill health. Referrals to the service are made by prescribing organisations such as Livewell Southwest, University Hospitals Plymouth NHS Trust, St Luke's Hospice and Practice Plus Group Hospitals which supports our approach to integration.

There have been no significant changes between the schemes commissioned between 2021-22 and 2022-23. A minor change has been the Rapid Response Dom Care, which has been changed to Intermediate Dom Care. The scheme invests into the market, contributing to market resilience and sustainability. The schemes continue to deliver a wide range of integrated approaches such as the partnership working between community and acute health providers to prevent unplanned admissions through the Frailty Nurses and Trusted Assessors working in integrated health and social care teams to prevent unplanned admissions to hospital.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

Please use this section to outline, for each objective:

- *The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care*

Plans for supporting people to remain independent at home for longer should reference

- *steps to personalise care and deliver asset-based approaches*
- *implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches multidisciplinary teams at place or neighbourhood level.*

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- *Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.*
- *Carry out collaborative commissioning of discharge services to support this.*
- *Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.*

The Better Care Funding is contributing to several schemes by helping to address our local pressures, including capacity in the community, pressure of the complex caseload and the use of bed-based care.

The schemes supported under the BCF have a clear focus around supporting individuals to stay safe, well and independent at home and the details set out below describe this with a focus around the interface into acute and community services. Alignment of our ambitions to deliver this whilst also responding to the significant and recognised challenges facing the Plymouth acute hospital system means whilst schemes support many aspects of this there is an agreed prioritisation of schemes that support admission avoidance and hospital discharge. We envisage that this will continue to evolve in the future as we seek to deliver the ambitions set out under the key priorities within the LCP plan and in delivery of the Devon ICS Community First strategy, but for the current planning process our schemes directly respond to the challenges facing Plymouth and the priorities agreed through the LCP infrastructure and Health and Wellbeing boards.

How BCF funded services will support delivery of the objective: Enable people to stay well, safe, and independent at home for longer

The Plymouth BCF schemes cover a range of initiatives that directly attribute to and support delivery of the central tenant that the best bed is your own bed, and we are committed to supporting individuals to remain at home and return home following a hospital admission. A significant portion of the schemes the BCF supports are focused on wrap around and enabling support to individuals living within their own home, and even where there are bed-based community provision as part of schemes these are underpinned by a rehab approach and capacity to support a timely return to individuals own home wherever this is possible.

There has been focussed work on improving outcomes for people being discharged from hospital by aiming to get patients to a safe environment, at home as soon as possible and optimising their independence. Each patient is considered for Homefirst and given the opportunity to live independently within their own community. The High Impact Change self-assessment highlighted that further work is required on embedding a Home First mentality.

Capacity issues across pathway 1 has led to an over reliance on short-term bedded placements. This can be attributed to the limitations surrounding home-based care. Work has been undertaken to increase home-based options as a priority, as part of our Home First approach. Despite this prioritisation, capacity gaps combined with increasing complexity has led to shortfalls leading to more bed-based options for expedient discharge from acute care. The embedding of a home first mentality ensures that this discharge pathway is considered first to maximise an individual's opportunity to be independent at home, safely and for longer.

The Better Care Fund contributes to enabling people to stay well, safe, and independent at home for longer through the following actions and schemes:

Community Equipment Service

The CES manages the delivery and installation, service and maintenance, collection of equipment that has been ordered by a prescriber, physiotherapist, district nurse or social services provider, as well as make adaptations to people's homes. This service supports better outcomes for individuals such as improved quality of lives for those using the equipment prescribed and helping them to feel safer and more independent, reducing the need for care. Assisting with discharge from hospitals, so more care can be offered in the community.

The service performance is measured by the call answering times, numbers of community equipment items delivered, collected, recycled (numbers and timescales to collect, clean and return to shelf) and scrapped the number of deliveries and collections as well within the timescale requested. Performance data from 2021/22 shows 30,359 items delivered, 12,475 items collected, 10,723 items returned, and 1,752 items scrapped.

The integration and joint working between local authorities and NHS and other healthcare providers, has been improving as we move into an ICS, which means any issues and problems can be mitigated more effectively, as more organisations are empowered to take responsibility and act. However, the service would have benefited from a greater level of resources, funding and staffing at both NHS Devon and Local authorities' levels to manage the contract, as well as clearer lines of responsibility between the organisations. The supply chains for Community Equipment Services were affected for some items due to global supply chain issues, and inflationary pressures linked to increase fuel prices are likely to be felt in the service over the next 18 months. Therefore, as these services and equipment are purchased around the country by lots of separate local authorities/ICS. It would be good to see a more joined up approach e.g., bulk buying, localised manufacturing/onshoring, electrification of delivery vehicles that would enable greater resilience.

The CES contributes to Length of stay -in hospital but focuses on Discharge to normal place of residence and Reablement for older people by supporting hospital discharge and making people safer and happier at home. However, challenges have been identified by the scheme such as Strong, system-wide governance and systems leadership, integrated electronic records, and sharing across the system with service users and an integrated workforce: joint approach to training and upskilling of workforce.

Disabled facilities grant

The Disabled Facilities Grants are managed by an internal team to Plymouth City Council. INCIC are the main delivery partner in the scheme which uses their dynamic purchasing system to coordinate bids from registered list of approved contractors in the delivery of adaptations. The Council has a statutory duty to approve mandatory Disabled Facilities Grants (DFG's) for major adaptations. This service outcomes are that more people are helped to remain living independently in their own homes, supporting the reduction of care needs, and improving the quality of living.

Service performance is primarily measured by the number of completed adaptations across the city and reviewed quarterly. In financial year 2021/22, there were 272 adaptations completed across Plymouth which consisted of over 420 individual adaptations. Working closely with our delivery partner INCIC has allowed the service to be more dynamic than in previous years as we are able to respond quicker to emerging need, improve competitive bidding and develop new programmes where required. Pooled or aligned resources and Integrated workforce: joint approach to training and upskilling of workforce have also been identified as successes for DFG. For example, appropriate coordination of resources best enables positive outcomes. DFG has a split when looking at necessary and appropriate, reasonable, and practicable which sees OT's and Community Connections team members working closely together to ensure that delivery meets the needs. Joint training and focuses on this ensure that the same messages are delivered throughout a client's journey, manages expectations, and increased the chances of customer satisfaction and needs being met.

However, Plymouth needs to develop a system approach to the use of assistive technology. As a single service they hold the capability to deliver and install through the homes where they are delivering major adaptations. Our knowledge is however limited in terms of the benefit installations have on ongoing care needs and the potential reductions that utilising this form of equipment holds. Work is however underway to develop this understanding and hopefully we will see progression on this over the coming months.

DFG is wide reaching and has the ability to reduce overall admissions and reduce the stay in care provision or hospitals. DFG's can be installed relatively quickly when fast tracked by an Occupational Therapist. The delivery of stairlifts, level access showers, hoists and other aids can assist with hospital and care discharges and their use once a need has been identified can prevent issues such as trips and falls.

Reablement, Rehabilitation and Recovery

The BCF funded Independence at Home Service aims to enable individuals to stay well, safe and maintain their independence within their own home and their local community for longer. The reablement model aims to support better outcomes for people leaving hospital by:

- Reducing the time people spend in hospital when they no longer need acute care preventing hospital acquired infections and 'deconditioning.'
- Assessing people in a more appropriate environment than the hospital giving a more accurate indication of their strengths and needs if ongoing services are required.
- Providing multidisciplinary reablement and rehabilitation plans, and if necessary short-term care and support, to help people gain and re-gain independence, preventing or reducing need for longer term care.

- The model also enables the urgent care system to prioritise acute hospital care for those people who need it.

Independence at Home is the DTA2 pathway for people medically fit for discharge and are committed to providing patients on this pathway a service on the same day of discharge. The objective is to provide the right care in the right place at the right time.

The purpose is to support a safe and timely hospital discharge for individuals medically fit, no longer needing hospital care. Assessments and care provision can then be tailored to support people to regain strengths and skills so that they can live as independently as possible.

Plymouth City Council prides itself on the quality of care it delivers to individuals, adopting a flexible approach to individual needs, enabling them to maintain their independence and preserve their quality of life. To help address hesitancy in using a care service, a care package is personalised to meet their individual needs, goals, and outcomes.

To achieve this, it is imperative we work in partnership with individuals and families to identify their own needs and goals, recognising that person-centred care planning is key to the person accomplishing the outcomes they want to achieve to obtain optimal independence.

We have sound principles for the way we run our service. Central to these is our belief that the rights of Service Users are paramount. Following the agreement of short-term goals, the team will support individuals to regain the skills and confidence needed to promote independence, care staff will continue to review progress accordingly, staff have been specialised in identifying and assessing an individual's need for ongoing care during the short-term rehabilitation programme.

In-house Quality Monitoring governance ensures the individual's care is delivered in the way they wish.

The team is dynamic and multi-skilled consisting of Managers, Care Coordinators, Community carers and an Occupational Therapist, working alongside partners such as the Adult Social Care provider, care providers, integrated hospital discharge team and community health provider to help prevent admissions to hospital, support hospital discharge following a period of inpatient hospital care and deliver health and care plans as part of multi-disciplinary teams within the community or care settings. The process is fundamental to support hospital throughput.

Intermediate Care Placements (DTA Pathway Provision and Care Coordination Team)

The BCF funded schemes aim to provide community care home capacity to enable respite, rehabilitation and reablement. This ensures patients maximise their independence before going home or being assessed for ongoing care. The funding provides contracted beds in local care homes with associated support for homes (as per CQC (Care Quality Commission) registration requirements). This underpins the D2A model of service delivery to reduce length of stay in hospital, prevent long term decisions being made in hospital, reduce dependency on long term care in care homes, weekend discharges and reduce in delays in discharge. Whilst we remain focused on prioritising Home First we recongnise that for some individuals a short term bedded placement may be required for a short period whilst assessing ongoing care needs. This is balanced by ensuring DTA provides a coordinated

approach to pathway management, from hospital admission through to discharge to a care home or home. The team provide support to ASC in making timely assessments in the right place, to ensure the onward care received enables positive outcomes for patients and the wider system.

How BCF funded services will support delivery of the objective: Provide the right care in the right place at the right time

The Plymouth system has made significant progress in improving the hospital discharge position and delays impacted through the availability of care for discharges within the Plymouth LCP area, however, the numbers of individuals who remain in hospital with no criteria to reside remain above the national target. The impact of delays in discharge are well recognised and the impact this can have on individuals risking their independence, increasing their long-term needs, leading to worsening health outcomes. Analytical work undertaken has also identified that blockages in discharging from intermediate care is a factor affecting system flow through urgent and emergency care. Many of the local schemes set out below are therefore focused on developing local services to provide the right care, in the right place and at the right time.

The approach to discharge in Plymouth focuses the principles of the Hospital Discharge Policy and optimising the Discharge to Assess (DTA) arrangements (Hospital Discharge and Community Support: Policy and Operating Model). The DTA model enables people to have an assessment outside of the hospital and aims to support better outcomes for individuals. In Plymouth there is a dedicated DTA team delivered by Livewell Southwest. From the High Impact Change Model self-assessment, recent input from ECIST suggests that locally we are still undertaking too much therapy assessment in the hospital pre-discharge. To address this, assessments need to reduce in hospital so that only screening questions are asked and to enable a professional handover to the Transfer of Care Hub- enabling a suitable decision to be made on the pathway. Working with ECIST, Livewell Southwest and University Hospitals Plymouth NHS Trust are working on a pilot.

The Better Care Fund contributes to providing the right care in the right place at the right time through the following actions and schemes:

Domiciliary care health

This scheme provides access to personal care provision through investment in the Plymouth domiciliary care market to support individuals as part of intermediate care responses to avoid hospital admissions and support timely discharge from hospital. The Better Care Fund continues to support jointly commissioned schemes which invest in the market to ensure the sufficiency of supply, to maintain and grow market availability to address unmet need. Market sufficiency is essential to maintain system flow through supporting hospital discharges, exiting individuals from Independence at Home and supporting admission avoidance interventions during periods of escalated need/crises. The BCF schemes invests in agency pay rates to bolster market capacity, improve provider sustainability and support providers in upskilling and retaining staff to manage increased acuity of need. The scheme enables people to be discharged to their usual place of residence, with a personalised package of care. Ensuring the individual receives appropriate care, at the right place (being

their home) and at the right time to support their ongoing health needs. To ensure there is appropriate care for individuals, this scheme ensures that there is adequate capacity to meet demand, thus reducing the need to redirect services which in turn mitigates the risk of negative patient outcomes.

Although the provision works well, the capacity remains insufficient. Further investment would support the schemes development, along with service reconfiguration. The scheme demonstrates successful practices of joint commissioning and contributing to the development of an integrated workforce.

VCSE schemes (Assisted Discharge Service- British Red Cross)

To support hospital discharge and to provide extra capacity a forward approach to working with our voluntary and community sector organisations has been taken. The Assisted Discharge Service is a jointly commissioned service provided by the British Red Cross. The service was commissioned to reduce delayed transfers of care and prevent readmission. The service supports the swift discharge once patients are medically fit by carrying out the following:

- a comprehensive home risk assessment to identify hazards, linking with fire services as needed and unmet support needs; ensuring the house is warm; waiting with them to meet ongoing care package providers, informing friends, neighbours, and family of arrival home; carrying out essential food shopping and prescription collection. Also support patients for appointments associated to their recent hospital stay/medical appointments to enable them to remain at home. Providing ongoing support for a period of 4 weeks, this will be through welfare calls.

These service activities support better outcomes for individuals through safe home return to promote living independently and maintaining sustainable support networks within the community.

Through enabling a swift discharge, the service can facilitate patients to be discharged at the right time, in the right place (to their home) whilst ensuring the right onward wrap around support is in place. The Assisted Discharge Service supports between 650-700 service users a year, with approx. 500 – 550 journeys home from hospital per annum. The service employs 3.6 FTE staff including a service manager, service coordinators and service assistants. The British Red Cross works flexibly in partnership with all key stakeholders across the system, both in hospital and in the community. Good working relationships have been formed with University Hospitals Plymouth and the ward staff which has seen the number of service users being discharged home from the hospital increase.

The VCSE links supporting system flow are further augmented by our local delivery of a personalised approach to discharge utilising Hospital Discharge Personal Health Budgets. These offer a flexible approach to the purchase of one-off-goods or short-term services that can either enable an individual to return home without support, or alongside a VCSE offer to enable a timely return home.

Frailty nurses

The provision of frailty specialist nurses, funded by the BCF, provide in-reach at the front door of University Hospitals Plymouth emergency department and as part of the acute frailty

unit. The team have been able to provide a nurse lead in-reach into ED and MAU for 12 hours 7 days a week - this has meant that the frailty service is not limited to the footprint within the unit.

The 4x WTE band 6 Nurses provide specialist input into comprehensive geriatric assessment to promote patient choice and options. The specialist nurses prevent, where possible, admission into hospital, support discharge, promote and access community services to provide an alternative to hospital admission and reduce length of stay in hospital if the admission was unavoidable. The team of nurses ensure older patients receive the right care in the right place at the right time. This service supports better outcomes for patients by focusing on a home first approach to their care, ensuring wherever patients are discharged to their usual place of residence. Outcomes are improved by empowering patients to have choice and control, through shared decision making with the specialist nurses and patients aiding in reducing the length of stay in hospital.

The team support between 7-9 patients a day through the MDT (Multi-Disciplinary Team) supported acute frailty unit, with 8 patients a day assessed in ED or MAU with a focus on discharge. Total number of patients seen by frailty team 2021/22:

- Acute frailty unit = 1425 over 254 operational days
- Frailty nurse in reach (ED/MAU) = 1769 over 365 operational days

To further improve the service increased training and development opportunities for team members - looking at non-medical prescribing, HEE (Health Education England) funding for enhanced practice models to further support patients and the medical teams.

Trusted Assessor

National best practice advises that some delays can be avoided, if the delay is caused by waiting for a care provider to assess and accept a patient into their service. The trusted assessor is an interface between the hospital and all our D2A care homes and can act on behalf of and with permission of the care home to resolve these delays. Also, a bed bureau service will support this role and release professional capacity to undertake patient assessments. This role will aim to drive forward a Trusted Assessment ethos throughout the discharge (DTA2) pathway to increase acceptance of placements without home needing to undertake an in-hospital assessment and reduce the overall delay in getting placement confirmed and patient moved. Poor placements lead to a greater risk of failed discharge and return to hospital. There have been significant delays for patients who need to be discharged to care homes in Plymouth due to available capacity and infection control issues. The BCF funds 1.6 FTE nursing posts who provide this function, enabling a swifter but considered discharge to a care home. Timely assessment enables patients care needs to be carefully considered, ensuring the right placement is facilitated into the most appropriate care setting.

The Trusted Assessor service achieves positive patient outcomes by suitably assessing the patient holistically on behalf of the care home. This ensures patients are placed into settings that can continue to meet their care needs, enabling the delivery of the right care, at the right time and in the right place.

The High Impact change model self-assessment highlighted that the Trusted Assessor service is mature in its development, particularly with independent care sector assessments. Further work is required in terms of clinical support following discharge, with this work in the process of being developed with partners including Livewell Southwest, University Hospitals Plymouth, Primary Care Networks, and the Older People's Mental Health team. This work aligns with the Enhanced Health in Care Homes framework.

Further improvement is required to continue building confidence with the care homes, to ensure they understand the cohort of the patients within their homes. This will help to build confidence and provide robust assurance processes.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The Caring for Carers Service provided by Improving Lives Plymouth is a responsive and flexible Carers' Support Service that supports carers in their caring journey: before caring, becoming a carer, living as a carer, moving on from caring and that enables them to maintain healthy wellbeing and resilience. The service is delivered in a co-productive way and includes deliverance of assessments of carers and support planning, that are Care Act 2014 compliant. The service works in close partnership with others within health and social care to raise awareness and recognition of carers and the value they provide in sustaining the system and including the delivery of key NHS Long Term Plan objectives relating to carers.

The BCF contributes towards payment of staffing to deliver service and towards the carer's personal budgets such as a break from caring to improve their health and wellbeing. There are statutory duties for both LAs and the NHS to ensure that services are provided for family and friend carers, via Care Act 2014 and recently passed Health and Care Bill 2022. Every year, more people take on a caring role. The enormous contribution of the country's carers not only makes an invaluable difference to the people they support, but it is also an integral part of our health and social care system, and it deserves to be better recognised. Carers UK estimate that care provided by friends and family saves the state £132 billion each year. The King's Fund 360o social care review showed that carers contribute the equivalent 4

million paid care workers without them the system would collapse. The number of carers receiving support from local authorities increased from 338,000 in 2020/21 to 389,000 now, although there has been a shift to more carers receiving advice, information, and signposting (59% compared to 50% in 2015/16). This fall in paid support for carers is due to the budget pressures and reduced spending power in local authorities.

The Caring for Carers Service is expected to improve the following outcomes for carers:

- Providing innovative support to adult carers to enable them to continue caring without detriment to their own health and wellbeing
- Offering a variety of ways to support carers, both as individuals and in groups, to prevent carers feeling isolated and reaching crisis point without having someone to turn to
- Offer of carers assessments and access to personal budgets for to help meet unmet needs
- Preventing carer breakdown by providing support to access a variety of services and opportunities to enable carers to take short breaks and have time away from caring
- Providing a programme of practical training skills for carers to support and empower them in their caring role
- Raising the profile of carers with professionals and throughout the city through awareness training, publications, and events
- Provide support to Primary Care Networks (PCN's) to implement the NHS England and Care Quality Commission framework of quality standards for carer-friendly GP practices
- Work in partnership with Devon Carers and Cornwall Carers services and University Hospitals Plymouth (UHP) to deliver UHP Hospital discharge carers support service
- Creation of Carers Passport in conjunction with Livewell Southwest, UHP, Cera Care, St Luke's, and Plymouth City Council

The performance of the service is measured through a quarterly excel workbook (including numbers of carers registered with the service, referral routes and types of support etc) and qualitative report; a quarterly hospital services report (including numbers of new carers, type of support received, number of referrals by hospital ward, admission type and discharge pathway) an annual report. Qualitative feedback for Plymouth from the Carers Hospital Services report included the following statements:

- "Thank you for all your support. You have been brilliant. You are the only one that has supported me. I really am grateful."
- G said she feels I am the only one that listened to her. She said that she will miss our conversations.
- "It has helped to talk about my caring responsibility with someone who understands"
- Carer said that he is very appreciative to have someone to talk to that will listen to him.
- The service achieved excellent results from the We Care Survey that was carried out at the end of 2021 by Carers Trust on behalf of the organisation. Headline figures as follows:
- 84% are satisfied that the people at Caring for Carers understand their needs (81% being Carers Trust average)
- 81% would recommend Caring for Carers to another carer (79% being Carers Trust average)
- 89% overall would rate the service highly (86% being Carers Trust average)

The service has worked extremely well in delivering an efficient and effective service that exceeds requirements. In the past year, these achievements have included:

- Co-delivering new hospital-based carers service,
- Development of a hospital ward accreditation quality scheme for carers based on the NHSE (NHS England) Supporting Carers in general practice: a framework of quality markers. It is currently being rolled out across the wards at University Hospitals Plymouth and will help to raise recognition of carers and ensure more inclusive support
- securing some funding from Carers Trust to create a new service that works with young adult carers (for carers aged 18-25), who are transitioning to become adult carers. Research shows that this cohort of carers often retreat from the reach of services this could be for number of reasons but can include young carers not identifying well with the adult service
- co-designing creation of Carers Passport in conjunction with Livewell Southwest, University Hospitals Plymouth, Cera Care, St. Luke's, and Plymouth City Council. A Carer Passport is a record which identifies a carer and sets out an offer of support, services, or other benefits in response. It helps to improve and embed identification, recognition, and support for carers in the day-to-day life of an organisation or community
- Playing a key role in the Mind the Gap project, working alongside Devon and Cornwall Chinese Association, Imagine – Torbay's Multi-cultural Group, Plymouth Race Equality Council, Refugee Service, commissioners and representatives from young carers and adult carers services identifying ways and means to best recognise and support carers from ethnic minority backgrounds. Mind the Gap being a programme to deliver the NHS Long-Term Plan Commitment to improve identification and support of carers from communities less likely to use and/or have positive experiences of services
- Support and encouragement for carers relating to Covid 19 including working with University Hospital Plymouth outreach team to provide a carers pop-up vaccination clinic at the Mannamead Hub and ensuring that carers are offered home visits to receive their vaccination for those unable to leave the cared for person

Carers service works in partnership with Devon Carers and Cornwall Carers services and University Hospitals Plymouth (UHP) to deliver UHP Hospital discharge carers support service. This service helps to ensure that the carer is fully involved in discussions regarding the discharge plans for the cared for person, thus helping to provide smoother discharge and reduce re-admission due to carer break-down contributing towards the following:

- Avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions)
- Length of stay in hospital (in-patients who have been in hospital for longer than 14 days, 21 days)
- Discharge to normal place of residence (hospital in patients who have been discharged to usual place of residence)
- Reablement (older people, 65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

The local contextual factors (e.g., financial pressures) for the service to continue to meet the needs with growing demand and integrated electronic records and sharing across the system with service users are local challenges. However, there is strong, system-wide governance and systems leadership and empowering users to have choice and control

through an asset-based approach, shared decision making and co-production which are local strengths.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care, and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Plymouth's Homelessness Prevention Partnership brings together key individuals to oversee the delivery of the single, structured, and integrated multi-agency programme of work with the aim of reducing and preventing homelessness in Plymouth through the provision of a platform for creative thinking, collaboration, shared vision, and ambition, combined with specific or emerging issue responses. The strategic aims and work streams mirror the priorities set out in the Preventing Homelessness and Rough Sleeping in Plymouth 2019-2024 document as well as the homelessness priority detailed by the Local Care Partnership. Delivery groups aligned to this work come together to tackle and address homelessness, tackle rough sleeping, improve housing conditions in rented housing, delivering an increased range of accommodation offerings including specialist housing to those most in need, delivering health and social care systems that support prevention and relief of homelessness, and children and young people homelessness prevention. Community Connections Major Adaptations Teamwork within this space to consider local data and work with partners to provide dynamic responses where possible to prevent blockages and increase accessibility to suitable housing options.

Plymouths Plan for Homes 3 also seeks to improve housing conditions and broaden choices, support the delivery of the joint local plan for housing numbers and coordinate funding and investment in the city to ensure local need is met. Community Connections Major Adaptations Teamwork in the delivery of this to ensure where development is informed, adaptations are delivered suitably and that the provision of supported living is aligned.

In 2015 Foundations carried out a survey, where they found that 16% of people applying for a DFG also received domiciliary care. For those in receipt of domiciliary care, they showed a

slight fall from an average of 15.7 to 14.7 hours per week they needed one year after the DFG work had been completed. While this shows a weak correlation between DFG funding and domiciliary care, it may be the unpaid carers that actually benefit from investment in adaptations which would not be reflected in the domiciliary care hours. They also found the average age of people who had been placed in residential or nursing care if they had a received a DFG was 80 compared to 76 for those who had not. For these people, the average age at death was 82 whether they received a DFG or not, which is an additional 4 years of residential care. With an average residential care place costing around £29,000 per year compared to an average DFG costing less than £7,000 as a one-off, it highlights the major impact that adaptations can have for social care budgets. We should consider adaptations as part of a preventative strategy alongside extra care housing, reablement or assistive technology services.

Better outcomes, lower costs research (2007) has also found that adaptations allowing people to live independently through assistance or prevention removes or reduces the need for intensive home care and can also provide better outcomes. Although there is national evidence on the potential benefits of DFGs (Disabled Facilities Grant), there needs to be more local evidence gathered to show the impact of DFGs on the reduction of domiciliary care, intermediate care, delay in residential care admission and reduction of caring responsibilities on unpaid carers. This work is currently being considered and a review is likely to be conducted in 2023 to explore the effectiveness of DFG's on the wider system and to see if there are additional actions required to maximise this.

Continued government funding has permitted the approaches developed locally to be integrated with clear pathways to ensure clients' needs are met. Shared strategic ownership has allowed localised processes to be co-designed, person centred and responsive to changing needs, markets, and priorities.

Occupational Therapists based predominantly in Plymouth City Council (Childrens) and Livewell Southwest (adults) are the gateway for adaptations. Whilst we have worked closely with these services for a lengthy period this relationship has now strengthened in the past 2 years seeing 2 Occupational Therapists dedicated to working within the DFG arena. This arrangement does not alter client pathways but works to provide greater and more focused assistance throughout the delivery of major adaptations inclusive of complex case support, changing needs post referral, engagement with Registered Social Landlords, system reviews and training.

Whilst we have strong relationships with multiple housing providers in the city, a review highlighted the greatest partner in this work being Plymouth Community Homes (PCH) with over 30% of adaptations last year being conducted in their properties. Over the past 2 years strengthened relationships between PCH and PCC have seen a financial commitment from PCH into the delivery of adaptations conducted within their properties thus maximising the funding available for DFG works across the city. In addition to this PCH have increased the dedicated resources within their teams focused on DFG. Whilst this relationship is key, we are also working alongside Devon Home Choice and the Housing Delivery service to increase housing choices for those with greatest need and to reduce the requirement of the

use of DFG wherever possible through increased development of wheelchair accessible and lifetime homes.

Community Connections implementation of a dynamic purchasing system to facilitate both the tendering and delivery of adaptations across the city has provided a transparent way to coordinate delivery, provide access to key stakeholders, ensure value for money, and better enable responses to changing or heightened needs. The system is currently being developed to be the gateway for referrals, making the best use of technology to reduce processes, administration and improve data capture at the initial stage.

Strategically we are aware that collaborative ways of working are vital in the delivery of work in this arena. As part of this system-based learning opportunities have and continue to be delivered. Most recently Community Connections facilitated a system-based event in Plymouth with Adult Social Care, Occupational Therapists, Registered Social Landlords, Contractors, Major Adaptations Team, and equipment suppliers. The event focused on current key relevant topics as well as considering developments within the field such as assistive technology. In relation to assistive technology the focus was on current knowledge base across the system, where best practice examples could be found and how systematic training could be done best given frequent enhancements across the field.

The results from this have fed into a wider strategic group focusing on the care needs for 18-64yr olds to see if a pilot scheme can be initiated in the city, if advice on technology can be given sooner and what the is the best procurement methodology.

The work in this arena is currently focused on enhancing the use of technology across the system to provide better customer experiences, reduced process for resources and improved speed from referral to adaptation. The shared strategic ownership enables dynamic responses to be implemented, operational resources to be equipped with tools required to do their job and for the client’s needs to be met in the most suitable and logical fashion.

The Independent Living Policy will be reviewed across stakeholders early 2023 to consider findings from the white paper and this will again draw together all relevant stakeholders and clients to review and refresh the approach to work in Disabled Facilities Grants.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- *Changes from previous BCF plan*
- *How these inequalities are being addressed through the BCF plan and BCF funded services*
- *Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered*
- *Any actions moving forward that can contribute to reducing these differences in outcomes*

The Plymouth Health and Wellbeing Board is committed to the promotion of equal opportunities, addressing health inequalities, and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation.

This is achieved by:

- Each organisation clearly setting out equality and diversity objectives E.g., NHS Devon Equality, Diversity, and Inclusion Policy.

- Carrying out Equality Impact Assessments to assess how new policies and changes or additions to our services could affect groups of people differently. In Plymouth City Council there is annual data profile called Understanding our communities created for each of the protected characteristics, used to inform the assessment.

- Using the NHS Equality Delivery System – a national toolkit that helps to provide better working practices and environments, free from discrimination.

Thrive Plymouth, led by the Office of the Director of Public Health, is Plymouth City Council's 10-year plan to improve health and wellbeing, reduce health inequalities in the city and remains the strategic approach towards tackling health inequalities having a focus on helping people to stay well through targeted interventions to those most in need. Tackling health and wellbeing inequalities is fundamental to the aims of the Plymouth LCP. Therefore, programmes of work will be expected to identify the health and wellbeing gaps relevant for their programme, have plans for tackling them and understand the impact of COVID19 and the mitigations needed.

Plymouth has entrenched pockets of deprivation and health inequalities which need to be addressed if the city is to genuinely achieve an economy that works for all. One mechanism to tackle this is the creation of a network of health and wellbeing hubs across the city which provides an integrated approach for people to easily access a wide range of support services and will integrate issues around health, community development and job. Plymouth West End Health and Wellbeing Centre, due to open in 2024, is a pioneering Health and

Wellbeing Centre intended to improve the wellbeing of residents and families and to transform healthcare access and opportunities in the heart of Plymouth, including in the city's most deprived council ward. It will provide joined up primary and community health and wellbeing services to a population identified to have the greatest health needs and lowest life expectancy in the city.

The Plymouth Health and Wellbeing System has a stated aim to reduce health inequalities, as well as improving outcomes and access for people to the services they need while improving people's experience of care. Much of our prevention work supports healthier lifestyles, promoting earlier intervention and harm reduction, developing accessible culturally sensitive services and anti-poverty approaches. There are a range of strategic approaches already under way: Thrive Plymouth, Plymouth Alliance, Wellbeing Hubs, and Trauma Informed Network, and a recently procured Integrated Care Partnership (ICP) bringing together community health, mental health, learning disability and social care in a partnership delivered by University Hospitals Plymouth NHS Trust with a sub-contract to Livewell Southwest CIC.

To understand our local population and their needs a Joint Strategic Needs Assessment is undertaken by the Local Authority and NHS Devon. Health and Wellbeing Boards (H&WB (Health and Wellbeing Boards)) are responsible for overseeing the production of the JSNAs (Joint Strategic Needs Assessment). The assessments are of the current and future health and social care needs of local communities. These are needs that could be met by services commissioned (bought) by the local authority, CCGs (Clinical Commissioning Group) (Clinical Commissioning Group) JSNA (Joint Strategic Needs Assessment) or by NHS England. Locally the JSNA (Joint Strategic Needs Assessment) process involves the production of a series of profiles and reports covering topics such as alcohol, healthy diet, healthy weight, long term conditions, mental health and wellbeing, dental health, smoking and vulnerable people.

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities, and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation.

The impact of COVID-19 has highlighted the importance of inequalities in certain communities, including BAME (Black Asian and Minority Ethnic). People from BAME backgrounds are at higher risk of COVID-19 related deaths; and vaccination hesitancy is higher in BAME communities than White communities. Devon's BAME population is small, according to 2011 Census data, BAME communities make up 3% of the Together for Devon geography. Historically there has been limited emphasis on understanding and addressing BAME health inequalities in the region.

The Integrated Care System for Devon (ICSD) commissioned a report on the 'Experiences of health and care in Devon for Black, Asian and Minority Ethnic communities and staff.' The report was researched and produced by independent specialists the Nous Group between September 2020 and February 2021.Following its publication NHS and Care Leaders across Devon have backed a series of 34 recommendations. The recommendations seek to improve the experiences of people from ethnic minority communities in accessing and working in local health and care services.

The report recommendations focus on key areas including:

- Building stronger relationships with ethnic minority communities to make sure health services meet people's needs
- Developing Black, Asian, and Minority Ethnic reference groups (staff and public), which will provide a platform for feedback to ensure NHS and care partners are listening to the voices of ethnic minority communities (staff and public)
- Developing cultural awareness training in partnership with ethnic minority communities to support inclusion across the ICSD
- Developing and improving translation services with communities to ensure everyone can access the healthcare they need
- Building a more diverse workforce that represents local ethnic minority communities across the ICSD and ensuring equal access to progression opportunities.

A development plan is in place to implement the report recommendations, in which 9 recommendations are complete (including co-design response to impacts of isolation among ethnically diverse communities), 18 are underway. These include improving accountability through measuring and reporting on ethnic minority patients and staff experience, outcomes, and employment, improving engagement with staff and communities and working with communities to create appropriate support for accessing healthcare.

A Devon-wide Ethnic Equality Network (DWEEN) has now expanded its membership, with a new structure to include Safe Space meetings and Strategic Influence meetings. Safe space meetings are supportive space for ethnically diverse network members to share experiences and gain peer support. The strategic meetings will be the forum where staff from ethnic diverse backgrounds and allies come together to tackle racism and promote inclusion at a strategic level across One Devon.

The key headlines from the developing Equality, Diversity and Inclusion strategy are that One Devon is moving towards a new approach to inclusion that prioritises co-production and working with community partners to understand the needs of our diverse communities in Devon. Inclusion should be at the heart of our organisational culture and is set to be the foundation of joint working within the One Devon and NHS Devon. Since the last BCF Plan, NHS Devon implemented a new Equality, Diversity, and Inclusion Team, which includes an Equality, Diversity and Inclusion Project Manager and System Equality, Diversity, and Inclusion Lead.

ICSs have a leading role in tackling health inequalities, through building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children, and young people, at both the national and system level. CORE20Plus5 remains the focus of NHS Devon's combined HI and prevention plan, with plans to strengthen leadership and system-wide awareness of health inequalities through a range of activities, including the participation in the national piloting of both the CORE20PLUS5 Connectors model; the support and investment we continue to make in the work of our Local Care Partnerships (LCP's); and our ambition to be a pilot area for the HEE Health Inequalities eLearning programme.

Embedding Health Inequalities across the Devon system is being delivered through several actions, including:

- Working closely with our workforce programme, NHS Devon will aspire to deploy Health Inequalities awareness to all staff. This will ensure the workforce:
    - Have a collective understanding of what health inequalities are, and how they can affect the population of Devon;
    - Are more confident in asking patients to share personal information about themselves that will assist us in ensuring that factors such as where they live, their ethnic background and other characteristics are not resulting in unacceptable differences in access; experience and outcome;
    - Are confident in identifying health inequalities;
    - Are confident in taking positive action to tackle any identified health inequalities experienced by the people they meet.

- Working closely with our colleagues in Communications & Engagement NHS Devon will aim to raise awareness of health inequalities within our population. This will support patients in being confident in why it is safe and relevant to share information about themselves.

- In 2022/23 NHS Devon revised the Quality and Equality Impact Assessment (QEIA) which will be launched across Devon to ensure HI is fully considered in all change. A "soft launch" within NHS Devon in Q3 will inform final revisions prior to a phased, wider rollout for completion by Q4 2022/23. This refreshed tool will view inequalities from the perspectives of those affected by them through co-design with the relevant inclusion health groups. Importantly, not only will this tool make it easier to identify potential inequalities brought about by change, but it will also connect those completing the assessment with best practice and easy to understand, tangible examples of how to mitigate against possible inequalities.

- Revisions to our governance structure for health inequalities will give increased focus supporting the Health Inequality priorities our LCP's, and the PCN's within them, have described, alongside the delivery of whole-Devon improvements.

- Establish even stronger links with our network of Health Education England HI Fellows.

- Build upon the work of Devon Communities Together cultural awareness programme that describes a collective understanding of why tackling health inequalities is important to our communities, to influence both public health & VCSE sector workforce and our population.

By November 2022, NHS Devon will have completed a homeless health needs assessment within each locality to give both a local, and aggregated whole-Devon, view. The homeless HNA will also be used to inform future commissioning requirements of Primary Care services to support the homeless population and ensure inequalities that may exist in the current provision are addressed across Devon. From a study undertaken in 2020 to understand attendance and discharge experiences of no fixed abode and addiction patients at Derriford Hospital Plymouth, a business case was developed to create a comprehensive service, through investment, for adults with complex needs related to homelessness, health, contact with the criminal justice system and substance misuse issues. In line with current best practice this service is being developed using the "Pathway" approach, providing 'end to end' support for individuals who are homeless. It involves not only medical staff, but a range of multidisciplinary professionals with expertise in social care, housing law and benefits issues,

ensuring that a person's full range of needs are supported. The service is expected to go live in September/ October 2022.

Currently work is being undertaken on Devon's overarching primary care and Community First strategies, People Led Change and the expectation is that addressing health inequalities will be a prominent feature of that work (strategy production July 2022).

Investment in prevention priorities continues both in whole-Devon workstreams, and in interventions at place via our £2m annual prevention fund.

Devon approaches 22/23 having made significant improvements in the capacity and leadership of the Health Inequalities programme. Through:

- The appointment of a Non-Executive Director with the responsibility for Health Inequalities
- Alignment of the HI, Prevention and Health Inequalities agendas under the portfolio of the Deputy Director of Commissioning of Out of Hospital.
- Identification of a whole-Devon SRO (Senior Responsible Officer) for Digital Inequalities
- Appointment of a Head of Health Inequalities and Prevention
- Appointment of an Acting Public Health Consultant for Health Inequalities, providing dedicated time to support the programme and interface more closely with the work of our three public health teams;
- Increased support to, and engagement with, the HEE funded Health Inequalities Fellows network in Devon;
- Dedicated project management capacity in place to support localities in taking action to deliver the priorities they will define to achieve the aims of our Equally Well aspirations.

Data and insight relating to the characteristics of the population who are, and importantly, are not, accessing our support and services remains a challenge for Devon. Our Elective Recovery plans will give focus to actions to addressing the quality, completeness, and availability of data within the Hip and Knee subset of Orthopaedics.

NHS Devon's Population Health Management programme is intricately linked with the Health Inequalities team. The Population Health Management Programme has the overall aim of having a systematic population health analysis at system, place, and neighbourhood level, by 2023/24 enabling LCPs (Local Care Partnership), PCNs (Primary Care Network) and partners including mental health and local authority, to understand their population's needs, including the wider determinants of health, and design interventions to meet them. As an end state, all LCPs and PCNs should be routinely utilising PHM (Population Health Management) to develop targeted interventions for identified 'at risk' cohorts. The One Devon Dataset (ODD) is in the process of being developed. The dataset will allow all data to be accessible in one place, with various organisations able to access the data.

Using the data made easily accessible by the One Devon dataset will enable us to inform the Better Care Fund schemes, ensuring better outcomes for the population as well those facing inequalities in accessing services.

University Hospitals Plymouth overarching Clinical Strategy sets out the trusts vision to deliver outstanding integrated care, unlocking better outcomes, reducing inequalities, and improving lives across Plymouth, Devon, and Cornwall. The strategy focuses on a personalised care model for the future based on understanding the needs and wants of individuals in their care, empowering them to manage their health and wellbeing and wrapping targeted support services around them, whilst also recognising the inequalities that might restrict access to care. This will be enabled by a Population Health Management (PHM) approach: using population health analytics in collaboration with key partners to stratify our population and deliver more targeted interventions, empowering individuals to self-manage conditions and reducing health inequalities. Further work is required for the aligning and coordinating with Devon ICS and Peninsula plans (including integration with the Devon ICS clinical strategy), however the clinical strategy closely aligns to NHS Devon's approach to addressing health inequalities for the local population.

Schemes

Across the Plymouth Health and Wellbeing Board, a variety of BCF Schemes are supporting the improvement of outcomes through transforming the quality, consistency and coordination of care and ensuring delivery of integrated and person-centred services. These services are developed to be accessible by the entire population whilst ensuring that heath inequalities are reduced.

The Health and Care Act 2022 has an explicit focus on addressing health inequalities, reinforcing the opportunity to improve services for disabled people. The Disabled Facilities grant funded by the BCF supports disabled people to access grants to improve their homes. The grant ensures those with a disability have an equal opportunity to remain living independently with the adaptations likely to improve the health and wellbeing of those individuals. The adaptations provided improve the accessibility of housing options from owner occupied, privately rented and social housing. This helps specifically address health inequalities by narrowing the gaps in accessible housing.

With caring having recently been announced as being a social determinant of health recently by UK Health Security Agency, the Caring for Carers service is a service to support carers with information and advice, drop-in support groups, leisure and social activities and workshops and training. The funding provided by the BCF helps to address the inequalities faced by carers by ensuring they are aware of services available to support them in their caring role as well as promoting personal health and mental wellbeing. The Caring for Carers service ensures the social determinants of health are addressed, thus reducing inequalities.

NHS Devon Integrated Care Board (ICB) meeting

Devon Operating Model

Date of committee	Date report produced
19 October 2022	11th October 2022

Author(s)		Report approved by	
Name and title:	Tracey Cottam/Warwick Heale Devon Operating Model Working Group	**Name and title:**	Simon Tapley, Chief Transformation & Strategic Planning Officer
Phone:		**Date:**	
Email:	tracey.cottam@nhs.net w.heale@nhs.net		simon.tapley@nhs.net

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

N/A

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

The purpose of this report is to ask NHS Devon Integrated Care Board to note and endorse the proposed Devon Operating Model to enable adoption, and continued co-design, to commence.

The Devon Operating Model will support the establishment of the new ICS architecture, it will build a shared understanding of the roles, accountabilities and responsibilities of each part of the system and it will respond to the System Diagnostic and ICS Maturity Framework Assessment results which identified the need to change ways of working across Devon.

Over a c.12 week period the proposed Devon Operating Model has been co-designed by colleagues across Devon, for Devon. Extensive engagement and involvement has been undertaken with all parts of the Devon system with many

partners experiencing this approach as a clear example of the new way of collaborative working.

To maintain momentum, the focus needs to move from one of co-design to that of adoption. The approach to adoption will see the continuation of collaboration, engagement and involvement of all parts of the Devon system. The design principles underpinning the co-design of the Model will be joined by five proposed Values to underpin the adoption approach.

The adoption of the Devon Operating Model is one of the core activities within the ICS Development Roadmap that will enable Devon to become a 'thriving' ICS by 2024/25. System partners are eager to commence adoption and the continued adaptation of the Operating Model through taking a 'learn by doing' approach. Evaluation of the adoption phase will be undertaken to enable progress to be assessed, with the Executive Strategy & Transformation Group having oversight of this work.

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

- All System Partners have been involved in the co-design of the Devon Operating Model via a series of workshops;
- Engagement with sovereign Boards and senior leadership groups has been undertaken;
- A Devon Working Group comprising of colleagues across Devon has had oversight of this work

The Devon Operating Model has not been formally presented to any other Committee at this stage.

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

In line with this, the NHS Devon Integrated Care Board are asked to:

1. Note the collaborative approach to co-design the Devon Operating Model
2. Approve the proposed Devon Operating Model as a 'work in progress' document rather than as the final design;
3. Endorse the adoption approach including the design principles and values;
4. Approve the adoption phase to commence from end October onwards
5. Note the adoption of the Devon Operating Model will be evaluated through a number of gateways, with oversight via the Executive Strategy & Transformation Group;
6. Confirm if sovereign organisations should be asked to formally agree to adopt the Devon Operating Model.

Impact on NHS Devon objectives

Objective	Impact

Objective 1	**The Devon Operating Model will be a core enabler to all NHS Devon Strategic objectives.** **Specifically, it will support Strategic Objectives 11 and 12.**
Objective 2	
Objective 3	
Objective 4	

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	None
Health inequalities	None
Workforce	Leaders and their teams will be required to work in a different way, adopting the five values and behaviours outlined in the Devon Operating Model. The approach to managing accountability will be strengthened and more transparent which may require additional System Development support such as senior System Leadership Development.
Resources and finance	None
Legal	None
Digital and Data	Provision of timely and effective data and intelligence will be critical to enable the Devon Operating Model to be successful, and to enable timely decision making.
Involvement, Engagement and consultation	Continued engagement and involvement of all system partners throughout the adoption phase will be critical to the success of embedding the Devon Operating Model.

One Devon Operating Model

DRAFT – Final Version

Contents

This operating model sets out how One Devon will work together to improve health and care for people living in Devon

Purpose of this document

The One Devon operating model outlines how the Devon Integrated Care System (One Devon) will work to better shape health and social care services around the needs of Devon's population – realising the benefits of integrated care. These benefits include:

- **Improving outcomes** in population health and healthcare
- **Tackling inequalities** in outcomes, experience and access
- **Enhancing productivity** and value for money
- Helping the NHS support wider **social and economic development**

This operating model has been co-designed with involvement from all parts of the health and care system. This document will introduce the new system architecture and Devon's vision for how it will operate. The operating model within this document articulates the future state of the working arrangements in Devon, as well as the roadmap to get there. The model articulated is deliberately flexible to allow for continued development and future iterations.

What this operating model covers

This operating model…

- Sets out the vision for the Integrated Care System (ICS) architecture
- Describes the values and behaviours expected by people working in One Devon
- Details the roles, responsibilities and functions for each part of the health and care system
- Sets out the governance arrangements and approach to performance reporting and assurance
- Outlines the Adoption Roadmap to implement the new operating model, to be supported by a 'learn by doing' approach

What this operating model does not cover

There are some areas the operating model does not address:

- Team structures or individual roles and responsibilities
- The definitive plan for the development of the operating model – this is a live document and will require further development and iteration

In addition, the implementation of the new system operating model **will not in any way impinge on the statutory duties of the individual organisations** following the **Health and Care Act 2022**

Executive Summary

Executive Summary: Overview

- One Devon is a partnership of health, local government and care organisations that are working to provide sustainable, quality health services and improved outcomes for Devon people
- Health and care organisations within Devon are facing growing pressures – these include the significant financial pressures being faced by NHS organisations and Local Authorities within Devon, the cost of living crisis and rising inflation. New collaborative ways of working provide the opportunity to respond to these pressures and improve health and care for people working in Devon
- To support these new ways of working, five values have been outlined to guide how system partners collaborate in One Devon. In One Devon, we will see partners:
  - **Putting Devon's people first**
  - **Trusting each other and working as one system**
  - **Making best use of the Devon £**
  - **Expanding our scope of collaboration**
  - **Driving innovation**
- To achieve these new ways of working, we must make best use of new collaborative structures in One Devon. These include One Devon Partnership, the Peninsula Acute Provider Collaborative, the Mental Health, Learning Disabilities and Neurodiversity Provider Collaborative, the Primary Care Provider Collaborative, Local Care Partnerships, and Neighbourhoods. Each of these structures have new roles that will draw together system partners and allow for greater integration of services across One Devon, both in 2022/23 and beyond.
- Through the new collaborative structures we can better deliver on our priorities in practice. Via application of this operating model to our Urgent and Emergency Care priority we have illustrated how these new structures might work together and help us to realise the benefits of collaborative working.
- To fully realise the benefits of new collaborative ways of working, development of these new structures is required. Five themes for this development have been identified, further supported by outlining the development journeys of these individual structures. These five themes are:
  - **Learn by Doing**
  - **Prioritise and implement**
  - **Shared Purpose**
  - **Trust and Collaboration**
  - **Moving Towards a system focus**
- The move to the new operating model will be a phased adoption process planned to take place through to 2024/25 and will need to respond to a changing One Devon context. This iterative process will ensure we can best provide for the health and care needs of people living and working in Devon.

Executive Summary: Overview

One Devon Partnership	The partnership body of the Integrated Care System – referred to in guidance as an ICP (Integrated Care Partnership)	**Voluntary, Community and Social Enterprise (VCSE) Assembly**	The consultative forum that advises on how best to use the relationships and resources provided by the VCSE organisations in Devon, also with a role in innovation, pathway design and embedding citizen voice.
NHS Devon	The Devon-wide NHS body in the Integrated Care System – referred to in guidance as an ICB (Integrated Care Board)	**Acute Provider Collaborative**	The collaboration of acute providers represented in the One Devon Partnership, and reporting to NHS Devon and NHS Cornwall & Isles of Scilly.
Local Authorities	There are three upper tier or unitary Local Authorities in Devon, responsible for the provision of social care and other wider public sector services.	**Mental Health, Learning Disability, and Neurodiversity Provider Collaborative**	The collaboration of MHLDN providers represented in the One Devon Partnership and reporting to NHS Devon.
Health and Wellbeing Boards	A formal committee of each of Devon's upper tier or unitary local authorities, charged with promoting greater integration and partnership between bodies from the NHS, public health and local government.	**Primary Care Provider Collaborative**	The forum that advises on primary care in Devon and provides a cohesive voice for primary care providers.
Local Care Partnerships x5	The collaboration of health and care providers in each locality of the One Devon Partnership and reporting to NHS Devon	**Neighbourhoods**	Integrated neighbourhood teams that work to inform commissioning of services and provide holistic care for people locally.

Executive Summary: The Architecture of One Devon

For each of the new structures in One Devon, partners have identified their key roles in 2022/23 and beyond:

One Devon Partnership

- Leading the co-production, development and agreement of the One Devon's five-year integrated care strategy, focusing on improving health outcomes and reducing inequalities.

NHS Devon

- The development and agreement of the Joint Forward Plan for Devon and the annual operating plan including revenue allocations, undertaking a strategic commissioning role and outlining the delegation of commissioning responsibilities.
- Undertaking a performance management role, to ensure services are safe, effective, patient-centred, timely, financially sustainable, efficient and equitable.
- Ensuring data and intelligence across the entire ICS is collated.

Acute Provider Collaborative

- Planning changes to the provision of NHS services across providers.
- Undertaking analysis of healthcare usage and population need to provide the basis for evidence based, outcome focused commissioning.
- Working together to ensure the best use of the totality of resources at their disposal.
- **The commissioning of acute services to meet the outcomes set by NHS Devon and NHS Cornwall & Isles of Scilly.**

MHLDN Provider Collaborative

- Planning changes to the provision of services across providers.
- Undertaking analysis of healthcare usage and population need to provide the basis for evidence based, outcome focused commissioning.
- Working together to ensure the best use of the totality of resources at their disposal.
- **The commissioning of MHLDN services to meet the outcomes set by NHS Devon.**

Primary Care Provider Collaborative

- Working to provide a coherent primary care delivery model across Devon, which meets the needs of the population and reduces inequality
- Sharing knowledge and best practice across primary care providers in Devon to deliver a more cohesive and integrated offer of care.
- Acting as a strong and united voice for primary care in Devon.
- **Driving the Devon-wide preventative strategy.**

Note: This reflects the current Provider Collaboratives operating across One Devon

Local Care Partnerships

- Supporting the development of the Integrated Care Strategy including articulating provisions that are specific to each locality.
- Enhancing integration in their LCP, including planning changes to the provision of services in place to deliver improved integrated care and performance.
- Improving performance of local services where joint working can improve overall performance.
- **Procuring and securing health and care services to meet the needs of local communities, commissioning at the level of place.**

Neighbourhoods

- Using neighbourhood population insight to inform the commissioning of services to improve outcomes and reduce inequalities.
- Delivering population health management at a neighbourhood level.
- Taking an asset-based approach across all settings to provide holistic care for people with long-term conditions.

Bolded items indicate additional responsibilities beyond 2022/23

Context

One Devon is a partnership of health, local government and care organisations that are working to provide sustainable, quality health outcomes for Devon people

The 2022 Health and Care Act formalised integrated care arrangements

- Integrated care systems have been in development for several years – there are 42 nationally and their aim is to bring together local authorities, NHS organisations and others to take collective responsibility of providing services to improve population health.
- The Integrated Care System in Devon is known as One Devon and includes all health and care partners working throughout Devon.
- The Health and Care Act 2022 transferred statutory powers from CCGs to other organisations, primarily the newly created Integrated Care Boards (ICBs). In Devon, this new ICB is called NHS Devon.
- In recognition of the varying nature of ICSs nationally, in terms of geographies and demographics, this legislation gave significant flexibility on how ICSs can operate.
- This Operating Model sets out how the system will work together to realise the vision for Devon and provides the framework to support delivery of health and care services to the population of Devon.

Alongside the legislation, national guidance has been released that recommends developing collaborative arrangements to deliver effective integrated care:

- **Provider collaboratives –** bringing together providers to improve pathways and deliver better outcomes, making best use of system resources in areas such as workforce, technology, and estates.
- **Place-based partnership** – called Local Care Partnerships in Devon, place based partnerships bring together a wide range of organisations, including Local Authorities, to deliver integrated health and care services across Devon's localities.
- **Neighbourhoods** – bringing together primary care services, NHS community services, social care and other providers to deliver more co-ordinated and proactive care throughout Devon. They work closely with other partners to deliver improved outcomes across different neighbourhoods.

We need all partners to draw together and undertake new collaborative ways of working – as outlined in this operating model

Growing pressures within the health and care system, and beyond, are strengthening the requirement for new collaborative ways of working:

- The health and care system nationally is under immense strain. The challenges that have been brought about by the pandemic have placed greater demand on our services, and it is a high priority nationally to ensure that people who had treatment delayed due to the onset of the pandemic are treated promptly.
- In addition, the cost of living crisis is now taking root, and people are feeling the negative impact on their wellbeing. As these challenges persist, One Devon will have to respond to the challenges that our population and staff are facing as a result of the high levels of inflation.
- These high levels of inflation are also an additional financial pressure that our organisations will have to accommodate and mitigate. The financial challenges that NHS organisations across Devon have had over the last few years are well documented, and it is critical that, as we move into the new policy era, our plans and structures work towards achieving a financially sustainable health and care system.
- These challenges impact us all and we are more able to meet them through joined-up, coordinated action. To do this requires a new operating model to guide our new ways of working.

Integrated Care Systems help us to address these challenges by working together more collaboratively:

The benefits of this integrated approach to health and care include:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development

This operating model brings together health and care organisations, local authorities and other partners to outline the structures in which they collectively operate within the One Devon Integrated Care System – these structures include:

- One Devon Partnership
- NHS Devon
- Consultative forums, including the Clinical and Professional Cabinet and VCSE Assembly
- Peninsula Acute Provider Collaborative
- Mental Health, Learning Disability, and Neurodiversity Provider Collaborative
- Primary Care Provider Collaborative
- Local Care Partnerships
- Neighbourhoods

Source [1] RCP Survey

One Devon Vision, Values and Behaviours

The operating model should act as an enabler for One Devon's work to achieve our vision

'Equal chances for everyone in Devon to lead long, happy and healthy lives'

The Way We Do Things Together in Devon	The Integrated Care Strategy	The Joint Forward Plan	The One Devon Operating Model
• "The way we do things together in Devon" provides a narrative describing why change is needed, what works well now and what needs to change. • It covers how working together differently could benefit the citizens of Devon and describes a new collaborative way of working that should underpin everything we do.	• The Integrated Care Strategy will build on the potential identified in The Way We Do Things Together In Devon and the Case for Change. • It will set out a plan to address the wider health, public health, and wellbeing needs of people living in Devon. • It draws on Joint Strategic Needs Assessments developed by Devon's 3 Local Authorities.	• The 5-year Joint Forward Plan will describe how NHS Services will be delivered to meet the local needs described in the Integrated Care Strategy over the next five years.	• This Operating Model sets out how the system will work together to realise the vision for Devon and provide the framework to support delivery of health and care services to the population of Devon. • It is flexible and responds to changes stemming from the Integrated Care Strategy, the Joint Forward Plan, and wider 'learning by doing'.
	Source: Health and Care Act 2022	*Source: Health and Care Act 2022*	

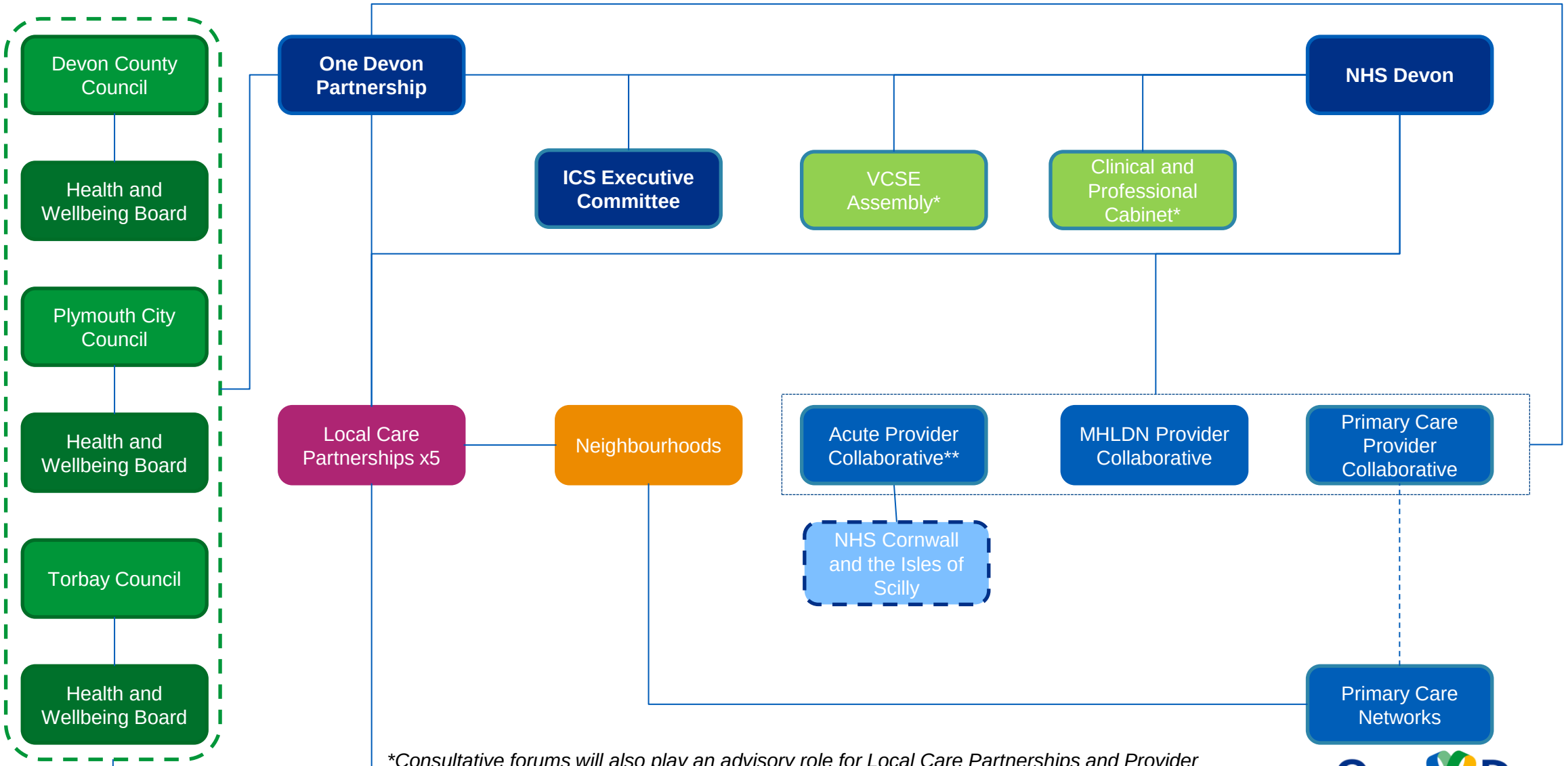
This Operating Model sets out how the system will work together to realise the vision for Devon and to provide the framework to support delivery of health and care services to the population of Devon

Five values have been outlined to guide how all staff throughout One Devon will work together to enable a thriving system

Values:	Our ambition for the future:
Putting Devon's people first	• As a system, we will centre our services on the needs of Devon's population and communities. This means listening to local people and our staff, involving them in the decision-making around the services we commission and deliver and being open and transparent about the difficult choices that we have to make. We will engage with communities, patients, Healthwatch and other groups. • In the commissioning and delivery of our services we will reduce inequalities and retain a focus on improving outcomes, driving improvements in everything we do.
Trusting each other and working as one system	• We will work together as one system to truly put the needs of Devon's population first. As we work together, it is important to take actions on behalf of the system, rather than in pursuit of organisational interest. • We will share resources in working as one system to achieve a shared vision and achieve financial sustainability – building trust between system partners is essential to achieve this approach.
Making the best use of the Devon £	• We will make the best use of public money across health and care services. This means it is important to invest in services that make the biggest differences to people's health and wellbeing, including preventative care. • We will not be limited by the boundaries of the services we are commissioned to deliver and instead will ensure every contact counts towards meeting the needs of our people. • Aligning financial incentives, distributing and pooling funds and sharing risk across the system will all be necessary to deliver value for money solutions and to ensure that we are providing a sustainable health system into the future.
Expanding our scope of collaboration	• As well as drawing closer together as One Devon, it is important to consider how we will leverage the full range of partnerships available to us to deliver the best services for our population – including with regional and national teams, organisations and businesses in Devon, and communities. • For those on the borders of Devon, partners in our neighbouring ICSs will contribute to health and wellbeing, whilst regional partners such as the Academic Health Science Network will also be critical to delivering transformation for the benefit of our population.
Driving innovation	• We will adopt a 'learn by doing' approach and respond flexibly to successes and failures where a change in our approach would benefit people living in Devon. • The requirement for new collaborative ways of working should also empower everyone to adopt innovative solutions, techniques and technologies to drive improvements in resident's health and wellbeing. • More integrated care should expand the range of interventions that can be made to improve the lives of our population and it is critical that we allow everyone to innovate and spread that innovation effectively, wherever possible.

Architecture of One Devon

One Devon Architecture:



*Consultative forums will also play an advisory role for Local Care Partnerships and Provider Collaboratives as determined by these groups

**The Acute Provider Collaborative spans Devon and Cornwall and the Isles of Scilly

One Devon Partnership

The One Devon Partnership (the ICP) is responsible for the co-production of the Integrated Care Strategy for One Devon

The purpose of an ICP in the 2022 Health and Care Act:

- *Prepare an Integrated Care Strategy setting out how assessed needs in relation to its area are met by:*
  - *NHS Devon, Local Care Partnerships and Provider Collaboratives*
  - *NHS England*
  - *The Local Authorities within Devon*

Our vision for a thriving One Devon Partnership in Devon:

The One Devon Partnership includes all health and care partners working in Devon and is responsible for the preparation, drafting and co-production of the Integrated Care Strategy, setting out how the needs of people in Devon are to be met by ICS partners. It advises on how arrangements for the provision of health and social care services could be more closely integrated to benefit people living in Devon. System Partners feel that the One Devon Partnership is an inclusive forum, and understand how the views, challenges and priorities of their organisations and our population (eg: via Healthwatch) contribute to a cohesive integrated care plan, and rely on the One Devon Partnership to enable increased collaboration with other system partners.

Primary responsibilities:

The partnership will adopt the full range of its accountabilities from 2022/23, including:

- Leading the co-design and co-production, development and agreement of One Devon's Integrated Care Strategy, focusing on improving health outcomes and reducing inequalities

The decisions made by the One Devon Partnership shape the Integrated Care Strategy for Devon

One Devon Partnership

What decisions does this group make?

The decisions that the One Devon Partnership makes will involve:

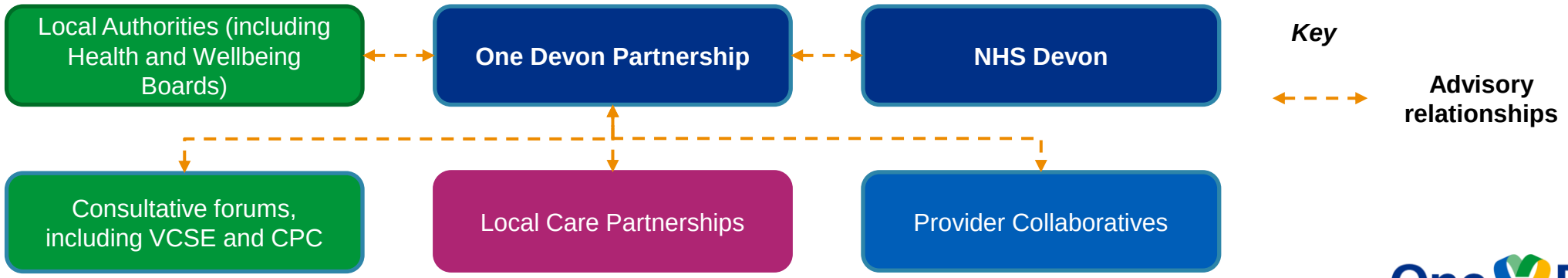
- Leading the co-design and co-production of the content and priorities of One Devon's Integrated Care Strategy incorporating insights from the Health and Wellbeing Boards and local Joint Strategic Needs Assessments.
- Advising on how arrangements for the provision of health and social care services should be more closely integrated to benefit people living in Devon and reduce health inequalities.
- Advising on the prioritisation of specific population-health focused objectives in One Devon.
- Advising on which services should be prioritised for transformation, savings and investment by NHS Devon, and where new models, tools and ideas should be advanced within the system
- Providing advice to system partners to resolve disagreements with serious implications. Where resolution is not possible through other avenues, the One Devon Partnership can issue a decision.

As the partnership body of One Devon, decisions made by the One Devon Partnership must involve and engage other health and care partners throughout Devon. They will play a key role in the continued development of the integrated care system and new way ways of working.

How does this group support other partners:

One Devon Partnership Relationships

The One Devon Partnership is the place where system partners including Healthwatch, Local Authorities, Local Care Partnerships, and Provider Collaboratives, come together to determine the strategic direction of One Devon. A cross-body membership with NHS Devon supports alignment in the NHS Devon delivery of the One Devon Strategy:



The primary responsibility of the One Devon Partnership is defined in the 2022 Health and Care Act

Responsibilities:

To enable the decisions to take place as articulated on slides 16-17 the following responsibilities need to be held by the One Devon Partnership:

Statutory Accountabilities: One Devon Partnership holds the statutory accountability to produce the Integrated Care Strategy as outlined in the 2022 Health and Care Act.

Other responsibilities are advisory in nature and require no formal delegations.

One Devon Partnership Structure:

- The One Devon Partnership will work via a core committee in order to be effective in its decision making, and is supported by further committees as necessary.
- This core committee has a broad representation outlined in their terms of reference:
  - Chair
  - ICB Chair
  - ICB CEO
  - ICB Executive Lead for ICP
  - 3 Health and Wellbeing Board Chairs
  - 5 LCP representatives
  - Acute Provider Collaborative Chair
  - MHLDN Provider Collaborative Chair
  - Clinical lead
  - Healthwatch member
  - Health Inequalities and Prevention Programme member
  - NHS Devon Citizen Engagement and Outreach NEM
  - 3 VCSE members
  - Director of Adult Social Care
  - Director of Children's Services
  - Primary Care member
  - District Council member
- Relationships will have to be established with additional partners including: Healthwatch, SWASFT, Citizen Forums and AHSN

Organisational Governance:

- The responsibilities of the One Devon Partnership are administered via the One Devon Partnership Core Committee, which operates via decision making by consensus
- Cross-body membership between the NHS Devon Board and the One Devon Partnership core-committee supports alignment between these groups, further supported via the ICS Executive Committee

NHS Devon

NHS Devon is responsible for developing a system plan in response to the Integrated Care Strategy, commissioning services and allocating budgets

The purpose of an ICB in the 2022 Health and Care Act:

- *Arrange for the provision of health services to meet the needs of people living in Devon, including the financial duties associated with this*
- *Arrange for the provision of health and care services in an integrated way when this would benefit those living in Devon, including through the reduction of inequalities*

Source: Health and Care Act 2022

Our vision for a thriving NHS Devon:

NHS Devon arranges for the provision of health services to meet the requirements of people living in Devon, and undertake the financial duties associated with this. They take a 'system first' approach, ensuring that services are provided in an integrated way when this would improve the quality of services, reduce inequality of access to services or reduce inequality of outcomes, undertaking an enabling role to support other partners in the commissioning and delivery of integrated care. They work closely with system partners (including SWASFT) and undertake engagement (eg: with Healthwatch and VCSE Assembly) to understand the wants and needs of people living in Devon. Partners understand what their responsibilities are and feel supported in delivering them. They trust NHS Devon and feel able to approach them when they would benefit from collective problem solving or delivery.

Primary responsibilities:

NHS Devon will adopt the full range of its accountabilities from 2022/23. However, it will progressively delegate elements of these responsibilities in line with the content on the subsequent pages. The phasing of this delegation will also be dependent on the system's progress within the System Oversight Framework, as outlined in the roadmap section of the document:

- The development and agreement of the Joint Forward Plan for Devon and the annual operating plan including revenue allocations, undertaking a strategic commissioning role, and outlining the delegation of commissioning responsibilities.
- The development of strategic change and transformation plans across Devon, working closely with Local Care Partnerships and neighbourhoods to understand the changing need of people living in Devon.
- Working with Local Authorities to identify specific services where commissioning should be joint between the NHS and Local Authorities and supporting the pooling of budgets where appropriate.
- Undertaking a performance management role, to ensure services are safe, effective, patient-centred, timely, financially sustainable, efficient and equitable.
- Ensuring data and intelligence across One Devon is collated, encompassing population health, healthcare and business intelligence to provide a holistic view of performance.
- Working to secure financial sustainability across One Devon.

The decisions that NHS Devon make will ensure that health services are provided to meet the needs of people living in Devon

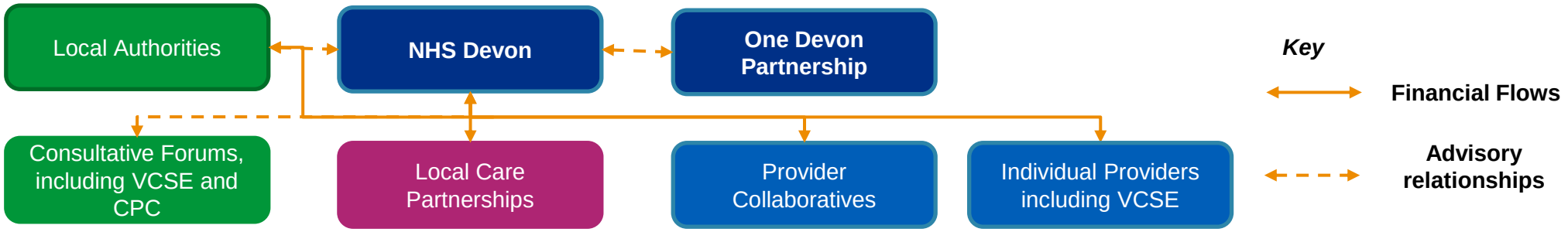
NHS Devon

What decisions does this group make?

NHS Devon will work with other partners, including Local Authorities, to make decisions on:

- The long-term financial strategy for the NHS in Devon
- The prioritisation and allocation of NHS capital spend
- The contents and implementation of the 5-year Strategic Workforce Plan
- The annual health and care plan for the NHS element of the One Devon budget
- The framework and quality standards with which to support and monitor outcomes-based commissioning
- Which health and care services across Devon could be best provided by a joint or delegated commissioning agreement
- Joint commissioning of services between the NHS and Local Authorities (in agreement with relevant Local Authorities)
- The delegation of commissioning responsibilities, empowering Provider Collaboratives and Local Care Partnerships to take responsibility
- Enabling delegated commissioning responsibilities
- Budget allocation and responsibility delegation to Provider Collaboratives
- Budget allocation and responsibility delegation to Local Care Partnerships
- The delegated commissioning of specialised services for those with rare and complex conditions (from April 2024)
- Ensuring services are safe, effective, patient-centred, timely, efficient and equitable
- How audits will be undertaken as a response to national guidance
- The NHS in Devon's response to inspection outcomes
- How One Devon will align to the national legal framework and develop a risk management strategy for One Devon's information governance processes
- How data and intelligence is collated across One Devon, and how it can be used across the system to improve and measure performance and impact
- How to better integrate enablers across the system
- Provide advice on how disagreements between two or more NHS partners are resolved, if escalated. In exceptional circumstances, these can be escalated to the One Devon Partnership for wider mediation if required.

How does this group support other partners:



The primary responsibilities of NHS Devon are defined in the 2022 Health and Care Act

Responsibilities:

To enable the decisions to take place as articulated on slides 20-21 the following responsibilities need to be held by the NHS Devon:

Statutory Accountabilities: NHS Devon holds the statutory accountabilities as outlined in the 2022 Health and Care Act – these are reflected on the previous pages

Organisational Governance:

The Board of the NHS Devon is responsible for ensuring that NHS Devon meets its duties as outlined in statute. In compliance with national guidance, the Board of NHS Devon consists of the following roles:

- Chair
- Chief Executive
- 1 Partner Member NHS and Foundation Trust
- 1 Partner Member Primary Care Medical Services
- 2 Partner Members Local Authorities
- 1 Mental Health Member
- 6 independent Non-executive Members
- Director of Finance (Chief Financial Officer)
- Medical Director (Chief Medical Officer)
- Director of Nursing (Chief Nursing Officer)
- Chief Transformation & Strategic Planning Officer
- Director of Strategic Workforce
- Chief Communication & Corporate Affairs Officer

NHS Devon structure:

Legislation provides ICBs with flexibility in how they establish committees, including the ability to appoint individuals from external or partner organisations to be members of a committee. Membership of the specified committees below is informed to balance partnership involvement and effective and efficient governance. NHS Devon works via a series of committees as outlined below:

- Audit and Risk Committee
- Remuneration and Internal ICB Workforce Committee
- Finance Committee
- Quality and Performance Committee
- People and Culture Committee
- ICB Primary Care Commissioning Transition Committee
- Clinical and Professional Cabinet
- LCP Oversight Committee
- ICS Executive Committee
    - Executive Strategy and Transformation Group
    - System Delivery Improvement Group
    - Executive Workforce (People Plan) Group
    - Executive Quality Oversight Group
    - System transformation and Efficiency Committee

These committees ensure links and engagement with individual organisations and clinical and professional forums as required in order to fulfil their functions.

The Acute Provider Collaborative

The Acute Provider Collaborative will work together to harness the benefits of scale in the commissioning and provision of acute services

The purpose of an Acute Provider Collaborative in the ICS Design Framework

- *Provider Collaboratives will work together to harness the benefits of scale in the commissioning and provision of their services*
- The Collaborative will also work to deliver sustainable services, as well as drive service and pathway redesign to improve access, quality and performance, whilst reducing inequalities

Source: Integrated Care Systems Design Framework 2021

Primary responsibilities in 2022/23:

- Planning changes to the provision of NHS services across providers
- Undertaking analysis of healthcare usage and population need to provide the basis for evidence based, outcome focused, commissioning including the voice of people with lived experience and engagement with the population (including Healthwatch)
- Working together to ensure the best use of the totality of resources at their disposal, in the interest of the populations of Devon and Cornwall & the Isles of Scilly

Our vision for a thriving Acute Collaborative in Devon:

The Acute Provider Collaborative is a partnership arrangement between acute providers in Devon and Cornwall & the Isles of Scilly. They work at scale with a shared purpose, clarity of resource, transparent data and effective decision-making arrangements towards the strategic objectives of the Integrated Care Partnerships, in order to;

- Reduce unwarranted variation in health outcomes, access to services and patient experience
- Improve resilience
- Ensure that specialisation and consolidation occur when this will provide better outcomes and value

The Collaborative builds on existing relationships with all providers feeling valued and respected, regardless of size, and creates new relationships where this would benefit joint working and increased collaboration.

Additional responsibilities beyond 2022/23

- The commissioning of acute services to meet the outcomes set by NHS Devon and NHS Cornwall & Isles of Scilly, to meet the needs of these populations

Decisions made by the Acute Provider Collaborative should be sensitive to local needs in supporting the provision of care for people in Devon

Acute Provider Collaborative

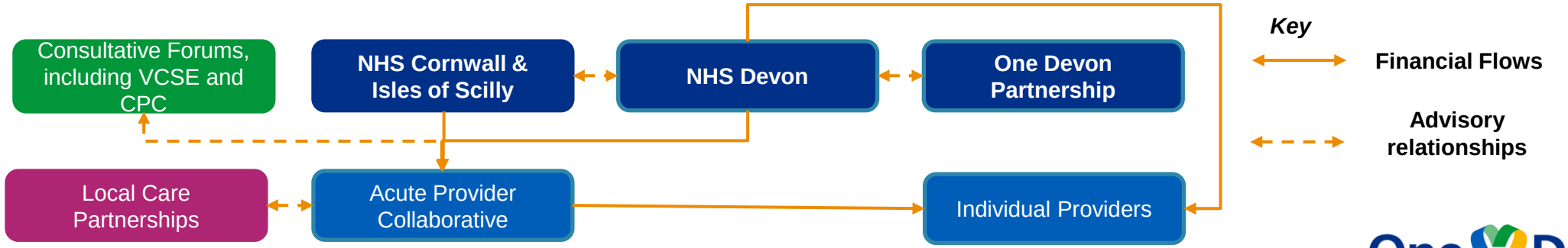
What decisions does this group make?

For services delivered in Devon, the Acute Provider Collaborative will work on:

- Deciding on how to deliver on the agreed strategy and priorities for Devon's acute providers, with reference to the needs of local populations – taking care to engage and consult with residents where appropriate – this may apply to short term acute provision or longer term planning
- Planning changes to the provision of NHS services across the acute providers, informed by LCPs to ensure local needs are met, and enhancing integration with local services
- Determining the model through which acute services are delivered to the population of Devon – escalating disagreements if needed to NHS Devon
- Deciding how to make use of the money allocated to the Provider Collaborative, and the constituent organisations of the Collaborative, by NHS Devon and other sources
- Considering how best to utilise the collective resources at their disposal in order to improve service provision, provide better value for money, improved patient and staff experience and better integrate research and innovation at scale.
- Determining where savings or additional funding is required to implement plans in response to the agreed strategy
- Agreeing on the flexible working arrangements for staff working between member provider organisations working across Devon to allow effective use of staff such as via staff passporting
- Determining how to respond to national initiatives whilst being sensitive to the needs of Devon's population

How does this group support other partners:

All NHS providers in Devon belong to a Provider Collaborative. Provider collaboratives work closely with LCPs, and may collaborate together where necessary. The Provider Collaboratives influence the direction of One Devon via representation on the One Devon Partnership Core committee.



The Acute Provider Collaborative is formed as a committee between NHS Devon and NHS Cornwall & Isles of Scilly

Responsibilities:

To enable the decisions to take place as articulated on slides 24-25, the following responsibilities will need to be delegated to the Acute Provider Collaborative:

NHS Devon

- Delegated commissioning responsibility for some aspects of the provision of acute care in Devon

NHS Providers

- Delegated authority to make changes to the provision of acute care in Devon

Provider Collaborative Structure:

- The Acute Provider Collaborative has elected to use a joint committee model, formed between the NHS Devon and NHS Cornwall & Isles of Scilly
- The following providers are members of the Acute Provider Collaborative:
  - Royal Cornwall Hospitals NHS Trust
  - Royal Devon University Healthcare NHS Foundation Trust
  - Torbay and South Devon NHS Foundation Trust
  - University Hospitals Plymouth NHS Trust

Organisational Governance:

- The Acute Provider Collaborative is constituted as a committee between NHS Devon and NHS Cornwall and Isles of Scilly. It operates via a ‘committees in common’ approach, with decisions being made via consensus between provider boards. Where consensus cannot be reached dispute resolution framework will be invoked.

The Mental Health, Learning Disability and Neurodiversity Provider Collaborative

The MHLDN Provider Collaborative will work together to harness the benefits of scale in the commissioning and provision of MHLDN services

The purpose of a Provider Collaborative in the ICS Design Framework

- *Provider Collaboratives will work together to harness the benefits of scale in the commissioning and provision of their services*
- The Collaborative will also work to deliver sustainable services, as well as drive service and pathway redesign to improve access, quality and performance, whilst reducing inequalities

Source: Integrated Care Systems Design Framework 2021

Primary responsibilities in 2022/23:

- Planning changes to the provision of services across providers, where integration with other services is required
- Undertaking analysis of healthcare usage and population need to provide the basis for evidence based, outcome focused, commissioning including the voice of people with lived experience and engagement with the population (including Healthwatch)
- Working together to ensure the best use of the totality of the resources at their disposal, in the interest of the Devon population

Our vision for a thriving Mental Health, Learning Disability, and Neurodiversity Collaborative in Devon:

The Mental Health, Learning Disability, and Neurodiversity Collaborative is a partnership arrangement between providers in Devon. They work at scale, with a shared purpose and effective decision-making arrangements to;

- Reduce unwarranted variation in health outcomes, access to services and experience
- Improve resilience
- Ensure that specialisation and consolidation occur when this will provide better outcomes and value

The Collaborative builds on existing relationships, with all providers feeling valued and respected, regardless of size, and creating new relationships where this would benefit joint working and increased collaboration.

Additional responsibilities beyond 2022/23:

- Commissioning of MHLDN services to meet the outcomes set by NHS Devon to meet the needs of the population

Decisions made by the MHLDN Provider Collaborative should be sensitive to local needs in supporting the provision of care for people in Devon

MHLDN Provider Collaborative

What decisions does this group make?

In the future state decisions that the MHLDN Provider Collaborative makes will involve:

- Deciding on how to deliver on the agreed strategy and priorities for Devon's MHLDN providers, with reference to the needs of local populations – taking care to engage and consult with residents where appropriate – this may apply to short term provision or longer term planning
- Planning changes to the provision of services across the MHLDN providers, informed by LCPs to ensure local needs are met, and enhancing integration with local services
- Deciding how MHLDN services are provided to meet the needs of people living in Devon
- Deciding how to make use of the money allocated to the Provider Collaborative, and the constituent organisations of the Collaborative, by NHS Devon and other sources
- Considering how best to utilise the collective resources at their disposal in order to improve service provision, provide better value for money, improved patient and staff experience and better integrate research and innovation at scale.
- Determining where savings or additional funding is required to implement plans in response to the agreed strategy
- Agreeing on the flexible working arrangements for staff working between member provider organisations working across Devon, to allow effective use of staff such as via staff passporting
- Determining how to respond to national initiatives whilst being sensitive to the needs of Devon's population

How does this group support other partners:

All NHS providers in Devon belong to a Provider Collaborative. The Provider Collaboratives influence the direction of One Devon via representation on the One Devon Partnership Core committee.

The MHDLN Provider Collaborative uses a lead provider model, with Devon Partnership Trust as a lead provider

Responsibilities:

To enable the decisions to take place as articulated on slides 28 - 29, the following responsibilities will need to be delegated to the MHLDN Provider Collaborative:

NHS Devon

- Delegated commissioning responsibility for MHLDN services in Devon

NHS Providers

- Delegated authority to make changes to the provision of MHLDN services in Devon

Provider Collaborative Structure:

- To discharge delegated responsibilities, the Mental Health, Learning Disability, and Neurodiversity Provider Collaborative will use a lead provider model, with Devon Partnership Trust as the lead provider
- The following providers are members of the MHLDN Provider Collaborative:
  - Devon Partnership Trust (DPT)
  - Livewell Southwest
- The MHLDN Provider Collaborative Executive Board has a wide membership, including Local Authority representation

Organisational Governance:

- As lead provider of the MHLDN Provider Collaborative, DPT is accountable to NHS Devon for the delivery of delegated commissioning responsibilities and will also act as the budget holder for the collaborative.
- The Strategic Oversight group is the decision-making body of the collaborative and operates via a principle of consensus. Where consensus cannot be reached, decisions can be escalated to the MHLDN Provider Collaborative Executive Board.

The Primary & Community Care Provider Collaborative

The establishment of a Primary & Community Care Provider Collaborative will be further co-designed during the Adoption phase

The Primary & Community Care Provider Collaborative provides a forum to reduce unwarranted variation in outcomes and drive the Devon-wide preventative strategy

The purpose of the Primary & Community Care Provider Collaborative as outlined in the Fuller Stocktake report

- *Support a common purpose across practitioners in communities, ensure a focus on unwarranted variation in access, experience and outcomes*
- *Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities*
- *Support primary care where it wants to work with other providers at scale*
- *Build a network of effective leaders to address key challenges in health and social care*

Source: Fuller Stocktake Report 2022

Primary responsibilities in 2022/23:

- Share knowledge and best practice across primary care providers in One Devon to deliver a more cohesive and integrated offer of care
- Support the development of effective Primary Care Networks
- Act as a strong and united voice for primary care in Devon

Our vision for a thriving Primary Care Provider Collaborative in Devon:

The Primary & Community Care Provider Collaborative works to support the sustainability of primary and community care services in Devon and ensures a single voice for primary and community care in decision-making at all levels within the One Devon system. It supports a common purpose across practitioners in communities, ensuring a focus on unwarranted variation in access, experience or outcomes, and supports primary care where it wants to work with other providers at scale. The Collaborative involves all types of primary care providers, including General Practitioners, Community Pharmacists, Opticians and Dentists, with all providers feeling valued and respected, regardless of size. They are comfortable to raise questions about the needs of their populations and share knowledge and best practice.

Additional responsibilities beyond 2022/23:

- Work to provide a coherent primary and community care (eg: 'out of hospital') delivery model across Devon, which meets the needs of the population and reduces unwarranted variation to reduce inequalities
- Drive the Devon-wide preventative strategy

The Primary & Community Care Provider Collaborative will advise on changes to the provision of primary care across Devon to reduce unwarranted variation

What decisions does this group make?

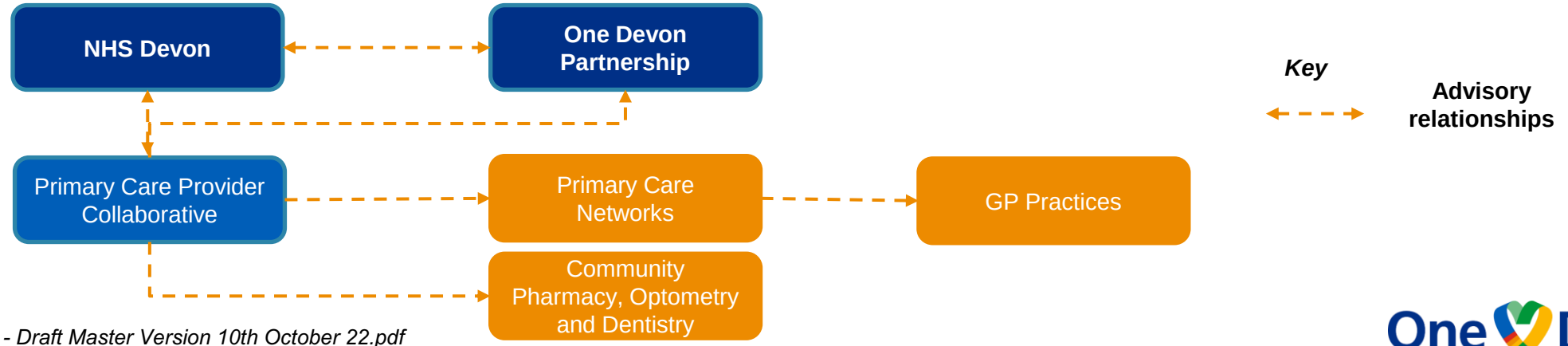
Primary Care Provider Collaborative

In their future state, the decisions that the Primary & Community Care Provider Collaborative make will involve:

- Advising which services to provide to meet the needs of people living in Devon, with a focus on Devon-wide prevention
- Discussing changes to the provision of primary care across the Provider Collaborative and enhancing integration between local services
- Advising on how to engage the population (including Healthwatch) and what communications to deliver to them
- Support the development of Primary & Community Care Networks across Devon

How does this group support other partners:

The Provider Collaboratives influence the direction of One Devon via representation on the One Devon Partnership.



Additional development work is required to define how the Primary & Community Care Provider Collaborative will operate

Responsibilities:

To enable the decisions to take place as articulated on slides 27-28, the following responsibilities will need to be delegated to the Primary Care Provider Collaborative:

Primary & Community Care Provider Collaborative:

- As a consultative forum, no formal delegations are made

Provider Collaborative Structure:

- The Primary & Community Care Provider Collaborative will operate as a consultative forum of NHS Devon – additional development work is required to define the membership and structure of the collaborative, including chairing arrangements.
- The precise membership of the collaborative is yet to be determined, but is expected to include representation from each of the Primary Care Networks, optometry, community pharmacy and dentistry

Organisational Governance:

- The Primary & Community Care Provider Collaborative is constituted as a consultative forum of NHS Devon. Further development work is required to define its terms of reference.

Local Care Partnerships

Local Care Partnerships are created in order to serve the health and care needs of people living in their area

The purpose of the Local Care Partnerships in the ICS implementation framework

- Involve all partners who contribute to health and care in their LCP, including housing, schools, Healthwatch and other Community Groups, employment & training and emergency services, in the co-ordination, planning and delivery of integrated services within localities and alongside communities
- Go beyond strategic planning, including joint commissioning, and integrated service delivery
- Work to reduce inequalities in their LCP

Source: Source:2021 Implementation Guidance

Our vision for a thriving Local Care Partnerships in Devon:

Local Care Partnerships are collaborative arrangements formed by organisations responsible for arranging and delivering health and care services in the 5 localities within Devon. They lead the detailed design and delivery of integrated services in their area, built on a mutual understanding of their local population, trust and a shared vision for the place. Respected as experts on the health and care needs of their population, LCP partners feel supported by the partnership and also feel that the LCP represents their views, opinions, and priorities at larger forums such as the One Devon Partnership, whilst also working to develop the economy in their area. The LCP is constantly engaging with people living and working in its area and people feel able to have an honest conversation about their health and care needs.

Primary responsibilities in 2022/23:

The primary responsibilities of the Local Care Partnerships are:

- Supporting the development of the Integrated Care Strategy via One Devon Partnership representation
- Develop and implement demonstrator projects, supported by the One Devon Partnership and NHS Devon to take a learn by doing approach, and embedding innovation throughout LCPs
- Solidify relationships with wider local organisations
- Enhancing service integration in their LCP

Additional responsibilities beyond 2022/23:

- Improving performance of local services where joint working can improve overall performance
- Planning changes to the provision of services in place to deliver improved integrated care and improved performance
- Delivering relevant strategic priorities for Devon that apply to the local population
- Procuring and securing health and care services to meet the needs of local communities, commissioning at the level of place

Devon's Local Care Partnerships will make commissioning decisions informed by a detailed understanding of the needs of local people

Local Care Partnerships

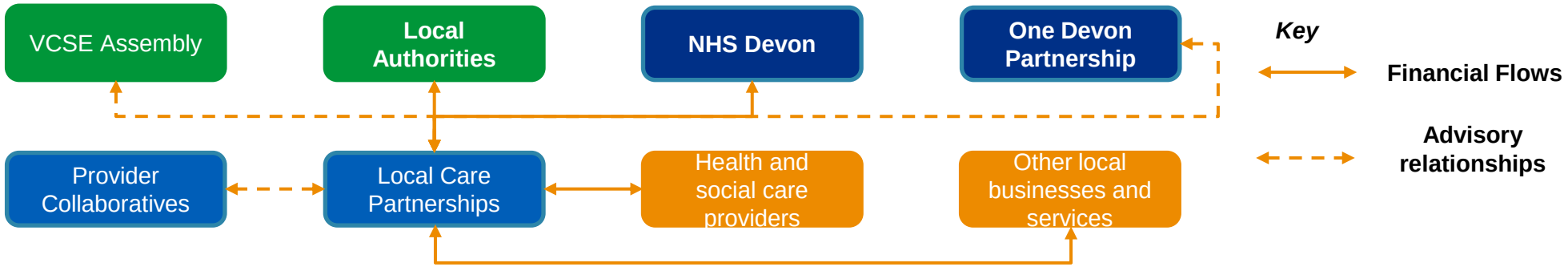
What decisions does this group make?

In the future, the decisions that Local Care Partnerships make will involve:

- Agreeing Local Care Partnership priorities as derived via partnership working with the relevant Health and Wellbeing Boards
- Agreeing the local response to the Integrated Care Strategy, coordinating delivery
- Coordinating services to meet the health needs of local populations
- Planning changes to the provision of services in place to deliver improved integrated care and improved performance –with a particular focus on improvement of preventative and proactive services
- Informing the Provider Collaborative around the needs of the population and ensuring the Provider Collaborative can balance working at scale with a local focus
- Deciding on how to commission services for the local community, where commissioning responsibility has been delegated by NHS Devon or a Local Authority
- Identifying how to optimise use of workforce to manage capacity, including with other partners such as the VCSE
- Identifying how to best make use of existing community groups and forums, transforming community engagement

How does this group support other partners:

There are five Local Care Partnerships in Devon: North Devon LCP, East Devon LCP, South Devon LCP, West Devon LCP, and Plymouth LCP. The LCPs influence the direction of One Devon via representation on the One Devon Partnership Core Committee. The close collaboration between health and care is core to LCPs, including Local Authorities, NHS providers, VCSE sector and other partners.



The Local Care Partnerships have agreed to work via a consistent governance approach in delivering health and care for their populations

Responsibilities:

To enable the decisions to take place as articulated on slides 36-37, the following responsibilities could be delegated to Local Care Partnerships by:

NHS Devon:

- Delegated commissioning responsibility for the provision of community health and care in LCPs

NHS Providers:

- Delegated authority to make changes to the provision of health and care in LCPs

Local Authorities:

- Delegated commissioning responsibility for the provision of some agreed services in LCPs

Local Care Partnerships Structure:

The Local Care Partnerships have agreed to work via a consistent governance approach to commission and co-ordinate health and care services for their population, and will each have:

- **An LCP Executive Group** – responsible for the development of LCP strategy and the representation of the LCP at partnership forums. Where the delivery group cannot reach consensus, decisions may be escalated to the executive group
- **An LCP Delivery Group** – operated by consensus, defining the LCP delivery plan and allocating resource against the workplan
- **LCP Specific Arrangements –** variable between Local Care Partnerships

The staffing of LCPs will include NHS Devon locality teams and agreed commissioning support functions, in addition to staff from partner organisations. They will avoid working in silos, working together with other LCPs and with Provider Collaboratives to share knowledge and resources and avoiding duplication.

Organisational Governance:

- Initially, LCPs will be formed as consultative forums, advising the LCP Oversight Committee of NHS Devon. Whilst constituted as consultative forums, the LCP Oversight Committee will be accountable to NHS Devon for the delivery of LCP responsibilities.
- As they develop, Local Care Partnerships will become committees of NHS Devon, able to access and hold budgetary responsibilities in their own right.
- Local Care Partnerships will be better placed to align budgets between Local Authorities and NHS. In addition they will be able to access pooled Local Authority funding via Section 75 and 76 agreements made between Local Authorities and NHS Devon as appropriate, in addition of Section 256 agreements and the Better Care Fund.

Neighbourhoods

Neighbourhoods enable organisations to deliver more proactive, co-ordinated and tailored care for their communities

The purpose of Neighbourhoods as in the ICS implementation framework

- Support Local Care Partnerships in establishing a shared understanding of communities' needs
- Support Local Care Partnerships in building relationships with all communities including excluded groups and those impacted by inequalities in access or outcomes
- Undertake engagement with their local population (including Healthwatch) and workforce
- Work with people and communities via a population health management approach

Source: Source:2021 Implementation Guidance

Our vision for a thriving Neighbourhoods in Devon:

As integrated teams, Neighbourhoods bring together teams from Primary Care Networks (PCNs), wider primary care providers, secondary care teams, social care teams, community leaders, voluntary sector and domiciliary and care staff to improve the health and wellbeing of a local community and tackle inequalities. They tap into existing community organisations and forums (including Healthwatch), harnessing ongoing work in promoting a culture of collaboration and pride, creating the time and space to problem solve together, and building relationships and trust between primary care and other system partners and communities. People living in a neighbourhood feel supported in accessing health and care needs, knowing where to get advice and how to be connected to the right services for them.

Primary responsibilities in 2022/23:

The primary responsibilities of the neighbourhoods include:

- Use Neighbourhood knowledge to inform the commissioning of services to improve outcomes, and reduce unwarranted variation and inequalities

Additional responsibilities beyond 2022/23:

- Deliver population health management at a neighbourhood level
- Build teams of primary and secondary care expertise to provider holistic care for people with long-term conditions
- Ensure people are aware of the treatment and non-clinical support options available to them and how to access them
- Support engagement with the Devon health and care workforce
- Undertake engagement with the Devon population
- Deliver health and care campaigns specific to local population needs

Neighbourhoods provide an in-depth understanding of the needs of their populations, advising Local Care Partnerships on appropriate action

Neighbourhoods

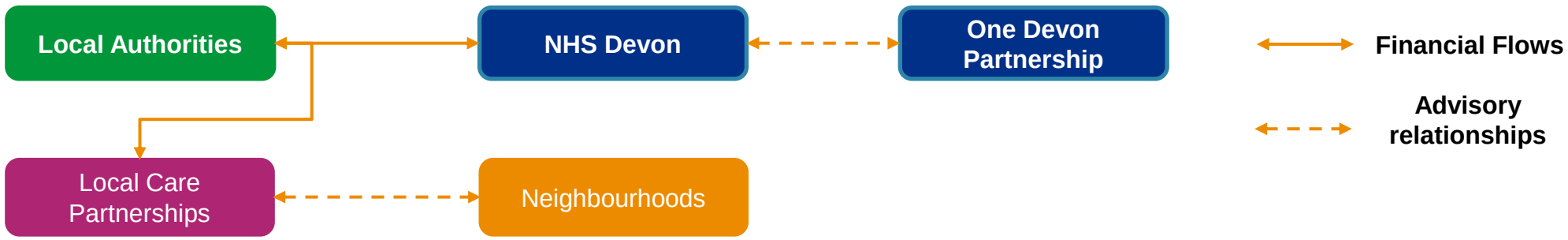
What decisions does this group make?

In the future, the decisions that Neighbourhoods make will involve:

- Agreeing the neighbourhood level population health management approach, considering both areas of strength and unmet need
- Identifying opportunities to improve outcomes for the neighbourhood population, with a focus on areas of unmet need
- Agreeing how to provide holistic care for people with more complex and chronic long-term conditions
- Agreeing on proposals to put forward to commissioners, including Local Care Partnerships – to access financial and workforce resource to deliver work where appropriate

How does this group support other partners:

Neighbourhoods influence the provision of care via Local Care Partnerships.



As consultative forums Neighbourhoods require no formal delegations

Responsibilities:

To enable the decisions to take place as articulated on slides 40-41, the following responsibilities will need to be delegated:

Further work is required to define the responsibilities of neighbourhoods, although an initial proposal seeks to establish them as consultative forums of Local Care Partnerships. As consultative forums no formal delegations would be required.

Neighbourhood Structure:

- The membership of Neighbourhoods is to be defined, however it is recommended that it constitutes the following:
  - Primary Care Networks
  - Local community and mental health services
  - Local social care providers (Local Authority and Independent Sector)
  - Pharmaceutical services
  - Targeted voluntary sector representation
  - Community champions
- Guidance suggests that Neighbourhoods should be coterminous with the established Primary Care Networks within Devon – further discussion is required to agree the most appropriate footprints for neighbourhoods given Devon's complex Primary Care Network footprints
- System partners agree Neighbourhoods must build on existing community work

Organisational Governance:

Further work is required to define the responsibilities of Neighbourhoods, although an initial proposal seeks to establish them as consultative forums of Local Care Partnerships

- As consultative forums Neighbourhoods would require no formal organisational governance separate to an agreed membership and Terms of Reference

Consultative Forums

There are also consultative forums who bring together and engage with experts in specific areas

The purpose of Consultative Forums:

Voluntary, Community and Social Enterprise (VCSE) Assembly

- Operates as a forum for co-production and engagement with the Voluntary, Community and Social Enterprise Sector
- Increase the capacity and capability within the VCSE sector to engage in improving health and care, population health and reducing inequalities
- Provide methods to share information on policy developments and key programmes so that the voluntary and community sector can engage in the delivery of health, care and well-being objectives

Clinical and Professional Cabinet (CPC)

- Bring together a diverse forum of experts across Devon to act as a source of independent, strategic advice and guidance to NHS Devon and the other organisations in One Devon to assist them in making the best decisions about healthcare for the population of Devon
- A representative of Healthwatch is a member within the CPC to ensure that the patient voice is represented and can inform CPC discussions

Source: ICS Implementation Guidance 2021

These forums have been identified in this operating model due to their being highlighted in published NHS guidance – One Devon will also develop relationships with other consultative forums, such as patient forums, safeguarding forums, and local strategic partnerships

Primary responsibilities:

The VCSE Assembly

- The VCSE Assembly is an open membership assembly representing 6,000 not-for-profit organisations operating within One Devon. This body allows VSCE organisations throughout Devon to engage in, inform and influence strategic partnership discussions.

The CPC

- The cabinet provides clinical and professional engagement and makes recommendations to NHS Devon with regards to both strategy and delivery. The CPC is made up of senior clinical and professional leads in addition to representatives from the LCPs.

Our vision for thriving consultative forums in Devon:

Drawing together respected experts, consultative forums provide the foundation for evidence-based decision making throughout One Devon.

Members of the forums feel listened to, and have clarity how their expertise is reflected in the One Devon strategy and policy. One Devon partners, including the One Devon Partnership, Local Care Partnerships, and Provider Collaboratives, feel able to consult with the forums to support their decision making as necessary.

Additional responsibilities beyond 2022/23:

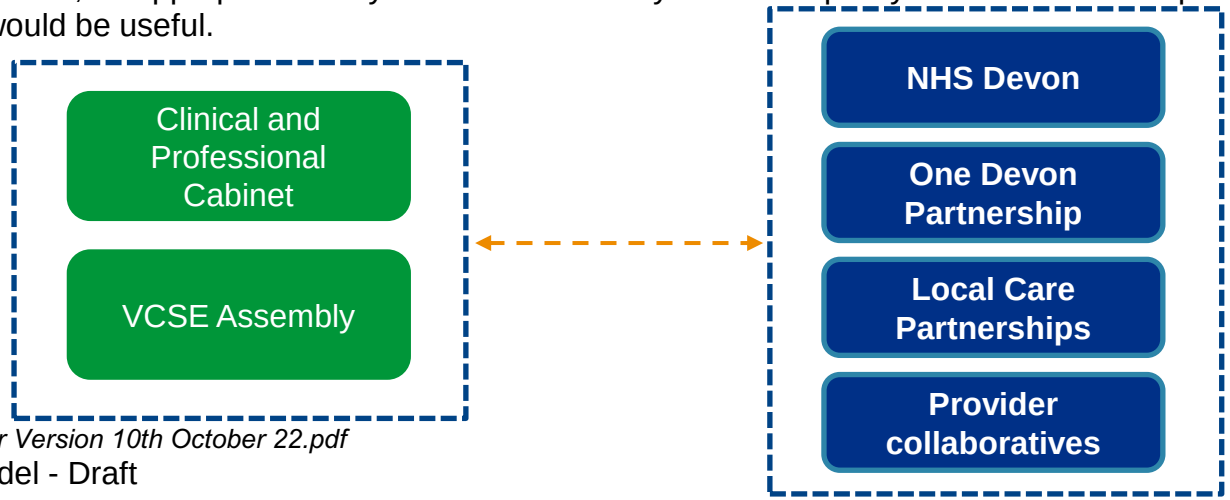
The consultative forums will fulfil their full role from 2022/23.

Consultative forums provide essential expertise, check and challenge into the proposals and policies adopted across Devon

	Voluntary, Community and Social Enterprise Assembly	Clinical and Professional Cabinet
What areas will these groups consult on?	**Areas that the VCSE Assembly may be asked to be consulted on/provide advice on:** • Mechanisms and infrastructure for Voluntary, Community and Social Enterprise engagement and integration • The extent to which system strategies and proposals are supported by evidence effective use of VCSE partners • The extent to which system strategies and proposals will contribute to the reduction of inequalities and improvement of population health	**Areas that the Clinical and Professional Cabinet may be asked to be consulted on/provide advice on:** • Mechanisms and infrastructure for clinical and professional engagement • The extent to which system strategies and proposals are supported by evidence of good clinical and professional practice • The extent to which system strategies and proposals will contribute to the reduction of inequalities and improvement of population health

How does this group support other partners:

The Clinical and Professional Cabinet and VCSE assembly influence the direction of One Devon via One Devon Partnership representation – and roles within the LCPs, as appropriate. They are consulted on system-wide policy and initiatives and partners feel able to ask for their input where their expertise would be useful.



External Partners

NHS Devon will work closely with the existing South West Provider Collaborative in the commissioning of specialised mental health care

What does the South West Provider Collaborative do?

The South West Provider Collaborative

The South West Provider Collaborative works to commission specialised services for people living in the South West. It includes the following members:

- Devon Partnership NHS Trust (Lead Provider)
- Cornwall Partnership NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Gloucestershire Health and Care NHS Foundation Trust
- Cygnet Health Care
- Elysium Healthcare
- Priory Group
- Livewell Southwest

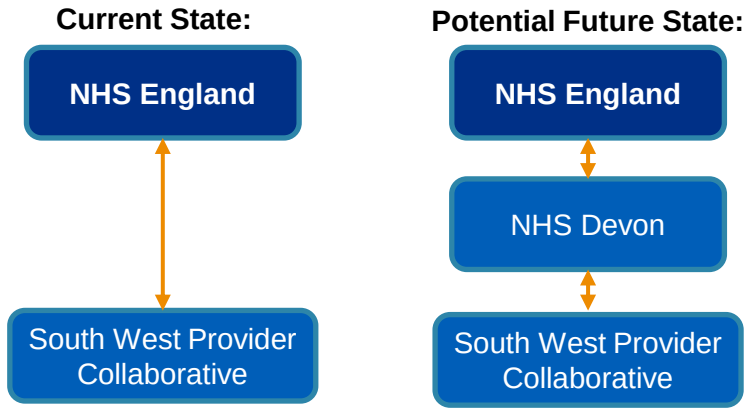
Services currently commissioned by the Collaborative include:

- Adult Low and Medium Secure Services
- Children and Young People's Mental Health Inpatient Services
- Adult Specialised Inpatient Eating Disorder Services

How might the South West Provider Collaborative change in the future?

Proposed changes from NHS England may impact how the South West Provider Collaborative commissions care:

- Currently NHS England directly delegates responsibility for the commissioning of specific specialised services to the South West Provider Collaborative
- In the future, NHS England is likely to delegate this responsibility to Integrated Care Boards, including NHS Devon
- There is then a decision to be made in partnership with the other members of the South West Provider Collaborative whether or not there are further delegations to be made to give responsibility for contracting the South West Provider Collaborative to a single ICB



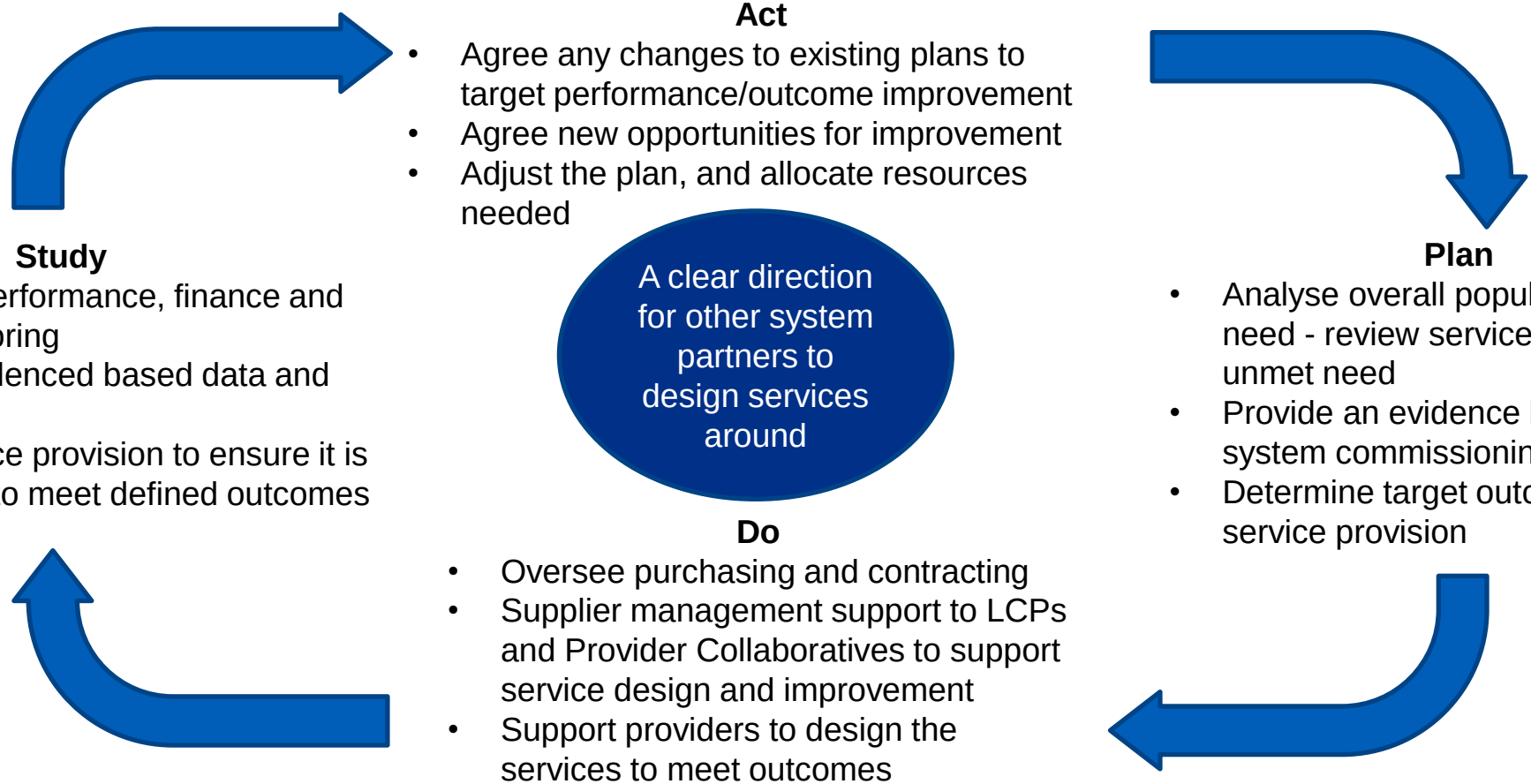
The new operating model will also provide a more streamlined set of mechanisms to interface with other external partners

Coordinating ICS Strategies	**In coordinating strategies, other ICSs will interface with:** • **One Devon Partnership -** when advising on matters relevant to the preparation of the Integrated Care strategy • **NHS Devon –** when advising on or aligning with NHS-specific strategies
Specialised Commissioning	**Once ICBs have taken responsibility for specialised commissioning, other ICBs will interface with:** • **The South West Provider Collaborative –** supported by DPT as the lead provider, for the provision of specialised mental health care • **The Acute Provider Collaborative –** for discussions surrounding the provision of specialised acute care
Clinical and Professional Networks	**Clinical and Professional Networks (assumed to include SW Academic Health Science Network) will interface with:** • **One Devon Partnership** – when advising on matters relevant to the preparation of the Integrated Care Strategy • **Provider Collaboratives** – when advising of the provision of specific acute, MHLDN or primary health care services, as well as the uptake of innovation and the co-ordination of research efforts across the region.

Working together as a system

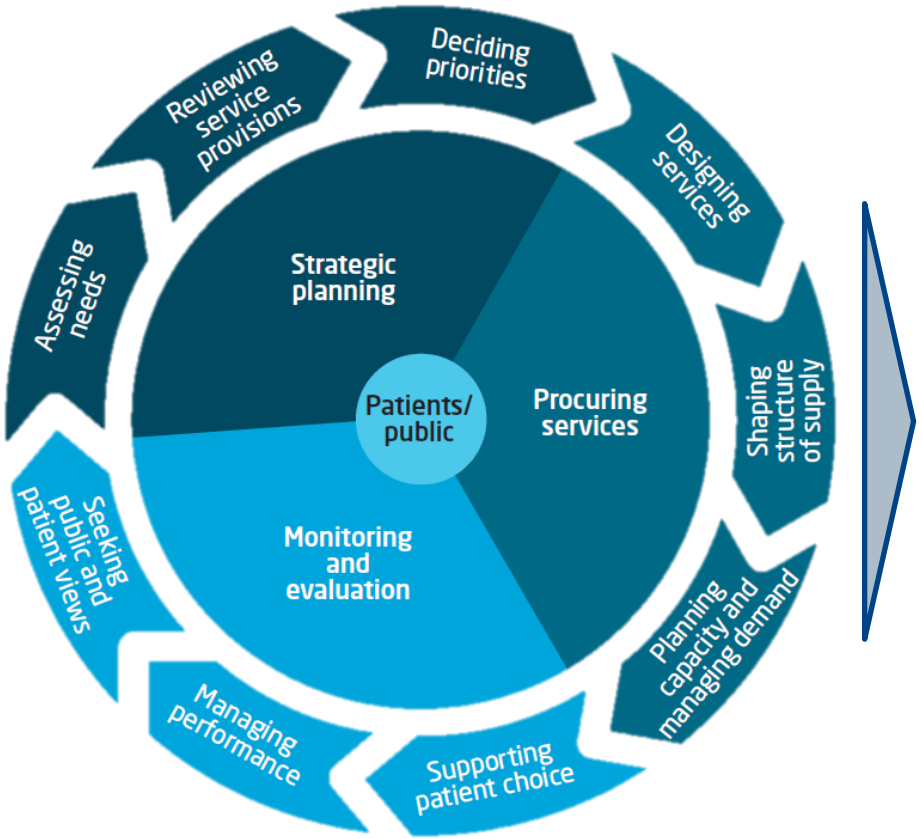
Under the new operating model, NHS Devon will adopt the role of strategic commissioner

Strategic commissioning places a greater emphasis on determining **what types of services** should be commissioned within the system, but not **how they should be delivered.** The responsibilities of a strategic commissioner can be understood through an **'analyse, plan, do, review**' framework



The full role of commissioning and organising services will be spread across the system and will need close cooperation

Commissioning refers to: "*The cycle of assessing the needs of people in an area, designing and then securing appropriate service.*" Historically, this has been done by CCGs, but under new arrangements Provider Collaboratives and LCPs will have a role in commissioning services alongside the ICB.



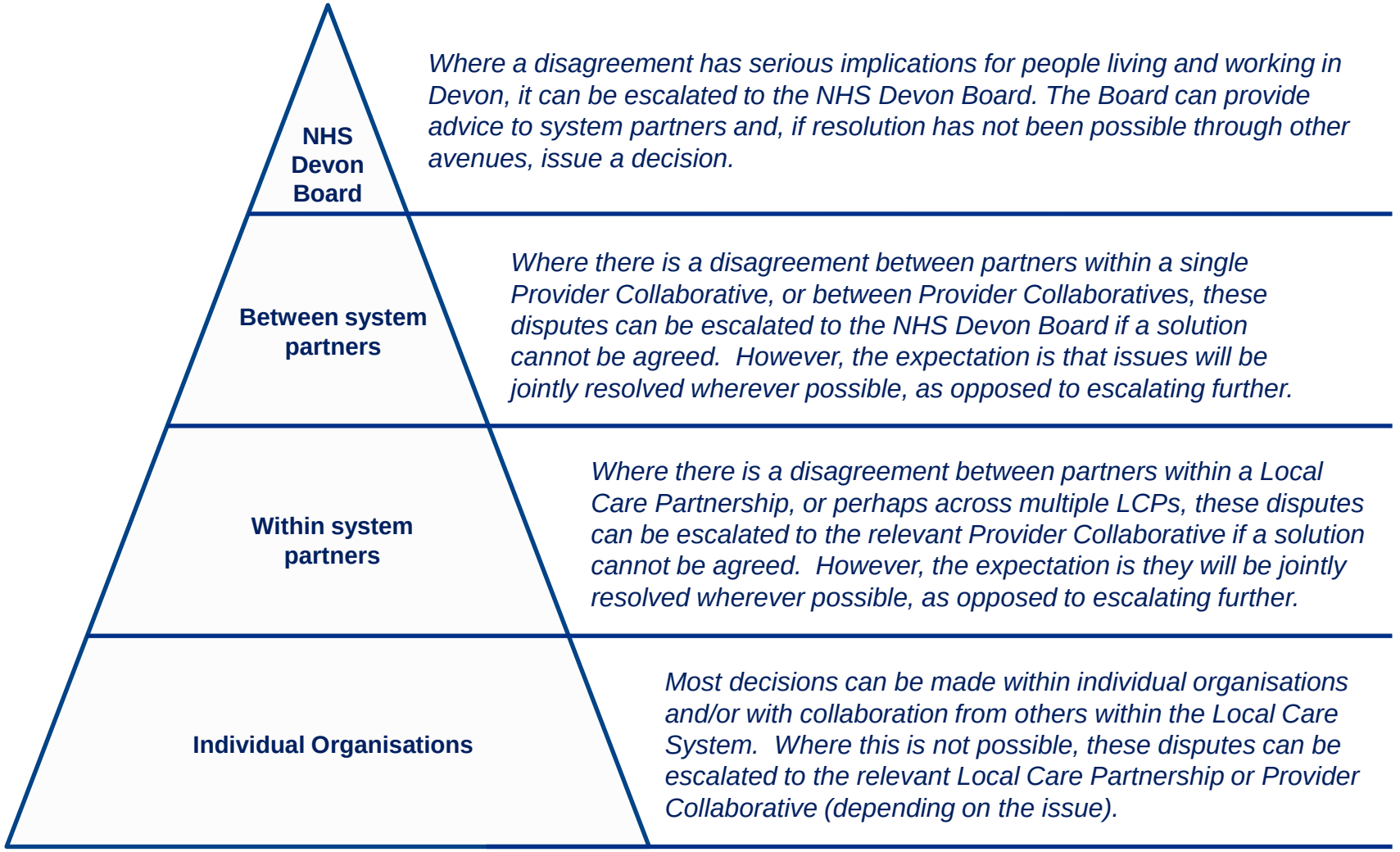
	Commissioning responsibilities
NHS Devon commissioning	• Strategic commissioning (Analyse, Plan, Do, Review) • Commissioning of specialised services (once delegated by NHSE) • Contract and procure services across the system
Provider Collaborative commissioning	• Design service provision at system level and configuration of those services • Coordinate design of pathways across different providers and reduce unwarranted variation and inequalities • Agree service changes that drive improvements in quality and performance – including planning capacity and models of care
Local Care Partnerships commissioning	• Determine specific needs at place and design services that address those needs • Coordinate integration of services at place providing • Lead engagement with population and articulate priorities within each place
Neighbourhood commissioning	• Designing proactive services, that are based on population, cohort and individual need

The operating model will be key to translating system strategic goals into meaningful change and help to bring structure to collaborative action

Mutual accountability describes the way partners in the system challenge and hold each other to account to ensure the delivery of agreed objectives, regardless of statutory accountabilities. By developing strategic objectives and assigning them to system partners, One Devon can embed mutual accountability for the shared objectives that have been co-developed by the One Devon Partnership

Agreeing strategic objectives through the Devon Plan	One Devon Partnership identifies and agrees the strategic goals to achieve over the next 5 years.
Aligning metrics to strategic goals	Overarching target metrics are aligned with the strategic goal to allow monitoring of improvement. These metrics should support for outcome based commissioning.
Distributing metrics throughout partners within One Devon	Supporting metrics are assigned to the collaborative structures within One Devon, including both Local Care Partnerships and Provider Collaboratives – these structures then become responsible for the improvement as evidence by those metrics
Attaching benefits to the successful delivery of metric improvement	Benefits such as additional allocated funding or greater autonomy are attached to the successful delivery of improvement, in line with agreed metrics

Any disputes that arise are dealt with at the correct level within the system, with reference to our values and behaviours



Where a disagreement has serious implications for people living and working in Devon, it can be escalated to the NHS Devon Board. The Board can provide advice to system partners and, if resolution has not been possible through other avenues, issue a decision.

Where there is a disagreement between partners within a single Provider Collaborative, or between Provider Collaboratives, these disputes can be escalated to the NHS Devon Board if a solution cannot be agreed. However, the expectation is that issues will be jointly resolved wherever possible, as opposed to escalating further.

Where there is a disagreement between partners within a Local Care Partnership, or perhaps across multiple LCPs, these disputes can be escalated to the relevant Provider Collaborative if a solution cannot be agreed. However, the expectation is they will be jointly resolved wherever possible, as opposed to escalating further.

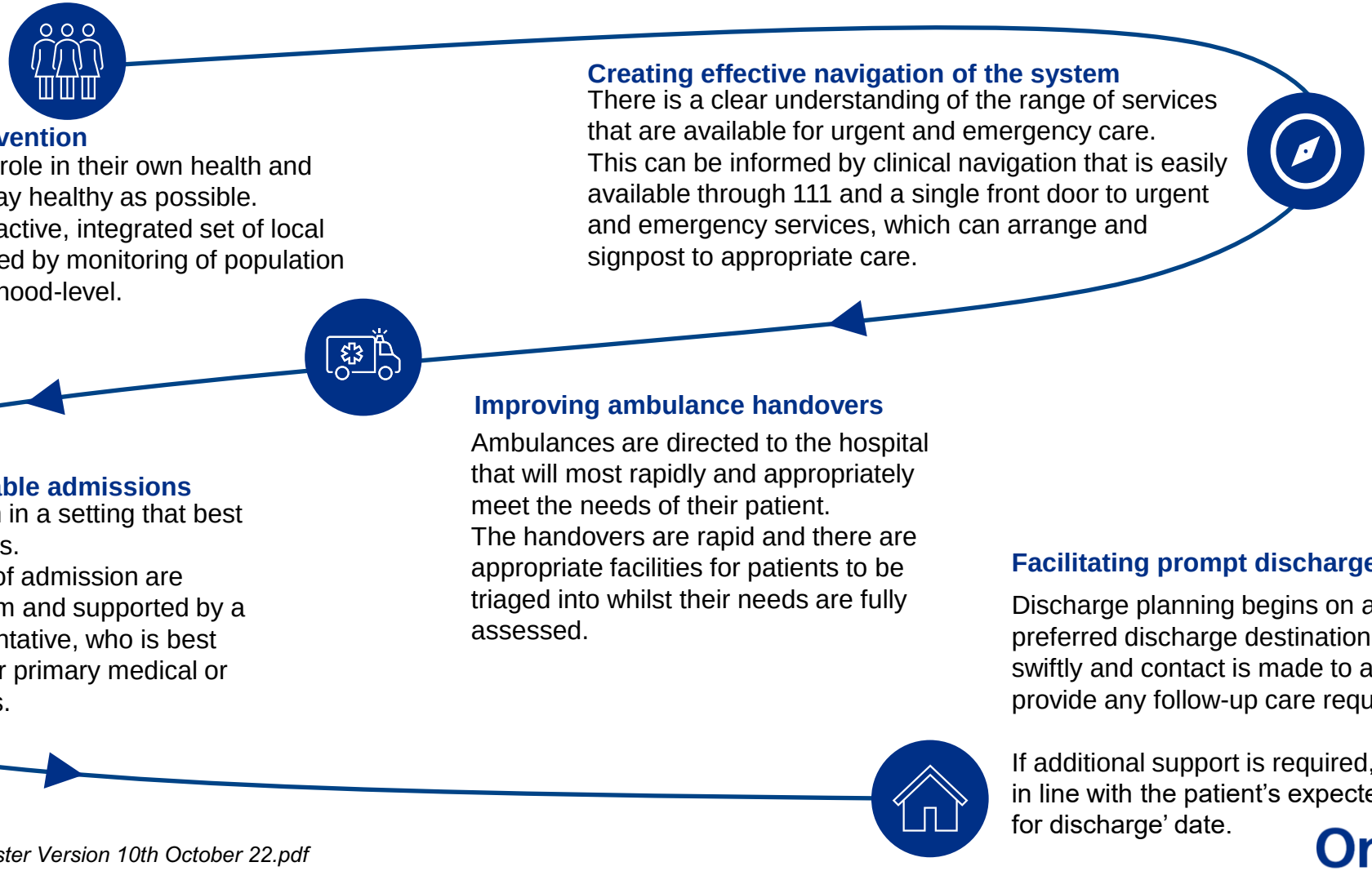
Most decisions can be made within individual organisations and/or with collaboration from others within the Local Care System. Where this is not possible, these disputes can be escalated to the relevant Local Care Partnership or Provider Collaborative (depending on the issue).

- **Putting Devon's people first**
- **Trusting each other and working as one system**
- **Making the best use of the Devon £**
- **Expanding our scope of collaboration**
- **Driving innovation**

Delivering Our Priorities Through the New Operating Model

Through the new structures, we can better deliver on our priorities– as shown in the example of Urgent and Emergency Care (UEC) (1/2)

What UEC might look like in One Devon in the future:



Developing effective prevention

Individuals have an active role in their own health and know what is needed to stay healthy as possible.
This is supported by a proactive, integrated set of local services, which are informed by monitoring of population health needs at neighbourhood-level.

Creating effective navigation of the system

There is a clear understanding of the range of services that are available for urgent and emergency care.
This can be informed by clinical navigation that is easily available through 111 and a single front door to urgent and emergency services, which can arrange and signpost to appropriate care.

Improving ambulance handovers

Ambulances are directed to the hospital that will most rapidly and appropriately meet the needs of their patient.
The handovers are rapid and there are appropriate facilities for patients to be triaged into whilst their needs are fully assessed.

Preventing avoidable admissions

Residents are seen in a setting that best matches their needs.
Those at high-risk of admission are known to the system and supported by a nominated representative, who is best placed to meet their primary medical or social requirements.

Facilitating prompt discharge

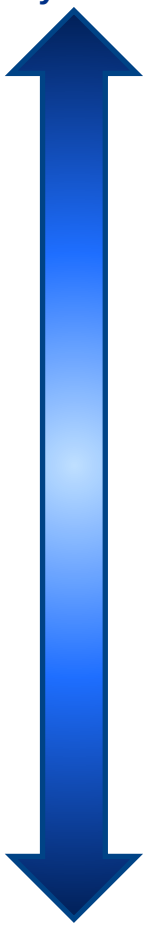
Discharge planning begins on admission. The preferred discharge destination is established swiftly and contact is made to assess ability to provide any follow-up care requirements.

If additional support is required, this is arranged in line with the patient's expected 'medically fit for discharge' date.

Through the new structures, we can better deliver on our priorities– as shown in the example of Urgent and Emergency Care (UEC) (2/2)

The below outlines **an example** of how the system might provide UEC services, under the new operating model but is not reflective of existing plans

System



Neighbourhood

- **The One Devon Partnership** will articulate the holistic requirement for UEC services through the Integrated Care Strategy – linking the different elements of the pathway, including the balance of preventative and proactive services with other reactive UEC services.
- **NHS Devon** will coordinate the response to this, primarily by setting an outcome-based commissioning framework and allocating budget to LCPs and Provider Collaboratives. NHS Devon might also directly commission services that will apply system-wide, including ambulance services (SWASFT) and NHS111. The ICB might also commission and manage a digital system that allows for rapid and continuous monitoring of patient need – necessary for adoption of a population health management approach (the necessity for a shared data architecture in UEC has been highlighted by system partners). NHS Devon will also coordinate the creation of a plan that articulates how the NHS workforce will deliver the initiatives outlined in the Integrated Care Strategy.
- Through allocated funding from NHS Devon each **Local Care Partnership** will commission services that support discharge for their population as well as anticipatory services that can support admission avoidance – depending on the needs of the population. This will be informed by key partners in the LCP including social care and housing. LCPs will be responsible to commissioning additional community capacity to help rebalance away from acute services and will also coordinate the involvement of wider public sector and charitable partners.
- The anticipatory services commissioned by the LCP will be informed through consideration of the preventative strategy – these will include services such as care home outreach and long term conditions management, and will be informed via engagement with key LCP partners including housing
- Through allocated funding from NHS Devon, the **Acute Provider Collaborative** will design the services that acute services will deliver. They will also take decisions about policies and protocols, central to maintaining effective patient flow and rapid patient transfer e.g. ambulance handover protocol. They will also feed into the workforce plan developed by NHS Devon.
- Through allocated funding from NHS Devon, the **MHLDN Provider Collaborative** will determine the pathways required for emergency mental health provision and will support effective management of patients in crisis. They will also feed into the workforce plan developed by NHS Devon.
- Each **Neighbourhood** should coordinate different services and support proactive identification of patients who are at risk of admission to hospital – and deliver proactive interventions tailored to their requirements to prevent admission. Neighbourhoods will also identify people who are admitted to hospital through use of data analytics, supporting more proactive discharge planning.

During periods of intense pressure where closer performance management is required, the new operating model will enable tighter collaborative working

Through the new ways of working, providers will retain their accountability for the delivery of services and achieving constitutional performance standards. However, there will be greater emphasis on shared responsibility for achieving these targets where the system must coordinate to support effective delivery.
Through the performance management system it is crucial that there are sufficiently robust mechanisms that combine with the system values to support improvement at organisational and system level.

Provide joined-up decision making	Coordinate system action	Jointly manage against targets
For example, when dealing with winter pressures: • The One Devon Partnership will agree system priorities • Provider Collaboratives should take decisions about deployment of shared resources • LCPs can determine initiatives to streamline discharge and coordinate community capacity including services supporting addressing the wider determinants of health • Neighbourhoods can make joined up decisions about how to manage individuals with complex needs and speed their discharge	For example when needing to make corrective decisions to stay on track with financial plans: • NHS Devon will retain oversight of the overall programme – tracking progress and identifying areas of poor performance and providing additional support where necessary • The Provider Collaboratives can determine where there are joint areas of cost and share resources to address these – as well as consolidating efforts, where appropriate • LCPs can develop alternative models of provision to provide improved and more cost-effective care	The Integrated Care Strategy (Devon Plan) will articulate strategic objectives that the system will aim to achieve: • NHS Devon will contract with target outcomes and will hold others to account in meeting these targets • Specific metrics will be allocated to system partners to deliver on in support of overall targets • For example, in support of elective recovery – the acute provider collaborative will focus on reducing long waits and, in support of this, LCPs will focus on reducing stranded patients

Adoption Roadmap

Five themes for the development of joint working arrangements have been identified – these will also be applied to adoption of this operating model

Learn by Doing	Change comes from undertaking real work together and acting upon the learning we generate. One Devon will be able to continually develop if we embed a culture of learning and improvement.
Prioritise and Implement	Implementing a small number of priority projects and programmes will create the conditions for us to deliver real change together on the journey towards the One Devon vision.
Shared Purpose	Defining and articulating (and continuously re-articulating) why we are doing what we are doing, and what we hope to achieve from it, thus supporting us as One Devon to collaborate to achieve our common purpose.
Trust and Collaboration	Increasing levels of trust and collaboration between us will be vital to creating the conditions to progress towards our One Devon vision.
Move Towards a System Focus	Movement towards our One Devon vision will be enabled by the extent to which we seek to listen to, understand and take into consideration each other's needs and constraints – we will resource system forums effectively to ensure that joint working is impactful and effective.

To move to this operating model system partners will each need to begin development of their working arrangements in Q3 2022/23

One Devon Partnership	The One Devon Partnership has defined its core committee membership and outlined its Terms of Reference. Initial focus will be on the co-production of the Integrated Care Strategy.
NHS Devon	NHS Devon is currently commissioning health services for people living in Devon. It is accountable for the financial performance of One Devon and is working closely with regional and national colleagues to reach financial sustainability. Looking ahead, a commissioning framework that articulates more detailed delineation of commissioning responsibilities across the system should be developed.
Acute Provider Collaborative	The Acute Provider Collaborative has defined its membership and outlined its terms of reference. Members are beginning to work together to ensure the best use of the totality of resources at its disposal and to plan changes to the provision of NHS services across providers.
MHLDN Provider Collaborative	The MHLDN Provider Collaborative has defined its membership and agreed its Terms of Reference. It is working to establish the required governance including financial due-diligence, creating the provider contract and creating the partnership agreement.
Primary Care Provider Collaborative	In implementing the operating model, the Primary Care Collaborative will work to define its membership and governance. Membership organisations will need to determine the best model of representation that ensures involvement across all parties whilst also creating a plan for primary care that has buy-in across the system.
Local Care Partnerships	Local Care Partnerships have agreed a governance approach and are working to identify their demonstrator projects and the available local and system resource including partners such as those in the VCSE. Initial focus should be upon determining local priorities, in line with the Devon Plan, and creating action plans around delivering on those priorities for the remainder of 2022/23.
Neighbourhoods	There are 31 existing Primary Care Networks (PCNs) in Devon. Development work is required to form Integrated Neighbourhood 'teams of teams' – this should include articulating membership and responsibilities of each neighbourhood by the start of Q4.

Cutting across the new structures, two enablers have been identified as key to the development of these new ways of working

Engagement undertaken across the system has consistently identified two key barriers to collaborative working in Devon – addressing these barriers will be key to the implementation of these new ways of working

Clarity of Resource allocation

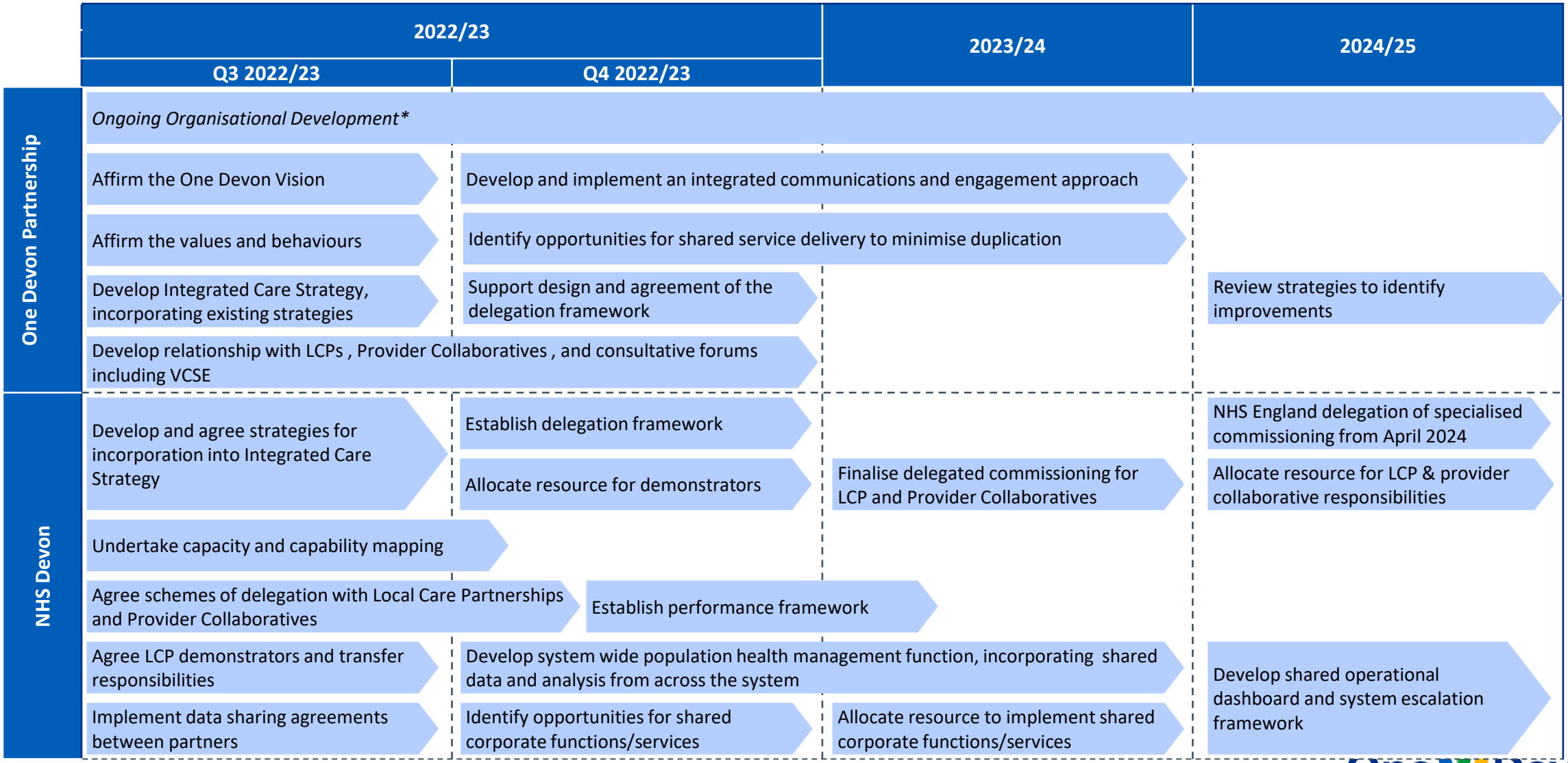
System partners have identified that clarity surrounding resource allocation is crucial to begin to implement these new ways of working. This includes:

1. Clarity around what staffing will be allocated to Local Care Partnerships, Provider Collaboratives and Neighbourhoods to support the delivery of their new roles and responsibilities.
2. Clarity around the budgetary power that each of these structures will be given. There was general agreement that LCPs and Provider Collaboratives should be given power to spend money, but further work is required to understand how this will be divided up across the system and how this will be balanced with resources allocated directly to organisations.

Data Architecture

System partners have consistently identified the lack of comparable, accessible data across One Devon as a significant barrier to collaborative working. The commissioning of a shared data architecture, supported by data-sharing agreements between partners in Devon, is a priority in implementing the operating model. Without this, outcome based commissioning, proactive models of care and the implementation of population health management approaches will prove to be challenging. All of these are seen as central to the responsibilities of the new structures.

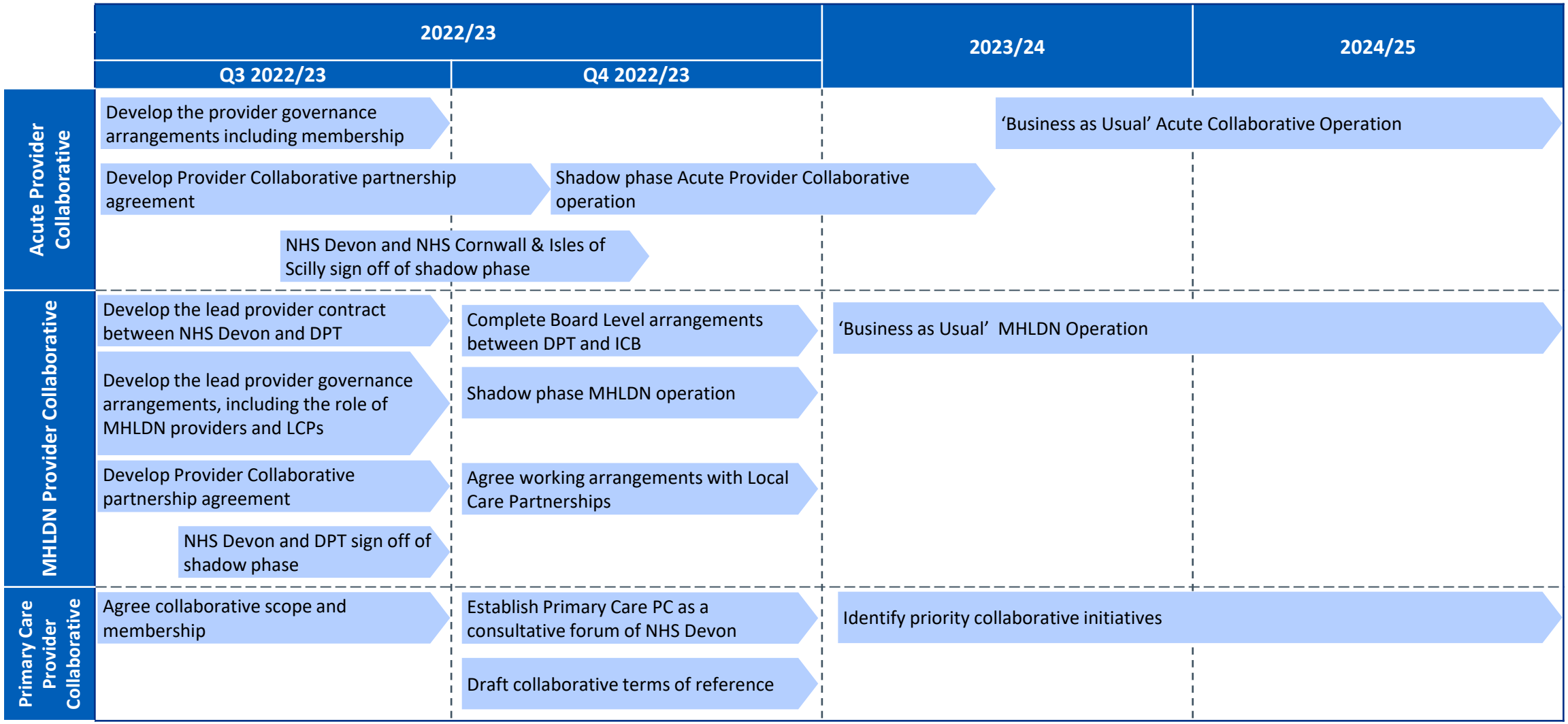
One Devon Partnership and NHS Devon will take a coordinating role and support wider system development



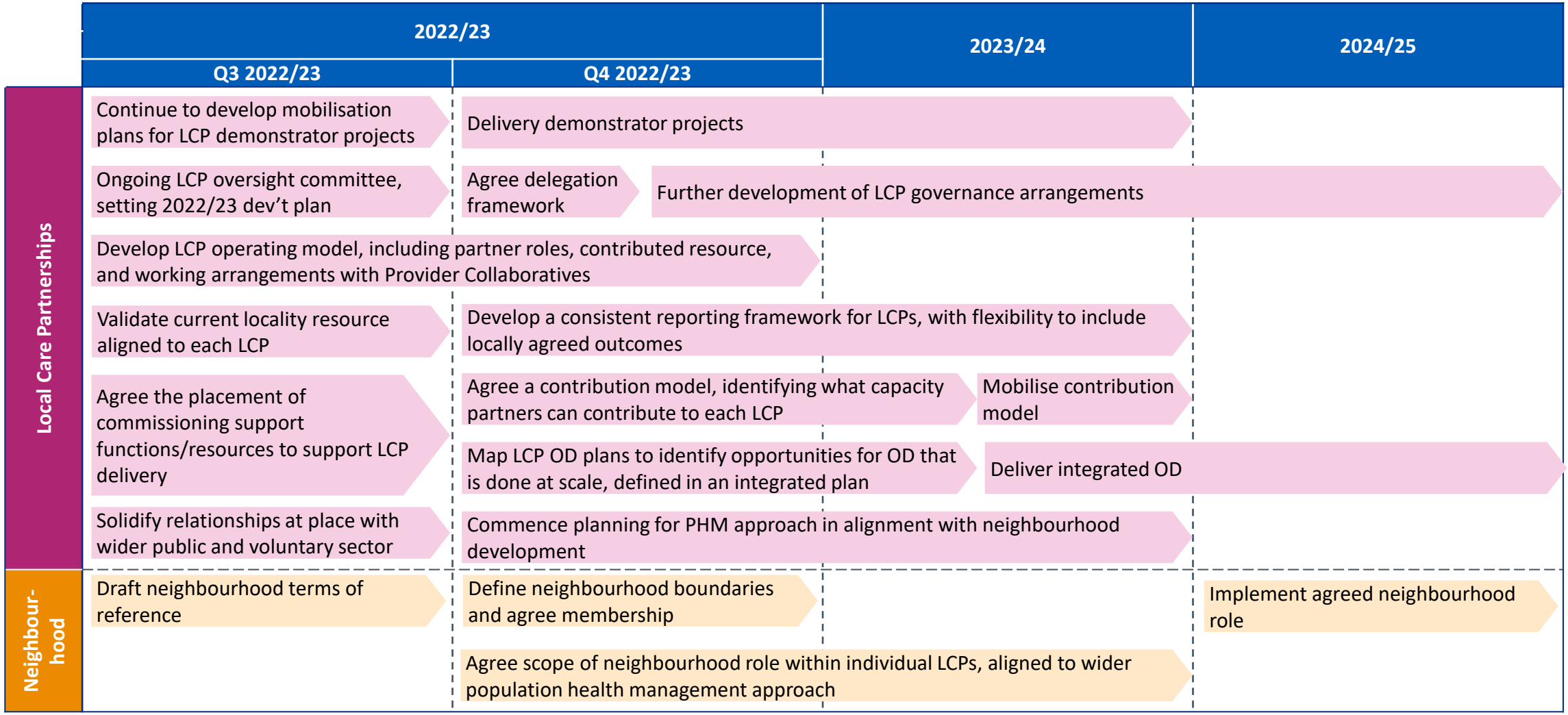
*A more extensive roadmap detailing specific OD activities has been separately developed

13. Devon Operating Model - Draft Master Version 10th October 22.pdf

The roadmap for the provider collaboratives lays out the trajectory for taking on full responsibilities through to 2024/25



Local Care Partnerships and Neighbourhoods will also take on additional responsibility as they mature



Partners must work together to agree the role and governance of the Neighbourhoods in One Devon

Work undertaken to develop neighbourhoods in Devon has thus far reflected national guidance – further work is required to to define the specific role, membership and resources of Neighbourhoods in the Devon context

What is the role of neighbourhoods in Devon?	What is the membership of neighbourhoods?	How can we ensure we harness the work of existing forums?	What is the resource required to deliver their role?
• Neighbourhoods should be foundational to integrating care locally and linking health and care services to the wider public sector, volunteer sector and businesses. • The system should align on how neighbourhoods effectively identify population need – and coordinate action to match this	• Although national guidance suggests neighbourhoods may be coterminous with Primary Care Networks, work is required to agree whether this is the most appropriate model for Devon • Work is required to agree the footprint for neighbourhoods and the membership based on those footprints	• System partners feel strongly that neighbourhoods should build on work already being done by community organisations, building neighbourhoods around these structures ensures their work is harnessed • This will vary by neighbourhood and should be mapped out for each one	• For Neighbourhoods to be effective there is a need for them to be able to manage their collective resources and to ensure this can be coordinated effectively. • The scope of this resource is to be defined and it should be clear if this is to be drawn from existing neighbourhood partners or will be in addition to the resources partners currently hold

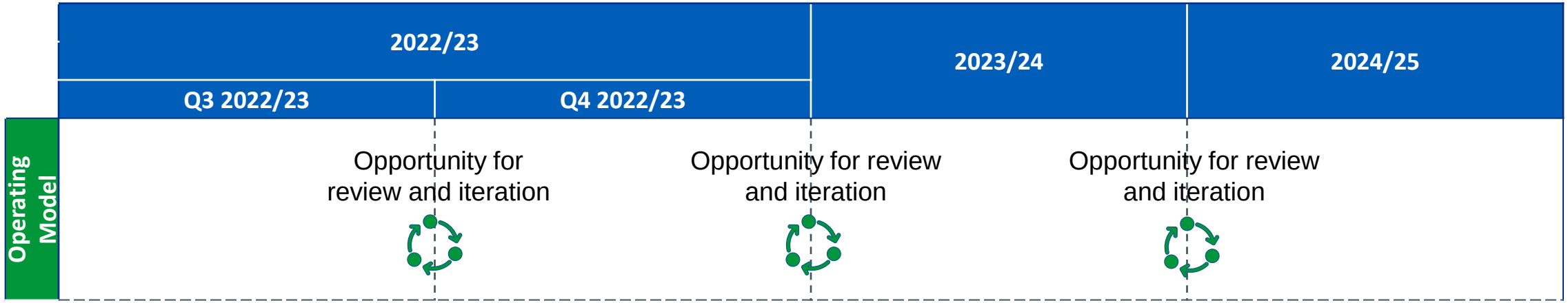
Conclusions and Next Steps

The One Devon Operating Model will be regularly reviewed and updated to ensure it serves the health and care needs of people living in Devon

Next Steps:

The operating model is part of a wider programme of ongoing development work within One Devon. Following initial approval the operating model will be regularly reviewed and iterated to ensure that it enables those working within the system to best meet the health and care needs of people living in Devon. Following the initial draft, opportunities to formally review and document changes to the operating model in the coming year have been identified:

1. Integrated Care Strategy Draft
2. 5 Year Joint Forward Plan Draft
3. Annual Planning cycle



NHS Devon strategic objectives 2022/23

Improve population health

Work in partnership with community and 'anchor' organisations (such as education and police) to address the social determinants of health — 1

Reduce health inequalities through public health and mental health support — 2

Enable a greater shift from treatment to prevention — 3

Improve services and reduce unwarranted variation

Deliver urgent and emergency care services that better meet people's needs — 4

Reduce the number of people waiting for elective care – with a specific short term focus on 104-week waits — 5

Improve the capacity of primary care – with particular attention to challenged areas, such as Plymouth — 6

Improve the quality of mental health services – particularly for Special Educational Needs and Disabilities services — 7

Support and treat more people in their own homes and communities to help them live healthily and independently — 8

Make more efficient use of our resources

Move out of System Oversight framework (SOF4) – including delivery of a balanced system financial plan — 9

Develop a workforce strategy that can ensure resilience of key services — 10

Maximise the use of digital technology and data so it is evidence based and outcome focused — 11

Minimise our negative impact on the environment and ensure services are green/sustainable — 12

Develop our culture and how we operate

Develop and embed a new culture for the 'One Devon' system and create stronger relationships built on integration and trust — 13

Develop a system operating model, so we are clear on system decision-making, local care partnership accountability, and development of a more locally-based, citizen-led approach to planning and delivering services — 14

NHS Devon board meeting

Committee chair report – Audit and Risk Committee

Date of board meeting	Dates of committees covered in this report
19 October 2022	14 September 2022

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

Reports discussed and assurances received

- Risk Report –The corporate risk register is reported to the Audit and Risk Committee and to the Board through the Chairs report.
- Internal Audit progress report – The committee were assured that work is underway on 2022/23 audit plan and this will be reviewed in November 2022 to ensure it remains fit for purpose.
- Internal Audit Plan – The committee approved two changes to the internal audit plan and agreed that the November meeting would be dedicated to an in-depth review of the internal audit plan.

Reports received and noted

- The committee noted the risk report
- The committee noted the Internal Audit progress report
- The committee noted the Internal Audit proposed plan

Risk register review updates

- Two risks with a score of 25 and which have the approval of the accountable officer these are risks:
  Risk 100 - SWASFT Call Stacking.
  Risk 153 - Planned Care System Capacity.

- Four new risks have added
  - Risk 164 – Poor outcomes for Children and Young People (CYP) with Neurodiverse needs.
  - Risk 165 – Children's Services review
  - Risk 166 – Avian Flu Swabbing
  - Risk 167 – Commissioning of high-quality services

- There has been 1 risk which has reduced in score during this reporting period.
  - Risk 152 - Return to office working- post restriction lifting

Committee decisions

- The committee agreed that a strategic review of all work, assurance and routes to the board take place to enable the organisation to function as a ICB.
- The committee agreed to escalate the concerns around risk management processes and to request dedicated time to review.
- The committee approved the Internal Audit Plan

Items of concern to be escalated to the board

- The ICB have now gone "out to market" for statutory audit. Following discussion with Grant Thornton it has been advised that as they undertake consultancy work at UHP auditing NHS Devon would breach the code of avoiding close association of consultancy and audit work.
- The committee request to escalate they are not assured that risk is being managed appropriately across the ICB and support the work to review and improve this.

Recommendations for the board

- Dedicated resource to undertake mapping a strategic review of work, assurance and routes to board happening across the organisation
- Dedicated scheduled time with board members to discuss risk management in depth.

Recommendations for other committees

- None

Terms of reference or other committee effectiveness issues

- None

Management of conflict of interests:

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

Audit & Risk Committee

August 2022 Risk Report

Date of committee	Date report produced
14 September 2022	06 September 2022

Author(s)		Report approved by	
Name and title:	Jodie Howland, Governance and Facilities Business Manager	**Name and title:**	Andrew Millward
Phone:		**Date:**	07 September 2022
Email:	Jodie.howland@nhs.net		andrew.millward@nhs.net

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

Executive summary (250 words max)
This paper provides the Audit and Risk Committee with relevant assurances regarding the risk process that is embedded within the ICB through the risk management framework policy. The data for this report was accessed on 06 September 2022. The Audit and Risk Committee is presented with a report from the corporate risk register of risk reporting to this committee (Appendix 1) showing status and management of these risks at this time. There remain two risks on the corporate risk register with a score of 25, which have been approved by the accountable officer these risks are: Risk 100 - SWASFT Call Stacking. See appendix 2 Risk 153 - Planned Care System Capacity. See appendix 3.

1 risk have changed score within the reporting period. See section 2.4.

The corporate risk register (CRR) is being monitored in accordance with the risk management framework policy as appropriate, this is being overseen by the Governance Team. The corporate risk register is reported to the Audit and Risk Committee monthly and to the Board through the Audit and Risk Chairs report.

In the reporting period (27 July 2022 to 6 September 2022) four new risks have been added to the corporate risk register. Details have been included in the report.

There is one risk which has been requested for closure. See appendix 8

Risks on the corporate risk register continue to be operationally managed to seek assurance that mitigating actions and controls are in place.

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

The Executives have responsibility for the risks identified on the Corporate Risk Register.

Each committee of the Board, following discussion with appropriate Executive(s), has approved any additions and / or closures to risk.

Key recommendations and actions requested

The committee is asked to;

1. Note that risk is being managed appropriately through the Corporate Risk Register
2. Note the status of risks reporting to the Audit and Risk Committee
3. Be assured that risk classified as very high/significant are being reviewed and managed appropriately
4. Note the risks scored as significant (appendices 2 & 3)
5. Note the new risks 164, 165, 166 and 167 (appendix 4, 5, 6 and 7)
6. Approve risk 38 for closure (appendix 8)

Impact on NHS Devon objectives	
Objective	**Impact**

Does this report have implications in any of the areas highlighted below?		
Area	**Yes (summarise implications)**	**No**
Quality of services	Risks are monitored	
Health inequalities	Risks are monitored	
Workforce	Risks are monitored	
Resources and finance	Risks are monitored	
Legal	It is a statutory requirement for the ICB to review and monitor the risks identified within the organisation	
Engagement and consultation		NO

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.

Risk Assurance Report
Audit and Risk Committee
06 September 2022

1. Introduction

1.1 This paper provides the Audit and Risk Committee with relevant assurances regarding the risk process that is embedded within the Integrated Care Board (ICB) through the risk management framework policy. The data for this report was accessed on 06 September 2022.

2 Corporate Risk Register

2.1 At the time of writing the report there are 34 risks being monitored on the corporate risk register, of which 15 risks are scored significant and 1 awaiting closure.

** Risk is scored using a 5x5 matrix which does not produce the following risk scores 7, 11, 13 & 14.

Period of report –27 July 2022 to 6 September 2022	
Total Number of Risks on Corporate Risk Register	34
New Risks	4
Risk score reduced since last report	0
Risk score increased since last report	0
Total Risks Pending Closure	1
Quality and Performance Committee	*17*
Primary Care Commissioning Transition Committee	*7*
Finance Committee	*2*
Audit and Risk Committee	*8*
Low risks (scored 1-3)	0
Moderate/Medium risks (scored 4-6)	5
High risks (scored 8-12)	14
Significant/Very high risks (scored 15 to 25)	15

2.2 There are eight risks which report to the Audit and Risk Committee and are detailed in appendix 1.

2.3 In the reporting period (27 July 2022 to 06 September 2022) four new risks have been added to the corporate risk register with the approval of the named executive for the area of risk.

Risk 164 – Poor outcomes for Children and Young People (CYP) with Neurodiverse needs. See appendix 6.

There is a risk of…

- Poor quality of care for young people in adequate community provisions
- Avoidable serious incidents
- Delayed discharge from acute paediatric wards
- Delayed discharge from the Devon wide place of safety with the consequence that other children are unable to access this resource
- Use of unregulated social care placements (often a long way from the young person's community setting)
- Poor long-term outcomes and life chances

- Increased dependence on adult health and social care services

Risk 165 – Children's Services review. There is a risk that the delays caused in finalising the Children Service Review has led to delays in progressing service line improvement within CFHD, Livewell Southwest and across wider programmes. See appendix 5.

Risk 166 – Avian Flu Swabbing. There is a risk that avian flu swabbing will not be available if needed in the event of exposure to avian flu. The impact of this is that swabbing will not be available when required, delaying the response to an avian flu event and potentially leading to avoidable transmission. See appendix 4

Risk 167 – Commissioning of high-quality services. There is a risk that commissioning decisions are not robust, due to reduced oversight of the local commissioning cycle. See appendix 7

2.4 There has been 1 risk which has reduced in score during this reporting period.

Risk 152 - Return to office working- post restriction lifting. This risk score has been reduced from 12 to 4. Now that the Covid 19 incident has been downgraded to level 2. NHS Devon have reduced the level of restrictions on staff and will continue to work to government guidelines on restrictions within the office.

2.5 A review of each risk is undertaken by the risk owner and the risk co-ordinator on a schedule appropriate to each risk. Requests to close risks, change risk scores and add new risks are being approved by the named executive lead.

The risk management framework policy specifies responsibilities for the management of risk within the ICB, with each risk having a named executive lead and senior officer as a risk owner. Risks with a very high-risk score are reviewed no less than monthly.

Risk owners and risk co-ordinators have been asked to ensure that executive leads are informed of any risk score and agree the change before any changes are made to the corporate risk register.

2.6 There are two significant risks on the corporate risk register with a risk score of 25 and have the approval of the accountable officer. Appendices 2 & 3.

Risk 100 - SWASFT Call Stacking. There is a risk that the population of Devon will not receive timely access to 999 emergency ambulance care when needed. The impact of this is upon patient experience and safety; public and professional confidence in the system and associated reputational impact. Reporting to Quality and Performance Assurance Committee.

Risk 153 - Planned Care System Capacity. There is a risk to patient safety and experience within commissioned acute trust services, due to long waiting times for elective care, including diagnostics, across Devon (adult and child). Reporting to Quality and Performance Assurance Committee.

3 Risk Management Review and Development

3.1 Work has begun on developing Risk Management arrangements for the ICB including its relationship with system risk management. This work will be completed for discussion at the ICB Board in September and will include:

- A refresh of the Risk Management Framework policy to ensure that risk management is used to shape the operations of the organisation rather than being an "add on". This will include clarification on the role of committees in managing risk.
- Refresh of corporate risk register (particularly focusing on the distinction between risks and issues and between ICB and system risks)
- A proposed risk appetite statement.
- Development of arrangements for managing system risk (and clarifying ICB role in this)
- Development of Board Assurance Framework based on Strategic Objectives to be agreed by ICB Board

3.2 There has been one request to close a risk during this reporting period.

Risk 38, Lack of clarity and visibility regarding ICS and its governance, is requested to be closed by the Audit and Risk Committee following the establishment of the Integrated Care Board on 1 July 2022. See appendix 8

4. Risk Management Training

4.1 The Governance team have produced a risk management presentation to give all staff an overview of risk management process within the ICB. The training presentation on teams can be found via this link Risk Management Presentation

The presentation will be updated following approval of the risk management framework policy.

A Risk Coordinator's Teams site brings everything together in a shared workspace where the risk coordinators can chat, hold meetings online, share files and training. This will enable ongoing development and support. The risk coordinators meet every two months. Following the internal audit, it was recommended that team risk registers are uploaded to this shared space on a monthly basis so that regular monitoring can be evidenced.

5. Recommendations

The Audit and Risk Committee are requested to:

1. Note that the risk is being managed appropriately through the Corporate Risk Register (appendix 9)
2. Note the status of risks reporting to the Audit and Risk Committee (appendix 1)
3. Note the risks scored as significant (appendices 2 and 3)
4. Note the new risks 164, 165 and 166 (appendices 4,5 and 6).
5. Approve the closure of risk 38

NHS
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Clinical Commissioning Group

DEVON CCG

Committee Risk Report : Audit and Risk Committee

Date produced: 05-09-2022 - 11:30

Produced by: jodie.howland@nhs.net

ID	Risk Description	Risk Opened	Previous Risk Score	Current Risk Score	Change	Reason For Changing Score	Exec Lead	Owner
109	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: • Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention • There is reputational impact due to potential patient harm or perception of the CCG is impacted by patient outcomes. • Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (COVID Risk wave 2 risk ID 02) (HISTORIC ID: Na)	06/06/2019	20	20	=	The risk has been reviewed but the score remains the same.	John Finn	Karen Barry
130	There is a risk that the CCG does not respond effectively to the COVID-19 pandemic. The impact of this is that the CCG may delay or disrupt the pandemic response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and perception of the CCG. COVID Risk Register Wave 2 risk ID 14 (HISTORIC ID: Na)	17/09/2020	Not set	12		current assessed status of risk	Darryn Allcorn	Phil Coutie
38	There is a risk that decisions will be made by the ICS which impact negatively on delivery of CCG functions As the ICS increasingly takes responsibility for decision making there is a risk that it will make decisions which a) have not had appropriate input/scrutiny from the CCG b) do not consider the CCG statutory functions c) are not supported by the CCG Governing Body These decisions may mean that the CCG may fail to adhere appropriately to one or more of its statutory duties or internal governance requirements, thus potentially failing in one or more of its legal duties. (HISTORIC ID: 319)	10/10/2016	9	9	=	Score reduced as we have transitional arrangements in place with ongoing monitoring GS	Simon Tapley	Ginny Snaith
129	There is a risk that a disruption to the availability of staff, IT and/ or telecoms, critical information, premises, supplies or suppliers/ contractors, may prevent the CCG from delivering its essential functions as set out in Directorate BCPs The impact of this is that CCG essential functions may be delayed or stopped with a knock on impact upon statutory functions, finance of CCG and Provider service delivery, and perception of the CCG is impacted by patient outcomes. (HISTORIC ID: Na)	17/09/2020	Not set	9		assessment of situation	Darryn Allcorn	Phil Coutie
127	There is a risk that Devon CCG may be subject to increased fraudulent activity during and following a pandemic or similar major incident The impact of this is potential , Financial loss to the CCG Phishing / Cyber attack Fraudulent staff absence / leave requests Information Governance Breaches Damage to CCGs integrity (HISTORIC ID: Na)	09/09/2020	Not set	6		Transferred from COVID RR to CRR following discussion at Exec August 2020	John Dowell	Ginny Snaith

128	There is a risk that ICB data will be compromised by unauthorised/accidental disclosure due to shared work areas with non-ICB organisations. This may be via data visible on desks and/or screens or telephone conversations. This also includes homeworking where area shared with other persons. The impact of this could be the ICB's ability to maintain patient, staff and/or corporate confidentiality. (HISTORIC ID: Na)	10/09/2020	Not set	6		agreed with GS	Andrew Millward	Ginny Snaith
131	There is a risk that the CCG will be unable to respond effectively in the event of an emergency or business continuity incident, through not meeting its statutory and policy obligations to be prepared to respond to emergencies and disruptive incidents. The impact of this is that the CCG may delay or disrupt an emergency response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and the perception of the CCG. (COVID Risk Register Wave 2 risk ID 15) (HISTORIC ID: Na)	17/09/2020	Not set	6		risk score at approval of risk	Darryn Allcorn	Phil Coutie
152	There is a risk that when colleagues return to offices following the relaxation of government restrictions related to the Covid-19 pandemic, that there will be the potential for office outbreaks of Covid-19 or impact on staff through social interactions outside of the workplace. The impact of this is would be potential staff shortages across all directorates due to the need for self-isolation or actual sickness. Potential for serious illness or death with a communicable disease. (HISTORIC ID: Na)	14/07/2021	12	4	▼	Following government advise and staff returning to the office	Andrew Millward	Ginny Snaith

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Risk Summary: SWASFT Call Stacking (ID:100)

Date produced: 31-08-2022 - 12:48

Produced by: jodie.howland@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
SWASFT Call Stacking	There is a risk that the population of Devon will not receive timely access to 999 emergency ambulance care when needed. The impact of this is upon patient experience and safety; public and professional confidence in the system and associated reputational impact.	Improve service performance	21/01/2019	09/01/2019	Quality and Performance Committee

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
25	5	5	SWASFT remain at critical incident level. No national targets for response times have been met in last five months. CEO & CNO approval received	15/11/2021
20	5	4	Score increased due to SWASFT have been in OPEL 4 for ten consecutive days this month due to the demand on services and the size of the call stack. The call stack has been the largest it has ever been; in excess of 375 patients at times.	09/07/2021
15	5	3	Call stacking is becoming more problematic across the footprint, including parts of Devon	05/01/2021
12	4	3	Discussion held with Dorset CCG highlighted the view that the risk held by SWASFT & others is far too high. There is no evidence in call stacking in Devon that adversely impacts the score & therefore QAC agreed to reduction in score	04/06/2020
20	5	4	• As requested by NHSE/I the risk has been increased back up to mirror the SWASFT risk score	02/08/2019
16	4	4	An action from Quality Assurance Committee was to review the risk and scoring. Although the call stack exists, impacts upon response times and could cause significant harm – there is no recent evidence of this (SZ)	21/06/2019
20	5	4	Risk score confirmed	21/01/2019

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Darryn Allcorn		Not Given	Russell Cooke	Sue Drew

Controls	Control Gaps
August 2022 - Risk reviewed and score to remain the same. The recommendations from the SWASFT system SI into ambulance response delays are being mapped into the improvement plans already in place. There are already 250 open actions on multiple improvement plans and 115 projects underway all aimed at improving ED's and SWASFT performance. There is stringent oversight and scrutiny from regional and national teams, including board to board meetings between organisations involved. Financial assistance is also included within a package which is required to see zero ambulance handovers of more than 30 minutes in September for UHP. This will release ambulances for more timely responses (RC) July 2022 - Risk reviewed and score to remain the same. SWASFT remain at fully escalated position. Utilised SOP EOC58 in last month; where category 3/4/5 calls are redirected to access other services. Demand high. Transfers and diverts being put in place across the system at peak times. National scrutiny on acute hospitals to reduce handover times, meetings involving national, regional and local executives. SWASFT system SI released- work for each ICB to develop recommendations for system improvement. SI review into divert completed resulting in recommendations around system SOP's for transfers and diverts. Continued work in localities and on previously listed work programs (RC) June 2022 - Risk reviewed and score to remain at 25. Resource Escalation Action Plan (REAP) level for SWAFST remains at 4. Improvement actions remain based in multiple plans amongst the locality work programs including; Ambulance handover delays recovery plans, Community Urgent Care plan, Effective Navigation of Patients in the Urgent Care System from 111 and 999, Enhanced Clinical Validation in NHS 111, Ambulance Demand Management, Long Term plan Urgent Emergency Care (UEC). The CCG's Associate Director for Urgent Care is overseeing. (RC)	August 2022 - There has been an increasing number of adverse incidents reported regarding long delays in the community awaiting ambulance response and outside ED during handover delays. Further SOP's for ambulance hospital handovers are in development. (RC) June 2022 - Diverts from one hospital holding ambulances outside their ED to another acute hospital have increased in number. The 'system SI' investigation report into ambulance response delays has yet to be released.

Assurances	Assurance Gaps

06. Appendix 2 SWASFT call stacking.pdf

August 2022 - None identified (RC)	August 2022 - No significant improvement in category 1 response (the most critical ill patients). There has been improvement in category 2 response times (heart attacks, strokes, sepsis, etc) compared to last month, but this is variable on a daily basis and still far beyond government targets. The same can be said for category 3 and 4. Resources are still limited by handover delays at acute hospitals, and staffing numbers. The summer holidays are also an added pressure of tourists in the region combined with staffing annual leave. The call stack has been in excess of 500 in recent months. Hear and Treat and See and Treat performance by SWASFT remains a positive high and is amongst the best in the country. SWASFT remain at OPEL 4 status. There has been an increasing number of adverse incidents reported regarding long delays in the community awaiting ambulance response and outside ED during handover delays. Further SOP's for ambulance hospital handovers are in development (RC) July 2022 - Handover wait times increasing resulting in long delays to respond to other incidents. Response times worsening. Reports of harm caused by long waits in ambulance and for responses in community. Different parts of system under different pressures; Western and Southern localities severe pressure (RC) June 2022 - The 999 demand remains high, with challenging peaks at weekends and B/H. No national target for ambulance response times have been met. The biggest factor impacting on ambulance response times is handover delays at acute hospitals. Hand over delays remain high in length of time and number in the West and Southern localities (RC)

Action	Date Added	Date Complete
UEC Leads managing actions within the action/improvement plan. Open actions being linked to the SWASFT report during September 2022.	23/08/2022	
Actions are based in each locality with workstreams focused on improving flow through hospitals, increased capacity within ED's, increasing MIU capacity, reduced conveyances through the Community Urgent Care program. SWASFT have their own detailed workstream on improving staffing, lowering sickness and finding alternatives to managing delays. Workstreams are considered at the Devon Urgent Care Board. The Devon System Winter Plan has further details on actions in times of extremis. February 2022 - there are many actions across many workstreams in relation to improving ambulance delays. The Devon UEC Board do look at each workstream and the actions, and the Devon winter plan is in operation	31/01/2022	18/02/2022
January 2022 - SWASFT are revoking staff from acute cohorting areas (to be replaced by hospital staff) which will free up approx., 2 x ambulances per site (JD) February 2022 - The hospitals are covering this themselves	14/01/2022	18/02/2022
June 2021 - Further in-depth review of Devon call stack in agreement with SWASFT (by the Western Locality Leads). A recent deep dive involving Western locality has identified that on one sample occasion, numerous patients in the call stack could have been seen by other providers; for example fallers waiting assessment could have gone to Community Crisis response teams. Work in this area is hoping to be progressed with SWASFT agreement regarding how else these patients could be managed October 2021 - Work in this area is being led by Paul Hurrell and Lorraine Webber. Presentations received on Falls prevention and Demand data slides re UCR along with the following commentary provided by Lorraine. • Analysis as part of the planning for urgent community response (UCR) service implementation highlighted falls as a significant reason for Emergency Department (ED) attendance and 999/111 calls. • Our UCR services will be fully operational from 1st November (8am-8pm, 7 days per week) in all localities. • There is a specific group working with South Western Ambulance Service Foundation Trust (SWASFT) and Devon Doctors (DDoc). The biggest challenge is that despite updating the Directory of Services (DoS) and making a single point of access (SPOA) in each locality, SWASFT are repeatedly not utilising this and referring people into the UCR. There is a plan to launch a large communication on this with them. • As a result of UCR demand modelling and in addition to the UCR funding allocations made to community services, Paul Hurrell has been collating locality plans around their aims for falls & fracture prevention this year. • There are also plans to provide some specific falls prevention and post fall protocol webinars for care homes in the next few months.	15/06/2021	12/10/2021
June 2021 - Increased information requests on Devon call stack at joint CCG meetings with main commissioner October 2021 - We have been receiving more information about the call stack size. It changes by the minute and is not easily divide up into CCG's. Snapshots of ambulance response delays have been provided. Call stack size is discussed in meetings with the lead commissioner.	15/06/2021	12/10/2021
June 2021 - Further requests to business information teams asking for specific Devon figures October 2021 - Devon and hospital specific figures are provided. They are to shortly change their distribution list to just four CCG email addresses. Contingencies are being made within the CCG to share the information.	15/06/2021	12/10/2021
June 2021 - Review of national paper / case studies on patients of long waits for ambulances when published. SWASFT took park in national work but have yet to see results September 2021 - No information from national review October 2021 - The national papers / case studies have yet to be published. Local Devon cases have been considered from information provided by SWASFT. Local case studies have been identified. System SI's for index cases of long waits are being considered. It is not clear if or when the national paper will be published.	15/06/2021	12/10/2021
Reviewed by Executive Team 19 October 2020 October 2020 - the risk is on all SWASFT CCGs risk registers and currently the scoring is under review	05/11/2020	28/10/2020
CCG leading on aspects of Joint Commissioner Action Plan June 2019 - this is ongoing and continues (SZ) February 2020 - This is an ongoing process and will remain live for some time, with each CCG in the footprint leading on different aspects therefore happy to close (SZ)	21/01/2019	10/02/2020
CCG review of SIRIs/Complaints and Yellow Cards pertaining to the risk June 2019 - the review has take place and action can now be closed (SZ)	21/01/2019	20/06/2019

NHS
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Risk Summary: Planned Care System Capacity (ID:153)

Date produced: 31-08-2022 - 12:48

Produced by: jodie.howland@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Planned Care System Capacity	There is a risk to patient safety and experience within commissioned acute trust services, due to long waiting times for elective care, including diagnostics, across Devon (adult and child). The risk to safety is greater for patients that fall into the Priority (P) 1, 2 and 3 categories, but risk also includes1 a) Not yet seen' patients referred by their GP but yet to be seen by acute secondary care services b) Patients waiting for a follow up appointment for acute services beyond their 'time critical' date In addition, there is CCG and System reputational risk, due to long waiting lists for elective care across Devon. Not in scope for this risk is adult and child community or mental health services. The impact of this risk is; • Patients poor experience of a long wait for definitive treatment • Patients may experience physical symptoms, for example increased pain / reduced mobility as a result of waiting longer • Patients clinical condition may deteriorate (physical harm), further impacting of safety and experience, but also potentially the complexity of the case. Subsequently this may lead to: • Increased level of intervention at the point of procedure, and increased length of stay • Increased support from the wider system, including Health and Social Care. For example, community nursing and social care support if unable to self-care and/ or medication support from primary care for pain control • Increased system support and communication to patients; Primary care activity has increased, due to concerned long waiting patients. Additional work by primary care and Communication teams is required, as patients seek to understand their individual waiting time experience – • Those providing care may suffer burn out due to the level of intensity required to manage lists, but also more complexity as risk grow. This may also impact on • Successful recruitment and retention across the system. • Increased Carer burden for those whose physical and mental health deteriorates as a result of the long wait	Improve service performance	19/10/2021	19/10/2021	Quality and Performance Committee

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
25	5	5	The risk score takes into account and approved by Accountable Officer 19/10/2021 - Potential risk to individual's physical health, due to an extended wait, including diagnostic delays. - Potential risk to individual's psychological health, due to an extended wait. - The collective impact i.e. the large numbers affected across Devon System experiencing these long waits. - The collective psychological and physical risk to staff across the Devon System. - The collective reputation system risk and being able to demonstrate Devon is effective and well led system. - The collective system financial risk and being able to demonstrate an increasingly deteriorating elective care position will not impact on system financial sustainability into the future.	19/10/2021

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
John Finn		Karen Barry	Jane Sangoor	Sharon Hobbs

Controls	Control Gaps

01.03.22 There is a clear and robust system wide plan. The capacity in the elective system to address this will be detailed and monitored as part of the 22/23 operating plan to be completed by mid April 22. The devon system will work towards delivery of 110% of 19/20 elective capacity building on trust capacity, use of the IS, etc capacity delivered through our TIF schemes through the accelerator schemes and capacity available via the region. System delivery arrangements are through the Planned Care Programme Board which takes place monthly. The plan is being delivered initially focus on reduction of 104ww and 52ww monitored through the planned care group and reporting monthly to the Chief Executive group. There have been initial improvements, however, the challenge to recover elective capacity to pre covid is immense and will not be achieved over the lifetime of the 22/23 plan. the risk score remains the same • National and local policies and procedures, including: - Continued prioritisation of patients using National Standards i.e. P1-4. - Mutual aid within Devon and between Devon and other regional providers. • Quality frameworks, including serious incident reporting and complaints and other patient experience processes, ensuring staff and patients are informed about escalate their concerns. • Governance process and arrangements, including reporting of risk from the Surgical Working Group through to Planned Care Board (System risk), the CCG Quality Assurance Committee (System and CCG risk) and the Devon Quality Surveillance Group (System risk). • Quality and Equality Impact Assessments (QEIAs) to measure impact of long wait plans, initiatives and other associated workstreams. • Other safety processes, including individual high priority patients and their risk still be discussed and supported by professionals across one of multiple sites. • Capacity controls, including: - Utilisation of the Independent Sector to manage capacity (low complexity). - Development of Accelerator Site and initiatives. For example, the Nightingale Hospital to provide ring fenced Elective Care capacity. • - Capacity plans, using the Elective Recover Fund (ERF). • Other initiatives, including plans to potentially development and trial of a Single Patient List (initially in Orthopaedics) to ensure that those in most need (based on clinical need and time waited) are offered the next available appointment in the System. NB this offer of choice remains with the patient. • Health Equalities Project (HEP) plans to develop ways to reduce risk for the 20% of the population in the most deprived areas of Devon, plus patients in BAME groups. Work includes Clinical Validation of waiting lists. • 'System Harm Group', formation to oversee and implement ways to check for physical harm and poor patient experience during long waits- led within the Planned Care Programme, reporting through the Planned Care Board; Communications, Commissioning and Quality Team matrix working (with providers). • System workforce plans, including active recruitment to vacant posts where this is an impact i.e. consultants. . The ICB committee is updated to reflect the reporting to the quality and assurance committee	• Sufficient Immediate capacity to treat current P2 and P3 patients regardless of the above controls.

Assurances	Assurance Gaps
• Clinical Validation data; patient experience. • Harm reviews completed at point of intervention to understand true impact of waits • Quality measures/ data, including: - Serious incident and lower level incidents associated with harm due to log waits. - Complaints and concerns; patient, carers, primary care and others. - Staff health and well-being - CQC and regulator assessments, feedback and formal reports. Further thematic analysis planned • Performance data (actual number of patients waiting x time, plus System percentage performance data) to assess level of immediate reduction to risk and to measure against trajectories. • System SLT clearly sighted on risk through governance arrangements (see above). • Individual Trust Board reporting on quality and performance measures around this risk.	• Consistent site of all Trust data to inform risk assessment, workstreams to reduce risk and to measure improvement. • Trusts have yet to join System Harm Group

Action	Date Added	Date Complete
System Harm Group meetings commenced 23 June 2021	19/10/2021	
October 21 "Principles for Protected Elective Capacity for 21/22" (e.g. hospital within a hospital) being considered/proposed to Planned Care Programme Board	19/10/2021	

NHS
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Clinical Commissioning Group

Risk Summary: Avian flu swabbing (ID:166)

Date produced: 31-08-2022 - 12:36

Produced by: jodie.howland@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Avian flu swabbing	There is a risk that avian flu swabbing will not be available if needed in the event of exposure to avian flu. The impact of this is that swabbing will not be available when required, delaying the response to an avian flu event and potentially leading to avoidable transmission. Additionally, NHS England have also specified that systems need to be able to offer an avian flu swabbing service (including out of hours), and this service not being available carries the potential for contractual requirements of the ICB to be unmet.	Commission high-quality and safe services that reduce health inequalities and improve health outcomes	26/08/2022	26/08/2022	Quality and Performance Committee

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
9	3	3	Reviewed and agreed by CNO	26/08/2022

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Darryn Allcorn		Not Given	Alastair Harlow	Sue Drew

Controls	Control Gaps
August 2022 - • 'Best endeavours' in-hours cover through existing teams. • System meetings including gap analysis and operating principles development, with involvement of all partner organisations, • Item included in Quality & Performance Committee report	August 2022 - • Out of hours service not currently available, • In-hours swabbing service provided on a 'best endeavours' basis and not guaranteed to occur, • Requirement for full PPE/RPE training limits personnel able to perform function, • Size of county means potentially long travel times if team is centralised, • Events are likely to be too rare for a fulltime team, • Not currently specified in provider contracts.

Assurances	Assurance Gaps
August 2022 - • Internal and external reviews of positive case, • Cases (actual and suspected) have been managed on a best endeavour, ad-hoc basis, • Discussions with UKHSA, commissioners and providers continue.	August 2022 - • Formal arrangements not in place, with ad-hoc process which has been demonstrated to not always be sufficient.

Action	Date Added	Date Complete
August 2022 - Formal arrangements not in place, with ad-hoc process which has been demonstrated to not always be sufficient.	26/08/2022	
August 2022 - Options paper for out of hours service currently being drafted by System Lead for IPC & will be taken to QLT/Commissioners	26/08/2022	
August 2022 - Examine how neighbouring systems have approached this issue	26/08/2022	
August 2022 - Continue discussions with UKHSA, commissioners and providers	26/08/2022	

NHS
Devon
Clinical Commissioning Group

Risk Summary: Children's Service Review (ID:165)

Date produced: 31-08-2022 - 12:42

Produced by: jodie.howland@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Children's Service Review	There is a risk that the delays caused in finalising the Children Service Review has led to delays in progressing service line improvement within CFHD, Livewell Southwest and across wider programmes due to: • Delay in agreeing the strategic direction • Lack of an agreed governance structure and senior leadership approach across the children's health system • Delay in agreeing where demand and capacity indicates the need for more resource The impact of this to NHS Devon is there is a risk of being: • Unable to agree on what the funding gap is and therefore what should be delivered from within the existing contract. • Unable to agree on what service should be prioritised for improvement work. • Unable to agree on actions identified within the Torbay Local Area Written Statement of Action which may not fall within contract. • Unable to triangulate robust information to prepare for and respond in a timely way to address inequalities, complete funding bids and measure the effectiveness of intervention. • Unable to allocate capacity and resource whilst still delay • Reputational damage among local authority partners • Unable to address the pressures within the wider acute and community system as dependent on engaging them in the pathway implementation. Community paediatrics is inextricably linked to children's community services. • Unable to agree on data required for contract due to review of Outcomes Framework being put on hold. Can't reach a decision on final report – contents, detail or recommendations Incomplete and inconsistent data provided including provider financial information	Improve service performance	03/08/2022	03/08/2022	Quality and Performance Committee

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
12	3	4	-	03/08/2022

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Jo Turl		Hannah Pugliese	Hannah Pugliese	Thomas Lannigan

Controls	Control Gaps
• Agreement between senior executives to prioritise the pathways in need of further review • CYP Long Term Plan Programme Board meets monthly and received updates on the CYP Long Term Plan o Game changer programmes being progresses with systems partners o Clinical lead posts out for recruitment • Summary DRAFT report presented to NHS Devon CCG Governing Body June 2022 • CCG Deputy Director of Finance meetings with Provider Finance • Contract Review Meetings – reinstated quarterly with new ToR with monthly Joint Transformation Meetings • Feedback from Livewell South West has been received and review document amended accordingly. • CFHD have provided follow up information for each service line	Partners who were involved in the review have not had the draft report shared and are questioning the lack of progress being made to finalise. This includes VCOs and children, young people and families who gave their thoughts as part of the review. Limited capacity within the provider organisations for wider pathway transformation Controls do not address the overarching funding gap and therefore enable planning across the landscape of children services.

Assurances	Assurance Gaps
1. Corporate risk agreed 2. Senior executive oversight of the progress 3. ICB reporting through IPQR 4. Provider reporting through Board reports	Oversight of the service activity and outcomes for CFHD is limited to the agreed Day one reporting. A review of the Outcomes Framework is one of the recommendations in the Children Service Review but this is also delayed pending agreement on the strategic direction.

Action	Date Added	Date Complete

Risk Summary: Poor Outcomes for CYP with Neurodiverse Needs (ID:164)

Date produced: 31-08-2022 - 12:43

Produced by: jodie.howland@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Poor Outcomes for CYP with Neurodiverse Needs	Context Much good work has been done to reduce the numbers of children and young people with autism (ASD) and learning disability (LD) that are admitted to mental health inpatient care in Devon. This work has significantly reduced numbers in hospital from an average of 17 inpatients at any one time in 2019, to an average of 4 inpatients at any one time during 2021. Psychiatric inpatient admission should only be used when there is an identifiable and treatable mental illness, and should not be used solely for the management of ASD or LD. Some admissions remain necessary in this group, but these would only be for young people with identifiable mental health needs that happen to have a comorbid presentation of LD or ASD. This change in practice is based on increasing evidence that admission to hospital is ineffective and damaging for Neurodivergent young people. The effects of this change in who we admit to hospital, has been that young people who present without a treatable mental illness, but in significant emotional distress need to be managed in a community setting. They frequently express their distress with risky behaviours such as self-harm, the use of suicidal language, or restricting their food or fluid intake. These risks are challenging to manage in a community setting, are poorly understood by professionals working outside of a health setting and are difficult to moderate. These young people often require short term de-escalation support that is not available in our system. The result is that we have a significant number of young people presenting to our hospitals (paediatric wards) or to our place of safety (POS), in emotional distress, with no onward pathway of care. Due to… There being gaps in our service structures for meeting the needs of young people with ASD and LD. Children, young people and their families are unable to access support in a timely way particularly when children present with challenging behaviours and this results in escalation of those behaviours. This leads to increasing levels of distress and often to a breakdown in education, family and care placements. Often the only place for these carers to seek support is via A&E and an admission to a paediatric ward or via police intervention to the Place of Safety. The lack of an onward pathway of provision in the community at that point causes delays in discharge as well as re admissions when discharge has been facilitated. There is a risk of… • Poor quality of care for young people in adequate community provisions • Avoidable serious incidents • Delayed discharge from acute paediatric wards • Delayed discharge from the Devon wide place of safety with consequence that other children unable to access this resource • Use of unregulated social care placements (often a long way from the young person's community setting) • Poor long term outcomes and life chances • Increased dependence on adult health and social care services The impact of this is (the impact statement should clearly state the effect of the risk to the CCG) • Reputational damage due to use of unregulated provisions and poor quality of patient care • Pressures within the acute paediatric and urgent care system • Short term financial impact of high cost placements and packages of care (often unregulated) • Long term economic impact of increased dependence on services	Commission high-quality and safe services that reduce health inequalities and improve health outcomes	03/08/2022	03/08/2022	Quality and Performance Committee

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
15	5	3	-	03/08/2022

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Jo Turl		Hannah Pugliese	Hannah Pugliese	Thomas Lannigan

Controls	Control Gaps
1. Delayed discharge protocol in place – effective in multi-disciplinary planning 2. Dynamic support register process to track and monitor individuals at risk of admission 3. Key worker pilot 4. Treatment teams – such as CAMHS 5. Trusts working towards autism accreditation 6. Diagnostic services for ASD and ADHD (long waiting times) 7. Clinical leadership for transformation programme	1. A system of universal surveillance and support 2. A needs based service to replace a diagnostic led approach 3. Integrated diagnostic services when these are required – including for Learning Disability and Developmental Language Disorders 4. An Intensive Home Treatment Team for LD & A supporting families and accommodation providers to support discharge and maintain CYP in their community setting 5. De-escalation accommodation 6. Range of regulated accommodation provision across Devon, Torbay & Plymouth.

Assurances	Assurance Gaps
1. Regular reporting to the Learning Disability and Autism Programme Partnership 2. CYP Transformation Steering Group oversight and delivery of programme for neurodiversity (game changer) reporting to CYP Long Term Plan Programme Board 3. Community contracts for children report to QAC 4. Launch event June 30th Neuro Diversity Transformation Programme – purpose to raise awareness of wider stakeholders and achieve buy in and turning concept to model	Oversight of the service activity and outcomes for this population of children and young people is very limited, recording and reporting currently for: • Waiting times for ASC • Admissions to tier 4 CAMHS Numbers of delayed discharges (LD&A and MH) is not routinely collated and impact of these on system. There isn't a system wide view of impact, consistent and good information is not collated or shared including social care, education.

Action	Date Added	Date Complete
Establish a programme of work and governance arrangements- HP by 01.06.22	03/08/2022	
Identify data needed to benchmark current position and monitor programme- HP, 30.07.22	03/08/2022	
Prioritise workstreams as below: A coordinated approach across health, social care, and education with alignment to agreed practices An integrated model of provision across health, social care, and education for those children with high levels of need in communities as well as accommodation-based care A culture of acceptance of responsibility and multi-agency working for children in crisis or accessing the risk support quadrant of the ithrive framework – workforce development programme Comprehensive packages of coordinated support across a range of statutory and voluntary agencies for those children at risk of crisis Development of Home Treatment service for LD&A (pilot first) Clear comprehensive support plans, jointly developed in partnership with young people and their families A focus on need, moving away from a purely diagnostic framework for accessing support Agreed multi agency escalation and information sharing processes – with audit for effectiveness and inform service development Clear processes around transition and development of the 0-25 offer including changes to commissioning where appropriate	03/08/2022	

NHS
Devon
Clinical Commissioning Group

Risk Summary: Commissioning of high quality services (ID:167)

Date produced: 05-09-2022 - 11:15

Produced by: jodie.howland@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Commissioning of high quality services	This risk replaces Risk 133 on the corporate risk register There is a risk that commissioning decisions are not robust, due to reduced oversight of the local commissioning cycle. The impact of this is: 1. Decisions may be made in isolation without thorough commissioning, clinical and quality oversight. 2. Contract and procurement deadlines may be impacted. 3. A gap in health inequalities may be widened due to impacted access to commissioned services. The risk is a result of: - • Capacity challenges within the ICB elective care team due to the oversight of the NHSE/I long waiter target; reduced oversight of the local commissioning cycle. • Significant operational pressures that the Devon healthcare system is currently managing, including the impact of urgent & emergency care and COVID on acute services . • Significant operational pressures that the Devon healthcare system is currently managing, including the impact of urgent & emergency care and COVID on acute services .	Commission high-quality and safe services that reduce health inequalities and improve health outcomes	01/09/2022	05/08/2022	Quality and Performance Committee

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
12	3	4	controls in place reduce likelihood of this taking place.	05/08/2022

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
John Finn		Karen Barry	Karen Barry	Sharon Hobbs

Controls	Control Gaps
• ICB response cell structure installed to maintain robust oversight of the 104ww delivery • Daily check in calls with ICB team as well as wider system partners • Reprioritisation of commissioning work to ensure urgent work packages are overseen as a priority • Daily updates with NHSE/I regional colleagues • Daily review of staffing capacity with an agreement to flex work portfolios on a daily basis in order to meet demand • Daily / weekly monitoring of available data, as well as twice weekly system situational reporting to maintain robust oversight • Progress on 104WW performance is overseen by the system Planned Care Programme Board • Weekly updates are shared with system CEO's through the RERSG	none identified

Assurances	Assurance Gaps
For each of the risks and controls a source of assurance is set out i.e.. What provides evidence that the organisation has identified the risks and has controls in place. (e.g. Internal audit report, report to Board or Board Committees) Please provide details of assurances below: • Progress on 104WW performance is overseen by the system Planned Care Programme Board • Weekly updates are shared with system CEO's through the RERSG • Bi-weekly updates are provided to SDIG • Daily sit-rep monitoring • Daily ICB team check-ins	none identified

Action	Date Added	Date Complete

• Re-focusing of daily staff workload to maximise oversight and productivity of priority deliverables or workstreams • Daily sit-rep report updated • Weekly senior stakeholder report (RERSG)	01/09/2022	

NHS
Devon
Clinical Commissioning Group

Risk Summary: Lack of clarity and visibility regarding ICS and its governance (ID:38)

Date produced: 05-09-2022 - 11:27

Produced by: jodie.howland@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Lack of clarity and visibility regarding ICS and its governance	There is a risk that decisions will be made by the ICS which impact negatively on delivery of CCG functions As the ICS increasingly takes responsibility for decision making there is a risk that it will make decisions which a) have not had appropriate input/scrutiny from the CCG b) do not consider the CCG statutory functions c) are not supported by the CCG Governing Body These decisions may mean that the CCG may fail to adhere appropriately to one or more of its statutory duties or internal governance requirements, thus potentially failing in one or more of its legal duties.	Commission high-quality and safe services that reduce health inequalities and improve health outcomes	10/10/2016	10/10/2016	Audit and Risk Committee

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
9	3	3	Score reduced as we have transitional arrangements in place with ongoing monitoring GS	21/10/2021
16	4	4	Transitional decision making process not agreed	15/09/2021
4	2	2	risk reviewed at Executive Team Meeting 20 Oct 2020 and score reduction agreed. GS	20/10/2020
9	3	3	STP/ICS arrangements under post-COVID review (GS)	23/06/2020
6	2	3	reviewed no change	01/10/2019
6	2	3	Governance arrangements and processes are in place. Tested major programmes of work in relation to YFC programmes and engaging in pieces of design work through future mandates which are being closely overseen by the Strategy (corporate governance) Directorate	02/08/2018
12	3	4	No Change	23/05/2018

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Simon Tapley	Sonja Manton	Ginny Snaith	Ginny Snaith	Tanya Harle

Controls	Control Gaps
21/10/2021 Transitional decision making in place. 15/09/2021 ICS task and finish group overseeing development of ICS governance arrangements. Developing a ICS transitional decision making structure. Developing an ICS decision making framework. (GS) Dec 2020 Updated by GS/JD Governance arrangements for the ICS agreed by all partners setting out ongoing requirements for decision making of statutory bodies CCG AO and Chair on Partnership Board Appointment of joint System and CCG AO 11/11/2020 Discussed at Audit Committee. the committee agreed the risk is still pertinent and requested a review of wording to better express the risk. 12/10/2020 Risk to be presented to Audit Committee for discussion and review November 2020	21/10/201 On going work required to monitor decision making during transition 15/09/2021 Controls as identified above in development but not yet agreed by ICS

Assurances	Assurance Gaps
21/10/2021 Audit Committee and remuneration committee providing assurance on ICS transition Dec 2020 Updated by GS/JD CCG Risk Management Process reporting at all levels of organisation Regular updates to Governing Body through Chairs and AO report and specific items of relevance Internal Audit of ICS Governance arrangements NHSE ICS designation process	No assurance Gaps identified

Action	Date Added	Date Complete
The task and finish group has been established to complete the review of governance (GS)	06/04/2021	

A review of ICS governance underway in ine with new white paper Feb 2021	17/02/2021	06/04/2021
Reviewed by Executive Team 19 October 2020	05/11/2020	
Arrange workshop for system organisation Audit Chairs to review proposed system Risk Management arrangements GS	17/12/2019	
14/05/19 – Review of governance arrangements for STP to be undertaken GS	21/05/2019	01/12/2019
26/06/18 OD work commenced by Accountable Officer with Directors	27/06/2018	14/05/2019

NHS DEVON CCG
Risk Report

Date produced: 07-09-2022 - 08:16

Produced by: jodie.howland@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners
100	Improve service performance [Reporting Committee] Quality and Performance Committee	There is a risk that the population of Devon will not receive timely access to 999 emergency ambulance care when needed. The impact of this is upon patient experience and safety; public and professional confidence in the system and associated reputational impact. (HISTORIC ID: Na)	August 2022 - Risk reviewed and score to remain the same. The recommendations from the SWASFT system SI into ambulance response delays are being mapped into the improvement plans already in place. There are already 250 open actions on multiple improvement plans and 115 projects underway all aimed at improving ED's and SWASFT performance. There is stringent oversight and scrutiny from regional and national teams, including board to board meetings between organisations involved. Financial assistance is also included within a package which is required to see zero ambulance handovers of more than 30 minutes in September for UHP. This will release ambulances for more timely responses (RC) July 2022 - Risk reviewed and score to remain the same. SWASFT remain at fully escalated position. Utilised SOP EOC58 in last month; where category 3/4/5 calls are redirected to access other services. Demand high. Transfers and diverts being put in place across the system at peak times. National scrutiny on acute hospitals to reduce handover times, meetings involving national, regional and local executives. SWASFT system SI released- work for each ICB to develop recommendations for system improvement. SI review into divert completed resulting in recommendations around system SOP's for transfers and diverts. Continued work in localities and on previously listed work programs (RC) June 2022 - Risk reviewed and score to remain at 25. Resource Escalation Action Plan (REAP) level for SWAFST remains at 4. Improvement actions remain based in multiple plans amongst the locality work programs including; Ambulance handover delays recovery plans, Community Urgent Care plan, Effective Navigation of Patients in the Urgent Care System from 111 and 999, Enhanced Clinical Validation in NHS 111, Ambulance Demand Management, Long Term plan Urgent Emergency Care (UEC). The CCG's Associate Director for Urgent Care is overseeing. (RC) [Control Gaps] August 2022 - There has been an increasing number of adverse incidents reported regarding long delays in the community awaiting ambulance response and outside ED during handover delays. Further SOP's for ambulance hospital handovers are in development. (RC) June 2022 - Diverts from one hospital holding ambulances outside their ED to another acute hospital have increased in number. The 'system SI' investigation report into ambulance response delays has yet to be released.	25 [15/11/2021] ▲ 25 (L=5 x I=5) [09/07/2021] ▲ 20 (L=5 x I=4) [05/01/2021] ▲ 15 (L=5 x I=3) [04/06/2020] ▼ 12 (L=4 x I=3) [02/08/2019] ▲ 20 (L=5 x I=4) [21/06/2019] ▼ 16 (L=4 x I=4) [21/01/2019] 20 (L=5 x I=4)	Risk Opened: 21/01/2019 Reviewed: 17/08/2022	[23/08/2022] UEC Leads managing actions within the action/improvement plan. Open actions being linked to the SWASFT report during September 2022.,	August 2022 - None identified (RC) [Assurance Gaps] August 2022 - No significant improvement in category 1 response (the most critical ill patients). There has been improvement in category 2 response times (heart attacks, strokes, sepsis, etc) compared to last month, but this is variable on a daily basis and still far beyond government targets. The same can be said for category 3 and 4. Resources are still limited by handover delays at acute hospitals, and staffing numbers. The summer holidays are also an added pressure of tourists in the region combined with staffing annual leave. The call stack has been in excess of 500 in recent months. Hear and Treat and See and Treat performance by SWASFT remains a positive high and is amongst the best in the country. SWASFT remain at OPEL 4 status. There has been an increasing number of adverse incidents reported regarding long delays in the community awaiting ambulance response and outside ED during handover delays. Further SOP's for ambulance hospital handovers are in development (RC) July 2022 - Handover wait times increasing resulting in long delays to respond to other incidents. Response times worsening. Reports of harm caused by long waits in ambulance and for responses in community. Different parts of system under different pressures; Western and Southern localities severe pressure (RC) June 2022 - The 999 demand remains high, with challenging peaks at weekends and B/H. No national target for ambulance response times have been met. The biggest factor impacting on ambulance response times is handover delays at acute hospitals. Hand over delays remain high in length of time and number in the West and Southern localities (RC)	Executive Lead: Darryn Allcorn Owner: Russell Cooke

153	Improve service performance [Reporting Committee] Quality and Performance Committee	There is a risk to patient safety and experience within commissioned acute trust services, due to long waiting times for elective care, including diagnostics, across Devon (adult and child). The risk to safety is greater for patients that fall into the Priority (P) 1, 2 and 3 categories, but risk also includes1 a) Not yet seen' patients referred by their GP but yet to be seen by acute secondary care services b) Patients waiting for a follow up appointment for acute services beyond their 'time critical' date In addition, there is CCG and System reputational risk, due to long waiting lists for elective care across Devon. Not in scope for this risk is adult and child community or mental health services. The impact of this risk is; •Patients poor experience of a long wait for definitive treatment •Patients may experience physical symptoms, for example increased pain / reduced mobility as a result of waiting longer •Patients clinical condition may deteriorate (physical harm), further impacting of safety and experience, but also potentially the complexity of the case. Subsequently this may lead to: •Increased level of intervention at the point of procedure, and increased length of stay •Increased support from the wider system, including Health and Social Care. For example, community nursing and social care support if unable to self-care and/ or medication support from primary care for pain control •Increased system support and communication to patients; Primary care activity has increased, due to concerned long waiting patients. Additional work by primary care and Communication teams is required, as patients seek to understand their individual waiting time experience – •Those providing care may suffer burn out due to the level of intensity required to manage lists, but also more complexity as risk grow. This may also impact on •Successful recruitment and retention across the system. •Increased Carer burden for those whose physical and mental health deteriorates as a result of the long wait (HISTORIC ID: Na)	01.03.22 There is a clear and robust system wide plan. The capacity in the elective system to address this will be detailed and monitored as part of the 22/23 operating plan to be completed by mid April 22. The devon system will work towards delivery of 110% of 19/20 elective capacity building on trust capacity, use of the IS, etc capacity delivered through our TIF schemes through the accelerator schemes and capacity available via the region. System delivery arrangements are through the Planned Care Programme Board which takes place monthly. The plan is being delivered initially focus on reduction of 104ww and 52ww monitored through the planned care group and reporting monthly to the Chief Executive group. There have been initial improvements, however, the challenge to recover elective capacity to pre covid is immense and will not be achieved over the lifetime of the 22/23 plan. the risk score remains the same •National and local policies and procedures, including: -Continued prioritisation of patients using National Standards i.e. P1-4. -Mutual aid within Devon and between Devon and other regional providers. •Quality frameworks, including serious incident reporting and complaints and other patient experience processes, ensuring staff and patients are informed about escalate their concerns. •Governance process and arrangements, including reporting of risk from the Surgical Working Group through to Planned Care Board (System risk), the CCG Quality Assurance Committee (System and CCG risk) and the Devon Quality Surveillance Group (System risk). •Quality and Equality Impact Assessments (QEIAs) to measure impact of long wait plans, initiatives and other associated workstreams. •Other safety processes, including individual high priority patients and their risk still be discussed and supported by professionals across one of multiple sites. •Capacity controls, including: - Utilisation of the Independent Sector to manage capacity (low complexity). - Development of Accelerator Site and initiatives. For example, the Nightingale Hospital to provide ring fenced Elective Care capacity. •- Capacity plans, using the Elective Recover Fund (ERF). •Other initiatives, including plans to potentially development and trial of a Single Patient List (initially in Orthopaedics) to ensure that those in most need (based on clinical need and time waited) are offered the next available appointment in the System. NB this offer of choice remains with the patient. •Health Equalities Project (HEP) plans to develop ways to reduce risk for the 20% of the population in the most deprived areas of Devon, plus patients in BAME groups. Work includes Clinical Validation of waiting lists. •'System Harm Group', formation to oversee and implement ways to check for physical harm and poor patient experience during long waits- led within the Planned Care Programme, reporting through the Planned Care Board; Communications, Commissioning and Quality Team matrix working (with providers). •System workforce plans, including active recruitment to vacant posts where this is an impact i.e. consultants. . The ICB committee is updated to reflect the reporting to the quality and assurance committee . A harm and long waits meeting has been set up to review areas of concern and work through actions to mitigate this risk [Control Gaps] •Sufficient Immediate capacity to treat current P2 and P3 patients regardless of the above controls.	25 [01/09/2022] = 25 (L=5 x I=5) [01/09/2022] = 25 (L=5 x I=5) [19/10/2021] 25 (L=5 x I=5)	Risk Opened: 19/10/2021 Reviewed: 02/09/2022	[19/10/2021] October 21 "Principles for Protected Elective Capacity for 21/22" (e.g. hospital within a hospital) being considered/proposed to Planned Care Programme Board, [19/10/2021] System Harm Group meetings commenced 23 June 2021 ,	•Clinical Validation data; patient experience. •Harm reviews completed at point of intervention to understand true impact of waits •Quality measures/ data, including: - Serious incident and lower level incidents associated with harm due to log waits. - Complaints and concerns; patient, carers, primary care and others. - Staff health and well-being - CQC and regulator assessments, feedback and formal reports. Further thematic analysis planned •Performance data (actual number of patients waiting x time, plus System percentage performance data) to assess level of immediate reduction to risk and to measure against trajectories. •System SLT clearly sighted on risk through governance arrangements (see above). •Individual Trust Board reporting on quality and performance measures around this risk. [Assurance Gaps] •Consistent site of all Trust data to inform risk assessment, workstreams to reduce risk and to measure improvement. •Trusts have yet to join System Harm Group The meetings that have been set up with the trusts to review these risks have not had the required attendance. This has been escalated through Darryn Allcorn who will escalate this further within the Director of Nurses meetings and this has also been escalated the Planned Care Programme Board	Executive Lead: John Finn Owner: Jane Sangoor

108	Improve service performance [Reporting Committee] Primary Care Transition Committee	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand, capacity and impact of COVID) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system, including patient safety, could be affected. It is acknowledged that the risk will vary from locality to locality over time, with the need to focus resources where need is identified. This risk replaces risk 09 (SDT) and 68 (NEW Devon) Risk 117 closed 27 May 21 and merged into Risk 108 (HISTORIC ID: Na)	Reviewed with Head of Primary Care (N&E) - Jan 21 / Feb 21 / Mar 21 / Apr 21 / 4 May 21 / 27 May 21 / 1 Jul 21 / 2 Sept 21 / 6 Oct 21 / 2 Nov 21 / 7 Dec 21 / 5 Jan 22 / 8 Feb 22 / 8 Mar 22 / 7 Apr 22 / 10 May 22 / 7 Jun 22 / 7 Jul 22 / 25 Aug 22 Dec 2020 - Review with Deputy Director for Primary Care 25 Aug 22 - ARSS 2022-/23 team continuing to support PCNs in maximising opportunities under ARSS to fully spend allocation. Primary care workforce bank in place and developing. GP strategy in draft format describes key areas of work to support sustainability of primary care including workforce, estates and targeting resources to areas of most need. 10 May 22 - Spring Access Fund (WAF) - additional funded capacity made available to Primary Care through digital locum pilot and additional in hours GP and AHP sessions. LMC GPAS GP alert status report continues to be reviewed and primary care team continue to work with practices facing resilience challenge. 5 Jan 22 - Through Winter Access Fund (WAF) additional funded capacity made available to Primary Care through digital locum pilot and additional in hours GP and AHP sessions 7 Dec 21 - Nursing workforce strategy drafted. PCCC will be provided with regular updates. 100% uptake of Community Pharmacy consultation Service (CPCS) is now a condition of release of winter access plan funding. This is being led through meds optimisation team. 5 Oct 21 –Current status update: LMC GPAS GP alert status as 1st October 21 shows North and West Devon Opel 4, East and South Opel 3. A number of practices continue to experience problems with COVID outbreaks in practices. We have seen an increase in the number of requests from practices to temporary close patient lists. 2 Sept 21 - process in place to approve at pace applications for exemptions to self-isolation requirement for household contacts subject to appropriate risk assessment and identified urgent need. Income protection agreements in place for LES and DES. Although agreed locally, any proposals to pause QOF are not currently allowable through NHSE. Current issue with availability of blood tubes is also likely to impact on primary care capacity. 1 Jul 21 - Comms campaign to publicly support General Practice. Campaign included an open letter, media releases, briefings for MPs and Councillors, and a social media campaign to highlight positive public reactions to excellent Primary Care working practices. Mitigations in place: - roll out of national COVID expansion fund - vaccination system workforce offer to PCNs - income protection for LES services where practices still actively involved in mass vaccination programme - implementation of primary care specific Phase 4 work stream with direct links to system Phase 4 processes. Jul 21 - Regular updates to PCCC on progress on workforce strategy delivery (including ARRS). Primary care team have met with all PCNs to review ARRS progress and to support every PCN to maximise recruitment opportunities under the scheme. 6 Apr 21 - new guidance re expansion of Additional Roles Reimbursement Scheme in for 2021/22 at system level to ensure that max benefit can be achieved from the scheme continues as part of workforce strategy 6 Apr 21 -Local Income protection for local enhanced services on the basis of PCN extending active participation in the vaccination programme for the associated period of time. Feb 21 - new guidance re expansion of Additional Roles Reimbursement Scheme in for 2021/22 including paramedics and mental health practitioner. Oct 20 - CCG attending virtual BMJ job fayre - stand promoting SW region. Attended virtually by Primary care team. 6 Oct 20 - LMC GP alert system sent out on weekly basis highlights either localities or practices of concern. It is acknowledged that the risk will vary from locality to locality over time, with the need to focus resources where need is identified. 16.12.19 risk score not adjusted due to current list dispersals (from 2 practice closures) 14 Nov 19 - Risk score has been reviewed in light of CQC contract suspension of one practice within Western system, given (material) impact on 3 practices covering circa 25,000 patients. Score has not been adjusted as this was felt to be a manifestation of the risk rather than an escalation of it.	20 [02/11/2021] ▲ 20 (L=5 x I=4) [01/07/2021] = 16 (L=4 x I=4) [02/12/2020] ▲ 16 (L=4 x I=4) [06/10/2020] ▼ 12 (L=3 x I=4) [29/05/2019] 20 (L=5 x I=4)	Risk Opened: 29/05/2019 Reviewed: 25/08/2022	[07/12/2021] 7 Dec 21 - On 3rd Dec 2021 NHSE released a letter to primary care seeking re-engagement in the COVID vaccination programme and detailed support measures to enable this, such as suspension of some Quality Outcomes Framework (QOF) and Investment and Impact Fund (IiF) indicators. There is a risk that this will impact on practice delivery of care primary care. PCCC have requested further discussion at PCOG. 5 Jan 22 -Subsequent to 3 Dec 21 NHSE requested Primary Care suspend all non-urgent work to focus on achieving booster vaccination target. Discussed at PCOG as per PCCC request - concern flagged re impact of this on managing backlog and risk of harm to those whose routine management would be affected. Position to be constantly reviewed with Mass vac leads as this is a rapidly changing position. Intention is to release Primary Care capacity from accelerated vaccination programme at earliest opportunity. 8 Feb 22 - On 27 Jan 22 letter from NHSE confirming priorities until end Mar 22 which are continue i) deliver of General Practice services including urgent care access and tackling the backlog of deferred care events ii) management of symptomatic COVID-19 patients in the community iii) ongoing delivery of the COVID-19 vaccination programme prioritising care homes, housebound and clinically vulnerable. Concern re impact of backlog raised at February 22 PCCC. Action taken for primary care team to look at how this could be quantified to better understand the impact on practices and patients. 8 Mar 22 - initial paper presented to March PCCC. 10 May 22 - Working with BI to understand impact on QOF, vaccinations and immunisations and screening where data is available . Collaboration Boards have also been asked to quantify backlog as part of the COVID expansion fund. 25 Aug 22 - Meeting scheduled with collaborative board leads to review where they are with this work. ,	Mar 22 - Monitoring / assurance • Monthly review of Early Warning Dashboard by new Primary Care Quality and Performance Group, including assessment of Electronic Declarations (E-DEC), PALS queries, Complaints, SEAs • Weekly General Practice Alert status (GPAS) shared with system • Reporting and assurance process in place for winter access fund (WAF) • Ongoing liaison with LMC to support practices with identified resilience issues • Monthly liaison with CQC • Any performance, quality or contractual concerns would be followed up under existing processes Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. Practice resilience toolkit Work continues to develop Primary Care Networks [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Paul Green

			10 Oct 19 - BMJ Job Fayre in London on 4th & 5th October 19; stand promoting SW region - supported by CCG staff and Plymouth GP. - Attended by Primary care team. 2 Sept 19 - Plymouth Prospectus circulated to Plymouth practices. Others were sent to practices in South Hams, West Devon and the rest of Devon to inform them of the prospectus and encourage them to send expressions of interest for when CCG launch our longer term transformation plans 7 Aug 19 - Reworked as Plymouth Prospectus; financial implications being reviewed; on track for 1 Sept 19 launch. Jul 19 - 100 day plan in design for Plymouth system 20 Jun 19 - risk reviewed at Primary care operational group. No further update Apr 19 - Work continues to support practices in working closer together and with wider parts of the system and also building on the skill mix development as outlined in the contract reform GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments March 2019 GP Strategy STP Workforce Group & Strategy Locality Workforce Groups GP Provider Collaborative Groups Regional Workforce Board 100 day plan in design for Plymouth system Regular review at Primary Care Operational Group Regular review at Primary Care commissioning committee Feb 19 - GP framework associated with the long term plan, having been released, is being reviewed for opportunities to further mitigate this risk [Control Gaps] Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support In part a lack of evidenced change to new models				

109	Improve service performance [Reporting Committee] Audit and Risk Committee	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •There is reputational impact due to potential patient harm or perception of the CCG is impacted by patient outcomes. •Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (COVID Risk wave 2 risk ID 02) (HISTORIC ID: Na)	25/04/22 Risk reviewed. Score to remain the same as per 01 March 2022. Plan being progressed in line with ICB arrangements 01.03.22 As of 25/02/2022 This risk will now be managed through the In Hospital Directorate. Through the 22/23 operating plan the ICS will look to ensure sufficient capacity in both the urgent and elective systems to allow recovery in the national performance standards throughout 22/23 for example sufficient diagnostic capacity and surgical capacity to ensure improved performance in the national cancer standards and RTT standards., A system plan to ensure recovery and maintenance of the UEC system will be in place to ensure recovery for urgent care standards. The plan is being delivered and monitored via the governance described. The risk score remains the same. February 2022 - Risk reviewed and score to remain the same. Planned Care team are exploring protected elective capacity for complex orthopaedic surgery, as this is a significant cohort of the >104 week waiters (AW) January 2022 - Risk reviewed and score to remain the same as the system will not achieve the required constitutional standards in 21/22. The H2 plan has established some performance trajectories, against which the CCG will monitor progress. The patient safety and quality team has maintained regular dialogue with providers regarding the impact of failures to achieve statutory targets and, through provider quality committees, has ensured a focus on preventing harm. Work ongoing to further develop IQPR to provide improved oversight for CCG Governing Body and shadow ICB. System Quality and Performance Groups being brought together in February 2022 to reduce duplication and ensure that risks are considered from both quality and performance perspectives simultaneously. H2 21/22 activity and performance plans submitted and being monitored within IQPR. Head of Performance Improvement now reporting to Chief Nursing Officer, to facilitate bringing together of performance and quality (AW) The weekly Tier 1 meetings with the region are now being expanded to include cancer [Control Gaps] January 2022 - Vacancy and long term sickness in performance team has reduced capacity to 50% temporarily (appointed to vacant post – in post from 17 January 2022) (AW) January 2020 - Opel 4 escalation at the start of January puts some risk into this delivery October 2020 - Lack of involvement in provider access meetings. Impact of MyCare , dues to Covid System perf group has been stood down, need to reinstate that infrastructure	20 [01/03/2022] = 20 (L=5 x I=4) [01/07/2021] ▲ 20 (L=5 x I=4) [04/05/2021] ▼ 16 (L=4 x I=4) [01/10/2020] ▲ 20 (L=5 x I=4) [22/10/2019] = 16 (L=4 x I=4) [31/07/2019] ▲ 16 (L=4 x I=4) [06/06/2019] 9 (L=3 x I=3)	Risk Opened: 06/06/2019 Reviewed: 02/09/2022	[14/01/2022] January 2022 - Continuing to maximise day cases and use of the independent sector., [14/01/2022] January 2022 - Mutual aid process in place to provide system support for planned care and UEC/COVID pathways to support maintenance of levels of planned care as far as possible. February 2022 - Planned Care team are exploring protected elective capacity for complex orthopaedic surgery, as this is a significant cohort of the >104 week waiters. , [27/08/2019] System performance meeting monthly with providers January 2022 - This meeting is ongoing and will continue until the new combined Quality and Performance Group is set up in Feb/March 2022,	01.03.22 Effective arrangements are in place for both elective and urgent care at place to ensure the delivery of the capacity and resulting performance improvements agreed in the 22/23 plan. Activity is managed via urgent care boards both at system and place. The planned care board ensures delivery of planned care and diagnostics and the Devon cancer delivery and strategic group oversees the cancer standards. All of these meetings take place monthly. Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. January 2020 - Scrutiny at Dec SPG has provided assurance on these plans and elective board 01.09.22 Additional scrutiny will now be in place as cancer figures are now being included in the Regional Weekly Tier 1 meetings [Assurance Gaps] February 2022 - none identified	Executive Lead: John Finn Owner: Karen Barry

134	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	There is a risk that Children and Family Health Devon do not recover the current position of increased waiting times and deteriorating RTT positions for CAMHS; Occupational Therapy; Speech and Language; Autism Assessment services. The risk score has again been reviewed (17.06.2021) and remains at 20. Initial trajectories were provided by CFHD December 2020 and Update March 2021. There has been some improvement in the OT service performance as well as Autism Assessment however services overall continue to struggle to make an impact on waiting list numbers and times. The impact of this is that children experience delay in accessing assessment, support and services for their physical, mental and communication development needs which may experience poorer quality and outcomes. CFHD are not yet achieving contracted service standards and NHS Devon cannot be confident that they will deliver the service improvements and transformation as set out in the contract agreed with NHS Devon CCG. There continues to be a lack of operational clarity in terms of service management and different service offer between Devon and Torbay, increasing wait times, regular queries and comments from families and schools, together with concerns regarding leadership and workforce capacity within the services that indicate CFHD are not yet achieving contracted service standards. The issues have been further intensified by the pause in a number of services as a result of COVID 19 and services are not currently being provided at the standard expected with increased wait times and reduced access to services(COVID Risk wave 2 risk ID 18)The CCG were notified 16.06.2021 that CFHD were starting their 'Roadshows' with staff to present their finalised clinical pathways, senior leadership structure and service/workforce models. The detail of this is still to be shared with the CCG and therefore remains unclear of improvements, impact and if risks remain in relation to workforce capacity and gap to deliver contract. (HISTORIC ID: Na)	Increased contact between the CCG and the provider CFHD has been put in place to discuss and scrutinise the performance of services especially in light of the response and pressures of COVID. There are fortnightly meetings to monitor the ASD assessment wait list and recovery plan. Where concern is raised this is escalated to Associate Director and action taken in direct discussion with CFHD Directors. Associate Director of Commissioning (Community Services) formally wrote to CFHD on 20/11/20 requesting that a copy of their Integrated Performance Report and Integrated Governance Group Report are shared with the CCG by 27/11/20. Trajectories for the services which are behind agreed performance level have been requested and submitted. These will be monitored through the Liaison and Restoration meetings that are already established and recovery plans monitored on an individual service level with the appropriate service manager to ensure that the agreed actions are being implemented. UPDATE 26.05.2022 Revised ASD trajectory for 2022/23 to address numbers waiting (1763). Average wait reduced to 45.3 weeks. Fortnightly calls between CCG and CFHD. Recognised improvement in ASD by inspectors although continue high numbers waiting remains a concern UPDATE 19.04.2022 Contract meetings reviewed and new format starting April 2022. Quarterly formal CRM; Monthly Joint Transformation Meeting UPDATE 28.01.22 DCC COMF funding has been rolled over into 2022/23 UPDATE 27.10.21 Score reverted to 20 based on the continued non achievement of improvement trajectories for ASD SLT and OT UPDATE 21.07.2021 Databook is now split by Devon and Torbay. Good engagement from CFHD at recent Torbay SEND Peer Review and performance data and service plan overview provided. Good engagement with partners on Autism programme and significant progress made on redesign on core assessment team and processes which has released efficiencies and confirmation that once wait numbers have reduced there is sufficient resource in core service to meet demand. CFHD have responded to communication from Director of Commissioning and have provided revised trajectories to achieve ASD waiting list reduction, these will be included in continuing fortnightly monitoring & support calls. UPDATE 17.06.2021 Continued good engagement and focus on ASD waitlist delivery - fortnightly call including NHSEI. Liaison & Restoration mtg held (16.06.2021) - good senior management represenation from CFHD and verbal updates provided. Planned update and attendance at QAC July by CFHD. UPDATE 01.06.21 continued engagement to oversee the ASD wait list recovery programme and development of Learning Disability & Autism investment opportunities through the NHSEI LD&A Programme UPDATE 30/03/21 The CFHD Alliance remains under enhanced surveillance whilst their delivery plan to address the backlog of assessments between April and November 2021 is actioned. Children & Family Health Devon (CFHD) have provided a breakdown of their delivery plan to address the ASD waiting list reduction plan between 1/4/21 – 30/11/21. The plan includes delivery of 2,500 completed assessments by November 2021 through an increase in capacity by employment of 20wte additional clinical staff via agency & 3 wte admin and subcontract with RDEFT and LWSW to complete 300 assessments. In addition internally 12 wte clinicians will undertake 3 assessments pw each; 1 wte clinician (clinical lead) undertakes 2 assessments per week – providing 38 assessments per week. The CCG will monitor progress against this waiting list reduction plan through: Weekly receipt of metrics/data report from internal performance monitoring meetings Fortnightly MS Team Calls between CFHD/CCG	20 [06/10/2021] ▲ 20 (L=5 x I=4) [21/07/2021] ▼ 16 (L=4 x I=4) [24/02/2021] ▲ 20 (L=5 x I=4) [27/10/2020] 15 (L=5 x I=3)	Risk Opened: 27/10/2020 Reviewed: 15/07/2022	[01/02/2022] Roll out plan for DCC COF funding to be agreed and mobilised 20/04/22- Remains outstanding, [24/06/2021] Stocktake Reset to be formally agreed between CCG and CFHD. CFHD to present update on service transformation and service performance against trajectory to July QAC 21/07 - Remains outstanding - Stocktake remains unsigned although headings are used to guide the liaison & restoration meeting agenda. CFHD did not attend July QAC due to administrative errors, Service performance and transformation postponed to August meeting, [01/12/2020] Alliance Board Performance and Governance Reports requested to be submitted by 27.11.2020. Not received, escalated to Lorraine Webber. 21/07- Remains outstanding and forms part of the Stocktake Reset agreement. Although service updates are verbally provided at monthly liaison and restoration meetings.,	•Performance and assurance meeting papers for meetings described above •Reports to Quality Assurance Committee (Quarterly) •Executive and Senior Manager escalation meetings with CFHD provider eg Safeguarding and CAMHS. •Presentations / reports for local authority scrutiny meetings eg. CAMHS and Autism presented to the Devon County Council Children Scrutiny Group on September 8th 2020 and Devon Children And Family Partnership meeting on October 13th, Group on September 8th 2020 and Devon Children And Family Partnership meeting on October 13th. UPDATE 26.05.2022 Children Service Review – due to June Governing Body meeting. Improvement in OT waits reported as well as numbers of children waiting for Autism assessment and improved average wait times in Devon from 59.4 week (March 2021) to 45.3 weeks (May 2022). Recruitment commenced for additional SALT posts funded by DCC COMF funding. UPDATE 19.04.2022 Draft report completed for Children Service Review. Current going through Exec Check and Challenge Process. UPDATE 28.01.22 information now received from CFHD following robust review of demand and capacity and proposed new service delivery model. This will be incorporated into the children's contract review that is reporting to GB in February. UPDATE 13.09.2021 Service review commenced Business case prepared for additional funding to support waiting list reduction- pending approval by DCC UPDATE 21.07.2021 Autism fortnightly team call – progress in wait list numbers reducing although currently off trajectory. The target for additional assessments is still likely to be met (end Nov). OT on target for trajectory. SALT however remains below trajectory and long waits with 2907 CYP waiting. Updated recovery plan has been requested. UPDATE 17.06.2021 Verbal update provided to Liaison & Restoration Mtg (16.06.2021). OT Abbreviated pathway has created internal efficiencies and increased capacity. Use of non recurrent funding £31k to recruit additional posts to address waiting list. Current on track for trajectory at 62.3% although improvement agreed is only 73% by March 2022 against contract of 92%. SALT introduced a new clinical decision model; reviewed all families against standards and increased the offer of getting advice at the start and reduced non patient activity which has increased clinical capacity. Non recurrent funding for additional 6 staff. Target to return to pre COVID levels and meet 92% by February 2022 currently on target 56%. All services have now migrated from paper to Care Plus system. It is expected that July data book will report by locality. Recognise the good engagement in wider ICS work and delivery of the LD and Community Nursing Services. UPDATE 01.06.21: Fortnightly monitoring & support calls between CCG and CFHD to review progress against ASD waitlist reduction plan trajectory. Progress reports are also provided to the CCG Exec Director, Devon DCS and NHSEI. UPDATE 26.04.2021	Executive Lead: Jo Turl Owner: Siobhan Grady

UPDATE 24.02.2021
Mtg held between Kevin Wheller, Liz Owen and Mark Tucker and Davina McDougall (11.02.2021) to discuss finance schedule and use of monies carried forward from previous year to address service wait lists.

[Control Gaps]
Current formal contract management has been paused in line with National guidance during the COVID – 19 period. Issues with service delivery during this period are raised through the contracting email and through the Restoration / Liaison Meetings which have recently been instated.

UPDATE 26.05.2022
Joint Transformation Mtg stood down in May due to Devon SEND Inspection Re visit preparation and planning meetings. CFHD Staff consultation extended to May 27th. Continued risk to number of staff vacancies, recruitment to SLCN posts and interoperability issues which may impact on change programme.

UPDATE 19.04.2022
CFHD commenced staff consultation. Risk to number of staff vacancies at senior management level and ability to deliver change programme

UPDATE 21.07.2021
previous gaps remain as stated above

UPDATE 16.06.2021
CFHD have not signed or agreed to actions and requirements set out for them in the 'stocktake reset document' and therefore have not shared to date service updates reports or documentation monthly to the Liaison & Restoration mtgs to provide assurance and have oversight of meeting service trajectories. Although verbal updates are provided there remains a challenge from CFHD as to purpose of the Liaison & Restoration Mtgs and level of scrutiny of the contract. CCG proposed that additional reports would not be required and it would be sufficient to just share reports already completed for their own Partnership Board. Capacity and prioritisation of work is rightly on CFHD organisational transformation however lack of more formal reporting to CCG remains of concern. Databook currently is not split between Devon and Torbay and therefore unable to routinely and easily report to each local authority separately on the joint funded contract. CFHD have also raised that there are some issues with the data provided in terms of completeness and accuracy.

UPDATE 01.06.2021
Liaison & Restoration (L&R) May mtg stood down. Stocktake reset revised and despite no formal sign off is being used to set agenda for meetings to ensure key performance areas are reviewed. Next Mtg due 16.06.21. A number of concerns have been raised with the Assoc Dir regarding minimal communication across key stakeholders about the CFHD planned pathway changes and transformation work. As well as CFHD engagement in wider ICS level transformation meetings to ensure a join up and work not being done in isolation. These areas have been discussed with the Childrens Alliance Director who has set up and chairs a Devon & Torbay Autism Strategy group.

UPDATE 24.02.2021
Regular Liaison & Restoration Mtg did not take place in February – stood down as previous week mtg held between Assoc Dir Commissioning and CFHD and agreement that focus would be on formalising a stocktake to review and reset the priority areas and providing assurance evidence against these. Current financial discussions are delaying progress against plans to address autism waits backlog.

UPDATE 20.01.2021
Exec to exec mtg used for escalation did not take place in January.

Liaison and Restoration arrangements still in place. Draft ToR written as requested by CFHD. ASD recovery action plan agreed between CCG, CFHD and DCC (March 19th 2021) to clear the Devon waitlist (2900 additional assessments). CFHD agreed to invest £1m of it's £2m received from CCG in addition to contract value for contingency and transformation. Information provided to Dfe and NHSE inspection monitoring visit on March 19th .

UPDATE 24.02.2021
Stocktake has been agreed between CFHD and CCG to reset the key priorities. This has identified the areas where there are ongoing concern and what evidence/action is required to move the provider from 'Enhanced Surveillance' to 'Routine Surveillance'. This includes updated trajectories to address wait lists as well as the wider transformation for each service and impacts.

UPDATE 20.01.2021 Continuing concerns escalated to AD and Director

[Assurance Gaps]
Some assurances have been provided however there remains concerns relating to governance processes, monitoring of incidents, experience for long waiting patients and referral management process. These are being followed up directly with CFHD Quality lead.

UPDATE 26.05.2022
April data book shows worsening numbers of CYP waiting for SLT 3150 (May 2021) to 3523 (April 2022). Workforce retention and recruitment still an issue.

UPDATE 19.04.2022
February data book shows worsening numbers of CYP waiting for SLT; ASD

UPDATE 21.07.2021
SALT remains off trajectory despite additional non recurrent staff being recruited. Revised recovery plan requested. Outcome of decision by DCC pending for additional funding to support SALT and reduce waits for Devon children. CFHD did not attend July QAC due to administrative errors, Service performance and transformation postponed to August meeting

UPDATE 17.06.2021
Workforce retention has been raised as a key risk (many leaving to take up post with private ASD provider). Therefore despite new additional non recurrent staff being recruited for wait list they are having to cover some of the gaps left in the core staff workforce as well as meet pressures from increased referrals for SALT. Provision of non complex ADHD in NDevon at risk of being withdrawn by CFHD as believed not to be in contract (Cmty Paediatrician complete in rest of Devon). CCG communicated with CFHD that as service activity and value transferred from Virgin in to new contract and has been provided since April 2019 then if this activity is to transfer to an alternative provider the funding would also need to transfer. Costs have been received from NDHT and timescale suggested April 2022 due to recruitment of paed and merger of RDE & NDHT..

UPDATE 01.06.21
Continued long wait list for SALT and OT. Evidence of impact of service

							change and investment with any revised trajectories requested for L&R mtg. UPDATE 26.04.2021 Stocktake Reset Document still in draft and yet to be agreed between CFHD and CCG although CCG still using it as basis for agenda planning and seeking assurance through liaison and restoration mtgs. UPDATE 24.02.2021 Risk has been increased. Until we receive information there remains an assurance gap. Action and Decision making for Autism waits remains critical. Mtg held between Kevin Wheller, Liz Owen and Mark Tucker and Davina McDougall – CCG finance are waiting on finance schedule from CFHD which sets out the costs to reduce the waiting list over 2 years (with the main bulk of assessments being contracted with Helios - this has still not started despite previously reporting that it had). CFHD still to confirm allocation of how funding held over from previous year could be used to support this scheme. CCG will then need to provide decision as to any further financial commitment. UPDATE 20.01.2021 Continued concerns in timeliness of agreed reports being shared due to internal governance sign off arrangements, pace of progress in safeguarding action plan, lack of understanding of budget and investment made in Autism assessment service. Summary provided to AD & Executive within an SBAR report for escalation with recommendations for : •3 month action plan •monthly exec to exec escalation mtgs •attendance by CCG at internal CFHD mtgs – Quality Committee; •financial summary from April 1st 2019 be provided	

146	Be an effective, well-led organisation with an empowered and inclusive workforce [Reporting Committee] Quality and Performance Committee	There is a risk that University Hospitals Plymouth NHS Trust is unable to deliver safe and effective services, due to a lack of robust clinical oversight and risk management in the ED - as highlighted during the CQC inspection (8th March 2021) and subsequent Section 31 letter (15th March 2021). Concerns include: ambulance handover delays, IPC concerns, poor flow through the hospital, in part due to ED, but also the wider hospital and the Trusts ability to ensure mitigation under pressure. The impact of this is that the delivery of patient care may be negatively impacted upon, both in potential harm and poor patient experience. In addition, there is a risk to wider System reputational damage. (HISTORIC ID: Na)	August 2022 - Risk reviewed and score increase under discussion. The trust is one of 6 trusts identified nationally where there is now an expectation that from September 1st 2022 there will be a zero-tolerance approach to ambulance handover delays in excess of 30 minutes. Oversight reporting will be to the national lead from the ICB and UHP (VC/JH) July 2022 - Risk reviewed and score to remain the same. Oversight and governance of the data set and KPI's are monitored through the Western UCB and IAG. In addition, compliance against the CQC compulsory regulatory criteria 'Must Do' actions and conditions will be achieved through monitoring and management of critical actions which form part of the exit criteria through the SOF process (VC) [Control Gaps] August 2022 - Long waits in the department have not reduced and latest data shows increase (VC/JH) July 2022 - It has been proposed that new KPI's make up the overall improvement plan with all partners committing to the workplan. Lines of accountability are yet to be agreed, with clear understanding as to what is expected with each partner in order to deliver to sustained improvements required against each KPI. It is acknowledged that agreement with local partners will be essential to positively impact the agreed metrics and ensure improvements agreed are achieved as described (VC)	20 [13/07/2021] ▲ 20 (L=5 x I=4) [24/03/2021] 15 (L=5 x I=3)	Risk Opened: 26/03/2021 Reviewed: 12/08/2022		April 2022 - The conditions of improvement work are being supported by the decrease in Covid 19 cases within the Trust (JH) [Assurance Gaps] August 2022 - The trust have reported incidents which on initial assessment indicate that monitoring of high risk patients and the monitoring and escalation of the deteriorating patient is a concern (full route cause analyses awaited). These are areas which should be monitored and overseen as part of the improvement work in relation to the CQC inspection October 2021 where concerns included access, flow, discharge, patients being cared for in ambulances outside a crowded emergency department, sufficient staff with the right skills, training and experience to keep patients safe (VC/JH) July 2022 - It has been proposed that new KPI's make up the overall improvement plan with all partners committing to the workplan. Lines of accountability are yet to be agreed, with clear understanding as to what is expected with each partner in order to deliver to sustained improvements required against each KPI. It is acknowledged that agreement with local partners will be essential to positively impact the agreed metrics and ensure improvements agreed are achieved as described (VC)	Executive Lead: Darryn Allcorn Owner: Vanessa Crossey

148	Improve service performance [Reporting Committee] Quality and Performance Committee	There is a risk that Devon Doctors is unable to deliver a safe and effective service to the population of Devon. This includes their 111 and Integrated Urgent Care Service (Out of Hours). The CQC and ICB have identified this is due to a lack of appropriate workforce, a poor organisational culture and issues within the leadership team. These issues run throughout the organisation, including Clinical Assessment Service (CAS) Hubs, treatment centres, and home visit provision. Their largest issue with workforce relates to call answering and telephone assessments. This workforce issue is caused by high attrition rates, high sickness levels and lack of clinicians willing to do shifts. The impact of this is delayed assessment, advice, referral, treatment and care to patients. This may result in harm and/or poor patient experience. This may be resulting in patients using other, less appropriate services, impacting the Devon system. There has been poor clinical oversight and governance processes putting patients at risk and a lack of organisational learning and an increased risk that the organisation does not learn from adverse events. There is a risk this continues with temporary and vacant positions within the governance structure. There could be an impact on reputation for the ICB with public and professional confidence in Devon Doctors deteriorating. Supersedes risks 105 and 126. (HISTORIC ID: Na)	August 2022 - Risk reviewed and score to remain the same. Contract Performance Notice in place, CQC monitoring further whistleblowing (RC) July 2022 - Risk reviewed and score to remain at 16. Reports of harm caused by long waits are present. CQC further engaged. Planned national contingency to cope with weekend demand has been put in place. Other providers being brought in to take calls through additional contracts. Contract performance notice remains in place, as does monitoring through meetings previously identified (RC) June 2022 - Risk reviewed and score to remain at 16. Actions from improvement plans continue to be monitored through contract performance notice, contract meetings, quality assurance committee, significant events and complaints meetings and end to end reviews. Information on staffing levels and rota fill is provided twice weekly. Internal critical incidents have been called during peak periods. National contingency has been instigated (RC) [Control Gaps] May 2022 - Incentive payments that have been running since Christmas have been stopped. Data from DDoc has been limited so monitoring challenging (RC) March 2022 - DDOC remains challenged with workforce, however assistance has been provided through joint working with HUC, improving call answering capacity. Anticipated increase to DDOC workforce through increased training courses has not come to fruition. High sickness levels and transfer of IUCS contract to another provider is quoted as the organisational reasons for continued staff pressures of attrition and poor recruitment. 999 and ED validations numbers have both declined recently (during feb), again relating to staffing challenges.	16 [04/04/2022] ▲ 16 (L=4 x I=4) [15/02/2022] ▼ 12 (L=3 x I=4) [12/07/2021] ▲ 16 (L=4 x I=4) [02/06/2021] ▼ 12 (L=3 x I=4) [06/05/2021] ▲ 16 (L=4 x I=4) [22/04/2021] 12 (L=3 x I=4)	Risk Opened: 26/04/2021 Reviewed: 17/08/2022		August 2022 - Mitigation has been arranged by the ICB, providing pre-planned national contingency from Friday evening through to Monday mornings to take 50% of calls. The ICB has also arranged for another 111 provider to be taking 111 calls for Devon. This is being paid by the call at significant extra expense (RC) May 2022 - Hertfordshire Urgent Care (HUC) joint working has helped performance (RC) [Assurance Gaps] August 2022 - Staffing levels remain critically low at DDOC, both in 111 and OOH GP services. Worse at weekends during peak demand. This has meant there are limited numbers of staff to answer phones, triage, assess, advice and treat patients. High call stack volumes. There are low numbers of GP's to cover OOH periods resulting in long delays for T/C or home visits. Cover has also impacted on community hospitals who DDOC provide medical cover for. There is also reduced capacity in answering HCP lines for advice, impacting directory of services provision. There have been further reports of patients suffering harm due to long delays in receiving assessment and advice in OOH provision. (RC) July 2022 - Staffing pressure continues. Low numbers of staff to answer 111 calls and in OOH primary care services. Resulting in long delays to assess, advise and treat patients. Worse at weekends. Abandonment rate in excess of 30% (target 5%), long time to answer calls. Call stack remains high at times. Reduced information flow remains an issue (RC) June 2022 - The number of calls abandoned remains above national averages, frequently over 30% and is increasing in early June. The length of time it takes to answer a call, is frequently above 10 minutes, is increasing in early June and is above national averages. The demand is varying; with weekends and holidays being very high. Call stacks remain very high in peak periods (in excess of 500 patients in triage queues). Main challenge continues to be staffing levels, this is in 111 and OOH services. Continues to be an attrition vs on-boarding lag and sickness levels remain high. Monitoring of position is challenging due to a reduced flow of information from DDOC (RC)	Executive Lead: Darryn Allcorn Owner: Russell Cooke

150	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Primary Care Transition Committee	There is a risk that the Mayflower group is unable to deliver safe and effective services due to a lack of workforce capacity and embedded governance processes putting patients at risk. There is currently limited assurance that patients have a fair, equitable and safe access to appropriate appointments. The impact of this is: * delayed assessment, advice, referral, treatment, and care to patients which may result in harm and/or poor patient experience, This may also be resulting in patients using other less appropriate services, impacting the Devon system or not receiving appropriate treatment at all, * that the delivery of patient care may be negatively impacted upon, both in potential harm and poor patient experience, In addition, there could be an impact on the reputation for the ICB with public and professional confidence in the Mayflower group deteriorating. (HISTORIC ID: Na)	August 2022 - Risk reviewed and score to remain at 16. July 2022 - Risk reviewed and score to remain the same as provider is only at 3 months into the contract and it is still very early days. Risk to be taken to primary care SLT in September to do a thorough review (VC/SC) June 2022 - Risk reviewed and score to remain the same. The ICB has formally written to MMG to continue to discuss ongoing concerns around performance and data (VC) [Control Gaps] August 2022 - Workforce capacity and recruitment issues continue to slow progress of improvement plans and the organisation continues to carry significant gaps (VC) July 2022 - Progress continues with the CQC action plan, although meetings have been stood down recently due to staffing. Overall clinical workforce staffing shortages continue with significant workforce gaps affecting the group from progressing with transformational and improvement workstreams (VC)	16 [22/10/2021] ▲ 16 (L=4 x I=4) [07/05/2021] 12 (L=3 x I=4)	Risk Opened: 07/05/2021 Reviewed: 12/08/2022		August 2022 - PSQ and Med Ops have seen overall improvements in development and implementation of governance processes such as SOP's (VC) July 2022 - PSQ and Med Ops continue to see overall improvements in development and implementation of governance processes such as SOP's – this still to remain embedded in practice (VC) June 2022 - PSQ and Meds Optimisation continue to state that although improvements seen around medicines management, not shown to be sustained yet. However the ICB have reduced the frequency of touchpoints as increased assurance around implementation of the CQC action plan but actual changes re: assess still being reported/evidenced (VC) [Assurance Gaps] August 2022 - There remains uncertainty regarding CQC actions and overall improvement for patient access at the present time (VC)	Executive Lead: Darryn Allcorn Owner: Vanessa Crossey
151	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	There is a risk that the activity relating to CHC assessments and reviews, and requests for joint funding is impacting upon the ability of both the provider CHC and ICB Complex Care teams to undertake their wider responsibilities around quality assurance and effectiveness. The impact of this will likely be: • clinical risks not being exposed and mitigated - a reactive service only presenting when risks are escalated to the team • escalating costs of packages of care & placements with no scrutiny and no oversight or ability to contribute to the quality assurance or improvement agenda within the independent sector • poor patient and family experience. An individual's care needs could unnecessarily escalate without the correct clinical intervention/oversight • remaining staff working within the team at risk of burn out possibly increased sickness levels • reduced number of staff with the right skills, competencies • limited capacity to ensure new staff receive the correct support and upskilling which will further impact on them functioning fully (Risk 151 to supersede risks 135 and 136) (HISTORIC ID: Na)	September 2022 - Risk reviewed and score to remain the same (SB) August 2022 - Risk reviewed and score to remain at 16. (SB). July 2022 - Risk reviewed and score to remain the same (SB) [Control Gaps] August 2022 - SBAR has now been considered by the exec team & a number of options are being considered. Outcome awaited (DA) August 2022 - Business case revised prior to being taken to Execs during August, date still to be confirmed (SB). July 2022 - Business case being submitted to the ICB executive committee, which focuses on increased workforce and reshaping of the CHC hubs to cope with the increased demand. The business case also includes a short term proposal to outsource referrals in a quicker timeframe, to ensure that individuals are placed on the right pathway sooner (SB)	16 [06/04/2022] ▼ 16 (L=4 x I=4) [13/07/2021] 20 (L=5 x I=4)	Risk Opened: 13/07/2021 Reviewed: 06/09/2022		September 2022 - The CHC teams are fully resourced staying on top of assessments (SB) May 2022 - Business case now drafted and due to go to Execs - awaiting outcome (SB). [Assurance Gaps] September 2022 - Although the CHC team are staying on top of assessments reviews will continue to be a risk. Business case to be updated to reflect this (SB)	Executive Lead: Darryn Allcorn Owner: Jo Shill
160	Achieve financial sustainability [Reporting Committee] Finance Committee	There is a risk that the operational plan for 2022/23 is not deliverable within the resources allocated to the system and this jeopardises the wider system plan. The impact of this is that the ICB will fail one of its key financial duties resulting in reputational damage, adverse assurance rating and need to cut expenditure in an unplanned way, jeopardising other key deliverables in its corporate objectives. This will have an impact on the Strategic Oversight Framework exit plan from level 4. (HISTORIC ID: Na)	Initial plan submission delivered a system wide £136m deficit. Plan reviews, check and challenge, and increased CIP reviews have improved this to £105m system deficit. This includes a breakeven CCG/ICB plan, but with a challenging £22.5m CIP programme. The £100m deficit sits in the provider side of the system plan. The underlying position for the CCG on exit run rate from 21/22 has marginally improved There is a clear joint planning process across all ICS organisations [Control Gaps] Uncertainty of the 22/23 allocations, the pace of change for convergence to population based needs weighted target The plan has not yet been signed off by NHSEI. The use and impact of funded ESRF (£39m) is at risk due to failure to deliver baseline 104% activity levels	16 [02/05/2022] ▲ 16 (L=4 x I=4) [06/04/2022] ▲ 12 (L=3 x I=4) [03/02/2022] 9 (L=3 x I=3)	Risk Opened: 03/02/2022 Reviewed: 06/04/2022		Multiple Director and Deputy Director of Finance forums, region and system wide Weekly Operating Plan Group meetings Existing underlying plans in place and understood System continues to meet with NHSEI Regional and National, including Julian Kelly. [Assurance Gaps] None	Executive Lead: John Dowell Owner: Ben Chilcott

157	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	There is a risk that combined historic workforce challenges, changing national and regional requirements including the requirements around continuity of carer, changes to thresholds for induction of labour, personalisation etc and the impact of the ongoing Covid-19 Pandemic will impact on safe delivery of maternity services and maternity services ability to implement national directives. The impact of this is •Potential for increased harm to baby •Potential for increased harm to mother •Increased staff absences due to stress and burnout •Potential for reduced retention for newly recruited staff •Reduced system-wide ability to deliver on maternity outcomes •Reputational risk due to non-delivery of national transformation agenda •Financial risk to non-delivery of Devon Game Changer schemes (HISTORIC ID: Na)	August 2022 - Risk reviewed and score to remain at 16. ToR continues in its development. The ICB continues to submit monthly quality surveillance reports to SW region. The LMNS are still awaiting feedback following the submission of the provider implementation plans for Continuity of Carer. Weekly reporting requested from the trusts (MC) July 2022 - Risk reviewed and score to remain the same. Perinatal Quality Surveillance is ongoing with Terms of Reference in development. The ICB continue to submit monthly quality surveillance reports to South West Region. Provider implementation plan for Continuity of Carer completed and submitted. Currently the ICB are to follow guidance as per NHSI letter B1523 sent post publication of Ockenden final report 30th March 2022 (MC) June 2022 - Risk reviewed and score to remain the same at 16. The Perinatal Quality Surveillance model is ongoing, we will be continuing to develop our local Perinatal Quality Surveillance group in line with the Perinatal Quality Surveillance model up to December 2022. In June/July 2022 we will be developing a term of reference and will be implementing a Clinical Reference Group to ensure robust learning. In the meantime, we continue to submit monthly Quality Surveillance reports to SW region (MC) [Control Gaps] August 2022 - Trusts are continuing to recruit staff into establishment agreed in line with Better Birth Rate + and Ockenden workforce funding, however recruitment of appropriate skill mix continues to be an issue. ToR under review, improvements required in attendance (MC)	16 [24/11/2021] 16 (L=4 x I=4)	Risk Opened: 24/11/2021 Reviewed: 12/08/2022	[06/04/2022] 1) April 2022 - Re: Continuity of Carer (CoC) - implementation - LMNS to revisit provider workforce plan to implement CoC plan. Currently the CCG are to follow guidance as per NHSI letter B1523 sent post publication of Ockenden final report 30th March 2022 July 2022 - Provider implementation plan for CoC completed and submitted. Currently the ICB are to follow guidance as per NHSI letter B1523 sent post publication of Ockenden final report 30th March 2022. LMNS submission with further details. Feedback pending. Action to remain open August 2022 - The LMNS are still awaiting feedback following the submission of the provider implementation plans for CoC, [09/02/2022] 3) Review term of reference for safety and governance group and strengthen oversite and learning from Incidents. Timescale: June 2022. Owner: Melanie Winterburn-Brannick April 2022 - Ongoing – due to Ockenden publication – awaiting full understanding, planning and implementation of Ockenden before completion of the S and G Tor and how the S and G group will sit within the perinatal safety surveillance model (as above) and how this will feed into/ alongside a clinical reference group (vice versa). Timescale changed to April to June 2022 August 2022 - Terms of reference under review, improvements required in attendance, [09/02/2022] 2) Develop a perinatal quality surveillance model that is compliant with the Ockenden recommendations. Timescale: April 2022. Owner: Hannah Pugliese April 2022 - This is ongoing as Ockenden report published on the 30th March - understanding, planning, and embedding implications for the LMNS perinatal surveillance model July 2022 - Perinatal Quality Surveillance is ongoing. Terms of Reference is in development. Full implementation of quality and safety processes anticipated December 2022. The ICB continue to submit monthly quality surveillance reports to SW region. Action to remain open. August 2022 - Revised reporting methodology is in development to be launched in line with Safety and Governance split to S and G and clinical reference group. This will ensure that reporting is robust and in line with national requirements. ToR under review, improvements required in attendance, [24/11/2021] 7) Strengthen maternity leadership at systems level. Action Owner – Darryn Allcorn. Timescale – May 2022 February 2022 - action being progressed job description developed April 2022 - 4 Heads of Midwifery (HOMS) now in substantive roles within the 4 provider units. Action owner transferred to CNO and timescale moved to May 2022 July 2022 - The ICB structures have been set with a system Director of midwifery as part of the CNO senior leadership team. The job description has been matched and agreed. Recruitment is currently on pause due tot he financial challenge and will continue to be discussed as part of the financial balance. The LMNS leadership with a quality lead, Midwife, programme lead and Commissioner are now fully established. Action to remain open,	August 2022 - Insight visits are continue, Continuity of Carer plans have been submitted and feedback is pending. Hot calls continue in response to increased pressures of workforce and capacity. Revised reporting methodology is in development to be launched in line with Safety and Governance split to S and G and clinical reference group. This will ensure that reporting is robust and in line with national requirements (MC) July 2022 - Insight visits are continuing for July/September 2022 (MC) June 2022 - Insight visits have commenced with further visits due in July/September 2022. All trusts are at least 'partially compliant' with all Immediate and Essential Actions from the Ockenden Interim report. All Trusts are a minimum of 80% compliant with IEA's (MC) [Assurance Gaps] August 2022 - None identified (MC)	Executive Lead: Darryn Allcorn Owner: Hannah Pugliese

						[24/11/2021] 6) Develop a prioritisation plan for the current maternity programmes of work to allow the wider system to respond to ongoing and unexpected challenges that may occur and respond collectively. Action Owner – Hannah Pugliese Timescale – to be reviewed July 2022 January 2022 - Clarity received from the regional team that the transformation deadlines are currently paused. Awaiting new dates February 2022 - complete for the period of the level 4 incident April 2022 - Weekly hot calls still occurring with region, understanding of cross trust working plan still insitu, should the need arise. Timescale changed from January 2022 - to be reviewed in July July 2022 - Hot calls continue in response to increase pressures of workforce and capacity. Weekly reporting requested from Trusts. Action to remain open,		

159	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Primary Care Transition Committee	There is a risk that the start of the system wide PHM implementation plan will be further delayed due to low numbers of Primary Care GP practices signing & returning information sharing agreements to enable data sharing. The impact of this is an inability to provide full PHM data packs to LCP's and PCN's to support population analysis, stratification & segmentation to support PHM as a Long Term Plan priority. It will also impact on a range of other LTP priorities and operational plan work programmes e.g. Anticipatory & Integrated Care, Health Inequalities & Prevention. Without 90-100% PCN sign up we will have incomplete data to support strategic intelligence and commissioning activity also. (HISTORIC ID: Na)	26.8.22 Revised: Controls 5 key actions agreed by JET 1/3/22 •IG documents for re-identification signed by all parties •IG documents for direct data extract from TPP/EMIS primary care extract solution •LMC inclusion on PHM steering group and supporting joint on communications to practices on data sharing •TPP/EMIS primary care extract solution capability and test extracts Communication plan in place to support system wide launch. 26.8.22 Revised Control Gaps: We can only extract GP practice held data where we have a signed information sharing agreement in place (ISA) Data extraction has to occur 4 weeks ahead of data being required for analysis and use by LCP/PCN's Update 26.08.2022 Update against 5 key actions: •IG documents for re-identification signed by all parties- in progress – DPO's & SIRO's agreed final DPIA's. Signed copies received by UHP, LWSW & TSDFT to date. Communication plan in place and writing to individual GP practices next week with requirement for signed DPIA's back by 16/9/22 •IG documents for direct data extract from TPP/EMIS primary care extract solution – in progress •LMC inclusion on PHM steering group and leading on communications to practices on data sharing – Complete. ICB Comms liaising with LMC to support joint approach. •TPP/EMIS primary care extract solution capability and test extracts – in progress – possible delays identified – PHM Programme Lead has fortnightly meeting with BI to monitor and escalate if required. PHM Programme Manager available 2 days per week to give additional capacity to BI team. •>80% Devon GP practices signed up to share and capable of sharing data – weekly reporting on practice signed returns in place – oversight through PHM Steering Group. Confirmed PHM SRO as Dr Alex Degan. Previous Controls: •Multiple communications and discussions between ICB and LMC including formal communication. •Formal Communication with DPO's and all previous requests and issues raised have been addressed. •Dr Paul Johnson has communicated with all practices and PCN Clinical Directors directly via email to recommend that sign up is required by 30/11/21. •Development of a Memorandum of Understanding (MOU) to provide assurance to practices that the CCG is responsible for the security of the data once they have shared it with us. •Attendance at Practice Managers Conference to provide information and respond to questions/concerns. •Engagement with GP's who participated in previous PHM development to support communications with other PCN's/clinical colleagues. UPDATE 01/08/2022 – Final documents have been sent to all organisations SIRO's, DPO's & Caldicott Guardians for sign off by 5 August 2022. Monitoring of practice/PCN and Trust's who have signed all IG agreements is underway and will report on progress to the PHM Steering Group. Update 13/07/2022 Risk Score reviewed, no changes recommended. TPP/EMIS primary care extract solution capability and test extracts – x 2 practices have agreed to support testing of data extraction. No change to progress on other key actions however Alex Degan, Ginny Snaith & Adele Jones have progress discussion with primary care and system DPO's and Caldicott Guardians in relation to both data sharing agreement and the reidentification DPIA – aiming for approval and subsequent sign offs week commencing 18 July. UPDATE 30/06/2022: No progress made against IG agreements for information sharing and re-identification data process – Dr Alex Degan updating PHM steering group monthly. Awaiting confirmation of Exec SRO for PHM programme as Dr Johnson leaves. Score reviewed – no change. UPDATE 01/03/22: JET agreed five key actions to be completed to enable PHM implementation start date to be planned. PHM Steering Group monitoring progress of these.	15 [06/06/2022] ▲ 15 (L=5 x I=3) [03/02/2022] ▼ 12 (L=4 x I=3) [07/01/2022] 16 (L=4 x I=4)	Risk Opened: 07/01/2022 Reviewed: 30/08/2022	[16/03/2022] 8.3.22: Positive discussion meeting between CCG and Primary Care DPO's to progress information sharing sharing agreements. Further meeting planned, [16/03/2022] 01/03/22: Five key actions agreed by Joint Executive Team: •IG documents for re-identification signed by all parties- in progress •IG documents for direct data extract from TPP/EMIS primary care extract solution – in progress •LMC inclusion on PHM steering group and leading on communications to practices on data sharing – Complete & LMC will support comms once DPO's provide assurance on ISA content •TPP/EMIS primary care extract solution capability and test extracts – will progress on completion of signed ISA •>80% Devon GP practices signed up to share and capable of sharing data – in progress, current 50% sign up ,	•A Risk log is held by the PHM Programme Manager. •Senior level communications between ICB and LMC have taken place. •All concerns raised by DPO's and LMC regarding wording detail within the ISA has been addressed. [Assurance Gaps] None.	Executive Lead: Jo Turl Owner: Todd Chenore

			UPDATE 28/01/22: A briefing paper provided to the JET on behalf of the PHM Steering Group on 14.1.22 set out the key contributary factors to a further delay in commencing the 2 year PHM implementation plan. The JET agreed to support the actions recommended to enable later launch of the implementation, these are; 1.IG documents for re-identification signed by all parties (Adam Tuckett, 28/01/2022) 2.IG documents for direct from TPP/EMIS primary care extract solution (Lee Coulson, 28/02/2022) 3.LMC inclusion on PHM steering group and leading on communications to practices on data sharing (Todd Chenore, 28/02/2022) 4.TPP/EMIS primary care extract solution capability and test extracts (Lee Coulson, 31/03/2022) 5.>50% Devon GP practices signed up to share and capable of sharing data (Todd Chenore, 29/04/2022) [Control Gaps] We can only extract GP practice held data where we have a signed information sharing agreement in place (ISA) Data extraction has to occur 4 weeks ahead of data being required for analysis and use by LCP/PCN's					

164	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	Context Much good work has been done to reduce the numbers of children and young people with autism (ASD) and learning disability (LD) that are admitted to mental health inpatient care in Devon. This work has significantly reduced numbers in hospital from an average of 17 inpatients at any one time in 2019, to an average of 4 inpatients at any one time during 2021. Psychiatric inpatient admission should only be used when there is an identifiable and treatable mental illness, and should not be used solely for the management of ASD or LD. Some admissions remain necessary in this group, but these would only be for young people with identifiable mental health needs that happen to have a comorbid presentation of LD or ASD. This change in practice is based on increasing evidence that admission to hospital is ineffective and damaging for Neurodivergent young people. The effects of this change in who we admit to hospital, has been that young people who present without a treatable mental illness, but in significant emotional distress need to be managed in a community setting. They frequently express their distress with risky behaviours such as self-harm, the use of suicidal language, or restricting their food or fluid intake. These risks are challenging to manage in a community setting, are poorly understood by professionals working outside of a health setting and are difficult to moderate. These young people often require short term de-escalation support that is not available in our system. The result is that we have a significant number of young people presenting to our hospitals (paediatric wards) or to our place of safety (POS), in emotional distress, with no onward pathway of care. Due to… There being gaps in our service structures for meeting the needs of young people with ASD and LD. Children, young people and their families are unable to access support in a timely way particularly when children present with challenging behaviours and this results in escalation of those behaviours. This leads to increasing levels of distress and often to a breakdown in education, family and care placements. Often the only place for these carers to seek support is via A&E and an admission to a paediatric ward or via police intervention to the Place of Safety. The lack of an onward pathway of provision in the community at that point causes delays in discharge as well as re admissions when discharge has been facilitated. There is a risk of… •Poor quality of care for young people in adequate community provisions •Avoidable serious incidents •Delayed discharge from acute paediatric wards •Delayed discharge from the Devon wide place of safety with consequence that other children unable to access this resource •Use of unregulated social care placements (often a long way from the young person's community setting) •Poor long term outcomes and life chances •Increased dependence on adult health and social care services The impact of this is (the impact statement should clearly state the effect of the risk to the CCG) •Reputational damage due to use of unregulated provisions and poor quality of patient care •Pressures within the acute paediatric and urgent care system •Short term financial impact of high cost placements and packages of care (often unregulated) •Long term economic impact of increased dependence on services (HISTORIC ID: Na)	1.Delayed discharge protocol in place – effective in multi-disciplinary planning 2.Dynamic support register process to track and monitor individuals at risk of admission 3.Key worker pilot 4.Treatment teams – such as CAMHS 5.Trusts working towards autism accreditation 6.Diagnostic services for ASD and ADHD (long waiting times) 7.Clinical leadership for transformation programme [Control Gaps] 1.A system of universal surveillance and support 2.A needs based service to replace a diagnostic led approach 3.Integrated diagnostic services when these are required – including for Learning Disability and Developmental Language Disorders 4.An Intensive Home Treatment Team for LD & A supporting families and accommodation providers to support discharge and maintain CYP in their community setting 5.De-escalation accommodation 6.Range of regulated accommodation provision across Devon, Torbay & Plymouth.	15 [03/08/2022] 15 (L=5 x I=3)	Risk Opened: 03/08/2022 Reviewed: 03/08/2022	[03/08/2022] Prioritise workstreams as below: A coordinated approach across health, social care, and education with alignment to agreed practices An integrated model of provision across health, social care, and education for those children with high levels of need in communities as well as accommodation-based care A culture of acceptance of responsibility and multi-agency working for children in crisis or accessing the risk support quadrant of the ithrive framework – workforce development programme Comprehensive packages of coordinated support across a range of statutory and voluntary agencies for those children at risk of crisis Development of Home Treatment service for LD&A (pilot first) Clear comprehensive support plans, jointly developed in partnership with young people and their families A focus on need, moving away from a purely diagnostic framework for accessing support Agreed multi agency escalation and information sharing processes – with audit for effectiveness and inform service development Clear processes around transition and development of the 0-25 offer including changes to commissioning where appropriate , [03/08/2022] Identify data needed to benchmark current position and monitor programme- HP, 30.07.22, [03/08/2022] Establish a programme of work and governance arrangements- HP by 01.06.22,	1.Regular reporting to the Learning Disability and Autism Programme Partnership 2.CYP Transformation Steering Group oversight and delivery of programme for neurodiversity (game changer) reporting to CYP Long Term Plan Programme Board 3.Community contracts for children report to QAC 4.Launch event June 30th Neuro Diversity Transformation Programme – purpose to raise awareness of wider stakeholders and achieve buy in and turning concept to model [Assurance Gaps] Oversight of the service activity and outcomes for this population of children and young people is very limited, recording and reporting currently for: •Waiting times for ASC •Admissions to tier 4 CAMHS Numbers of delayed discharges (LD&A and MH) is not routinely collated and impact of these on system. There isn't a system wide view of impact, consistent and good information is not collated or shared including social care, education.	Executive Lead: Jo Turl Owner: Hannah Pugliese

161	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Primary Care Transition Committee	Two sub-contracted providers of Devon Special Allocations Scheme have handed back their contracts to main contractor Access Health Ltd. (Fremington Health Centre (North) and St Levan Surgery (West)). There is a risk that we may see a domino effect of other sub-contracted providers handing back their contract. Access Health Ltd may be unable to secure new sub-contracted providers for patients previously managed by Fremington Health Centre (North) and St Levan Surgery (West). Access Health Ltd may not be able to deliver the contract. The impact of this is that patient experience of these patients may be negatively affected in the meantime. Patients may need to travel further. In the interim may not be receiving full level of service. Potentially a vulnerable group of patients not able to access services if service can't be provided. (HISTORIC ID: Na)	Reviewed with Head of Primary Care (N&E) and Senior Primary Care Manager - 7 Apr 22 / 10 May 22 / 7 Jun 22 / 25 Aug 22 25 Aug 22 •DDOC have secured sites in North Devon and South Devon. South Devon site is currently waiting for assessment by security firm before it can be used but this is expected imminently. DDOC continue to work to source a second site in the West. •ICB have asked for a weekly update, risk assessment and assurance of patients waiting for face-to-face appointments. •Continue to hold regular meetings with DDOC to monitor. Jul 22 - DDoc have struggled to find locations to provide face to face in hours in parts of the county (North, some patients in West, and South). DDOC are mitigating with virtual capacity, use of OOH and seeing patients at Clock Tower. Mar 22 . Contract review meetings held monthly by CCG with Access Health Ltd to discuss all contracts including SAS and monitor actions. . Where appropriate the CCG has requested information from Access Health Ltd for assurance that •adequate arrangements are in place for patients affected in order they can continue to access primary medical services through the SAS and are informed of any new arrangements. •There are plans to ensure future sustainability of the service. .Primary Care Team senior colleagues are meeting to establish a plan of action to be taken if Access Health Ltd hand back the contract to the CCG. .Primary Care Senior Commissioning Manager to escalate to Deputy Director of Primary Care and CCG Executive Team through Director of Commissioning – Out of Hospital where appropriate. [Control Gaps] None identified	15 [08/06/2022] ▲ 15 (L=5 x I=3) [10/05/2022] ▲ 12 (L=4 x I=3) [08/03/2022] 9 (L=3 x I=3)	Risk Opened: 08/03/2022 Reviewed: 25/08/2022	[07/04/2022] 7 Apr 22 - CCG meeting with DDoc to review model 10 May 22 - awaiting proposal. Concern as further provider has pulled out. 7 Jun 22 - Jun 22 - There is currently no in hours access for some patients. CCG seeking remedy to this from the provider. Jul 22 - NHS Devon have received a revised model which is going to SLT on 21st Jul 22. A QEIA has been completed and is going through process. Additional funding ask from DDOC is being analysed by finance. 25 Aug 22 - Awaiting feedback from QEIA panel. Primary Care Team and Finance continue to carry out due diligence on the proposed model. Responses to due diligence questions received from DDOC on 17 Aug 22,	Mar 22 . Contract review meetings are minuted and actions recorded and monitored. . Correspondence between the CCG Primary Care Team and Access Health Ltd regarding information requests and responses is filed appropriately and updates reported to the SAS Senior Commissioning Manager. . Primary Care risks on the corporate risk register are reported to and overseen by the Primary Care Operational Group and Primary Care Committee . Risks are included on the contract holder's risk register about loss of providers for each area affected (Plymouth and North Devon currently). Both are managed through Access Health Ltd.'s Quality Assurance Committee and are the responsibility of their Director of Primary Care, Mark Procter. [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Paul Green

149	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	There is a risk that adults with Eating Disorders are not able to access the necessary physical health checks. There is no commissioned service either within Primary Care or within the Specialist Eating Disorder pathway, for patients who require frequent monitoring, and Primary Care is increasingly not able to support them. The impact is that vulnerable patients are exposed to a very significant risk of compromised health states that can cause impairment or death. The committee responsible for this risk is updated to reflect the quality and performance committee (HISTORIC ID: Na)	Update 08/03/22: Clinical role to be advertised w/c 14/3/22. In the meantime, seeking acute physician input via mutual aid with acute trusts for the interpretation of results taken in primary care short term. Liaison with LMC ongoing but is fraught due to lack of progress over previous years. Update 24/01/22: Practices are wary of i) clinical risk and ii) workload. An approach has been agreed with DPT, LMC and CCG to test pathway impacts with pilot PCNs. Detail to be agreed in Jan 2022, but pilots will be designed to support the 6 practices. Update 28/06/22: Successful GP recruitment exercise this month for roles leading and supporting new physical health monitoring team linked to community eating disorders service. Start date tbc during July. [Control Gaps] Update 08.03.22: Following conversation with 3 of the practices so far, there is variation in the position practices hold. Some practices who have notified of not monitoring are continuing to monitor but without sufficient specialist support to manage some results. Some practices not monitoring though, and others who are will likely cease. Update: 08/03/22. The precise position of GP practices who have notified they are not monitoring is not fully understood. Some are still monitoring, some are not. This is being pursued with practices directly. Looking to conclude this understanding by 17/03/22. Update: 24.01.22: Long-term and pilot funding to be agreed and committed. Previously, there had been agreement in principle to a model. This now needs to be recosted against current plans and reconciled to MHIS or other funding. Important to give all parties confidence in the solutions being brokered. Update 28/06/22: While start date for newly recruited GPs still being confirmed the risk practically remains unchanged.	15 [01/09/2022] = 15 (L=3 x I=5) [29/07/2022] ▼ 15 (L=3 x I=5) [29/07/2022] = 15 (L=3 x I=5) [08/03/2022] ▲ 20 (L=4 x I=5) [31/01/2022] ▼ 16 (L=4 x I=4) [05/05/2021] 20 (L=4 x I=5)	Risk Opened: 05/05/2021 Reviewed: 01/09/2022	[28/06/2022] Update: 28/06/22: physical health monitoring team to be put in place and clinics to commence, pending start date of newly recruited GPs. Supported by HCAs and phys associate., [27/04/2022] Update 25.04.22: Likely medic to oversee interpretation of test results identified. Due to conclude in the first week of May at least as an interim solution. , [08/03/2022] Update 08/03/22: Current focus is on stabilising the position with primary care, alongside developing the future model but not reliant on the future model., [31/01/2022] Update 24.01.22: *Assurance for process attached to patients affected by practices declining to undertake health checks. *DPT-led recruitment of GP with special interest for pilot and services development. *Comms plan. *Definition of pilot and appraisal of its migitation of current risks in affected practices - ie not just its contribution to defining the long term model.,	Update: 31/05/22: Recruitment exercise for medical leadership and capacity appears successful, pending final negotiations with practices of the GPs involved during June. Update: 08/03/22. Controls now treat this as a system risk and seeking mutual aid short term from acute trusts, not simply relying on recruitment. Update 24.01.22: i) DPT has put in place a specialist phoneline for GPs needing support on the management of their patients or liaison with the Community Eating Disorders Team. ii) Adam Carrick has led recent re-engagement with LMC and agreed the Controls described earlier. iii) Dr Emma Chapman (CCG) engaged with pathway design. Update 28/06/22: Previous GP recruitment updated in May was for only one GP 0.2. The revised exercise has expended to three individuals: 0.5 + 0.2 + 0.2. [Assurance Gaps] Update: 31/05/22 Patients in primary care who do not respond to follow-up for physical monitoring are an unknown part of the risk. Not straightforward; likely to be risky and therefore but amongst patients with Capacity in the main. Update: 08.03.02. The small number of patients within practices who are truly not monitoring remains low however there is potential catastrophic risk for some individuals. Update 24.01.22: i) Having now quantified the risk in terms of numbers of patiens and their clinical rating (ie sutiable for monthly monitoring), need also to be clearer on the individual patient-level monitoring in place. ii) Comms with primary care needs to become more regular and framed around the progress being made. Joint btwn CCG, DPT and LMC. Understanding of needs of any short term solutions, whilst developing longer term solutions in Plymouth are yet to be ascertained. These will form part of the task and finish groups that are to be scheduled. Currently the proposed assurances will meet the need but may require significant funding and training of both the team and services it will support (primary and secondary care services). As identified, papers will be taken to CCG commissioning committee.	Executive Lead: Jo Turl Owner: Adam Carrick
147	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	There is a risk that NHS Devon does not currently employ the services of a designated doctor for safeguarding children. The impact of this risk is that NHS Devon will not meet the statutory requirement laid out in Working Together 2018 and Section 11 of the Children Act 2004, and will therefore be compromised in its responsibility to promote the health and wellbeing of children and young people of Devon (HISTORIC ID: Na)	August 2022 - Risk reviewed and score to remain the same. Risk discussed at the Safeguarding and Protection of Vulnerable People Steering Group in June. It was noted that the ICB have been unsuccessful in their attempts to recruit to this role following several attempts. It was also noted that this was a national issue and that NHS Devon Chief Medical Officer is linking regionally and nationally to try to progress (SF/SM) July 2022 - Risk reviewed and score to remain the same (MT) June 2022 - Risk reviewed and score to remain the same (MT) May 2022 - Approval from CND for the risk description to be updated (SD) [Control Gaps] July 2022 - None identified (MT)	12 [26/03/2021] 12 (L=4 x I=3)	Risk Opened: 26/03/2021 Reviewed: 09/08/2022		April 2022 - Designated Nurse vacancy has been recruited to and person starts on 18th July 2022 (CH) April 2022 - The Safeguarding Team continue to offer support to the Named Doctor network when required (CH) [Assurance Gaps] August 2022 - Risk raised at the National Safeguarding Steering Group at the request of the DCNO. The response was that this is a national issue and is being looked at. No timeline given (SM)	Executive Lead: Darryn Allcorn Owner: Michelle Thornberry

130	Lead the system's response to the coronavirus pandemic [Reporting Committee] Audit and Risk Committee	There is a risk that the CCG does not respond effectively to the COVID-19 pandemic. The impact of this is that the CCG may delay or disrupt the pandemic response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and perception of the CCG. COVID Risk Register Wave 2 risk ID 14 (HISTORIC ID: Na)	18/01/2022 - In order to provide resilience for the expected Omicron spike, Winter Room resilience enhanced for period to 27/02/2022 by re-institution of the Teams A & B utilised in earlier Waves; Two teams of 5 x Incident Directors & 6 x Incident Managers now in place. Prism participation in Winter Room stood down in favour of the enhanced staffing model. 22/12/2021 - System has contracted consultancy firm 'Prism' to provide support with the COVID pandemic & extreme pressures response. Winter Room leadership being provided by Prism six days a week from 20/12/2021. CCCG Incident Director still maintains Exec leadership of System incident response during period of duty. 16/11/2021 - Winter Room now in operation with rotas filled until end of 2021 and being populated up to April 2022. 19/10/2021 - In order to aid staff resilience, a Winter Room model of incident management is to be put in place for 01 Nov 21. This will replace the current IMT, increase the ops knowledge available to support the response & spread the load across seven teams on a rota. Winter Room to operate 7 days a week, 08:00-18:00 M-F, 09:00-17:00 Sat/Sun. 12/08/2021 - IMT significantly reinforced with teams of dedicated Incident Directors & Incident Managers, additional Inbox Admin and Meetings Admin. These have been put in place due to the increased cases (Wave 3) and the decision to incorporate the extreme pressures that the system is responding to within the IMT response. Work ongoing to determine whether to stand up additional incident cells; to date, a Workforce cell has been activated to support the response. 19/05/2021 reviewed no updates at this time PC 21/04/2021national requirement to maintain incident response structures PC 18/02/2021 • Incident Management Team comprising of Incident Director, Incident Manager, admin support, Loggists and Cells to lead on specific workstreams, in place • Overview of the incident response maintained by Executive Team • Regular reviews of the Incident response structures and responsiveness are being undertaken • Regular co-ordination and update meetings scheduled, internally, across the system and with Region; these meetings are reviewed and the frequency adjusted to meet the needs of the response. 27/01/2021 CCG has a structured incident Reponses team in place, this is being managed and monitored daily to respond to daily issues or escalation as required by the Devon Health and Social Care community or requests from NHSE/I 12/11/2020 Risk reviewed no changes identified PC •Incident Management Team comprising of Incident Director, Incident Manager, admin support, Loggists and Cells to lead on specific workstreams, in place •Overview of the incident response maintained by Executive Team •Regular reviews of the Incident response structures and responsiveness are being undertaken •Regular co-ordination and update meetings scheduled, internally, across the system and with Region; these meetings are reviewed and the frequency adjusted to meet the needs of the response. Currently the System meetings are only held if an issue is identified. [Control Gaps] No Gaps Identified	12 [17/09/2020] 12 (L=3 x I=4)	Risk Opened: 17/09/2020 Reviewed: 25/04/2022	[13/10/2020] 15/02/2022 Review of System incident management to be undertaken to determine appropriate structure for end of Feb onwards 18/01/2022 - Revision of Incident Manager & On-call Manager rotas ongoing at this time. Incident Director & Director on-call rotas resolved and in place. System Resilience Plan to be developed as part of the ICS preparations, once guidance received from NHSEI ,	19/10/2021 - Daily System calls M-F, with System check in calls on Sat/Sun in place; the multi-agency SCG/ TCG response has been stood down. 12/08/2021 - Daily System calls have been put in place, Mon to Fri, and regular weekly CEO calls are also in place. The CCG is also participating in the multi-agency SCG & TCG responding to the Major Incident declared due to the extreme pressures in the Cornwall system. 18/02/2021 CCG has a structured incident Reponses team in place, this is being managed and monitored daily to respond to daily issues or escalation as required by the Devon Health and Social Care community or requests from NHSE/I As part of a national requirement form NHSE/I the CCG has undertaken two mass vaccination exercises across Devon on 21/22 January 2021 No risk score change 27/01/2021 As part of a national requirement form NHSE/I the CCG has undertaken two mass vaccination exercises across Devon on 21/22 January 2021 Internal Interim Debriefing of the first wave completed and recommendations agreed by Executive Team •System Interim Debriefing of the incident response to the first wave drafted and awaiting submission to Executive Team. 18/02/2021 CCG has a structured incident Reponses team in place, this is being managed and monitored daily to respond to daily issues or escalation as required by the Devon Health and Social Care community or requests from NHSE/I As part of a national requirement form NHSE/I the CCG has undertaken two mass vaccination exercises across Devon on 21/22 January 2021 No risk score change 27/01/2021 As part of a national requirement form NHSE/I the CCG has undertaken two mass vaccination exercises across Devon on 21/22 January 2021 Internal Interim Debriefing of the first wave completed and recommendations agreed by Executive Team •System Interim Debriefing of the incident response to the first wave drafted and awaiting submission to Executive Team. [Assurance Gaps] no assurance gaps identified	Executive Lead: Darryn Allcorn Owner: Phil Coutie

132	Improve service performance [Reporting Committee] Primary Care Transition Committee	There is a risk that until robust reporting processes are embedded in general practice that there will be reduced assurance to fully understand how the learning from incidents will be shared and actions implemented. Additionally, there is an associated risk that until comprehensive and robust systems are in place to monitor quality and patient safety that only limited surveillance will be able to be implemented. The impact of this is that a failure to recognise the need for reporting incidents, completing a robust report in a timely manner and learning from incidents will be lost and the incident may therefore reoccur. That until the learning is embedded in practice the risk of the same incident reoccurring is not reduced and could occur repeatedly. (COVID Risk wave 2 risk ID16) (HISTORIC ID: Na)	Reviewed with Head of Primary Care (NE) - 3 Feb 21 / 24 Feb 21 / 6 Apr 21 / 5 May 21 /27 May 21 / 5 Jul 21 / 27 Aug 21 / 2 Sept 21 / 5 Oct 21 / 8 Dec 21 / 6 Jan 22 / 8 Feb 22 / 10 May 22 / 7 Jun 22 / 7 Jul 22 / 25 Aug 22 Updates from Quality team - 11 Jan 22 / May 22 / 11 Jul 22 Review with Deputy Director for Primary Care - Dec 20 Jul 22 - •Eastern and Northern PCNs have been named by the collaborative leads and have initiated pilots focusing on incident reporting in relation to work transfer and adverse events, utilising a revised PITCH submission form. Primary Care PITCH submissions have increased and locality based theme reporting has commenced. •A new practice soft intelligence spreadsheet has been implemented. June22 - • Monthly LMC meetings in place to share incidents, themes and concerns, CCG is currently sharing all PITCH submissions in relation to PC, LMC have been requested to share their data for triangulation of themes and concerns •Mid and Eastern PCN`s have been named by the collaborative leads to initiate a pilot focusing on incident reporting in relation to work transfer and adverse events •Weekly PC PITCH are now being reviewed with targeted feedback to submitters to improve incident reporting •Northern PCN have agreed to PSQ support for training and submitting multiple SEA`s regarding Safeguarding incidents/near miss •Safety Systems and PSQ leading on development of SEA/SI format for Medical Examiners submissions into PC Jul 21 - *Contractual arrangements agreed that we can request SEA's and SI's where we deem appropriate and proportionate through the "request for reasonable information" * Continued analysis of SEA and SI demonstrates that many investigations are still instigated by other providers, PITCH reports and CCG and there is not strong evidence to confirm that primary care has robust enough processes to assure the commissioner that this is yet in place and that they have mechanisms to initiate and identify their own SI. The CCG new Patient safety specialist role is now working closely across the system to implement the national Patient Safety Incident Response Framework (PSIRF) and primary care will be included in this workstream. May 21 - *Contractual arrangements have been agreed that we can request SEA's and SI's where we deem appropriate and proportionate through the request for reasonable information. *Continued analysis of SEA and SI demonstrates that many investigations are still instigated by other providers, PITCH reports and CCG and there is not strong evidence to confirm that primary care has robust enough processes to assure the commissioner that this is yet in place. * LMC continues to share LMC GP Alert System with CCG to alert re system pressures. * On primary care work plan for rapid progression. * Contract Levers SOP in place * Early warning dashboard now in place and reviewed on a monthly basis by the new Primary Care quality and performance group. 4 Mar 21 - Primary care and Quality to meet regarding the recently completed additional COVID learning paper planned. CCG new Patient safety specialist role is now working closely across the system to implement the national Patient Safety Incident Response Framework and primary care will be included in this workstream. Apr 21 - Early warning systems has been developed and tested, which will be reviewed on a monthly basis by the new Primary Care quality and performance group. October 2020 - A report and live demo on the Early Warning System is to be presented at the PCCC on 1st October and at the QAC in November (VC) September 2020 - Incident reporting processes are in place: The agreed process currently in place is to monitor safety incidents through a variety of systems, SEA, SI, Yellowcard/PITCH. Each month the incidents are required to have a clinical lead to review and follow-up: * Potential SI reported and currently in decision making process *SI review process in place * SI review shared with NHSE Performance Advisory Group *SEA themes are regularly identified and learning shared. *PITCH themes analysed and learning shared Access to 2 x Band 7 Primary Care Nurses who can support the work with the Safety Systems team to identify if the	12 [16/09/2020] 12 (L=4 x I=3)	Risk Opened: 22/09/2020 Reviewed: 25/08/2022	[01/09/2021] 27 Aug 21 - on going efforts to engage with GP practices to ensure they are familiar with the PITCH for reporting SEAs. Working with LMC to communicate with practices on how to use PITCH. 5 Oct 21 - Current work with a number of practices under CQC compliance would suggest that there is still a lack of robust reporting processes in place. In addition to ongoing lack of capacity and gapped posts we are unable to proactively work with practices to put in place improvement programmes. QI work is reduced to case by case and only when identified through SI or CQC processes. 8 Dec 21 - Following consultations with Collaborative board leads , LMC and Associate Medical Director (JC) there is a general agreement of a need for Safety processes to be imbedded within Primary Care. To progress further to reduce the risk there needs to be further consultation with the LMC with an agreed way forward in data sharing, thematic dissemination and resolution of raised Safety concerns. There are no identified plans for the transition to utilise Patient Safety Incident response framework (PSIRF) as part of the NHS patient Safety Strategy. 11 Jan 22 - Work continues at pace to ensure that GP practices and PCNs will be ready ahead of the PSIRF, but that due to operational pressures this work is taking time to embed. Evidence that some GP practices are not participating in other providers RCA/SI even when they have been requested to do so. In addition, many of our SI's continue to be identified through other mechanisms and few directly from practices – this means that we continue to have a lack of assurance around robust reporting procedures. 10 May 22 - New pathway is being developed to reduce this risk. Quality team to provide update as this progresses. 25 May 22 - work plan to relaunch PITCH with Comms and a supportive training tool, LMC collaboration for the launch is currently being negotiated 12 Jul 22 - work continues with LMC re supportive comms on revised PITCH process , [06/07/2021] 6 Jul 21 - Presentation re national Patient Safety Incident Response Framework (PSIRF) to be arranged for PCCC, QAC already completed. Also to be presented at collaborative boards asap ,	September 2020 - We have identified the risk each month on the Quality Assurance Committee flash reports. We have an internal audit report that reflects our assurances and gaps and has identified a number of processes that require implementing (VC) [Assurance Gaps] September 2020 - We have an internal audit report that reflects our assurances and gaps and has identified a number of processes that require implementing. There are workforce capacity issues that restrict the amount of quality improvement work and quality assurance functions over a large number of practices that requires a much more hands-on proactive approach to improving the culture of understanding why incident reporting is a must do. The BI, primary care team and PSQ team are in the process of developing a primary care early warning quality dashboard. The development of this has been severely delayed by the Covid-19 pandemic. The internal audit report actions and recommendations have also been delayed by the Covid-19 pandemic and workforce shortages (VC) Nov 2020 -Using the LMC GP Alert System to alert re system pressures	Executive Lead: Jo Turl Owner: Paul Green

			actions within both SEA's & SI's are completed & the learning embedded in practice. All primary care SI's will have 2 reviewers due to the lack of confidence in primary care governance processes (VC) [Control Gaps] Mar 21 - PCCC discussed lack of contractual lever to require SEA to be submitted. September 2020 - The level of responsiveness to discuss RCA's and ongoing actions for general practice continues to be mixed. The team continue to support and develop practices understanding of the RCA process, however it is becoming clear that there are a number of practices that do not wish to engage with the process of implementing actions and taking on board the learning from RCA's, most evident with regards to multi-agency RCA's. There is evidence that the same incidents are repeatedly seen across primary care and there is limited proactive localised development and improvement workforce capability within both primary care and PSQ teams to carry out this supportive quality improvement work. The 2 reviewers won't address the themes & trends as that goes back to governance & leadership & our lack of assurance around their processes (VC)					
120	Lead the system's response to the coronavirus pandemic [Reporting Committee] Primary Care Transition Committee	There is a risk that COVID-19 outbreak may lead to the possible work transference from secondary care into General Practice, impacting on GP practices ability to undertake routine work The impact of this is that the delivery of general practice is compromised and there may be funding implications if additional funding is sought. (COVID Risk wave 2 risk ID 09) (HISTORIC ID: Na)	Reviewed with Head of Primary Care (NE) - Jan 21 / 3 Feb 21 / 24 Feb 21 / 6 Apr 21 / 6 May 21 / 27 May 21 / 1 Jul 21 / 2 Sept 21 / 5 Oct 21 / 7 Dec 21 / 5 Jan 22 / 8 Feb 22 / 8 Mar 22 / 7 Apr 22 / 10 May 2/ 7 Jun 22 / 7 Jul 22 / 25 Aug 22 Dec 2020 - Review with Deputy Director for Primary Care 25 Aug 22 - Practices encouraged to use PITCH to report transfer of work issues. 8 Mar 22 - Formal advice given that if a GP has any concerns around the transfer of work, this should be raised with collaborative board chair for discussion and resolution with the LCP. 7 Dec 21 - reducing transfer of work from Secondary care to primary care features in the recent winter plan guidance. 5 Oct 21 - Community Phlebotomy LES extended to 31st Mar 2022 16/09/2021 -Reviewed by PCOG who recommended the impact score be increased to 4 2 Sept 21 - Reviewed with Head of Primary Care (NE) - PRIMARY CARE COMMITTEE AGREEMENT THAT IT SHOULD BE NOTED THAT THIS RISK HAS BEEN REALISED (ie work transfer is occurring) 27 May 21 - Following discussion at PCOG agreed that this risk would be subject to regular review and update at Primary Care SLT. 27 May 21 - Phlebotomy LES in place until 30 Sept 21. Devon wide solution being agreed by Commissioners for 1st Oct 21 onwards. 24 Feb 21 - Risk and risk score reviewed. Risk score still feels appropriate to the current situation. Aug 2020 Work being undertaken by Mandy Seymour and John Finn to identify the work transfer and to ensure that this is achieved in a planned way. COVID report due to monthly Primary Care Committee LMC impact monitoring Jul 2020 CCG Primary Care COVID lead identified Regular COVID updates from comms team to GP practices. CCG providing resource to support implementation of e-Consult and implementing changes to online booking and triaging within practices. CCG purchased additional laptops to support practice business continuity plans to enable remote working. Gen Practice representation to key Restoration and Transformation (R&T) workstreams being developed. R and T matrix style review of interdependencies arranged. Work being undertaken by Mandy Seymour and John Finn to identify the work transfer and to ensure that this is achieved in a planned way. COVID report due to monthly Primary Care Committee LMC impact monitoring [Control Gaps] None identified at present	12 [16/09/2021] ▲ 12 (L=3 x I=4) [13/07/2020] 9 (L=3 x I=3)	Risk Opened: 13/07/2020 Reviewed: 25/08/2022	[07/06/2022] 7 Jun 22 - Plan is for work transfer incidents to be recorded through PITCH. Numbers and theme will be collated at County and LCP level for Collaborative Board Charis to discuss and work with Local medical directors to address issues. 7 Jul 22 - Use of PITCH for reporting transfer of work issues has been piloted and initial finding have been reported to GP system operations group. Next steps will be roll out to wider Devon. ,	Mar 22 Regular reporting to monthly Primary Care Commissioning Committee LCP meetings as opportunity for issues to be raised and resolved at locality level LMC impact monitoring [Assurance Gaps] None identified at present	Executive Lead: Jo Turl Owner: Paul Green

121	Improve service performance [Reporting Committee] Quality and Performance Committee	There is a risk that the Mental Health Inappropriate Out of Area trajectory, agreed by MH providers (Devon Partnership Trust and Livewell Southwest), is not met. The impact of this for patients is poorer outcomes, poorer experience, increased cost and damage to the CCG's reputation due to not meeting the nationally derived target to eliminate OOA placements by 20/21. (COVID Wave 2 Risk 45) (HISTORIC ID: Na)	'Update: 19/1/22: Monitoring of numbers of people placed out of area is ongoing. Revised trajectories remain on track for achievement of zero inappropriate out of areas. LSW have completed analysis of their out of area to support placement needs and a system position has been derived. Update 30/11/21: Monitoring of performance in relation to the number of people out of area is ongoing. Revised trajectories have been received from DPT. This is due to challenges within the the procurement of beds that were beyond DPTs control. Monitoring against revised trajectories is ongoing. DPT have provided a detailed analysis of their out of area placements to support understanding of needs and demand. This analysis will be replicated with LSW to provide a system view of needs and demands. [Control Gaps] Update; 19/1/22: BI have been approached to support bed modelling capacity requirements to inform planning. Demand and capacity plans have been developed collaboratively to support planning, however, there is limited evidence nationally on which plans can draw an evidence base because all modelling in this context is predictive.	12 [01/09/2022] = 12 (L=3 x I=4) [01/04/2021] ▼ 12 (L=3 x I=4) [29/09/2020] = 16 (L=4 x I=4) [13/07/2020] 16 (L=4 x I=4)	Risk Opened: 13/07/2020 Reviewed: 01/09/2022	[31/05/2022] Update: 31/05/22: Unchanged from April's update, below. Update: 28/06/22: Unchanged from previous update - which is corroborated by the resubmission of the MH Ops Plan 22/23. Still intending to meet trajectory; but still fragile in respect of system pressures on MH beds., [27/04/2022] Update: 25.04.22 Risk currently remains unchanged. Ops Plan 22/23 trajectory reviewed and recommitted by all partner organisations but remains fragile based on system pressures and demand for MH beds.,	Update 31.01.21: Trajectory is on track. Update 30/11/21: Challenge's in relation to the mobilisation of the additional commissioned beds has been impacted by factors outside of DPTs control but that need to be managed to ensure safe and effective quality of care. These have delayed the opening of the beds which will not all come on line until q1 22/23.50% of the beds are now open. [Assurance Gaps] none identified at present	Executive Lead: Jo Turl Owner: Adam Carrick
162	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	Personal Health Budgets (PHBs) /Direct Payments can be used to pay for Personal Assistants (PAs) to provide care and support to individuals in receipt of Continuing Healthcare Funding. The PAs are employed by the Budget Holder. There is a risk that PHB Holders do not know the tasks they need to complete when they employ PAs, including: *Ensuring the PAs are adequately trained, to include core skills training and Delegated Healthcare Tasks (DHTs) and *Understanding their roles and responsibilities as a legal employer The impact of this is: *Potential patient harm – due to untrained staff caring for complex individuals, *Potential for sub-optimal care being provided by PAs, *Potential risk of safeguarding issues/abuse – for untrained staff taking advantage of budget holders, *Potential litigation to the ICB/financial compensation – due to harm to patients (above) and potential harm to PAs who are working and not sufficiently trained, eg Manual Handling incidents causing PA long term injury and *Potential reputational damage to the ICB – due to poor care provision; funding care with non-adherence to recommended mandatory/statutory training; budget holder's complaints and potential litigation for budget holders who have not fulfilled their responsibilities as an employer, which could result in budget holders personally being sued for damages (HISTORIC ID: Na)	August 2022 - Risk reviewed and score to remain the same (EB) June 2022 - Risk reviewed and score to remain the same. An 8 week period to work on the backlog of PHB work & develop processes including training has been agreed started w/c 27/06/2022 (EB) May 2022 - Risk reviewed and score to remain the same. Band 6 vacancy has now gone out to advert, interviews planned for end of June 2022. Training guide and PA passport have now been completed along with the training budget calculator - launch date to be confirmed (EB) April 2022 Risk reviewed and score to remain the same. Funding for 3 Band 7's for 12 months has been approved in order to take forward the embedding of the delegated care task policies. Plan on a page to be drafted within the next few weeks. A successful business case has been approved for a Band 6 to support the PHB's team and due to go out to advert by end of April 2022 (JS) [Control Gaps] August 2022 - Band 6 now recruited but not due to start until 22/08/22 (EB) June 2022 - Conditional offer made to successful Band 6 candidate proposed start date beginning September 2022 - HR processes underway. Sickness and volume of work still impacting the ability to mitigate this risk (EB) May 2022 - Due to sickness within the team, progress on mitigation has slowed up (EB)	12 [05/04/2022] 12 (L=4 x I=3)	Risk Opened: 05/04/2022 Reviewed: 09/08/2022	[05/04/2022] Longer term - Engagement with DCC in their exploration of future Direct Payment Support Services to improve processes and quality of support for PHB holders Action owner: Emma Blight Timeframe: to be determined, [05/04/2022] Continue working with Living Options Devon and Exeter College re training offers Action Owner: Emma Blight June 2022 - work with Living Options Devon has now ceased due to the funding handed back by Living Options Devon due to insufficient recruitment of PAs for the training. Work still ongoing with Exeter College, [05/04/2022] Review of PHB policy and User Agreement Action owner: Emma Blight Timeframe: to be determined, [05/04/2022] Update PHB Direct payment guide for Plymouth adults and children in Plymouth and Devon Action owner: Emma Blight Timeframe: to be determined August 2022 - Draft payment guide now completed. Needs to be signed off by Head of CHC/Nursing Quality Assurance, [05/04/2022] Full audit of training needs and what is completed for each Direct Payment funded individual. This should include a discussion with every PHB holder re training needs and options Action owner: Emma Blight Timeframe: to be determined,	May 2022 - Training guide and PA passport have now been completed along with the training budget calculator - launch date to be confirmed (EB) April 2022 Funding for 3 Band 7's for 12 months has been approved in order to take forward the embedding of the delegated care task policies. A successful business case has been approved for a Band 6 to support the PHB's team and due to go out to advert by end of April 2022 (JS) [Assurance Gaps] August 2022 - Band 6 now recruited and due to start role in 22/08/22 (EB) June 2022 - Conditional offer made to successful Band 6 candidate proposed start date beginning September 2022 - HR processes underway (EB)	Executive Lead: Darryn Allcorn Owner: Jo Shill
163	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Primary Care Transition Committee	The limited duration of the new interim contact (18 months) will provide a challenge in terms of meeting the timeline for a new procurement exercise. There is a risk that procurement of a longer term contract for Mayflower may not be successful. The success of this is dependent on several factors, including the ability of the interim contract holder to move to a sustainable resilient position. The impact of this is that the delivery of primary care services to patients may be adversely affected. It may also impact other GP practices in Plymouth and the wider system. (HISTORIC ID: Na)	Reviewed by Head of Primary Care - 25 Aug 22 Aug 22 - Head of Primary Care for Southern and Western to review at end Q2. • Increased investment to support LPC change delivery model • Monthly contract review meetings in place •Input from across ICB including, quality and meds op teams [Control Gaps] None Identified	12 [20/07/2022] 12 (L=3 x I=4)	Risk Opened: 20/07/2022 Reviewed: 25/08/2022		•Demonstrable commitment from LPC on changing service model •Outsourced experts in place to support organisational change [Assurance Gaps] None Identified	Executive Lead: Jo Turl Owner: Siobhan Cambridge

165	Improve service performance [Reporting Committee] Quality and Performance Committee	There is a risk that the delays caused in finalising the Children Service Review has led to delays in progressing service line improvement within CFHD, Livewell Southwest and across wider programmes due to: •Delay in agreeing the strategic direction •Lack of an agreed governance structure and senior leadership approach across the children's health system •Delay in agreeing where demand and capacity indicates the need for more resource The impact of this to NHS Devon is there is a risk of being: •Unable to agree on what the funding gap is and therefore what should be delivered from within the existing contract. •Unable to agree on what service should be prioritised for improvement work. •Unable to agree on actions identified within the Torbay Local Area Written Statement of Action which may not fall within contract. •Unable to triangulate robust information to prepare for and respond in a timely way to address inequalities, complete funding bids and measure the effectiveness of intervention. •Unable to allocate capacity and resource whilst still delay •Reputational damage among local authority partners •Unable to address the pressures within the wider acute and community system as dependent on engaging them in the pathway implementation. Community paediatrics is inextricably linked to children's community services. •Unable to agree on data required for contract due to review of Outcomes Framework being put on hold. Can't reach a decision on final report – contents, detail or recommendations Incomplete and inconsistent data provided including provider financial information (HISTORIC ID: Na)	•Agreement between senior executives to prioritise the pathways in need of further review •CYP Long Term Plan Programme Board meets monthly and received updates on the CYP Long Term Plan oGame changer programmes being progresses with systems partners oClinical lead posts out for recruitment •Summary DRAFT report presented to NHS Devon CCG Governing Body June 2022 •CCG Deputy Director of Finance meetings with Provider Finance •Contract Review Meetings – reinstated quarterly with new ToR with monthly Joint Transformation Meetings •Feedback from Livewell South West has been received and review document amended accordingly. •CFHD have provided follow up information for each service line [Control Gaps] Partners who were involved in the review have not had the draft report shared and are questioning the lack of progress being made to finalise. This includes VCOs and children, young people and families who gave their thoughts as part of the review. Limited capacity within the provider organisations for wider pathway transformation Controls do not address the overarching funding gap and therefore enable planning across the landscape of children services.	12 [03/08/2022] 12 (L=3 x I=4)	Risk Opened: 03/08/2022 Reviewed: 03/08/2022		1.Corporate risk agreed 2.Senior executive oversight of the progress 3.ICB reporting through IPQR 4.Provider reporting through Board reports [Assurance Gaps] Oversight of the service activity and outcomes for CFHD is limited to the agreed Day one reporting. A review of the Outcomes Framework is one of the recommendations in the Children Service Review but this is also delayed pending agreement on the strategic direction.	Executive Lead: Jo Turl Owner: Hannah Pugliese
167	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	This risk replaces Risk 133 on the corporate risk register There is a risk that commissioning decisions are not robust, due to reduced oversight of the local commissioning cycle. The impact of this is: 1.Decisions may be made in isolation without thorough commissioning, clinical and quality oversight. 2.Contract and procurement deadlines may be impacted. 3.A gap in health inequalities may be widened due to impacted access to commissioned services. The risk is a result of: - •Capacity challenges within the ICB elective care team due to the oversight of the NHSE/I long waiter target; reduced oversight of the local commissioning cycle. •Significant operational pressures that the Devon healthcare system is currently managing, including the impact of urgent & emergency care and COVID on acute services . •Significant operational pressures that the Devon healthcare system is currently managing, including the impact of urgent & emergency care and COVID on acute services . (HISTORIC ID: Na)	•ICB response cell structure installed to maintain robust oversight of the 104ww delivery •Daily check in calls with ICB team as well as wider system partners •Reprioritisation of commissioning work to ensure urgent work packages are overseen as a priority •Daily updates with NHSE/I regional colleagues •Daily review of staffing capacity with an agreement to flex work portfolios on a daily basis in order to meet demand •Daily / weekly monitoring of available data, as well as twice weekly system situational reporting to maintain robust oversight •Progress on 104WW performance is overseen by the system Planned Care Programme Board •Weekly updates are shared with system CEO's through the RERSG [Control Gaps] none identified	12 [05/08/2022] 12 (L=3 x I=4)	Risk Opened: 05/08/2022 Reviewed: 01/09/2022	[01/09/2022] •Re-focusing of daily staff workload to maximise oversight and productivity of priority deliverables or workstreams •Daily sit-rep report updated •Weekly senior stakeholder report (RERSG) ,	For each of the risks and controls a source of assurance is set out i.e.. What provides evidence that the organisation has identified the risks and has controls in place. (e.g. Internal audit report, report to Board or Board Committees) Please provide details of assurances below: •Progress on 104WW performance is overseen by the system Planned Care Programme Board •Weekly updates are shared with system CEO's through the RERSG •Bi-weekly updates are provided to SDIG •Daily sit-rep monitoring •Daily ICB team check-ins [Assurance Gaps] none identified	Executive Lead: John Finn Owner: Karen Barry

133	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	There is a risk that decisions to make changes to services commissioned by the ICB through providers are done so without full cognoscente, clinical oversight and agreement whilst responding to the COVID 19 outbreak and management of capacity and resource. The impact: a) decisions made in isolation may impact on other services or capacity in system b) inequitable access for patients to services (HISTORIC ID: Na)	September 2022 - Risk recommended for closure due as it will be superseded by risk 167. Awaiting Exec approval (SW) August 2022 - The in-Hospital Commissioning team are awaiting exec sign off of a new risk that will replace this risk. When agreed, this risk will be recommended for closure (SW) July 2022 - Risk reviewed although being superseded by a new risk. The new risk has been drafted by the planned care team etc., and will be finalised during August 2022 (SW) [Control Gaps] June 2022 - Mitigation previously described continues (SW)	10 [11/11/2020] ▼ 10 (L=2 x I=5) [27/10/2020] 15 (L=3 x I=5)	Risk Opened: 27/10/2020 Reviewed: 06/09/2022		September 2022 - Due to the addition of commissioning risk 167, assessment concludes this risk can now be closed. The new risk captures all existing issues in relation to risk 133 in the context of the current situation (SW) [Assurance Gaps] April 2022 - The risk exists for those who may be disproportionally impacted by changes to services, for example those in lower socio economic groups (SW)	Executive Lead: Darryn Allcorn Owner: Sara Wright
106	Achieve financial sustainability [Reporting Committee] Finance Committee	There is a risk to the CCG delivering a medium to long-term financially sustainable plan which achieves breakeven within the Financial Recovery Plan timeframe. The Financial Recovery Timeframe will be reset with the allocations in 2022/23, when the Financial Improvement Trajectory is indicated to be retired. The allocation for 2022/23 will be a one year allocation, with a further two years to be issued later in the year. The long-term Financial Plan was developed in the Autumn as a response to the NHS long-term plan. The high-level view submitted to NHS England as part of the Operational Plan for 2020-21 highlights that following the CCG maintaining the pre-CSF outturn recorded for 2018-19 in 2019-20 and then a return to financial balance in 2022-23 with the delivery of surplus in 2023-24. This plan needs to be refreshed in light of the change in allocations and system control total process, along with the Strategic Oversight Framework 4 exit criteria, which includes an LTP based on 19/20 to 21/22 exit run rate (HISTORIC ID: Na)	09 Dec 2021 - The finance regime for the remainder of 2021/2022 has been clarified. Early indication of the financial framework and allocations process are that this will change with existing resources continued and convergence adjustments towards a population based needs weighted target over an improvement timescale. This will shift focus towards efficiency and productivity, and delivery of annual breakeven duties. The timeframe and details are yet to be issued. The system has been identified under the Strategic Oversight Framework as level SOF4, "very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support". This has resulted in mandated intensive support delivered through the Recovery Support Programme , and the support from Bill Gregory (finance) and Jo Burrows (performance) from NHSEI. The SOF4 exit criteria are set out clearly and will inform long term planning. [Control Gaps] 1) CCG 2020/21 operational finance plan as part of the overall system plan did not meet NHS England issued control total requirements nor trajectory, prior to the suspension of planning; This may be reset as the revised finance regime is implemented for 2022/23. 2) Development of medium-term Financial Plan which supports the return of the system to financial balance and the strategy/transformation required to deliver it. 3) NHS England & Improvement response to both CCG financial plan and system submissions; 4) NHS England & Improvement Financial Framework & Strategy for allocating CCG & System funding beyond the Emergency Framework in place for 2020-21 remains uncertain, but indications of direction of travel have been trailed.	9 [06/04/2022] = 9 (L=3 x I=3) [09/12/2021] = 9 (L=3 x I=3) [09/12/2020] ▼ 9 (L=3 x I=3) [02/12/2020] = 12 (L=4 x I=3) [11/09/2020] = 12 (L=4 x I=3) [08/05/2019] 12 (L=4 x I=3)	Risk Opened: 08/05/2019 Reviewed: 06/04/2022	[05/11/2020] Reviewed by Executive Team 19 October 2020,	1) The CCG met the 2018/19 financial plan deficit for the CCGs, prior to access and application of Commissioner Sustainability Funding and delivered against the control total for 2019-20 as adjusted for the level of system risk identified at plan stage; 2) Robust CCG Operational financial plan aligned to the System Plan in place for 2020-21 with the technical accuracy of the plan being robust. The gap to formal control total is due to the systems ability to deliver level of savings originally required within the required Financial Recovery Plan timeframe; 3) Clear and identified process for update to and engagement with CCG Finance & Performance Committee in the development of its plans and exposition of the underlying position; [Assurance Gaps] None identified	Executive Lead: John Dowell Owner: Ben Chilcott
38	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Audit and Risk Committee	There is a risk that decisions will be made by the ICS which impact negatively on delivery of CCG functions As the ICS increasingly takes responsibility for decision making there is a risk that it will make decisions which a) have not had appropriate input/scrutiny from the CCG b) do not consider the CCG statutory functions c) are not supported by the CCG Governing Body These decisions may mean that the CCG may fail to adhere appropriately to one or more of its statutory duties or internal governance requirements, thus potentially failing in one or more of its legal duties. (HISTORIC ID: 319)	21/10/2021 Transitional decision making in place. 15/09/2021 ICS task and finish group overseeing development of ICS governance arrangements. Developing a ICS transitional decision making structure. Developing an ICS decision making framework. (GS) Dec 2020 Updated by GS/JD Governance arrangements for the ICS agreed by all partners setting out ongoing requirements for decision making of statutory bodies CCG AO and Chair on Partnership Board Appointment of joint System and CCG AO 11/11/2020 Discussed at Audit Committee. the committee agreed the risk is still pertinent and requested a review of wording to better express the risk. 12/10/2020 Risk to be presented to Audit Committee for discussion and review November 2020 [Control Gaps] 21/10/201 On going work required to monitor decision making during transition 15/09/2021 Controls as identified above in development but not yet agreed by ICS	9 [21/10/2021] ▼ 9 (L=3 x I=3) [15/09/2021] ▲ 16 (L=4 x I=4) [20/10/2020] ▼ 4 (L=2 x I=2) [23/06/2020] ▲ 9 (L=3 x I=3) [01/10/2019] = 6 (L=2 x I=3) [02/08/2018] ▼ 6 (L=2 x I=3) [23/05/2018] 12 (L=3 x I=4)	Risk Opened: 10/10/2016 Reviewed: 01/09/2022	[06/04/2021] The task and finish group has been established to complete the review of governance (GS), [05/11/2020] Reviewed by Executive Team 19 October 2020, [17/12/2019] Arrange workshop for system organisation Audit Chairs to review proposed system Risk Management arrangements GS,	21/10/2021 Audit Committee and remuneration committee providing assurance on ICS transition Dec 2020 Updated by GS/JD CCG Risk Management Process reporting at all levels of organisation Regular updates to Governing Body through Chairs and AO report and specific items of relevance Internal Audit of ICS Governance arrangements NHSE ICS designation process [Assurance Gaps] No assurance Gaps identified	Executive Lead: Simon Tapley Owner: Ginny Snaith

129	Improve service performance [Reporting Committee] Audit and Risk Committee	There is a risk that a disruption to the availability of staff, IT and/ or telecoms, critical information, premises, supplies or suppliers/ contractors, may prevent the CCG from delivering its essential functions as set out in Directorate BCPs The impact of this is that CCG essential functions may be delayed or stopped with a knock on impact upon statutory functions, finance of CCG and Provider service delivery, and perception of the CCG is impacted by patient outcomes. (HISTORIC ID: Na)	15/02/2011 BC Audit completed annually, the 2021 audit has been completed (Nov 2021) with the outcome: Significantly Assured. 16/11/2021 NHSEI EPRR Assurance completed - CCG rated as fully compliant with NHS England core standards for EPRR 19/10/2021 CCG Business Continuity Plan (BCP) in process of being revised as part of annual review process 15/06/2021 Internal Audit complete and report received: significant assurance given PC 19/05/2021 Risk reviewed no changes identified PC 21/04/2021 Internal Audit complete and report awaited 16/02/2021 Reviewed by PC - Assurances updated 27/01/2021 Business Continuity Plans have been reviewed across the CCG Audit South West are undertaking an internal audit as part of the annual requirement on Business Continuity Plans arrangements in the CCG 12/11/2020 Risk reviewed no changes identified PC •Business Impact Analysis undertaken at least annually •Business continuity risks reviewed by Directorates at least annually •Business continuity audit undertaken annually •NHSEI EPRR assurance, incorporating business continuity, undertaken annually and reported upon to GB •Trained Directorate BC Leads in place •EPRR Lead now in place with responsibility to maintain oversight [Control Gaps] no gaps identified	9 [17/09/2020] 9 (L=3 x I=3)	Risk Opened: 17/09/2020 Reviewed: 25/04/2022	[13/10/2020] 15/02/2022 - Directorate/service BCPs being returned, post review and sign off, at this time. 18/01/2022 - BC Lead training delivered on 11/01 and BCP template revised & issued to BC Leads. BC Framework and Plan to be revised by 30/11/2020. 22.12.21 - Pre-ICS DC preparations underway. Directorate BC Leads confirmed • BC Lead training booked for 11/01/2022 • BCP template revision underway for introduction at BC Leads training. • BCP reviews with Exec sign off required by 11/02/2022. Ongoing monitoring and review of plans - business continuity management is an iterative process.,	19/10/2021 NHSEI EPRR Assurance ongoing at this time completion by 03 Nov 2021 15/06/2021 Internal report received 21/04/2021 Internal Audit complete and report awaited 16/02/2021 NHSEI EPRR Assurance undertaken annually, last completed in September/October 2020 EPRR policy reviewed and approved by Governing Body 19 November 2020 Business Continuity Audit undertaken annually, completed in April 2021 NHSEI EPRR Assurance undertaken annually, last completed in October 2020 Business Continuity Exercise completed in March 2020 Review of Business Continuity plans undertaken in March/ April 2020 [Assurance Gaps] non identified	Executive Lead: Darryn Allcorn Owner: Phil Coutie
166	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	There is a risk that avian flu swabbing will not be available if needed in the event of exposure to avian flu. The impact of this is that swabbing will not be available when required, delaying the response to an avian flu event and potentially leading to avoidable transmission. Additionally, NHS England have also specified that systems need to be able to offer an avian flu swabbing service (including out of hours), and this service not being available carries the potential for contractual requirements of the ICB to be unmet. (HISTORIC ID: Na)	August 2022 - • 'Best endeavours' in-hours cover through existing teams. • System meetings including gap analysis and operating principles development, with involvement of all partner organisations, • Item included in Quality & Performance Committee report [Control Gaps] August 2022 - • Out of hours service not currently available, • In-hours swabbing service provided on a 'best endeavours' basis and not guaranteed to occur, • Requirement for full PPE/RPE training limits personnel able to perform function, • Size of county means potentially long travel times if team is centralised, • Events are likely to be too rare for a fulltime team, • Not currently specified in provider contracts.	9 [26/08/2022] 9 (L=3 x I=3)	Risk Opened: 26/08/2022 Reviewed: 26/08/2022	[26/08/2022] August 2022 - Continue discussions with UKHSA, commissioners and providers, [26/08/2022] August 2022 - Examine how neighbouring systems have approached this issue, [26/08/2022] August 2022 - Options paper for out of hours service currently being drafted by System Lead for IPC & will be taken to QLT/Commissioners, [26/08/2022] August 2022 - Formal arrangements not in place, with ad-hoc process which has been demonstrated to not always be sufficient.,	August 2022 - • Internal and external reviews of positive case, • Cases (actual and suspected) have been managed on a best endeavour, ad-hoc basis, • Discussions with UKHSA, commissioners and providers continue. [Assurance Gaps] August 2022 - • Formal arrangements not in place, with ad-hoc process which has been demonstrated to not always be sufficient.	Executive Lead: Darryn Allcorn Owner: Alastair Harlow

156	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality and Performance Committee	There is a potential risk that there will be a delay in DRSS being able to identify 'red flags' within 'routine' referrals, due to a sizeable and growing backlog of referrals awaiting administrative and clinical review. Whilst not a specific service specification, DRSS has assumed this 'gatekeeper' role to provide referring clinicians with the opportunity to raise the referral status from 'routine' and expedite as 'urgent'. The risk is as a result of: - A reduced operational referral management workforce (i.e., Band 3, Patient Choice Facilitators) due to redeployment of some staff to other priority workstreams (i.e., Oximetry@home & patient Outsourcing/ Validation work programmes) -Reduced productivity levels resulting from remote/ home working (e.g., poor internet/ network connections) -An increased number of new staff (not sufficiently trained/ skilled) and the need to use existing staff to provide necessary training -Outstanding vacancies yet to be filled (4 WTE as of 05/10/2021) The impact of this risk is: -Poor referral experience for patients -Delay in supporting referring clinicians with the identification of referrals raised as routine but which may need expediting due to identified 'red flags' -Potential for increasing individual service line workloads within Provider landscape, due to fluctuating onward referral volumes -Potential increase patient demand for GP Practices with patients querying referral progress -Reputation damage for Devon Referral Support Service and Devon CCG -Low staff morale within DRSS Not in scope for this risk are urgent referrals, including specific time framed pathways (e.g., 2WWs and Mental Health referrals), which remain a priority for processing each working day. In line with new ICB governance the commmitee responsible for this risk is now reflected as quality and performance (HISTORIC ID: Na)	-Re-organised distribution of workload to staff to ensure specialties where 'red flag' referrals are prevalent are processed as a priority, each day -Offering staff over-time working options to help address backlog -Daily review of staffing capacity within individual DRSS workstreams, to redeploy staff to referral management business activity wherever possible on a day-to-day basis -Implemented a phased return to office working & prioritising staff who cannot work efficiently remotely and new starters -Reviewed individual staff productivity and performance levels and implemented performance plans where relevant -Provided weekly updates to providers of current open referral numbers and average referral process turnaround timescales. -Sought advice from Nursing & Quality Team regarding clinical risk - This is now being monitored at the DRSS Monthly assurance meetings which take place. [Control Gaps] -DRSS has not taken decision to cease or reduce activity within Oximetry@home or Outsourcing/ Validation workstreams, to redeploy staff to focus on referral management activity	6 [01/03/2022] = 6 (L=2 x I=3) [15/12/2021] ▼ 6 (L=2 x I=3) [05/11/2021] 15 (L=5 x I=3)	Risk Opened: 05/11/2021 Reviewed: 02/09/2022		-Regular review of DRSS KPIs -Weekly discussion at DRSS Operational Meetings -DRSS priority workstream areas discussed on daily operational call -Weekly reporting/ updating of Providers on current referral status - The new monthly DRSS Assurance meetings with management input [Assurance Gaps] None identified	Executive Lead: John Finn Owner: Steve Matson
127	Achieve financial sustainability [Reporting Committee] Audit and Risk Committee	There is a risk that Devon CCG may be subject to increased fraudulent activity during and following a pandemic or similar major incident The impact of this is potential , Financial loss to the CCG Phishing / Cyber attack Fraudulent staff absence / leave requests Information Governance Breaches Damage to CCGs integrity (HISTORIC ID: Na)	18/01/2022 On-going review of processes to mitigate fraudulent activity CD 27/01/2021 The counter fraud officer monitors and oversees any fraudulent activities with support of specialist, reporting to Audit Committee or escalating any urgent matters to CFO and Board Secretary 16/12/2020 Risk reviewed by Head of Governance, update to assurances added Arrangements for invoice processing under continuous review by budget holders IT undertake regular phishing and spam email checks – clear process for staff to alert IT to any concerns which is logged and reviewed through both the CCGs IT provider and the NHS spam alert system. Counter Fraud Specialist in place as part of contract with internal audit provider Circulation of information to relevant staff on specific issues via Counter Fraud Specialist and other experts within the CCG raising issues in relation to fraudulent behaviours through team meetings and staff communications. [Control Gaps] Directorate managers across the CCG to review internal standard operating procedures for their areas of responsibility with support from the Governance team as necessarily to ensure relevant procedures are in place to monitor for fraudulent activity and address these with the CCGs counter fraud specialist	6 [03/09/2020] 6 (L=2 x I=3)	Risk Opened: 09/09/2020 Reviewed: 01/09/2022		07/04/2021 The audit is in the final stages and the report will be issued shortly and shared with relevant departments for responses. Audit being undertaken by Counter Fraud service Policies in place which cover areas which may be impacted by fraudulent activity ie HR, Finance, commissioning, procurement 16/12/2020 Head of Governance contacted Counter Fraud to enquire of any guidance / documentation to assist with discussions at directorate level to embedded good practice around vigilance of fraudulent activity. Counter Fraud specialist actively supporting CCG staff, attending staff briefings [Assurance Gaps] Directorate managers across the CCG to review internal standard operating procedures for their areas of responsibility with support from the Governance team as necessarily to ensure relevant procedures are in place to monitor for fraudulent activity and address these with the CCGs counter fraud specialist	Executive Lead: John Dowell Owner: Ginny Snaith

128	Be an effective, well-led organisation with an empowered and inclusive workforce [Reporting Committee] Audit and Risk Committee	There is a risk that ICB data will be compromised by unauthorised/accidental disclosure due to shared work areas with non-ICB organisations. This may be via data visible on desks and/or screens or telephone conversations. This also includes homeworking where area shared with other persons. The impact of this could be the ICB's ability to maintain patient, staff and/or corporate confidentiality. (HISTORIC ID: Na)	30/06/2022 Bridge House no longer occupied by DRSS. 22/11/2021 Stone Barn in use, same controls as other sites and home working. 19/10/2021 Pending greater attendance on site this risk is continually monitored to reflect work practices 15/09/2021 IG continued involvement with accommodation planning and relocation. Visit to Crownhill Court on 09 September 2021. Windsor House documents identified for disposal 09 September 2021 16/06/2021 Risk Reviewed no changes identified MS 19/05/2021 Risk Reviewed no changes identified MS 21/04/2021 Staff are mainly working from home. To be reviewed prior to return to office and on the move of staff to new offices in South Molton mid-year.MS During Health and safety quarterly walk arounds adherence to the clear desk is reported to IG team. 28/01/2021 Home working advice sent to all staff and staff advised to use headphones so conversations not overheard and papers and IT equipment shut down when in not in use. 16/12/2020 Risk Reviewed no changes identified MS 12/11/2020 Risk reviewed no changes identified MS 08/10/2020 'Homeworking' guidance created for all staff Screen lock (manual & timed) Clear desk Policy/Audit Secure lockers/cupboard Confidential waste bins/collections Secure printing via ID cards [Control Gaps] Lack of suitable private areas at home where calls may be overheard and screens viewed Secure storage for ICB equipment & work	6 [03/09/2020] 6 (L=3 x I=2)	Risk Opened: 10/09/2020 Reviewed: 01/09/2022	[28/07/2021] 21/07/2021: Bridge House completion is subject to agreed timeline of events and final date for handing over of keys. MS , [28/07/2021] 21/07/2021: Windsor House completion is subject to agreed timeline of events and final date for handing over of keys. MS June 2022 ,	27/01/2021 Directorate/team face to face meetings in progress Entry to buildings are via smartcard. Screens lock automatically after period of inactivity Clear desk policy and quarterly checks via the intranet and regular clear desk audit Personal & departmental lockers for secure storage of devices and documents Confidential waste bins are provided & appropriate disposal Printers activated by smartcard across all sites Isolated areas/rooms available for sensitive conversations Annual mandatory data security awareness training for all staff Data Security Awareness training for all staff and reviewed monthly and reported to the DPSG. [Assurance Gaps] Telephone calls, especially incoming, cannot always be taken away from the desk and to a separate area. Screens in view of shared office/living space whilst working from home during Covid-19	Executive Lead: Andrew Millward Owner: Ginny Snaith

131	Improve service performance [Reporting Committee] Audit and Risk Committee	There is a risk that the CCG will be unable to respond effectively in the event of an emergency or business continuity incident, through not meeting its statutory and policy obligations to be prepared to respond to emergencies and disruptive incidents. The impact of this is that the CCG may delay or disrupt an emergency response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and the perception of the CCG. (COVID Risk Register Wave 2 risk ID 15) (HISTORIC ID: Na)	22/12/2022 With the Winter Room Incident Manager role being covered by Prism six days a week for the next few months, should a multi-agency emergency response be required, the CCG Incident Director will lead it, and if they require support in working with LRF partners, will call upon the Manager on-call. 6/11/2021 With the Winter Room now in place, all Incident managers have been trained in emergency response processes in order to be able to effectively support the Incident Director during an emergency response in the community. 19/10/2021 All managers on-call trained and rota in place to December 2021 12/08/2021 Manager on-call rota not active and cover in place through to December 2021 in line with the Director on-call rota. 23 managers trained so far. 21/07/2021 Manager on-call rota being stood up from Saturday, 24/07/2021 15/06/2021 Manager on call rota has been deferred to end July 2021 09/05/2021 On call rota to commence 14 June 2021 21/04/2021 Increasing resilience in on call system by adding a manager on call rota to start late May 2021 18/02/2021 • Maintenance of the ongoing COVID Incident response structures and process to be maintained • Reviews of emergency and business continuity plans to be continued as per EPRR work plan • Training of On-call and other key staff to be maintained as per the EPRR work plan • Participation in system and multi-agency emergency preparedness exercises to be maintained as per the EPRR work plan. 27/01/2021The CCG response to the current pandemic incident/EU Exit (D20) / winter and flu is monitored daily to identify any challenges and issue that may arise and managed in accordance with EPRR and framework and policy 12/11/2020 Risk reviewed no changes identified PC •EPRR Lead recruited to lead on preparedness workstream; •An EPRR workplan in place to ensure that preparedness is maintained and that new requirements are implemented in a timeous manner; •Suite of business continuity plans and emergency plans in place •On-call system in place, supported by trained on-call staff, available to initiate a response 24/7; •Trained Directorate Business Continuity Leads in place to maintain their business continuity plans •Regular training is undertaken by On-call staff and BC Leads to maintain knowledge and skill sets •Regular exercising of business continuity plans and participation in the exercising of multi-agency emergency plans is undertaken to ensure skills are maintained, plans are tested and the CCG is integrated into the multi-agency response to emergencies; •EPRR Lead is engaged with NHS and multi-agency (LRF) EPRR planning to ensure the CCG is integrated into these plans. •EPRR Lead will fulfil the CCG responsibility of undertaking an annual assurance of Providers preparedness in line with the NHSEI EPRR Core Standards and annual assurance process, and reporting upon this to the AEO & GB. " [Control Gaps] •The incident response to COVID has placed most other EPRR work on hold, meaning that wider preparedness activities are not currently being undertaken.	6 [17/09/2020] 6 (L=2 x I=3)	Risk Opened: 17/09/2020 Reviewed: 25/04/2022	[22/12/2021] 18/01/2022 Manager on-call role now reverting to outside of Winter Room hours only, due to the re-establishment of the Team A & B incident management now picking up response to cmmunity emergencies. Manager on-call role now stood back up to 24 hours in order to be available to support the Incident Director in the event that they require support liaising with LRF partners during an emergency response in the community., [13/10/2020] On-call Induction training to be provided to new On-call staff before participating in the rota., [13/10/2020] Refresher On-call training to be offered to On-call staff before 31/12/2020, [13/10/2020] Maintenance of On-call rotas PC 24/07/2021, [13/10/2020] Ongoing refreshing of On-call pack and contact lists PC 24/07/2021,	16/11/2021 Annual EPRR Assurance completed, CCG rated as fully compliant with NHS England core standards for EPRR. All provider EPRR assurances undertaken and completd, Paper drafted for GB summarising the position. 19/10/2021 Annual EPRR assurance ongoing at this time, CCG/NHSE confirm and challenge meeting booked 03/11/2021. Outcome moved to November Governing Body. All provider assurance meetings complete. 12/08/2021 Annual EPRR Assurance requirements have been issued, with the CCG's confirm & challenge meeting to takle place with NHSEI SW on 13th October. Outcome to go to October GB. Provider EPRR Assurance meeting being booked in at this time. 21/07/2021 Review of incident structures being undertaken to ensure appropriate staffing and structure for the current pressures and the pandemic 21/04/2021 monitoring frequency has reduced to weekly for COVID and EU exit reporting has been stood down. Winter reporting has stopped. Light touch EPRR assurance 2020 is complete and CCG rated as fully compliant 18/02/2021 The CCG response to the current pandemic incident/EU Exit (D20) / winter and flu is monitored daily to identify any challenges and issue that may arise and managed in accordance with EPRR policy. no risk score change •CCG and Provider emergency preparedness reviewed annually against NHS England EPRR Core Standards as part of a national NHSEI process; the 2019 assurance rated the CCG as Substantially compliant with work required on only 2 of 43 standards. •Business Continuity Plans audited in December 2019 with a Significantly assured outcome. [Assurance Gaps] No gaps identified	Executive Lead: Darryn Allcorn Owner: Phil Coutie
152	Lead the system's response to the coronavirus pandemic [Reporting Committee] Audit and Risk Committee	There is a risk that when colleagues return to offices following the relaxation of government restrictions related to the Covid-19 pandemic, that there will be the potential for office outbreaks of Covid-19 or impact on staff through social interactions outside of the workplace. The impact of this is would be potential staff shortages across all directorates due to the need for self-isolation or actual sickness. Potential for serious illness or death with a communicable disease. (HISTORIC ID: Na)	Covid safe controls currently in place for each CCG site which include: Site attendance checklist Lateral flow testing prior to site visit, Use of face coverings when moving around the buildings Social distancing, Voluntary sharing of vaccination status [Control Gaps] Staff awareness of government guidance Staff awareness of CCG guidance	4 [01/09/2022] ▼ 4 (L=2 x I=2) [13/07/2021] 12 (L=3 x I=4)	Risk Opened: 14/07/2021 Reviewed: 01/09/2022		Continued review of government guidelines and communication to staff via the staff briefings updated Covid site specific risk assessments in place Log of all site attendances and lateral flow test results Continue to wear face coverings whilst moving around the buildings Continue with 1m+ social distancing Returning to offices working group Site Safety Coordinator meeting [Assurance Gaps] To be reviewed following any update of government guidance	Executive Lead: Andrew Millward Owner: Ginny Snaith

NHS Devon board meeting

Committee chair report – Primary Care Commissioning Transitional Committee

Date of board meeting	Dates of committees covered in this report
19 October 2022	22 September 2022

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

Reports discussed and assurances received

- The committee reviewed the monthly report from NHSE of **Dental, optometry, and community pharmacy services**. NHSE commissioning leads for these areas will be asked to present updates (one per month) to this committee to inform and provide a baseline of assurance for these services from which to build after delegated commissioning is transferred.

- The Primary Care Commissioning Transitional Committee (PCCTC) reviewed and discussed the **Quality Report** in which the meeting was updated on the increase in incident reporting due to a trial to support primary care with SI reporting and the strong themes which are indicated. Ways are being sought to effectively disseminate learning from the incidents. Work is being done to raise the profile of the New Patient Safety Framework.

- The PCCTC were updated on the progress of the **Population Health Management** workstream which has recently been relaunched. The One Devon Dataset (ODDS) joint working initiative has been signed-up to by many practices in all but 3 Primary Care Networks (these will need to report this contractually required information in their own way). The ODDS extracts a range of data which is anonymised for data interrogation at county and locality level as well as being used by the individual practices and PCNs to help with their work plans

Reports received and noted

- PCCTC received an update on the new **NHS Devon Primary Care Strategy (General Practice).** The final socialisation stage before sign-off has brought to light some comments which, when incorporated, will tidy this strategic framework ready for final approval. The committee thoroughly discussed any amendments which are to be made and voiced their approval both of the quality of the framework of principles and the manner in which the Primary Care team has engaged with, and succeeded in, inspiring General Practice across Devon to begin to work together in devising operational plans suitable for a variety of locality needs. This will ideally be approved at the next PCCTC and next executive Transformation committee as a base for developing primary care services ready for the full Out of Hospital strategy currently in development.

- PCCTC was updated on **contractual, and resilience matters** in a high-level overview report. This drew the committee's attention to the joint initiative which is providing an escalation and monitoring formal system response to changes in alert status in Primary Care across the county, as happens regularly for all other services. This will run as a pilot until the end of the year in order to test and adjust the protocol before adopting it as routine business in the New Year. The specific responses will be determined by a body known as the GPAS Response Group (GRG) formed by NHS Devon and LMC.
  The meeting was also informed of the assurance being sought by the team over proposed new partnership arrangements at one practice and the outcome of an assurance exercise which has provided information on the real benefits of a redesign which has made workload more manageable. Learning is to be shared.

- The final set of **Strategy metrics** using the old Primary Care Strategy targets was presented to the PCCTC. As the targets were deliberately aspirational, it is pleasing to note the progress to green and amber ratings in most of the metrics' areas.
  A draft for the new strategy metrics is being prepared for the next report.

- PCCTC received the second **finance report** of the ICB. The report was reviewed. Members discussed whether the new provider in a recent procurement will have time to transform the current model of spend within the short contract time available, as recruitment to short term contracts is hard. Due diligence is being done to understand the forecast overspend, to talk through their short-term progress and challenges, and to review their long-term plans. The meeting agreed that we need to stop expecting providers to change/improve difficult situations on a short timescale. We have learned that if we expect this – what the providers do is to fall back on the old model of working and come across the same problems as before. They need to be enabled to work in innovate, collaborative, and integrated ways so that long-term solutions are found.

- The **Deputy Director's Report** highlighted the government measures being put in place with regard to easing financial pressures on fuel prices for Practices

  It has been agreed that, for differential investment, our default for allocation of resource will now be the Adjusted Practice List which is felt to be a fairer way of making funding decisions as it is more aligned to health inequalities.

Risk register review updates

- PCCTC reviewed the **risk register**. With one risk (159) reporting in, for information only, which is held by a different system, and another risk (163) which will need updating for next month after a recent agreement on a contract extension.

Committee decisions

- None

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:

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NHS Devon board meeting

Committee chair report – People & Culture Committee

Date of board meeting	Dates of committees covered in this report
19th October 2022	28th September 2022

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

Reports discussed and assurances received

- Readiness to operate was discussed, the group were advised on the 10 areas of focus and the 4 workstream pillars where these all align to. It was agreed that any areas that turn from amber to red on the rag rating will be brought to the group to review and provide assurance on at the meetings. PR highlighted that some of the amber ratings seemed overly optimistic and would ask the team to review. See Areas of risk for those areas are in Red.
- The Executive workforce pillar update was provided for the group, PR advised that each month the group would start to do a deep dive into some of the workforce pillar areas. These are focused on the workstreams that are underway such as best place to work, Workforce Strategy, Workforce Capacity and Learning, Education and Development. The group agreed this would be a good use of time and it would be good to try and align up the updates to go alongside the People Plan updates.
- The group reflected on the first two meetings and how these have worked and agreed, it would be good to start looking into specific issues in depth and how the group will be able to support getting solutions in place.

Reports received and noted

- Readiness to operate was presented to the group and noted

- The executive workforce pillar update was presented to the group and noted.

Risk register review updates

N/A

Committee decisions

It was agreed that one of the early deep dives is to be around the Learning & Education workstream and understanding the Devon Learning Academy work which is being led by Natasha Goswell. To be brought back in November, noting that the deep dive topic for October is Innovation with Nigel Acheson. NA will be attending the October P+C committee to update members on system plans to create an infrastructure to bring clinical teams and leaders to come together through a system wide QI collaborative with high levels of senior clinical engagement to swiftly agree on how we are going to enable our clinical colleagues to deliver services differently using technology and alternative workforce solutions.

The committee requested this at our first meeting since we recognise that this work to transformation the way we deliver services is essential to us creating a safe and sustainable workforce plan.

PR to bring to the group any readiness to operate problems as they start to occur to allow the group the time to gain assurance and implement any measures.

Priorities for the next 3 to 6 months agreed:

1. **Innovation**: Bringing together clinical teams and leaders through a system wide QI collaborative.
2. **Workforce Planning:** We are currently working with HEE to create a workforce planning tool and methodology, which we aim to have in place during Q4. We also will share with the region once this is in place.
3. **Growing our own workforce:** The Devon Learning Academy work, creating workforce plans that rely less on overseas and also how we do this including involving universities and colleges.

Items of concern to be escalated to the board

- Leading Coordinated workforce planning using analysis and intelligence: As per bullet point 2 above, there is no standardised workforce planning methodology currently in place but a plan to create one for the Devon system that would then be shared more widely.

Recommendations for the board

N/A

Recommendations for other committees

N/A

Terms of reference or other committee effectiveness issues

n/A

Management of conflict of interests:

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GOVERNING BODY

Report title: Committee Chair Report – Quality and Performance Committee

Date of Governing Body: 19th of October 2022

Dates of Committees covered in this report: 5th of October, 2022

Chair's Name and Title: Professor Hisham Khalil, Non-executive Director NHS Devon ICB (Chair)

Contact Details: hisham.khalil2@nhs.net

Reports discussed and assurances received

The Committee received updated reports as detailed below

1. **Peninsula Trauma Network Peer Review Report-RDUH Eastern Province**
   A number of risks were identified by the report including gaps in clinical leadership, the unintended impact of implementation of MyCare and loss of flagging functionality and non-compliance with the spinal trauma pathway. The committee noted that this review was focused on one provider and that there is a need to appreciate what happens across the system.

   Action QPC0031
   There was a planned meeting on 7th of October between the Quality team and RDUH to discuss the action plan in relation to the identified risks.

2. **Ambulance Handover and Transfers**
   Committee members were appreciative of the detail and clarity provided by the presentation. There were significant concerns across the whole system in respect to the issues described in the presentation. There were particular concerns with regards to UHP in relation to patient flow, walk-ins and front door management. There are issues with physical Infrastructure in some trusts, workforce capacity particularly at consultant and medical level and delays with Cornwall patients being discharged from UHP.

   It is difficult for ICB Safety Systems to be in a position to confirm what harm has occurred to patients with the long ambulance waits. This information would be available through SWAST.

   Mitigations
   - It has been proposed to Cornwall that the Plymouth Care Hotel is to be extended by 10 beds to take Cornwall patients and Social work assessments to be undertaken by Plymouth to help speed up the 3 week delay.

- There is an International recruitment campaign ongoing for 175 Social care workers and Nurses to be starting soon to improve workforce. £6 Million is being put into acute hospitals to improve workforce.

- To consider whether Sound PCN could set up a pod for ambulatory care outside UHP ED

Action QPC0032

- Escalation to the ICB
- Committee requested an Executive decision to be communicated in respect of the unacceptable risks highlighted in the report and how actions/progress will be monitored- Statement from the ICB Executive Team required as to how performance will be monitored.
- The Committee would like sight of a robust system response for assurance and how this operationalised as a system?

3. **Integrated Quality and Performance Report**

The committee received the IQPR in its new format using Power BI. The committee members were appreciative of the enhancements provided by the new format with ease of identifying risks and a clear shift in respect to presentation of data and development of the narrative.

There is a significant increase in number of Never events observed. Committee are also aware of the noted delays across the system in respect to completion of incident investigations in a timely manner, leading to delays in learning within the system.

Further work underway led by the performance team to ensure narrative content development and to ensure performance and improvement trajectories are clearly articulated. Additional planned work includes regular communication provider partners and LPC leads. In addition, there will be further review of the IQPR to ensure appropriate links with regards to Financial reporting.

Action QPC0033: November QPC Meeting to focus on 104 week waits and delivery against cancer targets.

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Reports received and noted

1. Peninsula Trauma Network Review
2. Risk report

Risk Register Review Updates

System Quality Risk and Assurance Report including Risk:

The committee received a presentation on risk. The data from the report was done on the 23rd September. At the time of the report the rganisation had 33 risks, 17 of those report to this committee. 9 are categorised as very high and 8 are high. 16 of these risks were reviewed between the period of the 2nd August to the 23rd September. Since the last committee and at the time of writing the report 4 riks have been added to the risk register, 1 has moved in score and none of them are being recommended for closure.
Committee Decisions
The committee were happy to approve the addition of these risks.
Items of concern to be escalated to the Governing Body
The Ambulance handover delays
Recommendations for Governing Body
To note the reports received and positions of assurance by the Quality and Performance committee
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
1. **Membership of the QPC** Discussions in relation to attendance following the committee meeting highlighted potrntial issues of quoracy when more than one NEM is on leave. There is a proposal that Sarah-Lou Glover joins the committee. 2. Need for clarification regarding deputization for core executive members. •

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 and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.

The NHS Devon ICB has made every effort to ensure this report does not have the effect of discriminating, 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 board meeting

Finance Committee Chair report

Date of board meeting 19th October 2022	Dates of committees covered in this report 5th October 2022

Chair	
Name and title:	Kevin Orford, Non-Executive Director, Finance and Remuneration

Reports discussed and assurances received

Integrated Performance and Quality Report
Report received, with thanks to the teams who have re-worked the format to give more precise focus to key issues. Finance Committee asked for further work to connect performance, quality and workforce data to financial assurance work of the Committee. Meeting of IQPR team with Finance Committee Chair, Chair of Quality and Finance Committee and ICB Chair to be arranged to address this and other report development.

ICS Finance report. Position to end of August 2022 and Forecast.
Report received. Identifies adverse variance to plan at end August of £3m. Year-end forecast is that financial plan target will be met, but this requires mitigation of identified risk to delivery. Further assurance required on the mitigation which will be reported to next meeting.

Plymouth Health and Well-Being Centre Business Case Update.
Review of management response to Regional feedback on business case. Noted that we are still awaiting indication of capital availability.

ICB Finance Report
Report received and assurances received re delivery of 22/23 financial plan for ICB. Further assurance required re CIP delivery, prescribing forecasts and impact of pay award. This will be reported to next meeting.

Devon ICS Long Term Financial Model
Assurance received on progress of work to align financial challenge to transformation programmes. Committee thanked Devon CFOs for their work on this. Further work to be completed before communication. To be re-visited at next committee meeting.

Reports received and noted

Planning Update 23/24. Verbal report received. Further update requested for December meeting.

Equality of allocation and spend. Update received in advance of future ICB Board discussion and decision.

Plymouth Health and Well-Being Centre Update.
Review of management response to Regional feedback on business case. Noted that we are still awaiting indication of capital availability.

Risk register review updates

Deferred until Board Assurance Framework is determined

Committee decisions

Financial Risk Management process.
Approved Devon CFOs process to manage in-year financial process and noted that it is currently operating as part of this year financial management.
Devon Investment process
Approved policy of investment approval for Devon in accordance with SOF4 requirements.

Items of concern to be escalated to the board

Significant challenge to mitigate risk to delivery of financial plan.

Recommendations for the board

N/A

Recommendations for other committees

N/A

Terms of reference or other committee effectiveness issues

The Committee was observed by three members of the regional SOF4 recovery team, who will provide feedback to the committee on their observations.

Management of conflict of interests:

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NHS Devon board meeting

Remuneration and Internal ICB Workforce Committee

Date of board meeting	Dates of committees covered in this report
19.10.22	22.09.2022

Chair	
Name and title:	Kevin Orford, Chair

Reports discussed and assurances received

- **Freedom to Speak Up (FTSU).** The committee received an update and in particular a briefing on events to support FTSU month this October, which is an opportunity to promote the work of FTSU Guardians. Noted requirement for ICB Board training and development on FTSU.
- **Workforce Dashboard**. The committee received assurances on focus on workforce indicators. It is noted that appraisal and mandatory training performance are lower than targets set. The committee is to look further into these. The committee requested wider and deeper analysis of equality data, and grievance/disciplinary incidence.
- **Staff Survey**. The annual NHS staff survey will commence in October.

Reports received and noted

- **Chief Officers Report**. Noted updates on VSM pay award, accommodation review. Programme Board established for ICB organisational change and development to be chaired by JH and AM.
- **Cultural indicators from the previous CCG staff survey.** Noted results from previous staff surveys and noted work on cost of living survey

Risk register review updates

- N/A

Committee decisions

- Retire and return proposals will in future be for executive decision rather than committee decision.

Items of concern to be escalated to the board

N/A

Recommendations for the board

Summary of items for a Board update:

- The Board is asked to support Freedom to Speak Up activities during October.
- Board to commit to FTSU training during a future development session.
- Note NHS Staff Survey commences October.

Recommendations for other committees

Terms of reference or other committee effectiveness issues

- Agreed that Retire and Return proposals will in future be for executive decision rather than committee decision.

Management of conflict of interests:

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