NHS Devon

NHS Devon Integrated Care Board (ICB) meeting

Committee Suite, County Hall, Exeter

21 December 2022

10.00 to 12.15 hours

One Devon

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

Agenda for meeting in public

	Board pre-meet	Lead	Action	0945
	Members Pre-meet	All members	Discussion	
	Introductory items	**Lead**	**Action**	
1	Welcome, introduction and apologies Apologies – Liz Davenport	Sarah Wollaston	Discussion	10.00
2	Conflicts of Interest register	Sarah Wollaston	Noting	
3	Minutes of the meeting held on 16 November 2022	Sarah Wollaston	Approval	
	Industrial Action			
4	NHS Devon Management of industrial action – verbal update	Paul Renshaw	Discussion	10.05
	Leadership	**Lead**	**Action**	
5	Chair's report	Sarah Wollaston	Noting	10.15
6	Chief Executive's report	Jane Milligan	Noting	10.20
	Assurance and system oversight	**Lead**	**Action**	
7	Urgent Care and Winter Improvement	Anthony Fitzgerald	Noting	10.25
8	Quality and Performance Committee update	Hisham Khalil	Review and discuss	10.40
9	Integrated Quality Performance and Finance Report (IQPR)	Darryn Allcorn	Review and discuss	10.45
10	Finance Committee update	Kevin Orford	Review and Discuss	10.55
11	Finance reports I. NHS Devon month 7 report II. ICS month 7 report	Bill Shields	Review and discuss	11.00

Break				
	Strategy			
12	Integrated Care Strategy	Simon Tapley	Noting	11.20
13	Memorandum of Understanding NHS Devon and NHS England	Ann Cooper	Approval	11.25
	Governance and risk	**Lead**	**Action**	
14	Audit and Risk Committee update (verbal)	Graham Clarke	Discussion	11.35
15	People and Culture Committee update	Thandiwe Hara	Review and discuss	11.40
16	Primary Care Transition Committee update	Judy Hargadon	Review and discuss	11.45
17	Remuneration and Strategic Workforce update	Kevin Orford	Review and discuss	11.50
18	Action Log	Sarah Wollaston	Approval	11.55

Public Questions - on publication of the agenda, members of the public are invited to submit any questions related to agenda items no less than 2 days prior to the meeting to d-icb.governance@nhs.net. Appropriate questions and responses will be shared during the meeting and published on the website following the meeting			
Questions from members of the public	Sarah Wollaston	Discussion	12.00
Any other business			12.10
Close			**12.15**

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

Register last updated 28 November 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 Devon Urgent Care Strategy Oversight Group Peninsula Acute Sustainability Programme	Director of H Smith Safety Associates Patron of the FORCE cancer charity in Exeter Director on the board of the South West Academic Health Science Network	Wife works as an associate with the South West Academic Health Science Network Relative consultant Dermatologist at the Royal Devon University Hospital In-law is a GP partner in the Woodbury Practice	05/10/2018		12/05/2022			Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	Allcorn	Darryn	Chief Nurse	Quality and Performance Committee System Quality and Performance Group ICB Board Audit and Risk Committee (If Required) Quality and Risk Group ICS Executive Committee ICB Senior Executive Team Devon Urgent Care Strategy Oversight Group	Honorary Associate Professor University of Exeter Seconded to NDHT (to 18 September 2020) Strategic Chief Nurse, Nightingale Hospital Exeter System Chief Nurse, Devon STP		11/05/2020		01/02/2022	Direct	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
Prof	Asthana	Sheena	Independent Non Executive Director of Citizen and Community Involvement	Population Management and Health Inequalities committee ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Committee	Director, Plymouth Institute of Health & Care Research (PIHR). It is likely that members of my institute will undertake funded research for NHS Devon partners Trustee of Change Grow Live (a national charity that provides substance use, CYP, domestic violence, prison etc services. Devon does not currently contract services to CGL Member of the Advisory Committee on Resource Allocation (ACRA) which independently advises on NHS funding formulae Member of the project board of the proposed West End Health and Being Centre in Plymouth	Partner runs a research consultancy specilising in the integration and analysis of large data (inc NHS)	10/03/2022		10/03/2022				NHS Devon ICB
	Brown	Steven	Director of Public Health, Communities and Prosperity	ICB Board	No interests declared		19/11/2020		09/11/2022				Devon County Council
	Clarke	Graham	Independent Non Executive Director of Audit and Risk	ICB Board Audit and Risk Committee NHS Devon Finance Committee Primary Care Commissioning Transitional Committee	Non-Executive Director of Medicine Discovery Catapult Non Execuitve Member at the Deparment of Health & Social Board Chair of HUC (East of England 111 and Urgent Care Provider) Trustee and Treasurer of the Cornwall Community Foundation	Spouse is CEO of Cornwall Partnership Foundation Trust and a Board Member of Cornwall & Isles of Scilly ICB	01/01/2020		04/08/2022				NHS Devon ICB
	Cooper	Ann	Interim Strategic Governance Adviser	ICB Board Audit and Risk Committee	Contractor with TIAA ltd – internal audit services Bank contract as governance adviser with NHS Frimley		01/06/2022		24/11/2022			Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	Davenport	Liz	Chief Executive Torbay and South Devon Trust	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Integrated Care Partnership Committee ICS Executive Committee 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
	Fitzgerald	Anthony	Chief Delivery Officer	NHS Devon Finance Committee ICB Senior Executive Meeting System Delivery and Improvement Meeting Risk Management ICB Board Session ICB Board ICS Executive Committee	No interests declared		15/11/2022		15/11/2022				NHS Devon ICB
	Green	Joanne	Interim Board Secretary	ICB Board	No interests declared								

	Hara	Thandiwe	Independent Non Executive Director of Inequalities and Population Health	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee People & Culture Committee	Trustee of Plymouth and District Racial Equality Council, a voluntary organisation that work to promote race equality. member on the NIHR SW Clinical Research Network Board.		16/03/2022		16/03/2022			There should be no conflict of interest in current circumstances, but this may arise if, they became a provider during the course of time. I will declare my interest at any meeting that may result in them being considered for service provision and leave the meeting if necessary. This should not raise any conflict, that I can foresee except that it is research related. There is no commissioning involved, but thought to mention it anyway. I will declare my interest at any meeting that may result in them being considered for service provision and leave the meeting if necessary.	NHS Devon ICB
OBE	Hargadon	Judy	Independent Non Executive Member Primary Care (Interim)	Member of Primary Care Commissioning Transition (PCCT) (Chair) ICB Board Remuneration & Internal ICB Workforce Quality and Performance Committee People & Culture Committee	Member of Women's Equality Party	Spouse is Chair of Dartington Hall Trust Brother is a GP in Cornwall	01/05/2019		14/07/2022	Financial / Personal	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	Howland	Jodie	Governance and Facilities Business Manager	ICB Board One Devon ICP Partnership Board Audit and Risk Committee Building Coordinators Green Team Integrated Care Partnership Committee			11/02/2020		08/08/2022		Indirect	Any shift allocation that I am supporting with will be agreed and approved by a third party	NHS Devon ICB
Prof	Khalil	Hisham	Independent Non Executive Director of Quality and Performance	ICB Board Audit and Risk Committee Quality and Performance Committee	Practising Consultant in Derriford Hospital Limited Private Practice in Nuffield health Plymouth Director for Private Practice- Dormant Company Trustee of the Peninsula Medical Foundation		01/09/2004		24/02/2022				NHS Devon ICB
	Lee	Tracey	Chief Executive for Plymouth City Council	ICB Board Remuneration & Internal ICB Workforce	Director of Destination Plymouth Ltd		03/09/2022		13/09/2022				Plymouth City Council
	Lou Glover	Sarah	Ordinary Member for the Devon Integrated Care Board for Mental Health	ICB Board Remuneration & Internal ICB Workforce	Trustee of Honiton Health Matters who hold community conversations Director of Parental Minds C.I.C, for parents/caregivers who are supporting their child/family/friend with their mental wellbeing A Director, including a Non-Executive Director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations An advocate for a particular group of patients Ambassador Volunteer with DIAS Community group which may have potential to give rise to influence decisions made by the ICB. A volunteer for a provider		28/06/2022		28/06/2022				NHS Devon ICB
Cllr	McInnes	James	Chair of One Devon Partnership Board (ICP)	ICB Board	Elected member of Devon County Council		2005	2025		General Interest		Where a piece of work or an item on a Board agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote	Devon County Council
	Milligan	Jane	CEO ICS for Devon	ICB Senior Executive Team Senior Leadership Team (SLT) Audit and Risk Committee (If required) ICB Board NHS Devon Finance Committee ICS Executive Committee Executive Workforce Committee People & Culture Committee Remuneration & Internal ICB Workforce (If Required)	Member of Cornwall and Isles of Scilly ICB	Partner Trustee for Action for Stammering	31/12/2020		21/06/2022	Personal	indirect	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	Millward	Andrew	Chief Communications and Corporate Affairs Officer	ICB Senior Executive Team Staff Partnership Forum Audit and Risk Committee (If Required) Vacancy Control Panel Equality, Diversity and Inclusion Group ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group ICS Executive Committee Executive Workforce Committee People & Culture Committe Peninsula Acute Sustainability Programme	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University Non-Executive Board member of Delt Shared Services		19/06/2018		10/10/2022	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB

	O'Kelly	Frank	Primary Care Partner for NHS ICB	ICB Board Primary Care Commissioning Transitional Committee Remuneration & Internal ICB Workforce	GP Partner at Amicus Health Blundell's School Lead Doctor Clinical Lead for STEER Education Member of the National Armed Forces Reference Group CQC Manager for Amicus Health Attends Tiverton High School Welfare Meeting fortnightly		01/01/1999	11/07/2022	Financial			NHS Devon ICB
	Orford	Kevin	Independent Non Executive Director of Finance and Remuneration	ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Committee Quality and Performance Committee	Non Executive Director on the board of Royal Devon and Exeter NHS FT (Ceased 30.06.22) Non Executive Director on the board of Northern Devon Healthcare NHS Trust (Ceased 30.06.22) Director and Majority Shareholder of Kevin Orford & Associates Ltd, which undertakes consultancy contracts with NHS organisations outside of the South West of England Non-Executive Director on the Board of the Intellectual Property office, a government agency in the Department of BEIS.		01/01/2012	15/07/2022				NHS Devon ICB
	Renshaw	Paul	Director of Workforce Stategy	ICB Board Audit and Risk Committee (If Required) ICS Executive Committee Executive Workforce Committee People & Culture Committee ICB Senior Executive Team Devon Urgent Care Strategy Oversight Group	Non-active Consultancy partner for Linea Consulting . No remuneration for this position. No work carried out for Linea to date. Quarterly online meetings take place out of normal business hours.i attend these occasionally		2018	10/10/2022	Partner	Direct	Any Conflicts of interest at meetings will be highlighted and would seek line manager approval for any work to be carried out prior to any taking place	NHS Devon ICB
	Tapley	Simon	Chief Transformation and Strategic Planning Officer	ICB Senior Executive Team ICB Senior Leadership Team Audit and Risk Committee (If Required) Vacancy Control Panel ICB Board NHS Devon Finance Committee Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee Eastern LCP Executive Group South LCP Executive Group ICS Executive Committee Peninsula Acute Sustainability Programme		Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon ICB Step-son is a Receptionist at Albany Surgery	01/11/2016	04/08/2022	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
Dr	Wollaston	Sarah	Chair for ICS Devon	ICB Board Audit and Risk Committee (If Required) NHS Devon Finance Committee (If Required) Remuneration & Internal ICB Workforce Quality and Performance Committee People and Culture Committee Primary Care Commissioning Transition Committee	Trustee of Landworks, a Dartington based charity that works with ex offenders and people at risk of going to prison to support them into employment and reduce the risk of reoffending	Spouse is president of the Royal College of Psychiatrists and a consultant forensic psychiatrist employed by Devon Partnership Trust Relative is a registrar in Obstetrics and Gynaecology on the South West training scheme (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

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Minutes of a meeting of NHS Devon Integrated Care Board held in public on Wednesday 16 November 2022 between 9.30am and 1pm via Microsoft Teams	
Name and initials	*Title and organisation*
Board Members:	
Dr Sarah Wollaston (SW) Chair**	Independent Chair, NHS Devon
Sheena Asthana (SA) **	Non-Executive Member
Graham Clarke (GC) **	Non-Executive Member, Audit and Risk, NHS Devon
Thandiwe Hara (TH)**	Non-Executive Member, People and Culture, NHS Devon
Judy Hargadon (JH)**	Non-Executive Member Primary Care, NHS Devon
Hisham Khalil (HK)**	Non-Executive Member, Quality and Performance, NHS Devon
Kevin Orford (KO)**	Non-Executive Member, Finance and Remuneration, NHS Devon
Jane Milligan (JM)**	Chief Executive Officer and Accountable Officer, NHS Devon
Nigel Acheson (NA)**	Chief Medical Officer, NHS Devon
Darryn Allcorn (DA)**	Chief Nursing Officer, NHS Devon
Bill Shields (BS)**	Chief Finance Officer, NHS Devon
Anthony Fitzgerald	Director of Delivery, NHS Devon
Andrew Millward (AM)**	Chief Communications and Corporate Affairs Officer, NHS Devon
Paul Renshaw (PR)**	Director of Strategic Workforce, NHS Devon
Simon Tapley (ST) **	Chief Transformation & Strategic Planning Officer, NHS Devon
Partner Members:	
Liz Davenport (LD)**	Chief Executive Officer, Torbay and South Devon NHS Trust representing acute trusts
Sarah-Lou Glover (SLG) **	Mental Health Representative
Tracey Lee (TL)**	Chief Executive, Plymouth City Council representing local authorities
Frank O'Kelly (FOK)**	Primary Care Representative
In attendance:	
Helen Braid (HB)**	Head of Governance, NHS Devon
Steve Brown (SB)**	Director of Public Health, Devon County Council
Leanne Coates (LC)**	Business Manager (minutes)
Joanne Green (JG) **	Interim Board Secretary, NHS Devon
Jodie Howland (JHo)**	Governance and Facilities Business Manager, NHS Devon
Cllr James McInnes (JMc)**	Chair Devon Integrated Care Partnership
Apologies for absence	Kate Shields (KS) Chief Executive Officer, Cornwall and Isles of Scilly ICB

Minute number	
1	**Welcome and Apologies for absence** The Chair (SW) welcomed the patient who would be telling his story about his experience in Barnstaple Hospital's A&E department On behalf of the Board, SW extended a warm welcome to Bill Shields (Chief Finance Officer) and Anthony Fitzgerald (Director of Delivery) who had recently joined NHS Devon. Apologies for absence were received from the Chief Executive of Cornwall and Isles of Scilly ICB, Kate Shield. SW advised that the Board would be discussing a proposal for letting a contract for provision of oxygen in the private meeting later in the day, in addition to aspects of the developing primary care strategic framework.
2	**Conflicts and Declarations of Interest** Members noted the Conflicts of Interest Register which had been circulated as part of the meeting pack. No new declarations were made. The amendment of Tracey Lee's job title was noted and would be amended by the Governance Team. The meeting was deemed quorate.
3	**Minutes of previous meeting - 19 October 2022** The chair thanked Kevin Orford for amendments received and included in advance of the meeting. The Minutes of the last meeting were then approved without further amendment.
4	**Citizen's voice** On behalf of the Board, the Chair invited the patient to share his experience of attending the A&E department of Barnstaple Hospital. In summary, in mid-August this year, the patient told the board that he had been fitted with an Implanted Cardiac Defibrillator several years ago and was under ongoing supervision. After suffering a loss of consciousness at home he had been contacted by the hospital's Cardiology Department advising there had been an incident triggered by his ICD asking him to attend the A&E department immediately. He remained in the waiting room for 36 hours, with various tests being completed during this time. During his long wait the coffee machine located in the waiting room did not work and he had not left the room for fear he might miss the doctor. He had a very uncomfortable night, due to lack of space to sleep normally, although he was moved to an area that was not an acute medical room but allowed him to get some rest in the early hours. The following day he was moved to accommodate another patient. The patient was later told that he had suffered a cardiac arrest, as identified by the ICD, which had saved his life. After being discharged from hospital, the patient told the board that he continued to suffer psychological trauma for which he had received counselling and in time, peer support from a local group. When considering his experience, he had been informed that the delay had been due to technicians not working at weekends. On behalf of the Board the Chair thanked the patient for sharing his experience and on behalf of the whole board expressed her apologies that his experience had been totally unacceptable and that it had obviously been extremely upsetting for him. The Chair asked several members to respond to the points raised by the patient's story. In responding, all members apologised for this extremely poor experience. The following key points were made in response, together with the action(s) which should be taken: Chief Nursing Officer (DA) - the treatment received by the patient did not align with the agreed medical pathway and he was working with colleagues to understand the reasons for this. Physical improvements to this department were part of a framework programme of

	improvements and he would also investigate the provision of hotel services in A&E as, for example, patients keeping hydrated was extremely important. The Chief Executive of Torbay and South Devon NHS foundation Trust (LD) - advised this was a timely reminder of the impact of poor flow through the hospital, which identified the need to ensure pathways were efficient and communication between services and staff was effective. She suggested this was part of a wider issue for the acute provider collaborative to deliver sustainable services for communities. The Chief Medical Officer (NA) – considered it encouraging that the ICD had worked well. However, he agreed the pathway required improvement to ensure patients were directed to the right place in a timely manner. He stressed the psychological distress of such an event should not be underestimated. The Mental Health representative (SLG) asked if the patient had sought psychological support and in response the patient advised that two weeks after discharge from hospital, he had received an invite to attend an arrythmia support group which had had found extremely helpful. He had also received support from "Talk Works", and he was now participating in online therapy called "Silver Works". He considered this to be a positive step in confronting his fears and had found talking to non-clinical people about his experience most useful. In recognising the poor experience, members appreciated that front line staff were working extremely hard in difficult circumstances. It was agreed that patient pathways must direct patients in a way that avoided unnecessary waits in emergency departments by making sure they could be seen rapidly in the most appropriate setting. In conclusion, the Chair thanked the patient for telling the Board his story and undertook to advise him about progress being made in addressing the points raised', which also included the unacceptable response to his formal complaint to the Trust. She suggested the Board should ask the Quality and Performance Committee to review the complaint processes of providers to ensure these were fit for purpose. **Action 24 - The Chief Nursing Officer would investigate the points raised above and would advise the patient and Chair of the outcome as soon as possible**
5	**Chair's report** On behalf of the Board the Chair (SW) congratulated Councilor James McInnes on being appointed Chair of One Devon Partnership. The Chair highlighted that, following a ballot of its members, the Royal College of Nursing (RCN) had decided to take industrial action and the impact of that decision on services. The Director of Workforce (PR) advised this would affect all trusts in the ICB's area. He further advised several other unions were currently balloting their members and the British Medical Association had indicated its intention to ballot their members in January 2023. This industrial action would obviously have a major impact across the NHS. The Director of Strategic Workforce (PR) advised members about "Operation Arctic" which was currently happening. And was a three-day exercise testing processes and procedures in the event of strike action. He advised there would also be several exemptions from strike action, with discussions happening across the system to ensure consistency in approach . The dates of the action should be known shortly, with a series of communications being prepared for issue once such clarity was received.
6	**Chief Executive's report** The Chief Executive (JM) advised the Board that Steve Barclay had recently been appointed as Secretary of State for Health and Social Care. She was aware the new ministerial team were working closely with colleagues, with a focus on primary care and ambulance waits and how data was used to ensure collaboration across social care. An announcement regarding future resources was expected, as part of tomorrow's Autumn Statement, with further announcements expected next week. Work continued planning for winter, ensuring clinical and managerial cover over weekends and out of hours. The emergency preparedness team was

	also being prepared to respond to any incidents, which included any caused by the impact of industrial action.
7	**Performance framework – elective care winter plan** The Board was advised of the requirement, by NHS England, for each provider in Devon to self-certify its readiness for the above. It was noted all acute providers had approved their respective statements. Members noted that all areas covered by the self -certification were covered by the planned care programme or diagnostic programme or the cancer plans. It was further noted that productivity required more focus, e.g., theatre productivity and diagnostic delivery remained challenging. The Board was assured that each trust had a clear plan which would be managed through the programme. A Non-executive Member (SA) asked about the approach being taken to patient discharge and whether it was sufficiently creative using for example, alternative forms of provision for the step-down service. In response the Chief Executive (JM) advised that all options were considered, including working closely with voluntary sector organisations. Innovative approaches continued to be actively pursued, in liaison with the local authority to ensure the right model of care was in place for each patient. It was suggested this also related to the patient story told earlier i.e., flow through hospitals. This was a key concern for the Board, and it was agreed it was incumbent on members of the Board to ensure a whole system approach was being taken. The Chief Executive of Torbay and South Devon NHS Foundation Trust (LD) advised that discharge of patients was multi-faceted, and the system must seek to optimise all availability and ensure it was as efficient as possible. She advised that work continued to improve the process, but there was still much to do. In support, the Director of Transformation (ST) agreed that a range of options for discharge were being developed. There had been issues with the "l home first pathway 1 domiciliary care" process however, over the past week there had been considerable reductions in Plymouth, Exeter and Torbay. He advised that Torbay and South Devon NHSFT had performed the best on weekend discharges. He advised there was further work to do on complex discharges, however, those formed a small element of the overall discharges required daily. The target should be to ensure 80% of simple discharges are achieved by 5 pm. He advised this had yet to be achieved by any acute provider in the area. A Non-executive Member (SA) commented on the pressures being experienced already and suggested that while quality should never be compromised, services might need to be organised differently. **Having considered the report and the self-certifications provided by each acute provider, the Board approved the self-certification for submission to NHS England.**
	Review of findings – East Kent Maternity and Neonatal services report The Board was reminded of the background to the investigation and subsequent report into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. The report had identified four key areas requiring action indicating where the NHS could be much better at: • identifying poorly performing units • giving care with compassion and kindness • teamworking with a common purpose • responding to challenge with honesty Members noted that NHS England (NHSE) had now requested every Trust and ICB to review the findings of this report and for boards to be clear about the action they would take, and how effective assurance mechanisms were at 'reading the signals' It had stressed that the publication of the delivery plan should not delay any actions in response to this report and the actions being taken in response to the report of the independent investigation at Shrewsbury and Telford NHS Foundation Trust.

The Director of Nursing had reviewed the report's recommendations and in the paper before the meeting, summarised how the above-mentioned actions related to NHS Devon. He advised members that Devon Local Maternity and Nursing Services (LMNS) had recently completed a series of insight visits, with the NHSE Regional Team, to review each Trust's self-evaluation of compliance against the interim Ockenden Report. These insight visits formed part of a strengthened approach to perinatal quality surveillance and be part of an annual cycle of onsite reviews by the ICB. There was a well-established safety and governance subgroup within the LMNS programme which provided a monthly Perinatal, Quality Surveillance (PQS) Report to the LMNS Board followed by the regional PQS Systems Group. Further actions to be taken included:

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

The Board was pleased to note the LMNS was committed to fulfilling its role in ensuring that maternity and neonatal services in Devon were safe and of high quality and that it would work in partnership with maternity and neonatal services, across Devon, to confirm the actions that needed to be taken to meet the four key areas of improvement:

- Monitoring safety performances – earlier warning signs needed before significant harm is caused
- Standards of clinical behavior – instances of harmful lack of professionalism
- Flawed teamworking – the teamwork was found to be dysfunctional
- Organisational behavior – attempting to look good while doing badly

The Board noted the role of the LMNS in implementation of the recommendations included:

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

Progress with implementation would be reported via the LMNS Safety and Governance meeting and be reported to the Devon LMNS Strategic Board. There would also be work with the Maternity Voices Partnership Chairs to provide support and guidance in response to queries and concerns from women, birthing people and families. A further meeting would be held later this month with Heads of Midwifery to discuss their views, immediate actions and any support required for the initial response whilst further implementation guidance was awaited from NHSE. In the meantime, work continued implementing the actions contained in the Ockenden Report.

In considering the report, members commented that the recommendations could apply across a range of services. There should be a focus on culture, with staff and service users being encouraged to identify concerns. The Board recognised the importance, as part of its assurance process of getting out of the boardroom or bringing the ward into the boardroom,

A Non-executive Member (KO) questioned the ICB role and the importance of capturing patients' views and experiences. He suggested the need to capture this vital information as part of the Board's assurance process and suggested consideration needed to be given as to how best to achieve this. The Chief Medical Officer reminded members about the various national patient surveys, the data from which should be utilised by the Board. He strongly supported patients being partners in their care. In addition, the Chief Nursing Officer reminded members of the strong voice provided by Maternity Voices Partners, with each maternity

	service having an active Chair. He considered the maternity voice to be very strong which was sighted at system level. In response to a question from a Non-executive Member (GC) the Chief Medical Officer advised there was an extensive data set which could be utilised as part of the Board's assurance process, albeit the information could be delayed. He also advised that maternity services had 6 or 7 channels of element which could be checked against. A Non-executive member (JH) noted that actions within the report were for other organisations and requested the Board receive a more explicit report about what the system needed to do rather than simply relying on another organisation's report. In support. A Non-executive Member (SA) stressed the importance of not just focusing on the clinical aspects of maternity care. The Chief Nursing Officer advised that the psychological impact of the reports on maternity teams should not be underestimated and there were ongoing conversations with heads of midwifery about how best to support their teams. In support, the representative for Primary Care (FOK) stressed the importance of developing an open culture with staff feeling able to speak up about any concerns they might have, in addition to development of the formal complaints process. This was supported by the Mental Health representative (SLG) who also stressed the importance of celebrating positive achievements. She was also keen to understand how best to capture patient feedback and involvement them in coproduction of services not just participation. In conclusion the Chief Executive advised that she considered Maternity Voices to be one of the most active and productive patient participation groups group in the country and suggested that a representative be invited to attend a future Board development session. **Having considered the report in detail, including the various comments above, the Board received and noted the national report and requested a further report be submitted to Quality and Performance Committee on how the recommendations related to the NHS Devon area. In addition, a Board development session involving Maternity Voice to be arranged.** **Action 24 – JHo to include a Maternity Voice development session to the forward planner**
9	**Finance report - NHS Devon Month 6 report** The Chief Finance Officer (BS) presented the above-mentioned report which detailed the ICB's financial position for the period ended 30 September 2022, setting out the year to date and forecast financial position as well as the risks to deliver a break-even plan. He was concerned that the information contained within the report was out of date and he undertook to ensure that future reports provided more timely information. The position at month 6 indicated a planned deficit of £18million which had been agreed at the commencement of the year. Members noted there were significant risks within this financial position and that work continued with NHS providers to deliver a better financial position. Members were aware of the significant risks within the financial position in the ICB and each of the providers in the Devon system. Members were advised that NHS England had produced a protocol which had to be complied with by any organisation seeking to change its financial position during the year. It was noted there remained a small window of opportunity to change the ICB's financial position and the protocol had been discussed by BS with each of the provider organisations. BS advised the position reported showed that, while there had been unforeseen circumstances during this year, the fundamental problem had been a failure to deliver cost improvements. This was a long running deep seated issue which needed to be reviewed across the whole system. The Chief Executive (JM) advised of the need to achieve delivery against the cost improvements across the whole Board which would lead into the operational planning approach over the next year or two.

	The Chief Executive of Torbay and South Devon NHS Foundation Trust (LD) accepted the challenge about providing focus on cost improvement planning and advised it should mainly be delivered through more strategic change programmes. In response to a query by a Non-executive Member (HK) BS advised that that each cost improvement programme had to complete a quality impact assessment which was checked to ensure there were no adverse effects on quality of care or clinical safety. The Chair of the Integrated Care Partnership (JMc) advised that local authorities were having very similar conversations and he stressed the importance of collaborative working to minimise the effect on the wider system. He advised the financial settlements for local authorities should be known shortly which would in turn impact budget setting. This work was being completed in liaison with Cornwall.
10	**Working together to deliver service transformation in Devon, Cornwall and Isles of Scilly Peninsula Acute Provider Collaborative - Peninsula Acute Sustainability Programme update** Members were reminded that earlier this year, it had agreed to the establishment of the above-mentioned Collaborative as a vehicle for joint working with other acute trusts across Devon and Cornwall. This provided an oopportunity to deliver innovative and sustainable services for the community based on evidence being data driven and clinically led. The Board considered a paper which had been submitted to all provider organisations in Devon and Cornwall and the ICB in Cornwall. All organisations had been asked to endorse the strategic ambition and design principles of the programme. The paper summarised progress to date and sought endorsement of the workplan to be implemented over the next 3-6 months, aiming to bring forward recommendations for change during 2023/24. The paper included an update on the work being undertaken, the outcome of which strengthened the need to develop out of hospital services and in the longer term, should reduce the need for hospital-based care. With enhanced primary care and community-based services, the ambition would be to support people to keep well and maintain their independence. It suggested the need for acute care would remain, with the right intervention at the right time provided by clinical teams, with the right skills having a direct impact on outcomes for the individual. A Non-executive Member (JH) welcomed this work and highlighted the importance of enhanced primary and community-based services. She stressed the significance of regular consultation with those working in the services. It was noted that a primary care representative would be included once a nominee had been confirmed. This was supported by LD who commented on the good support provided by the ICB's Communications and Engagement Team and from regional colleagues. The Chief Executive (JM) reflected that in speaking with her Cornwall colleagues, she felt there was a need to work with them on this programme and joint commissioning going forward. A Non-executive Member (SA) welcomed the paper and raised a question about data collection, recognising that quality was key and very often enabled services to run more smoothly. However, such data was often difficult to capture and might be better obtained using exchanges and visits etc. SA felt a wider understanding of work being undertaken by the Communications team would be useful. **Action 26 – Communications paper to be added to the forward planner** The paper was also welcomed by a Non-executive Member (KO) who referred to the financial context and the possibility of the ICB being involved in setting the objectives and questioned how much of the financial gap could be addressed through this work and by other means. The Mental Health representative (SLG) questioned if the membership could be extended beyond the NHS and include local authority and voluntary and community services organisations to promote working together as a whole system.

	In response to the above, LD advised that a development session was being held later that day regarding the role of ICB and how best to support this work. She stated there clearly needed to be a link between and health and care strategy and the supporting financial framework needed to be developed and owned by all Boards. She advised there was a difference in view between Cornwall ICB and this Board with three issues remaining to be resolved, including clinical sustainability of services, workforce sustainability and financial stability. Regarding the group, care had been taken to keep its membership as small as reasonable. She stressed the commitment to engage with a broader range of stakeholders in due course. It was noted that planning to date had focused on programme design. **Having considered the paper in detail, the Board endorsed the paper, subject to the comments referred to above relating to closer and joint working where appropriate.**
11	**Integrated Care Strategy update** The Board considered a paper which set out the proposed strategic goals of the Devon Integrated Care Strategy, which had been distilled from the output of the Change Leaders event held on 12 October 2022. Members were reminded the Strategy would be approved by the Integrated Care Partnership (ICP). The Devon Plan would encompass both the Integrated Care Strategy and the 5-Year Joint Forward Plan, which formed the ICB's response to the Strategy. Members noted that a draft version of the Strategy had to be published by 19 December 2022 for consultation and were advised by the Director of Transformation, about the proposed strategic goals and the further refinements which had now been made. In supporting the Strategy , Councillor James McInnes advised he was content with it for consultation purposes, following which he considered further refinement might be required. He stressed the importance of including strategic goals which were both challenging and achievable. Members commented on the Strategy and the need to ensure that resources were available to achieve the goals identified. It was pleasing to see the drive to work on the wider determinants of health, however, more clarity was needed as it was considered expectations could be easily misinterpreted. In response, the Chief Executive stressed the Strategy would be published for consultation, and it was vital the Plan was recognised by local people as being real. She suggested identifying five key priorities to which the ICB could contribute positively, and which should align with health and wellbeing strategy and the Devon plan. **The Board endorsed the Draft Integrated Strategy in readiness for publication for consultation by 19 December 2022.**
12	**Integrated Quality and Performance report (IQPR)** The Board considered the above-mentioned report which provided 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 Chair advised that as part of the governance review it would review how those concerns were being examined and escalated to the Board so that the committees and board could seek further assurance where necessary on behalf of the public Members noted the One Devon system had submitted its 2022/23 Operating Plan which would 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 sat at an £18.2m deficit. Operationally the ICS remained under extreme pressure and although Covid inpatient numbers were declining, the summer surge of visitors, elective backlogs and staffing challenges had meant that services continued to compete for resources. This had resulted in a sustained position of increased risk, including delays in urgent care and delayed discharges due to poor community capacity. Emergency Departments ' performance and ambulance conveyancing targets had continued to decline, impacting on operational performance against both urgent and elective care standards across the system. Planned Care 104 week waits continued to reduce, but NHS Devon continued to have significant numbers of patients waiting beyond 104 weeks at the end of July 2022 (target of zero). System wide work was underway to understand the implications of harm in relation to long waits in elective

	pathways. In addition, and in response to ensuring the system addressed the elective care backlog, multiple actions had been put in place to maximise efficiencies, capacity and ensure safe and high-quality care was delivered. The principle remained that elective care was safely, sustainably, and reliably provided as a system. Statistical Process Control (SPC) charts had been introduced into the IQPR to demonstrate the system performance alongside the NSHE accepted standard reporting format. The use of this reporting would be phased in across future iterations of the report. The Chief Nursing Officer (DA) drew out key headlines from the report as follows: • The impact on emergency and urgent care remained exceptionally challenging. This had a high impact on category 2, time critical individuals for ambulance response. • Covid prevalence continued to reduce. This was likely to last until mid-December. Based on the uptake of vaccines the ICB performed well, 80% of the vulnerable population having now received vaccine. • Work continued to ensure primary care was able to play its role of treating patients out of hospital wherever possible • 111 continued to miss its performance but had improved slightly • Out of area placements for mental health patients had reduced with people being brought back into the Devon footprint. • Speech and language therapy and autism waiting lists had seen an increase in referral rates • Turnover in the Devon workforce remained exceptionally high. The Director of Strategic Workforce (PR) advised that regarding the staff turnover figure, several leavers were likely employed in other parts of the system. He advised the actual leaver rate for the ICB stood at 7.7% In response to a query from the Mental Health representative (SLG) concerning out of area placements, the Director of Transformation advised that this figure was closely monitored to check that patients were being placed in the most appropriate area for treatment as it was recognised that on occasion treatment out of area would be the best place for a patient's treatment. Members discussed the risks surrounding this service and the criteria for accessing services which could lead to those patients not meeting the criteria becoming lost. To mitigate against this, the inclusion of some metrics relating to community services would be helpful. The Chair commented that she had met with voluntary and community providers and been advised that such organisations were carrying high levels of risk in getting statutory services to respond when they had concerns about a patient. In turn the ICB might lose these valuable services if the Board did not provide them with the assurance they required. In support the Mental Health representative (SLG) suggested the need to capture the level of risk being held by community services. Work was needed to identify where people were being referred to and whether they were being referred to the correct service. The Chair advised the One Devon Partnership would examine this area in depth in January 2023. The Chair questioned the treatment of patients who postponed their planned care and had been waiting 104 weeks. In response the Chief Nursing Officer advised that any individuals rejoin the waiting list and be assessed according to clinical validation, they would not simply be added to the end of the waiting list.
13	**Assurance Committee updates and escalations** The Board received and noted the following reports from committees of the Board:

	(a) Audit and Risk Committee Internal Audit progress report including revised internal audit plan 2022/23 – the Committee was assured that work continued on the plan which would be reviewed at future meetings to ensure it remained fit for purpose. The draft Risk Management Framework had been considered, with a Risk Seminar happening the day after the meeting which had been most useful in developing the Board's appetite for risk etc. Any changes required would be included in the Framework and submitted again to the Committee for consideration. Unfortunately, the ICB had still not been able to appoint an External Auditor. The Chief Finance Officer advised that he had contacted the regional office of NHS England for advice, and he anticipated the ICB would be referred to the National Audit Office for support in appointing an auditor. A further update would be provided to the next meeting of the Committee. ***(b) Finance*** Due to the Committee meeting the day before the Board, the Chair of the Committee gave a verbal report and highlighted the following issues: • The Committee reviewed the IQPR and finance report presented today in addition to the financial recovery plan. A more complete plan would be considered by the Committee at its next meeting in December 2022. • Discussions continued about the possible establishment of a Health Inequalities Committee. • With regards to planning for 2023/24, the importance of alignment with workforce planning was key. • The Committee had considered a procurement for provision of home oxygen services which would be discussed by the Board in private session. ***(c) Primary Care Transition Committee*** The Committee Chair advised that in terms of primary care funding, Devon was below. While funding had been received from NHS England it was not guaranteed that this would mean the target was achieved. The Mental Health representative (SA) suggested that due to current uncertainty about the Cavell Centre, this should be included on a risk register and was advised that this had been included on the Committee's register as part of the risk around primary care estates. In noting the point about the Cavell Centre, the Chief Executive of Plymouth City Council expressed her gratitude for the Board's support, suggesting this was a good example of joint whole system working. ***(d) Quality and Performance Committee*** The Committee Chair referred to the East Kent Maternity Report which had been escalated (see minute 9 above). He suggested there should be a system wide communication strategy of the actions taken by the system. This was supported by the Chief Communications and Corporate Affairs Officer. The IQPR report had also been considered in detail, with the Committee seeking assurance on the effectiveness of proposed actions. ***(e) People and Culture Committee*** In the absence of the Committee Chair, a Non-executive Member (JH) advised there was nothing to escalate to the Board and further advised the Committee was giving serious consideration to the issues around workforce.
14	**Action log**

	The Board agreed the closure of the items marked request to close and noted the actions which remained in progress. **Questions from members of the public** **The Chair advised that no questions had been received.** **Any Other Business** The Chief Executive (JM) provided an update on Cornwall and Isles of Scilly ICB and advised that arrangements were being made for a meeting of executive directors across Cornwall and Devon. In response a Non-executive Member (SA) suggested the need to increase engagement with patients and in response AM confirmed there was a progarmme of engagement work across the peninsular which could be reported to either a future Board meeting or form part of a Board development session**.**

Minutes approved	Date:	Signed by chair:

Report of the NHS Devon ICB chair

NHS Devon Integrated Care Board

Date of committee	Date report produced
21 December 2022	9 December 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:**	9 December 2022
Email:	Nick.pearson@nhs.net		

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

N/A

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

This document represents the chair's report and includes updates on the Integrated Care Strategy, urgent and emergency care / ambulance delays, updates on the Integrated Care Partnership and HSJ Out of Area Placements.

The report is for information only.

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

N/A

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

Impact on NHS Devon objectives	
Objective	**Impact**
Objective 1	**Reporting only**
Objective 2	**Reporting only**
Objective 3	**Reporting only**
Objective 4	**Reporting only**

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	None - reporting only
Health inequalities	None
Workforce	None
Resources and finance	None
Legal	None
Digital and Data	None
Engagement and consultation	Engaging communities and stakeholders in our work

Report of the NHS Devon chair

NHS Devon Integrated Care Board

9 December 2022

One Devon Partnership Board

This month saw Councillor James McInnes conduct his first One Devon Partnership board meeting as the sole chair.

I would like to extend my congratulations to James on his appointment and my ongoing support as vice chair.

Members received the draft Integrated Care Strategy, and the key focus of the meeting was to discuss and suggest further amendments to the draft before it was agreed for further sign off by partners.

The strategy will form the basis of our work together as a system across Devon and in particular is being co-produced so that it can inform and be consistent with our own forward plans for NHS Devon as set out in further detail below.

The board also heard from Professor Sheena Asthana about an opportunity to apply for a grant to address social, economic and environmental challenges affecting coastal and disadvantaged communities

This could see bids of up to £50,000 to develop resource and support capacity across the partnership, with successful phase one applicants applying to a £20 million fund for research to address issues that contribute to sustainable economic growth.

The partnership will be supporting this initiative.

The Voluntary Community and Social Enterprise (VCSE) Lead for NHS Devon updated members on plans for the allocation of £300,000 from NHS England for a cost of living fund to be managed by VCSE partners in local communities.

Members received an update on the progress of our 5 Local Care Partnerships. Whilst still at an early stage, they will play an increasingly important role in bringing system partners together to plan and implement improvements in the delivery of health and care for their local populations. They are especially important in areas such as community care and prevention, urgent and acute care pathways, mental health and children's services. They will play a key role in identifying and tackling inequalities.

Integrated Care Strategy

As highlighted above, each Integrated Care Partnership is required to produce an Integrated Care Strategy by the end of December 2022.

This sets the direction for the system, setting out how NHS commissioners, local authorities, providers and other partners can deliver more joined-up, preventative and person-centred care for the whole population across the course of their life.

The strategy is intended for use by all partners within the system, who will need to respond to it in their own future plans, including the NHS 5 year joint forward plan.

It will drive a focus on the challenges and opportunities to improve the health and wellbeing of people and communities.

The Devon strategy was developed on behalf of the One Devon Partnership, by a representative group of partners from across the system, known collectively as the Devon Plan Working Group.

The strategy sets the context and summarises the key needs of the population, through 12 Devon Challenges.

Given the short timeframe for production of the strategy, the starting point was a review of all of the engagement undertaken by health and local authority organisations with staff, patients and the public.

A ‘change leaders’ event in mid-October developed a list of proposed strategic goals, linked to the 4 key aims of an ICS, and both these and the rest of the Strategy, have been refined and iterated over the past weeks, by members of the Devon Plan Working Group and through further engagement with the One Devon Partnership, our five Local Care Partnerships, the three Local Authority Overview and Scrutiny Committees and other forums.

The Interim Strategy was shared by Partnership members on 9 December, for final comments prior to approval by the One Devon Partnership and subsequent publication to system partners by the end of December.

It will then inform the development of the Devon 5 Year Joint forward Plan, which is required to be produced before the end of March 2023.

Cost of Living summit

I attended the Cost of Living summit last month, joining more than 70 people from the statutory and voluntary sectors attending this ICP-organised event.

The summit was a good platform for us to come together as a system to hear about the support on offer to individuals, neighbourhoods and communities this winter and to reduce as much as possible the impact of the cost of living crisis.

So much good work is going on and it was great to see connections being made.

One of the key issues was the development of a cost of living dashboard, including a cost of living index. The methodologies were discussed and this is currently with members of the VCSE to provide valuable feedback.

Feedback from the summit will feed into the next phase of the dashboard development which includes the potential to map access to services such as supermarkets, schools, GP surgeries and post offices, and also to look at the data from various levels of geography including Local Authority and Local Care Partnership Level.

This meeting also allowed for discussion of the VCSE's views on distribution of the NHS England funding of £300,000 to support activity on the cost of living crisis across the Integrated Care System.

The fund will now be managed by the Voluntary and Community Sector for the Voluntary and Community Sector through a small grants programme.

The sector has recent experience of delivering this type of scheme through the Covid Outbreak Management Fund grants programme which was successfully managed across the Devon County Council area and resulted in 80 plus VCSE organisations receiving much-needed funding.

This will be replicated using the same governance and decision making structures but will be slightly adapted to include VCSE partners in Plymouth and Torbay and NHS Devon colleagues as part of the decision making process.

VCSE leaders through the VCSE Assembly and statutory sector partners will form a small working group to establish the finer details of the fund, and more detail will follow as this develops.

It was an excellent summit and helped us as a system to understand our collective service offer and the need to identify gaps through the dashboard.

Out of Area Placements

NHS partners in Devon have been working to reduce the number of people receiving mental health care outside Devon where this could and should be available locally. Joint working between the Devon Partnership NHS Trust and NHS Devon has led to a significant improvement in the number of inappropriate out of area placements for people from Devon.

Although Devon has historically seen higher levels of inappropriate placements than most other parts of the country, recent data gathered by NHS Digital confirms that there has been major progress.

This is good news for those who depend on services and for their families and I would like to extend my thanks to everyone across the Devon Partnership Trust and NHS Devon who has made this possible.

Change is a constant

It is now almost a month after the Chancellor's autumn statement and perhaps the biggest message in terms of health and social care was the importance of delivering services within existing financial envelopes for the next few years.

This will mean our trusts becoming more efficient at a time when we are under significant pressure. We must drive down the backlogs in elective care while also improving ambulance response times and urgent and emergency care.

Part of the answer to this is changing the way we do things; from services that are separated from each other by geography or artificial boundary to those that are increasingly integrated, wrapping around each patient or citizen.

We, as the ICB will play our part in this, setting strategy and direction of travel and working differently with our partners so that previous distinctions between commissioner and provider become increasingly redundant.

Nothing less than huge cultural change is needed to get us from where we are to where we are going, and I know that all involved – and every board – are determined to get this right for our population as a whole.

Senior System Leadership Development

Over previous years Devon has attempted different approaches to system leadership development, with mixed success.

We know that there is a need to strengthen senior system leadership in Devon to change our ways of working, create the conditions and environment for success and create one consistent leadership voice – all critical if we are to exit SOF4, recover services and deliver our longer-term ambitions to improve services for people and communities.

Work is being completed to produce a proposal for senior system leadership development involving the One Devon Partnership, the NHS Devon Board, the ICS Executive Committee and Chairs from Provider organisations. The proposal will be presented to the Board in early 2023.

Chair's visits and speaking engagements

I have had the opportunity to undertake a range of visits and speaking arrangement this month.

I had the pleasure of being invited to the Torbay Health and Wellbeing Network Event, where I introduced One Devon and the importance of the Voluntary Community and Social Enterprise (VCSE) in our work. It was an opportunity to hear direct about the range of projects within the community as well as listen to key asks from partners if we are to strengthen co-working. I have taken these forward to the One Devon Partnership Board which will now be holding a session on how statutory

services respond when the VCSE tries to escalate concerns about individuals they are assisting.

I also attended the Newton Abbot Locality Forum where I was invited to meet with Patient Participation Groups (PPG) and to discuss the support that is being offered within One Devon, together with Healthwatch. PPGs are an important avenue for engagement with people who use primary care.

Thank you to Judy Hargadon, non-executive member for primary care for joining this meeting.

I attended the Integrated Care System (ICS) Network Conference at the end of November to listen to and share examples of best practice from across the country

I presented at the Royal Devon Council of Governors meeting where I was invited by the Chair to provide an overview of the Integrated Care System and NHS Devon and to set out how we are working with councils and other organisations to promote a joined-up approach to care. Members of the Council of Governors also wanted to share their views and expertise on a range of issues from primary care to dentistry and urgent care.

Also in November, I was delighted to visit the North Devon Hospice in Barnstaple with Jane Milligan, where we were given a tour of the hospice and an overview of the services that they provide. It is a truly exceptional place.

It was an opportunity to hear more about their Hospice to Home services which offer care and support for patients and their careers in their own home. We are all agreed on the importance of making it possible for more people to be supported to spend their final days in the place of their own choosing and are committed to examine the ways that we can achieve this across the Devon system.

NHS Devon

Report of the chief executive

NHS Devon Integrated Care Board report

Date of committee	Date report produced
21 December 2022	9 December 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:**	9 December 2022
Email:	Nick.pearson@nhs.net		

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

N/A

Executive summary (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, EPRR, system pressures, asylum seeker support, awards successes, visits and speaking engagements. There's also articles about culture change,

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

N/A

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

Impact on NHS Devon objectives	
Objective	**Impact**
Objective 1	**Reporting only**
Objective 2	**Reporting only**
Objective 3	**Reporting only**
Objective 4	**Reporting only**

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	None - reporting only
Health inequalities	None
Workforce	None
Resources and finance	None
Legal	None
Digital and Data	None
Engagement and consultation	Engaging communities and stakeholders in our work

Report of the chief executive

NHS Devon Integrated Care Board

9 December 2022

Covid-19 and vaccination update

December marks the second anniversary of the vaccination programme. So far in Devon the programme has administered more than 3.5 million COVID vaccinations.

This is an amazing achievement by any standards and I would like to thank everyone involved, whether doctor, nurse, manager, volunteer or cleaner.

You have played a very significant role in the pandemic, ensuring that patients, public and staff have been kept as safe as possible.

Thankfully since the last peak in the autumn, cases of COVID have continued to fall.

However, the number of number of people admitted to hospital with flu in England has risen quite sharply as cases in the community rise.

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

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

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

Seasonal flu and COVID vaccinations are often made available at the same time so it’s now a good deal easier to get covered. And if you aren’t eligible for the seasonal flu vaccination, it is offered on the High Street.

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

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

Winter Update

Supporting the system

NHS Devon has made some temporary changes to further support our system in Plymouth, which as board members know, is facing a combination of pressures as a

result of ambulance delays, discharge challenges and increasing numbers of patients in the emergency department.

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

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

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

Winter communications with patients, carers and the public

NHS Devon leads on a winter communications campaign that is a professionally developed joined-up system approach for One Devon, owned by partners in the Integrated Care System.

The plan is informed by data and insight from previous winter campaigns, as well as learning from the COVID-19 vaccination programme and national NHS England messaging. It is informed by behavioural science with messages crafted with behaviour change in mind, noting that shifting people's behaviour often takes time as people form new habits.

The campaign began in September with work to promote flu and COVID-19 vaccination and the campaign works through themed weeks, involving advertising, working with the media and the use of social media, outdoor advertising, digital marketing and radio.

This winter, the campaign will include a door-drop of a winter health services guide targeted at homes within two miles from one of our four Emergency Departments (ED) as data suggest highest attenders are those that live within close proximity of ED.

Key message areas being covered by the campaign are:

1. Think 111 First – campaign to encourage contacting 111 before attending ED, or visit 111 online
2. Flu and COVID-19 booster vaccination – Increase uptake in all groups and increased focus on outreach and health inequalities.
3. GP access – promotion of enhanced access, different models of care, face-to-face/telephone and online access, wider clinical roles in the general practice team
4. Early discharge – system-wide campaign to support early discharge from hospital and improve flow
5. Inequalities – focus on seldom heard groups working with local communities and community champions to undertake engagement and insight work, ensuring services are inclusive, translated, and easy read documentation.

Support to access services and information outside of digital platforms, particularly for people with learning and/or physical disabilities.
6. Digital offer – online and video consultations, NHS app, ORCHA health and wellbeing app library, HANDi paediatric app and links with RSV
7. Mental health - support available for people, especially as we approach Christmas and New Year, and launch of 24/7 crisis lines, as well as crisis cafes and IAPT services
8. Pharmacy and self-care – promoting the GP community pharmacy consultation service (CPCS) for minor illness, raising awareness of pharmacy services, and the new local self-care campaign "Treatment starts at home"

In addition to this Devon-wide campaign, a local Plymouth campaign has been created by partners from UHP, Livewell Southwest, NHS Devon and Plymouth City Council, South Western Ambulance Service to explain to the public what is being done to prepare for winter and provide them with reassurance on the work underway in Plymouth to address the challenges and waits people face.

This campaign includes:

- ✓ Creating and distributing health services guide to go through letter boxes in local postcodes. This will also be available in digital form online.
- ✓ Creating a mini series of 'Improving health and care in Plymouth' videos with common branding showing the improvement work and developments across the Plymouth health and care sector. These cover areas from investment in Same Day Emergency Care to discharging patients so they can get Home in Time for Lunch, from GP care to services to help people once they leave hospital. These will run throughout the winter months, in line with a campaign schedule. The videos are all available to watch here.
- ✓ Undertaking media work - working with local media to meet their 'wish-list' for filming and interviews this winter

Torbay Hospital

Torbay Hospital has opened its new Acute Medical Unit. This has been a long-awaited project and it is great to see the additional facilities on offer to support a wider variety of patients who require varying levels of care.

My huge congratulations to Torbay Hospital's chief executive, Liz Davenport and her team.

Strep A

There is a lot of concern from parents about invasive Group A Strep which is affecting a small number of children throughout the country.

NHS Devon is taking steps to facilitate interviews with a local paediatrician to increase knowledge among parents about this illness.

We are also promoting the HandiApp, which gives advice on common childhood illnesses and when to seek help.

Industrial action

As I write industrial action is set to go ahead in Devon on two dates, December 15 and 20.

It is obviously a fluid situation but NHS Devon is coordinating its response and I will update verbally to ensure members have the very latest information at the board meeting.

South West Learning Disability & Autism Capital Inpatient Development

The South West has seen a substantial reduction in the number of people with a learning disability or autism in hospital over the past year.

This has been possible due to an award of £40.5m to develop regional learning disability and autism inpatient beds, which focus on ensuring that resources for inpatient care are focused on care when it is needed, is much closer to home and aligned with the agreed regional clinical model.

There remains a case for around 20 in-patient beds in the South West, with a view that these would be divided between two sites – one within Devon and the other in the Bath, North East Somerset, Swindon and Wiltshire area.

Further work and engagement is required on the specifics of this so that a consistent clinical pathway for the service can be provided, recognising that systems have different levels of community infrastructure in place.

I am pleased to see we are moving in the right direction. NHS Devon will continue to provide support in the ongoing development of this model and any associated work.

Emergency planning success

I am pleased to confirm that NHS Devon has been rated ‘substantially compliant’ for our Emergency Preparedness, Resilience and Response (EPRR).

As an ICB we must plan for, and respond to, a wide range of incidents and emergencies that could affect health and patient care.

We have received notification in response to a return that we are fully compliant with up to 99 per cent of the relevant NHS EPRR Core Standards. There is a little work to do before we reach full compliance in 2023 but it’s a great start.

I would like to thank everyone who has contributed to this successful outcome.

Treating asylum seekers with respect

I would like to take this opportunity to update the board on work we do with people seeking asylum.

With greater numbers of refugees and asylum seekers arriving in the UK, there has been a growing need for a wider dispersal of people across the country with Devon starting to see higher numbers of refugees and those on resettlement schemes.

NHS Devon (as delegated through NHS England) has a lead role in coordinating the health services for refugees and asylum seekers arriving in Devon.

Many refugees are escaping repressive regimes and/or are arriving from war-torn countries where healthcare is not always the top priority.

People's immediate health needs are supported on arrival and they are supported with access to information on how to access urgent and emergency healthcare, followed by local GP registration, providing access to medicines through community pharmacies and health screening.

The Home Office recently decided to accommodate some asylum seekers at a hotel in Exmouth but other areas are also helping.

The cost of the accommodation is funded by the Home Office but some other costs are picked up locally, including for medical cover. This, of course, does not impact on people's access to their GP.

Many of those seeking asylum are very vulnerable indeed and it is vitally important that Devon plays its part in helping people to return to as normal a life as possible.

NHS Devon will continue to work with other organisations to provide the support that they so desperately need.

Value-based approach

Devon is exploring the potential benefit of adopting a Value-based Approach (VBA) to health and care. This is broadly understood as, 'the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person'.

VBA has been successfully adopted in other places, including Wales, Scotland and numerous places internationally. It provides a lens through which we can better understand the value and impact of the health and care we deliver:

- personally (what matters to an individual)
- technically (best outcomes with available resources)
- for a population (distribution of resources to achieve equitable outcomes)
- and societally (participation and connectedness)

The research into VBA has taken a phased approach (see below). This builds on the principles outlined in 'The way we do things together in Devon' narrative, co-developed by clinical and professional leads across One Devon and adopted by the Integrated Care Board and One Devon Partnership in July 22.

- **Phase 1** of the VBA review is complete. The recommendations of the review report sponsored by the Clinical and Professional Cabinet (CPC) have received support from Devon ICS Strategy and Transformation Group and the Devon ICS Executive Committee.
- **Phase 2** of the VBA review begins in December 2022 and includes the production of an Options Analysis, to include assessment of the 'right approach' to implementation of VBA in Devon. This will include agreement around priorities for enabler development and the initial areas of focus (or rapid intervention projects), both to inform the investment and benefits analysis and to prepare for implementation if support to progress is agreed (decision-making route to be agreed). Target date for completion of Phase 2 is April 2023.
- **Phase 3** of the VBA review will be implementation, in terms of enabler programme support and rapid intervention projects. Estimated start date April/May 2023.

I will continue to provide updates on this as the programme develops.

Award Success

I'm delighted to be able congratulate many successful teams in Devon this month.

Two Devon projects were highly commended in the HSJ Patient Safety Awards 2022 and one in the HSJ Awards 2022.

The 'Whole Systems for Whole People' project was highly commended as a partnership of NHS Devon, Devon County Council, Torbay Council, Plymouth City Council and Devon and Cornwall Police and Crime Commissioner. The project works to improve support to people experiencing domestic abuse and / or sexual violence.

The Southwest Ambulatory Orthopaedic Centre was highly commended in the Safe Restoration of Elective Care category.

The Centre is based at the Exeter Nightingale Hospital and is an integrated care system approach to tackling the backlog in elective care by developing a revolutionary ambulatory centre for elective orthopaedic surgery.

The team was also recognised at both the National Orthopaedic Alliance Excellence in Orthopaedics Awards earlier in October and in the acute sector innovation of the year in the HSJ Awards.

My huge congratulations to both teams on their wins and to One Northern Devon, University Hospitals Plymouth's Covid Vaccination Programme and the Southwest Provider Collaborative, which were also shortlisted for the HSJ Awards.

In addition, I would like to highlight the Devon Children and Family Health Devon Assertive Outreach team, who won the Royal College of Psychiatrists' Psychiatric Team of the Year: Children and Adolescent's award in November.

At time of writing we are due to celebrate further success with NHS Devon's Exceptional People Awards, taking place on 12 December.

I'm looking forward to seeing everyone for this annual event where I will hand out awards to very deserving people.

As always, my congratulations to those nominated. I would also like to express my thanks to those that took the time to nominate their colleagues.

Visits and Speaking Engagements

I had the pleasure of visiting North Devon Hospice in Barnstaple with Dr Sarah Wollaston earlier this month, where we were given a tour of the building and gained a broader understanding of the services that are offered.

It was great to speak with the chief executive there and meet staff members who are looking after people in end of life care. They are doing a brilliant job and we were was most impressed with the facilities and the level of care being offered.

I also visited Sidmouth Hospital and was delighted to meet various staff members in the inpatient ward, ambulatory care and urgent community response. It's a great little hospital with lots of useful services for the population they serve.

Finally, I went along to the Budlake Centre at Whipton Hospital, which is another community hospital run by Royal Devon University Healthcare NHS Foundation Trust.

I welcomed the opportunity to visit these smaller, community hospitals and meet the members of staff providing care in the community.

My thanks to everyone who took time to speak to me.

World Antimicrobial Awareness Week

With global antimicrobial resistance on the rise, Devon played its part by promoting world antimicrobial awareness week.

It is vital that we continue to increase awareness of global antimicrobial resistance and encourage best practices for using antimicrobials responsibly among the general public, health workers and policy makers, whilst avoiding the spread of drug-resistant infections.

We recognise the ongoing work that is required to continue to provide protection to the public and thank everyone for their support.

Happy Christmas

It's customary at this time of year to say a few words about the last 12-months.

Yet again our staff have been outstanding. Whether on the front line or in an office, our people are second to none.

Thank you for everything you have done this year and every year.

Your care and support means so much to me personally – but more importantly, so much to patients, their families and friends.

If you are able to take leave at all over the festive break, I hope that you enjoy a restful time with those you love and cherish. And for those who are working, thank you so much. I trust you can enjoy at least a little downtime when you are able.

Integrated Care System (ICS) executive committee updates

The following are key updates from the ICS executive committee

System Improvement Assurance Group

The SIAG has advised it has received Peninsular Acute Provider Collaborative endorsement to proceed to the next phase of the Peninsular Acute Sustainability Programme, which was endorsed by all Trust Boards in October / November.

Work is ongoing to ensure that all workshops take place before the end of the calendar year.

I would also like to highlight that system leaders have been invited to a "board to board" meeting with NHS England on January 24.

SOF4

On 29 November we received correspondence from NHS England regarding the Recovery Support Programme (RSP).

Last year NHS Devon and University Hospitals Plymouth were placed into NHS Oversight Framework segment 4 and the RSP.

Following a recommendation from the NHSE South West regional team, it has also been agreed that Royal Devon University Healthcare NHS Foundation Trust and Torbay and South Devon NHS Foundation Trust should be placed into NHS Oversight Framework segment 4 and receive support from the RSP.

We welcome this intensive support as the RSP will help us to collectively address our greatest challenges, including waiting times, balancing finances, leadership and

taking the difficult decisions needed to configure our services in a way that ensures we can meet the growing demand for healthcare with the staff and funding available.

Virtual Wards

Virtual wards commence this month and provide a total of 85 additional bed equivalents, providing clinical support and treatment outside of a hospital.

Funding has been made available for additional capacity for frailty and respiratory care outside of hospital.

Given previous concerns around the predicted COVID surge and increasing flu presentations in hospital, we are working with providers to bring forward respiratory virtual ward capacity.

This work is continuing, with RDUH/Eastern & Northern and UHP/Western on track.

There is a possibility that Southern/TSD scheme may be delayed until January, but this is under review.

NHS Devon

NHS Devon Integrated care board Meeting

Urgent Care and Winter Improvement

Author(s)		Report approved by	
Name and title:	Anthony Fitzgerald Chief Delivery Officer	**Name and title:**	Jane Milligan, Chief Executive Officer
Phone:		**Date:**	7 December 2022
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

N/A

Executive summary

The presentation of the Integrated Care System's (ICS) Urgent Care and Winter Improvement plan seeks to provide the necessary assurance to the NHS Devon Board regarding the immediate actions necessary to improve service delivery

The report references the outlined approach and key actions to improve performance programme and the arrangements for winter resilience.

The apportionment of additional funding to support winter pressures and urgent care improvement is included within the Finance and Performance Committee papers

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

Discussed at the Finance & Performance Committee, however not presented

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. To note the approach to UEC improvement
2. To note the approach to Winter Resilience

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

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

3

NHS Devon Integrated care board meeting

URGENT CARE IMPROVEMENT & WINTER RESILIENCE

1 INTRODUCTION

Performance information has seen continued deteriorating position against most metrics across the system, demonstrating a failing position. Continued improvement is needed to provide assurance of a statistically significant improvement.

2 CURRENT PERFORMANCE

In line with performance across many systems, in Devon delivery against the constitutional standards for urgent care has failed to meet national standards.

Fig 1 - URGENT CARE PERFORMANCE

	Metric	Target	Latest Date	System Value	System Variation	System Assurance	Royal Devon University NHS Foundation Trust Value	Royal Devon University NHS Foundation Trust Variation	Royal Devon University NHS Foundation Trust Assurance	Torbay and South Devon NHS Foundation Trust Value	Torbay and South Devon NHS Foundation Trust Variation	Torbay and South Devon NHS Foundation Trust Assurance	University Hospitals Plymouth NHS Trust Value	University Hospitals Plymouth NHS Trust Variation	University Hospitals Plymouth NHS Trust Assurance
UEC	A&E all types seen within 4 hours	95%	2022-10	57.7%			58.1%			57.0%					
	A&E Type 1 seen within 4 hours	95%	2022-10	45.0%			49.2%			35.7%					
	Attendances Type 1		2022-10	23,915			10,934			5,521			7,460		
	Type 1 Admissions (conversion rate)		2022-10	27.7%			29.8%			22.4%			28.4%		
	Emergency Admissions via A&E		2022-10	6,622			3,262			1,239			2,121		
	ambulance arrivals delayed over 30 minutes		2022-10	49.0%			29.1%			68.5%			73.9%		
	12 hr trolley waits	0	2022-10	1,694			486			313			895		
	Time lost to Ambulance Handover Delays		2022-10	10,673			797			3,348			5,880		
	Mean ambulance response times cat 1	7	2022-10	11											
	Mean ambulance response times cat 2	18	2022-10	79											

In terms of time lost to ambulance delays all systems have submitted trajectories to reduce hours lost; however, however these trajectories are not yet being consistently met.

3 DEVELOPING IMPROVEMENT PLANS

Whilst several plans already exist and are being implemented across the system, these need to be reviewed considering current levels of performance. Where necessary these will need to be revised to ensure appropriateness, timeliness and sustainability.

Following discussions with NHS Southwest (Region) regarding the System Oversight Framework (SOF) exit criteria, there will be a simultaneous identification of the system-wide key actions aligned to each thematic area with the development of the Trust and the overall ICS Improvement Plans. These will focus on the key elements of:

- Urgent Care
- Elective Care, including Cancer & Diagnostics
- Finance
- Service Strategy
- Leadership

In terms of Urgent and Elective Care each Trust will develop its own *integrated performance improvement plan* that will identify improvement against baseline data and with revised trajectories where necessary. The key primary care enablers will be brought together into a system plan with accountability for delivery through the Devon ICS Chief Delivery Officer (CDO).

Urgent Care Improvement must be seen in the context of overall improvement workstreams focusing on key areas of delivery. Each of these is being reviewed in terms of delivery and allocated support and accountable leadership.

Fig 2 – IMPROVEMENT PRIORITIES

4 KEY AREAS OF FOCUS - URGENT CARE

In response to the Tier 1 status of UHP with respect to UEC and the direct involvement of the national UEC Taskforce, a Core Team will be established to develop the UHP Integrated Performance Improvement Plan and drive the delivery of the agreed actions.

Each Trust will articulate its internal governance arrangements for oversight of delivery of the plan. For UEC actions, there will be a dual line of reporting to the Trust/ICB Board and the System UEC Oversight Group.

In line with the agreed regional governance arrangements, oversight and scrutiny of performance will be on a weekly basis via the Devon System Improvement and Oversight Group with monthly exception reporting of any actions that are off trajectory through to the Southwest Regional Support Group.

The UHP UEC Taskforce lead and National Elective Recovery lead will be invited to be part of the Devon System Improvement and Oversight Group. This will be of critical importance in ensuring a continuous and joined-up approach to dynamic management of risks and opportunities for improvement.

- Reduction in No Criteria to Reside
- Reduced demand for ED

2

- ED booking into Primary Care
- GP Streaming
- Virtual ward
- Direct 'pull' from SWAST stack
- Effective use of Treatment Escalation Plans to reduce emergency admissions
- Creation of additional physical capacity
- Further development of Pan-Devon dynamic risk escalation

5 NEXT STEPS

Improvement arrangements and governance for exist criteria for SOF4 arrangements are currently being finalised with the Regional Team however in the meantime additional support for UHP has been mobilised.

6 DEVELOPING WINTER RESILIENCE

NHS England published the Going Further for Winter letter on 18 October 2022 set out the key actions to be undertaken by systems to improve operational resilience going into winter. This included all systems setting up a 24/7 System Control Centre (SCC) to support system oversight and decision making based on demand and capacity across sites and settings.

The SCC has now been set up to balance the risk across acute sector, community, mental health, and social care services with an aim of ensuring that clinical risk is appropriately dispersed across the whole ICS during periods of surge. Led by operational leaders and harnessing the power of Integrated Care Systems (ICSs), the SCC will ensure a consistent and collective approach to managing system demand and capacity as well as mitigation of risks.

The purpose of the SCC is to ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all acute, community, mental health, primary care, and social care services.

The SCC ensures:

- Visibility of operational pressures and risks across providers and system partners
- Concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges
- Dynamic responses to emerging challenges and mutual aid
- Efficient flows of information

Based on the requirements of the NHS England SCC guidance, the following extract from the Standard Operating Procedure provides an overview of the Devon ICB resource and structure for system oversight and tactical response aligned to the NHS England SSC specification. The Devon SCC will be operational from 08.00 to 18.00 hrs and then use existing on call arrangements beyond those hours. Hours of operation will be reviewed daily and extended as necessary.

Fig 3 - STANDARD OPERATING PROCEDURE

Operating Hours	Monday-Friday 0800 -1800 • A System Operations Manager will lead each shift supported by the Delivery Support Officer and STT administrator.
	Saturday-Sunday 0900 -1700 • A System Operations Manager will lead each shift. • They will be supported by the on-call Director and Manager where escalation/executive support is required

Location	• The STT will predominantly be a virtual function using MS Teams. However, a physical location is being developed for times of extreme pressure and the coordination of response during periods of planned industrial action.
Operational Delivery	• The STT will have operational oversight of all elements of the health economy, supporting risk sharing across the system & ensuring that the approach to managing system pressures is a collective and collaborative task and supports rapid de-escalation when pressures occur. • There will also be a requirement for the STT lead and wider team to support the on-call Director/Manager in the event of a EPRR incident declaration within the STT operating hours
Provider Data Updates	• Data updates will be sent by each provider through to the NHS Devon Unscheduled Care Dashboard three times a day at 0800, 1030 & 1600hrs.
System Tactical Team Calls	• The STT System Operations Manager will Chair the daily 0830, 0900 and 1700 calls detailed below. The 1000 regional call be Chaired by the NHSE SW team with NHS Devon represented by lead System Operations Centre Manger or deputy. • STT administration will join 0900 System call and will capture the provider data and actions Monday to Friday. On Saturday and Sunday, the daily system call will be Chaired by the on-call Director with the System Operations Manager capturing data and actions. • The daily system call will enable providers to advise the STT and partners of capacity status, escalate any organisational risks, system support requests and overview of actions to mitigate/resolve issues around congestion/surge/delays in handover and/or DTAs. • Should a system escalation call be required this will be arranged and facilitated by the STT during normal operating hours and the on-call Director/Manager out of hours.

System escalation will be manged through the triggers defined and agreed within the NHS Devon System at Capacity Plan and the plan protocol has been developed in partnership with system partners.

The development of the SCC has been based upon existing partnership working arrangements with a method of continuous improvement and risk management thresholds across all organisations. NHS Devon will continue to ensure all escalation protocols within the ICS are aligned to the national OPEL framework (Fig 3) and weight these to the determination of the system OPEL score.

The risk thresholds currently agreed with each Trust will be monitored and reported via the live UEC and SWASFT dashboard, supported by in-day escalation. At a high level these include:

- Number in ED, and DTAs in ED (RAG thresholds agreed)
- 30 min ED review of patients in ambulance queue
- Time to triage/clinical review/decision
- Ambulance call stack by ED catchment
- Ambulance queues at each ED and length of time awaiting handover
- Cat 2 response times, trigger over 1 hour
- Ambulance Forecourt Divert SoP in place
- Discharges completed by 5pm against daily discharge targets
- Number of patients with NC2R
- Covid/IPC patients and closed and empty beds due to IPC

Fig 4 - DETERMINATION OF NHS DEVON OPEL SCORE

OPEL 1	• **ICS** capacity is such that Providers can maintain patient flow and are able to meet anticipated demand within available resources. The ICB will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	• **ICS** is starting to show signs of pressure and Providers are experiencing increased pressure impacting on the ability to maintain patient flow and meet anticipated demand. The ICB will be required to take focused actions in Providers showing pressure to mitigate the need for further escalation. • Enhanced co-ordination and communication will alert the local system to take appropriate and timely actions to reduce the level of pressure and risk as quickly as possible. ICB's will keep regional NHSE colleagues informed of any pressures, with detail and frequency to be agreed. Any additional support requirements should also be agreed locally if needed.
OPEL 3	• **ICS** is experiencing major pressures. This is compromising providers ability to maintain patient flow, and these continue to increase. • Actions taken in OPEL 2 have not succeeded in returning to OPEL 1. • Further urgent actions are now required across the local system by all partners and increased external support may be required. NHSE regional teams will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. • Sustained OPEL 3 for >72hrs should prompt a review of staff Health and Wellbeing plans. • Providers should consider taking OPEL 4 actions to prevent further escalation.
OPEL 4	• **ICS** continues to experience major pressure and there is increased potential for patient care and safety to be compromised. Providers are unable to maintain patient flow and patients are being cared for in overcrowded emergency department(s) and in ambulances. • Actions taken in OPEL 3 have not succeeded in returning to OPEL 2. • Ambulance response times are compromised, and patients are experiencing delays in receiving pre-hospital care. • All available local escalation actions taken, external extensive support and intervention required and co-ordinated at Executive level. • Decisive action must be taken by the ICB to support provider to ensure patient safety and a safe balance of system risk. If pressure continues for more than 48 hours an extraordinary ICB meeting should be considered with NHSE regional representation. • Regional teams in NHSE will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. The regional UEC operations leads will have an ongoing set dialogue with the national UEC operations team providing assurance of ICS action and progress towards recovery.

NHS Devon Integrated care board Meeting

Committee Chair report – Quality and Performance Committee

Date of board meeting	Dates of committees covered in this report
21 December 2022	7 December 2022

Chair	
Name and title:	Professor Hisham Khalil, independent non-executive member

Reports discussed and assurances received

The Committee received updated reports as detailed below:

1. **Children and young people autism and speech and language therapy deep dive**

The committee noted that it is important to understand and view the position of the speech and language therapy service, communication needs and autism as part of broader neurodiversity conditions.

The committee heard that:

- Both autism and speech and language therapy services have been through a service improvement process with a number of efficiencies realised.
- However, the numbers of children and young people waiting for an autism diagnostic assessment remains high across Devon, Torbay, and Plymouth (this does not include those waiting on acute paediatric lists in Devon and Plymouth).
- The demand for the diagnostic pathway remains high in comparison to the clinical capacity. The average length of time waiting for an Autism assessment continues to remain high, over 80 weeks overall
- Community paediatrics also provide autism assessments. Data for this is not

routinely collected and the committee heard that the team are unable to extract autism data from the general paediatric referral information.

- Speech and language therapy services were stood down during the initial waves of the COVID-19 pandemic. As a consequence, there has been unprecedented demand and referrals to both Livewell South West and Children & Family health Devon. (Worth noting that pre-COVID Livewell were meeting the <18 weeks RTT).
- The current number of children waiting totals 4,022 (3276 Devon and Torbay; 746 Plymouth).
- Changes to the model of delivery as well recruitment to additional posts are being implemented. However, the trajectory currently being considered spans 2 years.

The committee discussed the following:

- Workforce issues and plans to improve the current lack of capacity
- Funding concerns

2. Integrated Quality and Performance Report (IQPR)

The committee heard that:

- 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 and emergency 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.

The Committee discussed the following areas:

- *The Winter Demand and Capacity Programme/ Urgent and Emergency Care*

There is a significant decrease in patients with 'no criteria to reside' and an increase in bed capacity. However, this has not yet translated to an improvement in urgent and emergency care metrics.

The Committee questioned where the lead was coming from to unpick the understanding of the slow response of UEC metrics. Discussion followed about the significant activity in this area and when to decide that 'actions in place' are not having the desired outcomes.

- *Primary care*

The Committee discussed the need for greater detail in the IQPR of Primary Care data, including access metrics. The Committee has already agreed a Primary Care 'Deep dive' as a topic in its January 2023 meeting.

3. **Feedback from NHSE following the observation of the November 2022 meeting.**
   The Chair of the Committee received verbal and written feedback from NHSE regarding the 2nd of November meeting.
   Areas that went well included:
   - The meeting agenda and papers went out early,
   - The flow of information was well-considered
   - Deep dives were based on highlighted IQPR metrics and the good practice of agreeing 'deep dives' for future meetings
   - Insightful questions from INEMs
   - Deferring 'non-assurance' issues to the executive team
   - The IQPR metrics were linked to patient experience and safety when presented
   - The recognition of gaps in 'data' in the IQPR
   - Good consideration of Health Inequalities and the triangulation of information
   - A commendation of the discussion of the 'Planned Care harm paper' and the East Kent maternity report
   - Decision making with each item on what the next steps were
   - The sensible suggestion of 'update papers' rather than a 'new paper' to reduce demand on time of colleagues preparing papers.
   - The recognition by the Committee that it is still 'learning' and 'improving'

   Area that worked less well included:
   - Not all papers were introduced in relation to reason for the paper and the request from the Committee
   - Discussion of some operational issues
   - Several open actions, some of which were there for a long time
   - The IQPR data was focused on Quality indicators and less so on workforce issues, performance and financial issues
   - The purpose of the 'deep dives' should be clearly stated with adequate notice
   - Need to focus discussions in the committee on a number of Quality metrics to allow more detailed discussions
   - A suggestion to include a patient representative in the membership

4. **The Citizens Voice**

The Committee received verbal feedback from Healthwatch committee member. Themes included difficulty in access to services, both physically and digitally. The Committee discussed how this intelligence can be linked back to quality and safety.

The Committee discussions included:

- The Citizens voice should not be limited to an individual who has a lived experience of one part of the system and their own set of circumstances. It needs to have more breadth and representation.
- Healthwatch are represented at the Quality and Performance committee and in the Primary Care transition committee.

- Healthwatch and the ICB Head of patient experience have met with ICB CNO to draw together all the areas of patient engagement / strategy to align with the National quality board expectation in its "improving experience of care "document.
- The Committee agreed that this needs to be fed into the governance review for all committees

5. Emerging Quality and Performance Issues

Group A Streptococcal and Invasive Group A Streptococcal Infections

The committee heard that:

- Scarlett fever and group A Streptococcal infection (GAS), including invasive GAS, have been at lower levels than normal for the last two years during the pandemic. This year, the spike in infection in spring lasted longer, and the spike expected in winter has started earlier and is resulting in higher levels of infection than normally expected at this time of year, particularly in younger children.

- Marked increases in Scarlet fever notifications are also being seen.

- Investigations are underway following reports of an increase in lower respiratory tract GAS infections in children over the past few weeks, which have caused severe illness. A high burden of co-circulating viral infections may be contributing to the increased severity and complications through co-infection.

- Clinicians should continue to be mindful of potential increases in invasive disease and maintain a high index of suspicion in relevant patients as early recognition and prompt initiation of specific and supportive therapy for patients with iGAS infection can be lifesaving.

Planned Industrial Action from Nurses and Nursing Support workers

- The Royal College of Nursing has confirmed that in their ballot of members they have reached the legal threshold for industrial action on 15th and 20th December.
- 43 organisations cross England will be taking part, and this includes all of the providers in Devon, along with the ICB.
- This will be managed in a tactical response room on the day, responding as issues arise.
- Planning is underway collectively across the system, including detailing derogations where possible, although national Derogations from the College are still not clear.
- CNO recommends a standing item on the quality and performance committee for the next three months to understand the impact on the quality metrics.
- At a conservative estimate it is thought that 12 hrs of lost elective activity could take several weeks to catch up

- Several other health unions are also now balloting members for industrial action, so the situation will be ongoing

Reports received and noted

None.
The children and young people's eating disorder waiting standard paper was received late, and due to staff sickness, no officer was available to triangulate queries. This item was therefore deferred.

Risk register review updates

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

Committee decisions

- The Committee approved recommendations of confidential paper Mr A.
- The Committee agreed to have a standing item on quality impact of industrial action

Items of concern to be escalated to the board

- Suggestion for a 'patient representative' / the patients' voice to be fed into governance review
- Committee wishes to compliment the South Western Ambulance Foundation Trust for its perseverance in managing challenging conditions, the long handover times, the verbal aggression and meeting patients expectations.

Recommendations for the board

- To note the reports received and positions of assurance by the Quality and Performance committee
- Discussions took place after the committee meeting on questions to be asked/purpose of 'deep dives' and the need for multi-source inputs /triangulation for Assurance and specifically for 'deep dives'. These will be summarised by the Chair of Q&P in the ICB meeting.

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.

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NHS Devon

NHS Devon Integrated care board meeting

Integrated Quality, Performance and Finance Report

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

Executive summary (250 words max)
This report provides a consolidated update on key strategic issues and measures of outcomes, performance, quality, finance, and activity to provide the necessary assurance to the ICS, at both place and system level that issues are being identified and addressed. The IQPR is submitted to the Quality and Performance Committee, and the Finance Committee to identify areas of operational, quality, or financial performance that require further investigation and assurance. Areas of concern or interest identified by the IQPR review may result in further investigations or a deep dive being undertaken to seek greater assurance on the actions associated with improvement and the effective management of safety and experience for patients within services.

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

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

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

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

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

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

Integrated Quality, Performance and Finance Report (IQPR)

Owner: Performance Team

November 2022

FINAL Version

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Executive Summary

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

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

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

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

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

Acronyms

Acronym	Full Meaning	Acronym	Full Meaning	Acronym	Full Meaning
ADHD	Attention Deficit Hyperactivity Disorder	ICU	Intensive Care Unit	QOF	Quality Outcomes Framework
AHP	Allied Healthcare Professional	IHA	Initial Health Assessment	RAG	Red Amber Green
BI	Business Intelligence	IPC	Infection Prevention Control	RDUH	Royal Devon University Hospitals
BPTW	Best Place To Work	IPS	Individual Placement and Support	RHA	Review Health Assessment
CAS	Clinical Assessment Service	IR	International Recruitment	RTT	Referral To Treatment
CFHD	Children and Family Health Devon	IUCS	Integrated Urgent Care Service	SAR	Safeguarding Adult Review
CIC	Community Integrated Care	KPI	Key Performance Indicator	SEMH	Social Emotional Mental Health
CIC	Children In Care	LA	Local Authority	SI	Serious Incident
CLD	Criteria Led Discharge	LD	Learning Disability	SLN	Speech and Language Needs
CPD	Continuing Professional Development	LMC	Local Medical Committee	SMI	Severe Mental Illness
CQRM	Contract Quality Review Meeting	LOS	Length Of Stay	SOG	Strategic Oversight Group
CYP	Children and Young People	LSW	Livewell South West	SPC	Statistical Process Control
DPT	Devon Partnership Trust	LTC	Long Term Conditions	SST	Safety Systems Team
DSAF	Devon Spring Action Fund	MDT	Multi-Disciplinary Team	SWASFT	South West Ambulance Service Foundation Trust
ED	Emergency Department	MHSDS	Mental Health Services Data Set	T&F	Task & Finish
ED	Eating Disorders	MRSA	Methicillin-Resistant Staphylococcus Aureus	T&O	Trauma & Orthopaedics
EHWB	Emotional Health and WellBeing	MSSA	Methicillin-Sensitive Staphylococcus Aureus	T&SDFT	Torbay & South Devon Foundation Trust
EIP	Early Intervention in Psychosis	NCTR	No Criteria To Reside	TDSAP	Torbay and Devon Safeguarding Adult Partnership
GP	General Practice	NHSE	NHS England	UASC	Unaccompanied Asylum-Seeking Children
HALO	Hospital Ambulance Liaison Officer	NICE	National Institute for health and Care Excellence	UC	Urgent Care
HCA	Health Care Assistant	OOH	Out Of Hours	UCR	Urgent Care Response
HEE	Health Education England	OPEL	Operational Pressures Escalation Levels	UHP	University Hospitals Plymouth
HR	Human Resources	PHSO	Parliamentary and Health Service Ombudsman	VCP	Vacancy Control Panel
HWB	Health and Well Being	PiPOT	Person in Position of Trust	WIC	Walk In Centre
IAPT	Improving Access to Psychological Therapies	PITCH	Peer Improvement Tips for Care and Health	WITNe	Workforce Intelligence & Transformation Network
ICB	Integrated Care Board	PPG	Practice Plus Group	WTE	Whole Time Equivalent
ICS	Integrated Care System	PSQ	Patient Safety and Quality		

Key to Variance & Assurance Icons

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

Operational Performance

Urgent and Emergency Care – System Overview

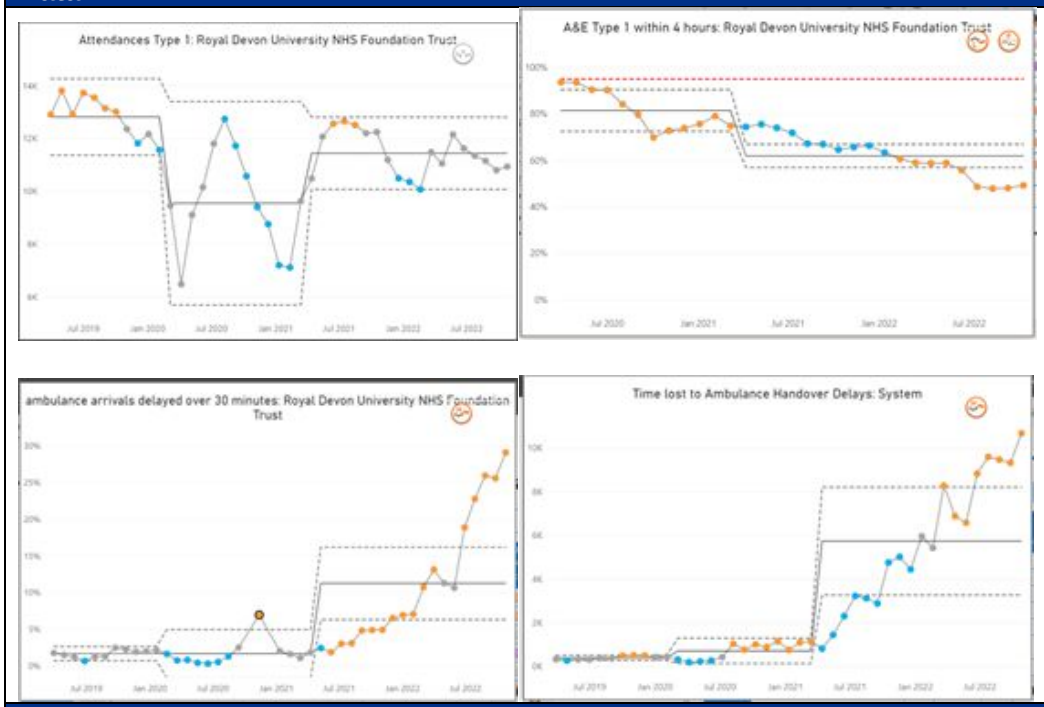
				System			Royal Devon University NHS Foundation Trust			Torbay and South Devon NHS Foundation Trust			University Hospitals Plymouth NHS Trust		
	Metric	Target	Latest Date	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance
UEC	A&E all types seen within 4 hours	95%	2022-10	57.7%			58.1%			57.0%					
	A&E Type 1 seen within 4 hours	95%	2022-10	45.0%			49.2%			35.7%					
	Attendances Type 1		2022-10	23,915			10,934			5,521			7,460		
	Type 1 Admissions (conversion rate)		2022-10	27.7%			29.8%			22.4%			28.4%		
	Emergency Admissions via A&E		2022-10	6,622			3,262			1,239			2,121		
	ambulance arrivals delayed over 30 minutes		2022-10	49.0%			29.1%			68.5%			73.9%		
	12 hr trolley waits	0	2022-10	1,694			486			313			895		
	Time lost to Ambulance Handover Delays		2022-10	10,673			797			3,348			5,880		
	Mean ambulance response times cat 1	7	2022-10	11											
	Mean ambulance response times cat 2	18	2022-10	79											

Analytical Summary: October data has seen continued deteriorating position against most metrics across the system, demonstrating a failing position. UHP has seen a continued reduction in emergency department admissions and conversion rates. Continued improvement is needed to provide assurance of a statistically significant improvement.

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

Operational Summary

Causes (RDUH-East):

- 111 call abandonment and lack of primary care streaming
- Change in catchment area to support UHP and T&SD with ambulance handovers between 10/10/22 and 7/11/22 – led to increase in ambulance arrivals, admissions and out of area onward care delays
- Bed capacity pressure and restricted flow to beds in the hospital – patients awaiting packages of care or placement to enable discharge averaged 84 which is an improvement on previous month.
- Reduced capacity at Sidwell Street Walk in Centre. The WIC was closed on Mondays and Thursdays due to staffing constraints.

- Current vacancies and sickness in Medical and Nursing teams
- Reset week took place between 3rd – 11th October and generated a reduction in inpatients in beds, those with a LOS > 21 days and waits for a bed in ED.

Actions:

- Winter plan, including demand and capacity funding being implemented. Further detail on Page 17.
- Additional ED consultant cover provided from November on weekdays will mitigate increasing demand and support 4-hour performance, this equates to an additional 6.5 WTE Consultants now in post, rising by a further 1.5 WTE by March 2023.
- Review of SWASFT border change being undertaken by NHS Devon to identify learning.
- Live in carer scheme extended for winter. There are currently 9 live-in care staff available, and all are being utilised which has enabled additional flow.
- SWAST direct referrals to Urgent Care Response in place to avoid unnecessary admissions. This service went live on 1st November 2022. Referral position is being monitored closely and impact will be reported from December 2022.
- Recruitment programme continues at pace, with onboarding training in place. A Trust wide initiative is underway to fill vacancies and improve staff retention. The key areas for recruitment that affect urgent care are within inpatient wards, walk in centre, Emergency Department. This includes registered nurses, nurse practitioners, ward clerks, health care assistants.

Causes: (RDUH- North)

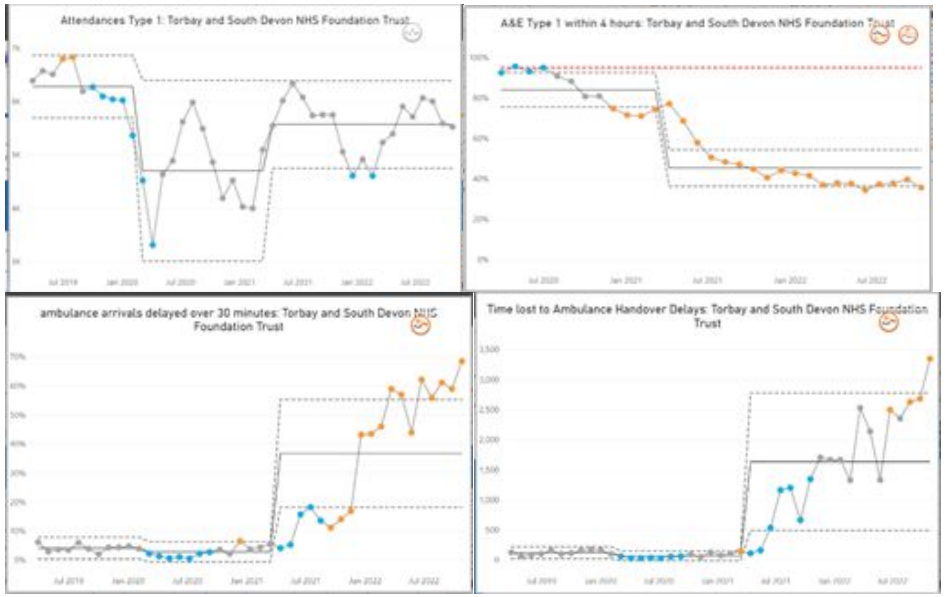
- Poor flow continues with 60-70 patients with no criteria to reside (NCTR) resulting in a reduced active bed base. Whilst daily discharges are improving slightly there continues to be significant additional patients joining the waiting list, hence limited impact on over-all NCTR waiting.
- Covid numbers in hospital rose to 40 mid-October causing reduction in available bed base. Covid related staff sickness also impacted negatively on flow at a percentage of 5.69% of the total workforce.

Actions:

- Re-set week took place between 3rd – 11th October and provided valuable learning into flow opportunities, currently being considered for sustainable models/implementation. This includes support from social care in house working alongside enhanced discharge liaison.
- Head of Operations now in post who will have a targeted focus on improving patient flow and improving performance in ED.
- Permanent staffing for discharge lounge now in post including a Band 6 registered nurse and Band 2 HCA Monday to Friday 9-5. Currently numbers through the discharge lounge are relatively low (3-4 patients per day) as there is not yet an area available for those who require bedded support.
- Business case for new location and facilities for discharge lounge in process for approval and will include expansion of the area and ability to provide facilities for those who require bedded care. This is being presented to the Trust board this week.
- Additional posts now in post to support flow and discharge, including 7/7 discharge co-ordinator rota & liaison teams
- Doctor's assistant posts will be recruited following a job matching process to support urgent care pathways and ED.
- Criteria-Led Discharge (CLD) progressing with strong clinical engagement as phased implementation is underway.
- Additional porter services for winter surge to support flow efficiencies at time of increased demand in place.
- SWAST direct referrals to Urgent Care Response in place, to avoid unnecessary admissions, data will be available from December 2022 as project went live 1st November 2022.
- Additional short-term rehabilitation beds available with winter monies, this currently equates to 14 new beds available to support rehab. All beds are utilised currently to support flow.

Urgent and Emergency Care – Torbay & South Devon

Data



Analytical Summary

- The number of Emergency Department (ED) attendances is variable but is within the expected range, and back to pre-Covid levels for this time of year. There is a downward trend, however it must be acknowledged that the Newton Abbott UTC and Totnes MIU are seeing increased attendances partially due to active streaming from the main ED.
- There is a statistically significant downward trend that has stabilised but not at a level that is not palatable for the LCP and a key focus.
- What isn't demonstrated here is that there is an average ambulance attendance increase from around 50/day to over 60/day in a steady progression from the end of October (which is not captured here).
- There is a statistically significant upward shift in the number of ambulance arrivals delayed for over 30 minutes, this appears to be in line with a downwards deflection in minors but an increase in higher acuity Resus and Majors patients within the attendance totality.
- There is a statistically significant upward shift in the total hours lost to ambulance handover delays. This is linked with the above.

Operational Summary

Causes:

- Type 1 attendances are in line with pre-covid levels at this time of year (pre-covid T&SD had one access point and some activity is now directed to Medical Receiving Unit and Surgical Receiving Unit so activity looks lower).
- Delays in ED continue due to poor outflow of patients to inpatient beds. This is an impact of increased length of stay at acute and community settings with patients waiting for onwards moves.
- Continued OPEL 4 due to the impact of continuing high demand with noticeable high clinical acuity, and effects on internal flow secondary to in-

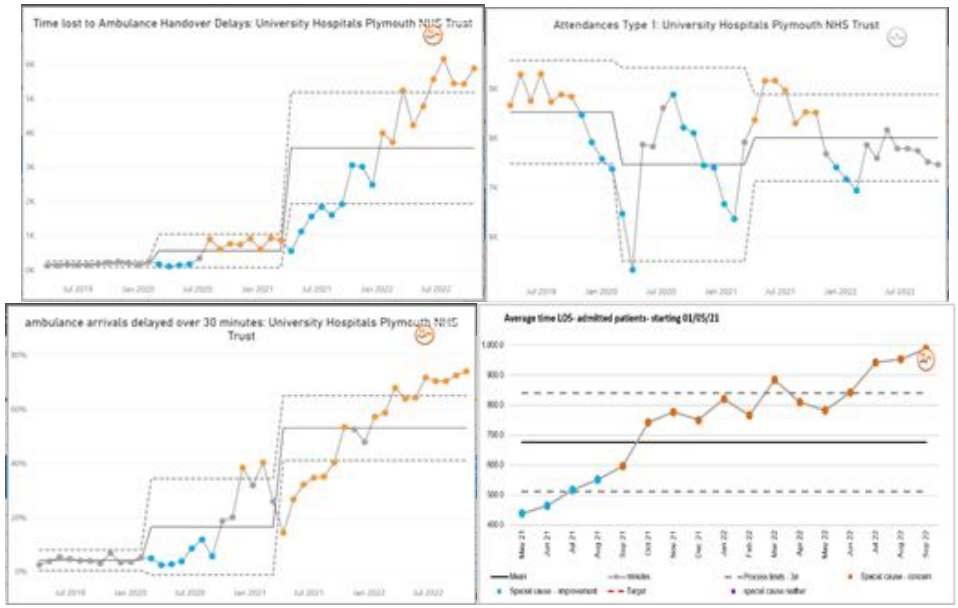
patient nosocomial/community infections including covid + and contact restrictions.

Actions:

- Operational focus on discharges and flow to bring forward discharges to earlier in the day. Target of 30% before mid-day. This is managed via the clinical site team every day and assurance sort via the 4 x a day command meeting.
- Discharge team (MDT including an enhanced clinical and admin support) for weekend discharges. This is now in place with Executive support. A target of 60 discharges per day across all pathways, and 33% of those discharges to leave before 12:00 each day, with a further focus on utilising the discharge lounge is being monitored.
- Learning from internal critical incident. The extreme escalation standard operating policy in ED being reviewed and implemented.
- 6 hour ambulance focus including joint working with SWAST to ensure patients are safe with delayed handover. Ongoing with the SWAST HALO and ED clinical team.
- Implementation of a new model to enable flow from ED to the wards in line with learning from another provider. This is being implemented in line with new plans on on-boarding and cohorting of patients.

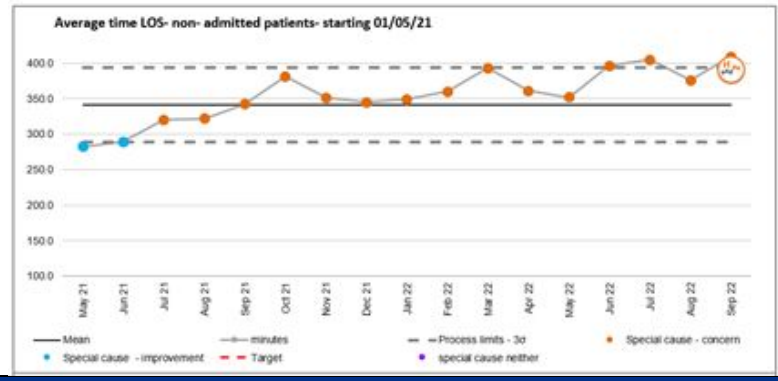
Urgent and Emergency Care – University Hospitals Plymouth

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 continued statistically significant upward shift in the total hours lost to ambulance handover delays.



Operational Summary

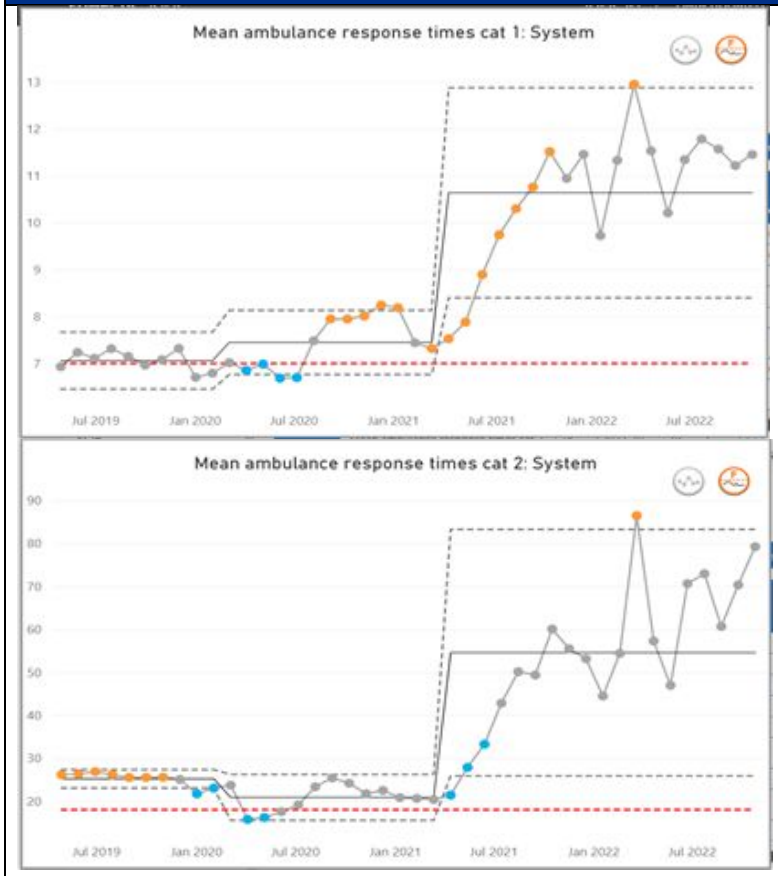
Causes:

- Crowded ED due to space constraints and other factors, including delays in reviewing patients with a decision to admit.
- Second ED front door restarted in Sept 22, currently having a limited impact, although improvements seen in early November
- Ability to provide senior cover within the SDEC service, process & capacity issues limiting activity and impact in supporting ED flow.
- Limited capacity within front door frailty assessment service limiting full impact of admission prevention.
- Improved but still challenging discharge position across all areas. Discharge position for patients requiring discharge to Cornwall very challenging, average length of delay currently 13.9 days compared to 5.1 for Plymouth and 3.3 for Devon

Actions:

- The creation of additional surge capacity within the ED with additional space and staffing. 14 additional trolley spaces created 07/22.
- Increased Same Day Emergency Care (SDEC) capacity with an additional 6 spaces from 15th September 2022
- Increased Surgical SDEC and a restart of GP admissions through Medical Admissions Unit/Acute Ambulatory Unit. GP admission, Medical Triage Unit (MTU) model in place in Acute Assessment Unit (AAU) and Medical Assessment Unit (MAU) for 1 month, data collection underway to determine if this is assisting SDEC improvements
- Increased falls provision from Urgent Care Response and Out of Hours nursing services. Falls masterclass delivered in Dec and Jan. Recruitment for falls service underway with a plan for go live Jan '23. Funding gap identified and currently working to resolve.
- Increased resource for the Hospital to Home pathway 1 service. Currently delivering 24 slots per day. Additional posts interviewed and offered and plan to increase capacity to 40 slots per day due December 2022
- 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. First two care homes live on 4/11/22 with training and go live dates booked for a further 15 by end of Nov 22.
- UHP improvement week (W/C 7th Nov) Key areas of focus: Weekend discharge, Community Hospital flow, therapy at the front door, complex discharge, discharge lounge, discharge information, transfer times, transport, and CT capacity. Outputs to form focused action plan for improvement with agreed targets.

Ambulance response times (Cat 1 and Cat 2)

Data	Analytical Summary
	Ambulance response times are influenced by overall levels of demand, call answering times and capacity to respond which is heavily influenced by hours lost to handover. Overall demand is down on the same period in 2021, and close to that in 2019 and 2020. The percentage of patients conveyed to ED remains low: 38% through September and October. This rate is now the lowest rate across England. Comparable information is only available in August; however, it shows the SWAST ED conveyance rate is 45% (national range 45-57%). Call answering times in September improved on previous months to 52% of calls answered in 5 seconds (target 95%). Mean call answering time, also improved to 56 seconds. There has been a statistically significant upward shift in the mean response time for both category 1 and category 2 post quarter 3 2020/21. The targets of 7 minutes for category 1 and 18 minutes for category 2 will not be met without further intervention. Across the Trust, during October 37,000 hours were lost to handover against an improvement trajectory of 17,000 hours. The average handover time was 1 hour, 25 minutes (target 15 minutes).

Operational Summary

Cause:

- Ambulance response times have a positive correlation with hospital handover delays. South Western Ambulance Service Foundation Trust (SWAST) category 1 and 2 response times are amongst the worst in England. SWAST also have the highest average handover time in England. Derriford and Torbay Hospitals routinely have delays of more than 250 hours per week.
- Call answering times are also influenced by duplicate/subsequent calls, which are currently accounting for 20-30% of all call activity. Duplicate/subsequent call rates increase when handover delays are higher, as callers ring back to escalate cases, get an update on response time etc.

Actions:

- All systems have submitted trajectories to reduce hours lost; however, the trajectory is not being met. Handover improvement plans are in place for Derriford and Torbay, monitored fortnightly through the Devon ambulance cell.
- Through August, a “pathway to paramedic” role was advertised, where recruits start as an EMD (Emergency Medical Dispatcher). There has been significant interest in the role, and it is anticipated this will enhance the numbers of EMDs to meet the trajectory of 250 WTE EMDs. Turnover in the role remains an issue however, and SWAST have authorised retention payments to EMDs to reduce turnover. As at the end of September, there were 199 WTE EMDs in post.
- To mitigate the effect of handover delays on response times, SWAST are providing additional conveying resource hours per week (double crewed ambulance and patient support vehicles) than their “People Plan 2” forecast suggests would normally be required. This includes the provision of third-party ambulance response. During winter, a “risk share” has been agreed across all the south-west systems. If hours lost to handover across the south-west increase above 3900 hours per week, additional payments are made to SWAST against the system trajectory and SW position. The funding will purchase additional response resource, including third-party provider. Through October, the full risk share was payable of £800k; the Devon payment amounted to £219k.
- A SW transformation sub-committee will oversee the delivery of the 2022-23 transformation plan. There are three priorities: availability of alternative response models (e.g. Urgent Community Response), access to clinical information (summary care record) and, simplified pathways to support 999 with appropriate redirection of the patient. A sub-group has been convened to start work on alternative response models including access to acute and community services (e.g. Same Day Emergency Care, mental health crisis response, falls response etc.)

Winter Demand and Capacity Programme

As part of winter planning Devon ICS was awarded £24m of non-recurring funding to support extra capacity, equivalent to 310 beds. This funding has been split across the following schemes to support flow and discharges and as at the end of November 2022 197 beds had been opened.

Scheme	Details	Progress
Western LCP	Acute Escalation Beds - 31 beds + 3 discharge lounge spaces UHP Expanded ED Capacity: ED surge capacity of 6 additional trolley spaces for ambulance handover Enhanced Discharge Capacity - Care Hotel – 30 beds. Step down capacity Age UK – 9 beds. Increased agency capacity – 4 beds. Complex 1:1 support – 6 beds.	10 Same Day Emergency Care (SDEC) beds now available overnight (availability not yet at 100%). 10 beds open at Mount Gould Community Hospital focused on post-acute rehabilitation. 6 additional trolley spaces staffed by UHP via agency now reliably in place to provide additional ED surge/ambulance handover capacity. Care Hotel – 40 beds now fully operational. Age UK fully operational. Agency approval received and commencement 28th November. Complex support – agency deployment to be staggered with commencement 21st November.
Southern LCP	Acute Escalation Beds - 37 beds and internal flow capacity. 24 Rehabilitation beds: Dawlish Hospital/Mapleton – 8 beds. Repurposed P2 capacity – 20 beds. Complex 1:1 support – 6 beds.	18 beds in place. Recruitment underway to deliver a further 19 beds in December. All 24 rehabilitation beds unlikely available before Q4 22/23 due to availability of recruitment. To mitigate delay, 16 additional P2 beds available end November. 6 Mapleton beds open. Agency supporting 1:1. Exploring alternative options.
Northern & Eastern LCP	Acute Escalation Beds. East – 18 beds and internal flow capacity. North – 1 beds and internal flow capacity. Enhanced Discharge Capacity. East - Live-in Carers increase (equivalent 8 beds).1:1 agency support to placements (equiv. 5 beds). Community Urgent Care Response support to SWASFT (equivalent. 17 beds). Reablement Beds (up to 10 beds). North - Increased workforce capacity equivalent to 10 beds & Barn Park – 8 beds plus 6 in scoping.	East - Staffing restricting progress, 3 beds open. Discharge Coordinators – appointed and planned start Dec. North - Additional 11 beds open – temporary staff currently being used to support these beds. Recruitment to internal posts ongoing with some slippage. East - Live-in Carer expansion on track with all 8 in place.1:1 placement support went live on 17th October. Pilot to review Ambulance call stack to identify and refer patients who could be managed by Community Urgent Care Response services (and avoid ambulance call-out and potential hospital admission) went live on 1st November. Option 6 reablement beds being worked up (end Dec '22). North - Enhanced capacity being covered by agency staff which will transition to substantive staff as recruitment completes. Barn Park 8 beds open & 6 additional beds still in scoping.
Mental Health	Enhanced Discharge Capacity - 6 additional private beds and 1 Adult Place of Safety bed. Input to care homes	Additional beds and Place of Safety open Expert Mental Health In-reach to care homes mobilised from 1st November
Virtual Wards	Virtual Ward Capacity: Phase 1 – 53 bed equivalents. Phase 1 + - 32 bed equivalents. Western – 1 bed equivalent	Western open and main go live for December on track
IUC Service	Devon IUCS capacity	In place with Vocare since August 22

Planned Care: System Overview

				System		
	Metric	Target	Latest Date	Value	Variation	Assurance
RTT	RTT Incomplete Waiting list		2022-09	175,200		
	RTT 18 weeks	92%	2022-09	52.4%		
	RTT over 104 weeks	0	2022-09	630		
	RTT over 78 weeks		2022-09	3,394		
	RTT over 52 weeks		2022-09	16,380		
Diagnostics	Diagnostics within 6 weeks	99%	2022-09	64.2%		
	Diagnostic Total activity		2022-09	39,107		
Cancer	Cancer 2 week wait	93%	2022-09	51.9%		
	Breast Symptomatic 2 week wait	93%	2022-09	31.3%		
	Cancer 31 day First	96%	2022-09	92.4%		
	Cancer 31 day follow-up drug	98%	2022-09	99.6%		
	Cancer 31 day follow-up sugery	94%	2022-09	80.9%		
	Cancer 31 day follow-up radiotherapy	94%	2022-09	97.8%		
	Cancer 62 day urgent	85%	2022-09	60.6%		
	Cancer 62 day screening	90%	2022-09	78.3%		
	Cancer 62 day Upgrade	85%	2022-09	70.4%		
	Cancer Faster diagnosis	75%	2022-09	70.2%		

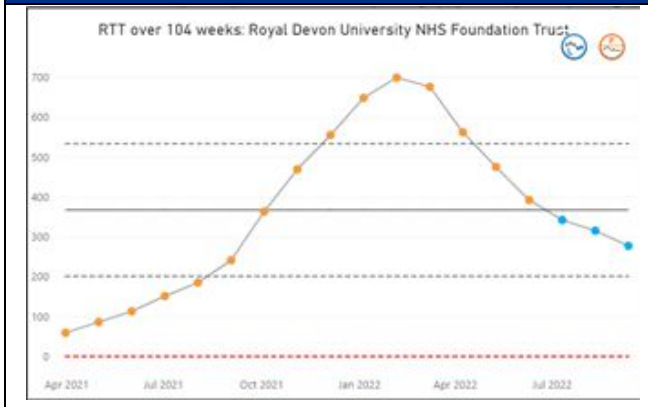
Most of the system performance for the month has remained within normal common cause variation indicating no significant change. However, a significant number of the metrics are failing to achieve the national targets and will continue to do so without intervention.

The system has seen 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, and diagnostic pathways.

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

Planned Care: System 104 Week Wait

Data



Analytical Summary

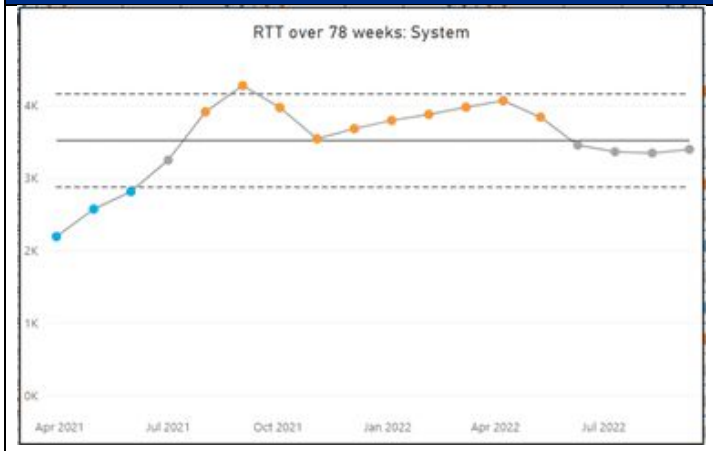
The RTT 104 week wait metric exhibits special cause variation which raises concern. It continues to fail the target of zero 104-week waiters at individual acute provider and system level.

Operational Summary

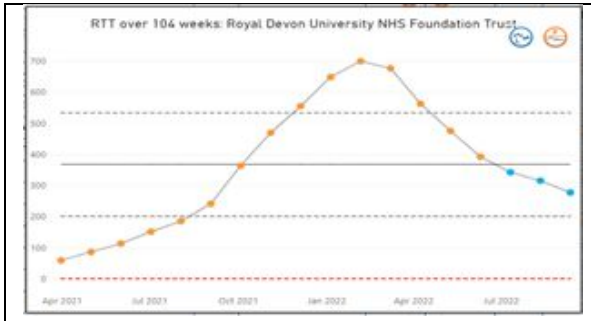
- The current forecasted position for Devon at the end of November was 505 which is 137 adverse to the trajectory submitted in June 22.
- Long waiting patients continue to be a priority workstream across the system with weekly meetings with regional and national colleagues in place.
- The NHSE 10-Week Plan is currently being implemented across the system and as of week commencing 14th Nov, the initiative is in week 6. The plan focuses on the delivery of treating all long waiting patients in specialties with fewer than ten patients waiting above 104 weeks by December as well as ensuring no patient is waiting above 104 weeks on a non-admitted pathway by the end of March 23.
- Further phases will be implemented, following the delivery of the 10-Week Plan, to increase performance and delivery over quarter four and then longer-term elective recovery planning.
- Key actions for the delivery of quarter four elective recovery will be to identify the changes that can be made to support improvements in elective recovery trajectories in the period from January to March. Trust plans for this are to be submitted to NHSE by the 16th of December. Outputs include:
    - Updating activity volumes and forecasting the impact on 104w and 78w trajectories
    - Detailing short-term recovery plans for specialties which are particularly challenged e.g., T&O, Neurology and Cardiology.

  Following this the longer-term focus will be to develop the provider and system plans for elective recovery as described in the 23/24 operating plan. Outputs include: -

Planned Care: System 104 Week Wait Continued

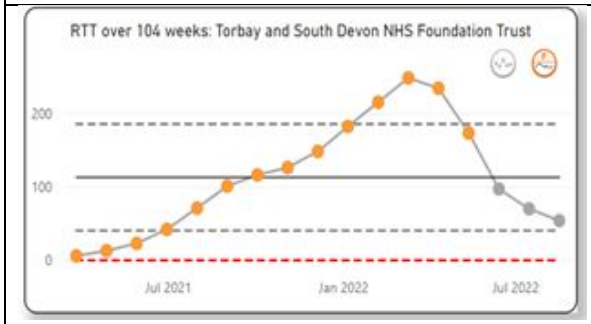
Data	Operational Summary
	○ Supporting the development of elective elements of 23/24 operating plan in accordance with national timetables • Development of a 3-year elective recovery plan incorporating the ability to amend if any changes to policy or operating conditions. • Theatre efficiency programmes are being developed to support the delivery of the 10 Week Plan and ongoing elective recovery. This includes plans to implement and deliver opportunities from the Model Hospital programme and the Getting it Right First Time (GIRFT) programme. These include achieving best practice day case rates, length of stay and procedures per list, for example 4 joints per hip/knee list. • The focus for elective recovery is now including patients waiting longer than 78 weeks. The system is ensuring that all patients, have either had a clinical review or clinical validation within 12 weeks of their last review. This will ensure appropriate clinical prioritisation and support is in place to move patients to alternate providers via mutual aid. Plans are being developed across providers as to how this will be achieved. • New guidance on managing patient choice delays has been released by NHSE: All patients waiting over 104+ weeks through to end March 2023 have been reviewed in line with this guidance. This process will now continue for all patients waiting more than 78 weeks. • The long wait patients are typically some of the most complex and are disproportionately impacted by the pressures throughout the system; Providers are challenged by the increased demand for cancer services in some specialities, competing emergency demand and significant wider workforce challenges.

Planned Care: Trusts 104 Week Wait



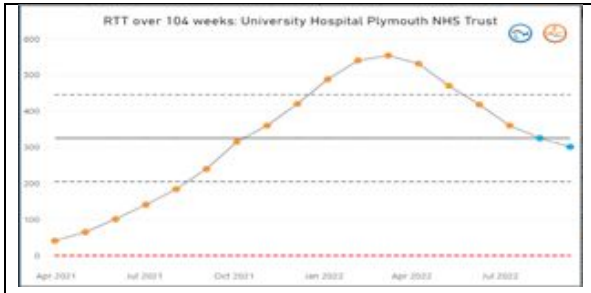
RDUH Operational Summary

- RDUH are currently forecasting 195, 104 week waiters at the end of November.
- Current trajectory for December is 203 patients which is a worsening position due to the issues detailed in the previous page. This trajectory is updated weekly.
- Most challenged specialities are orthopaedics which will have 116 patients waiting at the end of November and colorectal surgery which will have 44
- Key risks to this position are, impact of urgent care pressure on bed base leading to elective cancellations, delays in the delivery of insourcing and the access to gynae urodynamics diagnostic support from another provider.
- Glanso lists are in place throughout November and December to support additional capacity at weekends. Key focus will be on Orthopaedics, ENT and General Surgery. This usually adds one additional day of elective activity per week via an all-day Saturday list.
  Revised criteria at Nightingale being implemented which projects a potential 6 additional patients so far to be treated before the end of November.
- BMI complex abdominal mutual aid is being sourced as well as additional mutual aid for cardiology and orthopaedics at the Cleveland Clinic London. Planned impact being 30-60 Cardiology patients being treated before 31st March-23 and potentially 3 orthopaedic and 3 spinal a week from January 23.



TSD Operational Summary

- TSD are currently forecasting 39, 104 week waiters at the end of November 22.
- Current trajectory for December is a worsening position to 42 patients.
- Most challenged speciality is orthopaedics which will have 14 patients waiting at the end of November.
- Patient validation continues across several specialties.
- Additional OP clinics are due to commence supported by agency staffing. This will support an additional 60 patients being seen per week across Gastroenterology and Urology, commencing early Dec-22.
- Additional consultant into the LGI service via a neighbouring Trust on secondment, who will assist with capacity in outpatient (addition to current baseline) and theatre.
- Revision of pathway for Pain Service; requiring patient engagement from the outset (upon receipt of referral)
- Use of insourcing to increase capacity in ENT.
- Use of Physio in OP clinics to increase the capacity (ENT but potential to review in other specialties).
- OP Clinic template changes – return capacity to pre-covid levels



UHP Operational Summary

- UHP are currently forecasting 246, 104 week waiters at the end of November 22. The trajectory is updated weekly.
- Current trajectory for December is 239. Most challenged specialities are orthopaedics which will have 126 patients waiting at end of November, and neurosurgery which will have 94. This includes 23 patients on a non-admitted pathway.
- The UHP pilot with the Schoen Clinic for direct provider to provider mutual aid is underway with UHP managing the end-to-end process for patients. This process also includes direct reporting to NHSE on progress for regional oversight and governance. Non-admitted patients are to be included as part of this pilot, starting with an initial trail of 12 patients from Neurosurgery
- The administration side of Mutual Aid (MA) is working to get ahead and ensure all patients are contacted. UHP is reviewing the complexity of patients who can be treated at the weekend.
- Initiatives such as the Right Patient Right Place project are supporting the rising demand though reducing length of stay for non-medical patients to help maximise patient flow and theatre efficiency schemes such as the implementation of Model Hospital methodology.

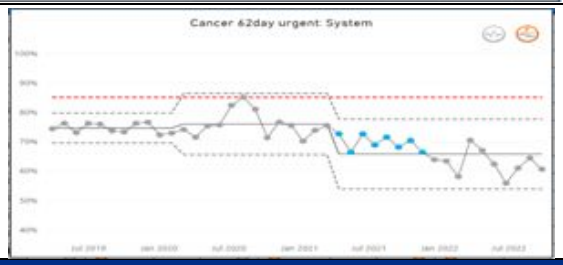
Cancer 2 Week Wait and 28 day faster diagnosis: System

Data	Analytical Summary
	• The Cancer 2ww metric is consistently failing the target, it displays common cause variation, there is no significant change nor indication of improvement in this system wide metric • 2ww performance is 50% against a 93% standard. The 2ww performance remains under pressure due to the increase in referrals, this has been coupled with a scheduled reduction in activity planned for the EPIC implementation at RDUH North particularly impacting dermatology and delaying the implementation of the restoration plan.
	• The Cancer 28 day Faster Diagnosis Standard (FDS) for the system shows common cause variation as it oscillates around the target, achieving 70% for the system in September against a 75% standard. However, UHP has achieved this target in September at 78%. • Challenges in the diagnostic pathway for LGI, Urology, Gynaecology and Breast continue to be the greatest risks to achieving 28 days. • This performance is in line with the trajectory submitted within the 22/23 operating plan.

Operational Summary

- The four most challenged tumour sites for 2ww across the system are Lower GI, Urology, Breast and Skin caused by increased demand and capacity issues with endoscopy, LGI outpatients, Urology capacity, breast radiology and dermatology outpatient capacity. Several actions are being put in place to support recovery and once agreed and completed the impacts will be assessed.
- Actions –
  - All Trusts are being monitored in delivering imaging within the standard and are all achieving within 14 days. Performance against the 28-day cancer diagnosis standard is 70% against the national standard of 75%. This in line with the trajectories submitted in the 22/23 operating plan.
  - All Trusts have a cancer recovery action plan in place. Trusts, ICS, and Cancer Alliance meet weekly to actively monitor and mitigate issues as they arise.
  - 2ww recovery includes partial redirection to a provider in Plymouth for LGI and implementation of the FIT (Faecal immunochemical Test) pathway.
  - Additional capacity for Prostate biopsy, endoscopy and gynae pathways is being commissioned through funding from ICB and Cancer Alliance.
  - Dermatology services are providing additional clinics and converting routine activity to 2ww to support reduction in backlogs. RDUH North insourcing to clear backlog by the end of March 2023 and T&SD are piloting solutions. These initiatives will be quantified and confirmed in December 22.
  - The UHP and RDUH cancer pathway mapping process is complete. Action plans and notes are currently being circulated for comments. The teams will then be working through the series of interventions identified, before agreeing timeframes for implementation.
  - T&SD are currently supported by the NHSE Intensive Support Team focussing upon the recovery of the cancer targets (28 days, 31 days and 62 day).

Cancer 31 day first seen and 62 day Urgent: System

Data	Analytical Summary
	The Cancer 31 day metric is currently failing the target, there is no significant change or indication of improvement in this system wide metric. Delays in booking surgery and delivery of oncology and radiotherapy continue have an impact on achieving this standard. For September performance was 93% against a 95% standard.
	The Cancer 62 day metric is consistently failing the target, it displays common cause variation. There is no significant change or indication of improvement in this system wide metric. September performance was 60% against an 85% standard

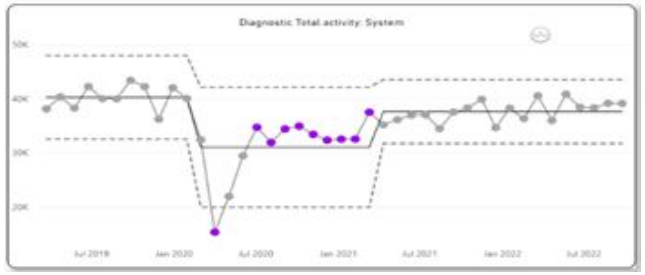
Operational Summary

- The two most challenged tumour sites in the system for this standard are Urology and Lower GI.
- Devon's 62-day performance was under pressure pre Covid and has not recovered post pandemic.
- Staff vacancy rates and service capacity, particularly within diagnostic elements of pathways are the primary cause of pathways not meeting the standard.
- Backlogs are being cleared with the additional diagnostic capacity being delivered. UHP have reduced their over 62-day backlog by over 20 patients in one week.
- In relation to the 62-day standard there were 1,091 open pathways in September against the operating plan monthly target of 608 derived from 19/20 position.

Actions:

- NHS Devon and providers are working together on initiatives to improve performance to close the gap. The elements of the pathway that cause the delays have been identified and are the focus of activity to provide additional capacity. Funding has been allocated through the cancer alliance and the totality of the capacity and its impacts will be available in January 23.
- Additional prostate biopsy commissioned from Nuffield to end of year for system began 3/10/22.
- Successful finding request via cancer alliance £1.8m for mobile capacity to deliver trans perineal biopsies, cystoscopies and hysteroscopies across all providers, awaiting confirmed delivery date
- Approved additional prostate biopsy capacity for UHP. Start Nov 22 pending confirmation of equipment delivery providing an extra 50 biopsies per month.
- Expansion of a pilot in Northern Devon with independent sector for increasing dermatology capacity is being investigated
- Extended faecal testing pathway has been agreed to improve outpatient pathways in Lower GI.

Diagnostics

Data	Analytical Summary
	**Activity** The total diagnostic activity is yet to show significant sustained improvement, the variation to date appears to be common cause.
	**Performance** The system wide performance against the 6 week diagnostic standard continues to show common cause variation and is consistently failing the target. In August 64.2% was achieved against a target of 99%. The national target has been amended during post pandemic recovery to 75% with no patients to wait more than 26 weeks. These targets are not on track to be delivered by March 23.

Operational Summary

The most challenged modalities in the system for this standard are endoscopy, MRI (especially Cardiac in T&SD), Urology, and in RDUH East specifically Audiology, Echocardiography and Sleep studies.
The investment in Exeter Devon Diagnostic Centre (also known as CDC or Nightingale) has supported the performance remaining consistent across the year within imaging. Activity peaks show the impacts of Wait List Initiatives and weekend insourcing, mitigating external pressures upon demand and capacity.
A monthly activity report for the Community Diagnostic Centre (CDC) is produced and shared at Planned Care Board.
There are 15 modalities measured in the diagnostic standard, not all modalities have received investment. Plans are in place to achieve CT, NOUS and Gastroscopy 75% standard by end of March 2023.

Actions:

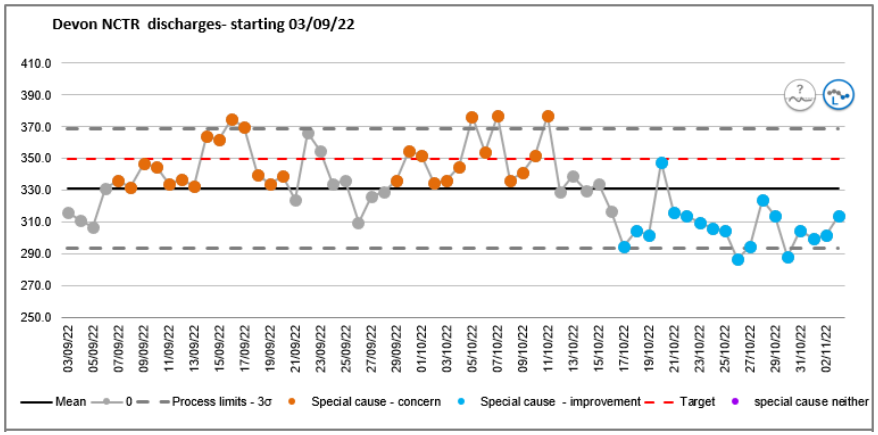
- Endoscopy mobile unit now operational at Torbay (5 days) now endeavouring to achieve 7 days working with insourcing on weekends
- Capital bid for £1.7 to provide a staffed unit at Tiverton for recovery to mitigate the effect of enabling works decision due 21/10/22 (still awaited from NHSE)
- Endoscopy funding request for £800k for additional endoscopy capacity awaiting approval in December
- A paper has been submitted to the Planned Care Board recommending:
  - Trust leads to come together to explore the options for DEXA support for RDUH North.
  - Agreement in principle to enact mutual aid to support long waiting patients as an ICS

Hospital Discharge

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
No Criteria to Reside (NCTR)	5%	13/11/2022	12%		

Percentage of beds occupied by patients with no criteria to reside

Trend Chart



Analytical Commentary: Devon has agreed a target of no more than 5% (110) beds occupied by patients with no criteria to reside. As of 13th November, current position is 12% (271) beds occupied across the acute trusts in Devon. Since the middle of October there has been a downward trend in the number of patients who have no criteria to reside, although yet to meet local and national targets.

Operational Summary:

Pathway 0:
All Trusts at the end of October are achieving between 60% and 70% against the Target of 80% of discharges prior to 5pm.
Actions to enable improvement:

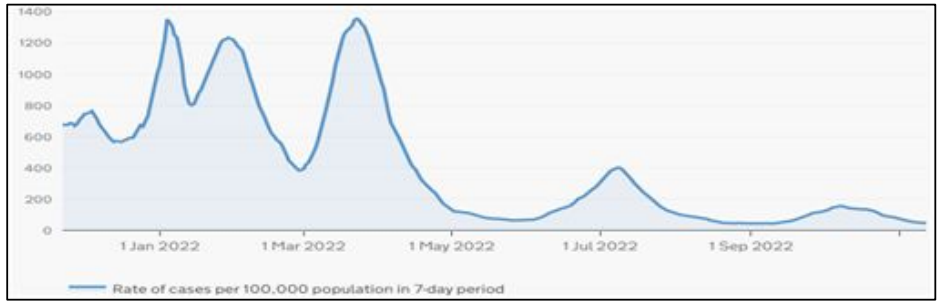
- Promotion of Help me Home for Lunch initiative
- Criteria Led Discharge roll out
- Focus on weekend discharges to achieve 60% of weekday target, during October improvement has been seen on Saturdays across all trusts average of 60% with further work required on Sundays with an average of 46%.

Pathway 1-3:

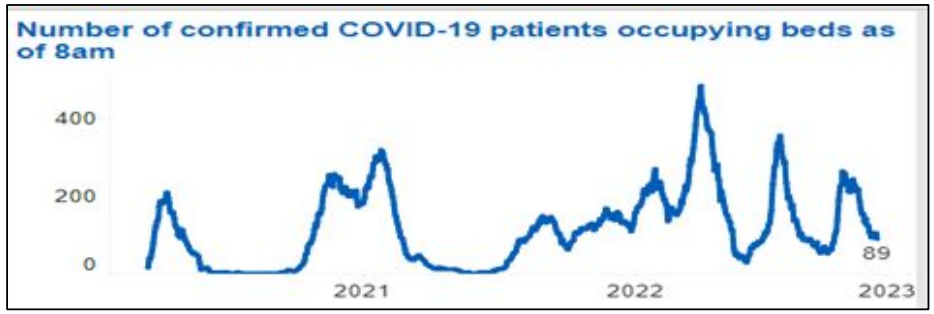
- Demand & Capacity (community capacity creation) – investment of c.£9m in schemes to create beds ahead of winter. Locality level plans are in delivery/development. This additional capacity will support reduction of delays due to available social care market capacity. Plans vary by scheme and area. An increase of 81 beds providing new capacity in October.
- National 100 Day Challenge – implementation of 10 interventions to improve acute hospital discharge. 4 interventions RAG rated Red are now either Amber or Green. The system will now focus on 3 key interventions as a priority; Ensure MDT Engagement in early discharge plan, plan expected date of discharge and discharge within 48 hours of admission and Apply 7 day working to enable discharge of patients during weekends. Impact of this intervention has been a notable improvement in the proportion of individuals being discharged earlier in the day and a stronger proportion of discharges at the weekend compared to regional average position.

Covid Update

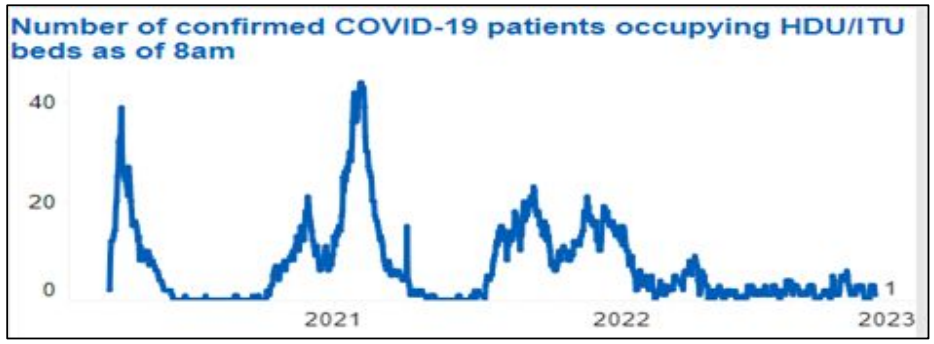
Covid infections have fallen since a peak in early October but are expected to start rising again in late November/early December, with a further peak towards the end of December or early January.



The number of Covid patients in hospital beds has reduced from the most recent peak of 264 at the beginning of October down to less than 100 in late November. However, numbers are expected to rise again from early December.

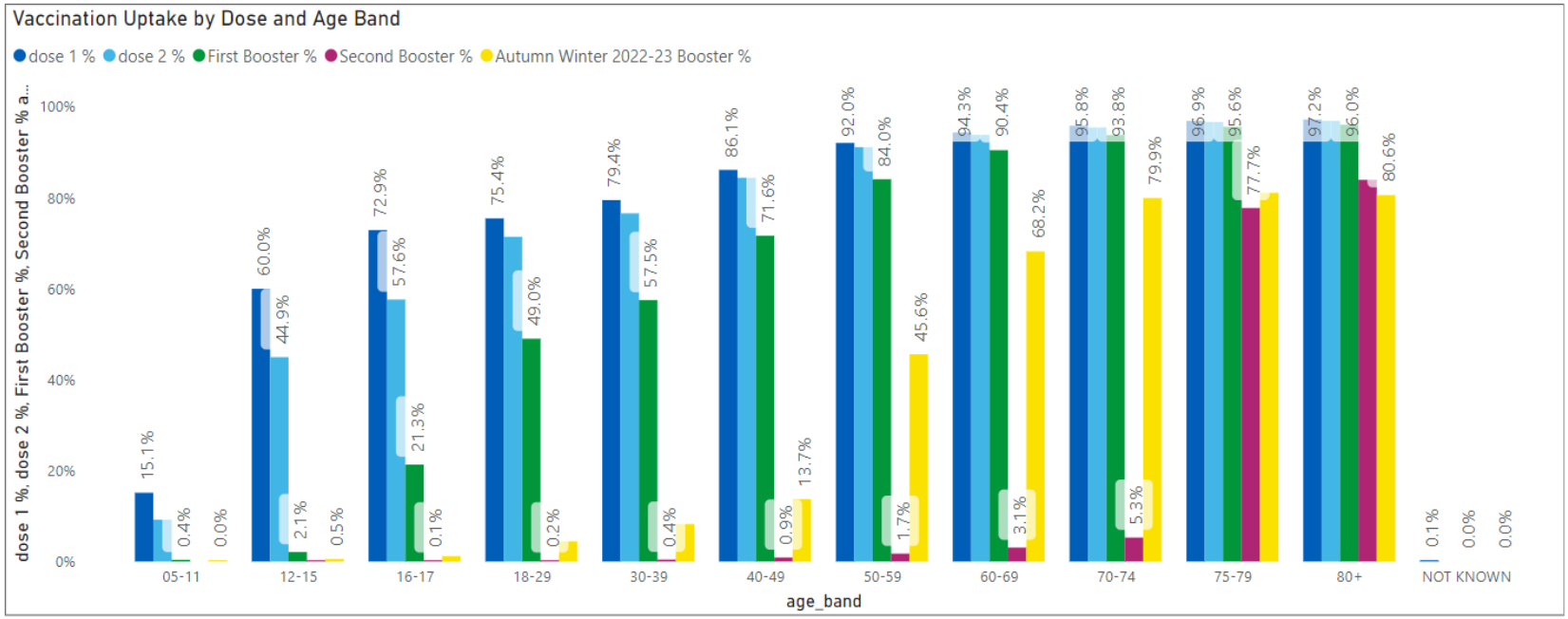


Covid patients in ICU continue to remain low. As of 20thNovember there was just 1 patient with Covid occupying an ICU bed in Devon.



Covid Update: Vaccinations

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

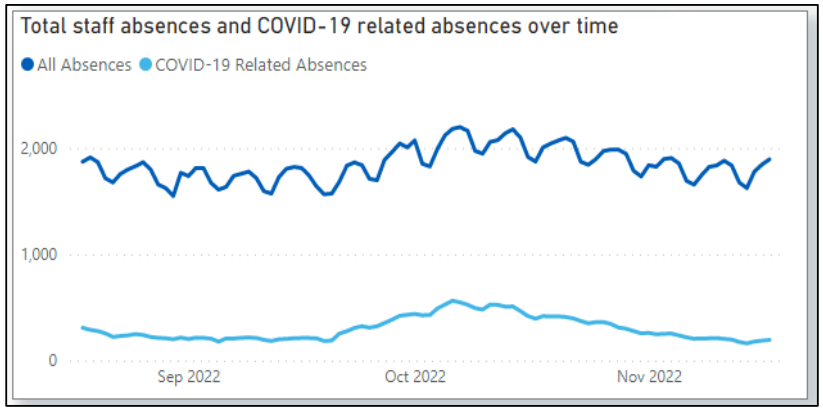


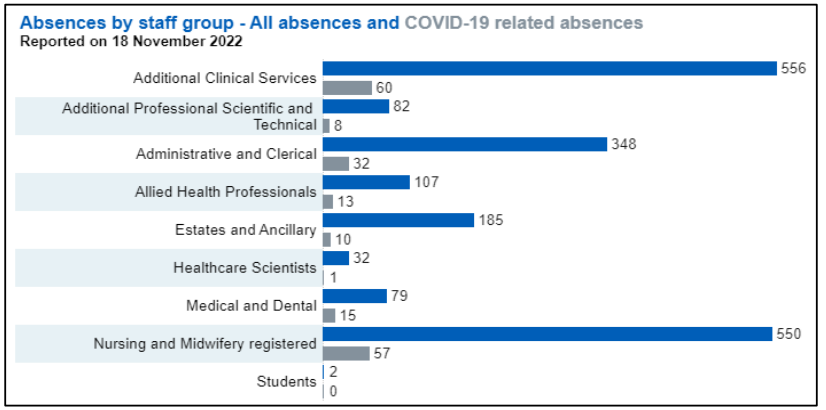
Covid Update - Workforce Absence

Covid-related absences have decreased at a steady rate since the start of October across all providers, falling to around 0.5% of working days in mid-November.

Latest figures show 5.4% of staff are absent in total across Devon's providers, 0.6% of which were Covid-related (although still much lower than the 3%+ Covid absences seen during October and previous Covid peaks).

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





Primary Care: Clinical Activity

Theme: General Practice Clinical Activity Backlog

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

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

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

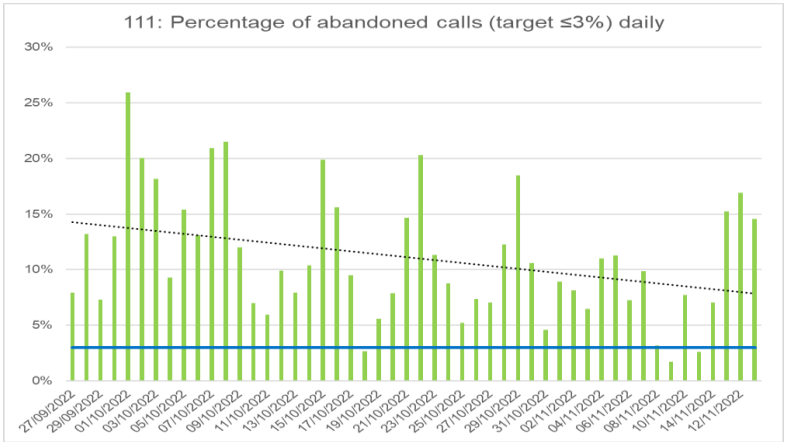
Primary Care: Clinical Activity

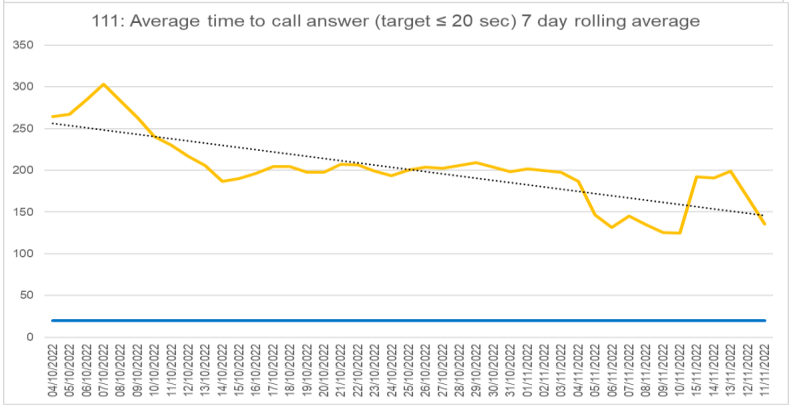
Actions undertaken in last month:	Impact:
Primary Care completed action to access BI Team to review quantification of activity data that could be utilised to monitor accumulation of delayed work, for example QOF (Quality Outcomes Framework), Public Health screening metrics, immunisation rates and referral activity. We have liaised with NHSE to source QOF data held by them as this reflects the pre-Covid position in terms of QOF achievement.	Potential data sources identified, for example, QOF data from NHSE, to help identify backlogs. Once available, this data will be used to assess the extent of delayed services and plan improvement (anticipate reporting January 2023 with the QOF information)
Re Devon Spring Action Fund (DSAF), practices that have not been able to spend their original allocation have had monies clawed back as part of the October payment process.	DSAF provided additional financial support enabling practices to secure additional clinical sessions, from both existing staff providing extra sessions and locum practitioners

Actions for next month/s:	Intended impact:	Date impact will be realised:
Continue to work with BI to quantify outstanding practice and provision of services including review of LTC (Long Term Conditions) associated QOF data, comparing where possible to pre-pandemic levels. At present we do not have access to pre-Covid QOF data as this is held by NHSE (as it was prior to delegation). We will continue to seek this information from NHSE to get the baseline for QOF comparison against current achievement.	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. Awaiting response from NHSE regarding provision of QOF data dating back to pre-Covid (prior to delegation). Once the QOF data is available it will be reviewed and compared to current year achievement to date to enable some assessment of clinical backlog related to LTC management.
DSAF – 3 practices remain with outstanding queries; reminders will be sent with a deadline for information to be returned for any further payment(s) to be made.	Additional financial support has enabled practices to secure extra clinical sessions, from both existing staff providing additional sessions and locum practitioners.	Once all claims have been finalised it will be possible to look at the number of sessions that have been funded.

Integrated Urgent Care Service: NHS 111

Data





Introduction

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

IUCS includes NHS 111 calls and online, clinical assessment service (CAS) and out of hours face to face treatment.

Analytical summary

Due to the early stages of the contract, it is difficult to forecast future performance. However, early indicators suggest that performance is improving against key metrics for 111 services.

Abandoned calls have reduced since the PPG contract commenced at the end of September although they do increase at weekends. However, there is a general downward trend of calls abandoned. Average time to answer calls is also improving and is on a downward trend.

The improvements are down to 111 calls taken as part of a national PPG network, and the engagement of a sub-contractor to take calls whilst recruitment to the Devon service continues up to establishment. PPG continue to recruit across their call handling network to ensure that they have sufficient capacity to fulfil their contractual performance requirements. PPG have made significant improvements in increasing staffing establishment. As the service becomes fully established in Devon, commissioners will work with PPG to identify a trajectory toward meeting national and local performance requirements. It should be noted that, not unlike other urgent care organisations across the country, IUCS services/providers nationwide are struggling to meet demand and deliver national targets.

Data

IUC service key metrics:	PPG				2021		
	Fri	Sat	Sun	weekly	Fri	Sat	Sun
	04-Nov-22	05-Nov-22	06-Nov-22	position	05-Nov-21	06-Nov-21	07-Nov-21
calls received	817	1765	1602	7217	932	1827	1704
calls answered	727	1566	1486	6599	751	1151	944
% of calls abandonded	**11%**	**11%**	**7%**	**9%**	**18%**	**36%**	**44%**
SLA %	69	68	66	69%	37	13	6
Average Wait to Answer (nearest min)	**3**	**3**	**3**	**2**	**6**	**18**	**24**

IUC Key Service Metrics:	PPG				2021		
	Fri	Sat	Sun	Weekly	Fri	Sat	Sun
	11-Nov-22	12-Nov-22	13-Nov-22	Position	12-Nov-21	13-Nov-21	14-Nov-21
Calls Received	860	1768	1596	7321	1195	2546	2161
Calls Answered	733	1469	1353	6469	743	1173	975
% Calls Abandoned	15%	17%	15%	12%	38%	54%	55%
Average Wait to Answer (nearest minute)	4	6	6	3	7	12	14

Analytical summary

Weekend performance is not yet as good as that on weekdays, in comparison with the same period last year, however, that there has been a significant improvement in call waiting times and calls abandoned.

Information on CAS and OOH activity will increase over time as the contract progresses and information is quality assured.

Early intelligence suggests that there has been an increase in clinical demand, as more calls get answered identifying the “true” demand for 111 services.

PPG are experiencing difficulties accessing sufficient clinical workforce to deliver the optimal service in CAS and OOH. There is a national home working clinician pool which provides Devon patients with improved access to clinical resource. Numerous other actions are underway to secure clinical capacity to see patients face to face out of hours. Dedicated exec level resource has been sourced by PPG to progress this and there are weekly meetings to deliver plans and monitor progress.

The first contract and quality report, which will include measures commensurate with patient experience, will be available for the Contract Quality Review Meeting (CQRM) week commencing 21st November.

Mental Health: System Overview

Metrics

			September 2022 Data		
Key Performance Indicator	National Target	System Target	Actual	Variation	Assurance
Community Mental Health access (2+ contacts)	18,942 Q4	17,452 Q4	16,360		
Children & Young People's Access (1+ contacts)	14,037 Q4	13,477 Q4	12,200		
Children & Young People Eating Disorders routine cases	95% Q1	95% Q4	44.4%		
Children & Young People Eating Disorders urgent cases	95% Q1	95% Q3	85.71%		
Dementia Diagnosis Rate	66.7% Q1	60% Q4	55.2%		
Early Intervention in psychosis (EIP): % entering treatment within two weeks	60%	60%	70%		
IAPT Access	9,310 Q4	7,983 Q4	7,144		
IAPT – first appointment within 6 weeks	75%	75%	94.13%		
IAPT – first appointment within 18 weeks	95%	95%	100%		
IAPT Recovery	50%	50%	50.9%		
Individual Placement and Support (IPS) access	300 Q1 954 Q4	642 Q4	397	N/A	N/A
Perinatal Access Rate	1,115 Q4	1,028 Q4	1,034		
Physical health checks for people with severe mental illness (SMI)	7,448 60%	7,448 60% Q3	40.43%		
Inappropriate out of area bed days	0 Q4	0 Q2	479		
Annual health checks for people with a learning disability	75%		19%	N/A	N/A
Reducing adults and CYP with LD in specialist inpatient beds	31		45		

System Summaries

Analytical Summary

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

Operational Summary

Due to the ongoing national major incident relating to the 'Advanced' outage of electronic patient records, affecting system providers, performance information is not available for several reporting metrics, this affects both local and national reporting. NHSE is sighted on the issues and providers are using an alternative system with their operations board having oversight of any potential safety or quality issues.

The continued duration of the outage and the subsequent gap in data for the period of the outage will have an ongoing impact on reporting.

Issues with the EIP data have not yet been resolved and a query has been raised with NHS Digital MHSDS team. We anticipate a meeting will be arranged between ICS Devon, Livewell, NHS Digital and the Southwest mental health team in the next few weeks.

IAPT appointments offered within 6 and 18 weeks continue to perform consistently well and exceed the targets. Improvements can be seen in the Perinatal Access Rate, Physical Health checks for people with SMI and inappropriate out of area bed days. CYP eating disorder routine referrals and the dementia diagnosis rate continue to experience special cause variation of a concerning nature. The remaining indicators are all within common cause variation with no significant changes to note.

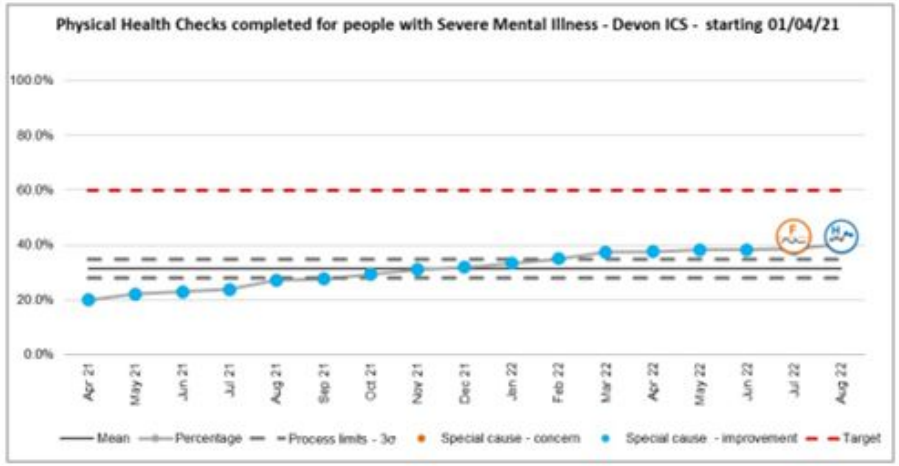
Mental Health: Severe Mental Illness – Physical Health Checks

Key Performance Indicator	Target (National)	Target (System)	Latest Period	Actual	Variation	Assurance
Physical health checks for people with severe mental illness (SMI)	60%	53.11% (Q2)	Aug-22	40.43%		

KPI Description

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

Statistical Process Chart



Data Source: GDPPR dataset, NHS Digital

Analytical Commentary

The measure is showing special cause of an improving nature but is not achieving the LTP target.

Operational Summary

NHS England identified a target of 60.0% of people with SMI accessing physical health assessments in 2022/23. ICS Devon submitted a trajectory to reach this by the end of quarter 3. This trajectory has now been revised for achievement by the end of quarter4 2022/2023.

Actions and Assurance

Monthly trajectory and recovery plan in place which includes:

- Utilising additional capacity through our commissioned independent provider to increase access. This should enable achievement of 56% by the end of Q3.
- Targeting the component of the check that is preventing achievement of all six components to meet the target.
- Working with primary care through Webinars and other communications to promote delivery and uptake of additional capacity.

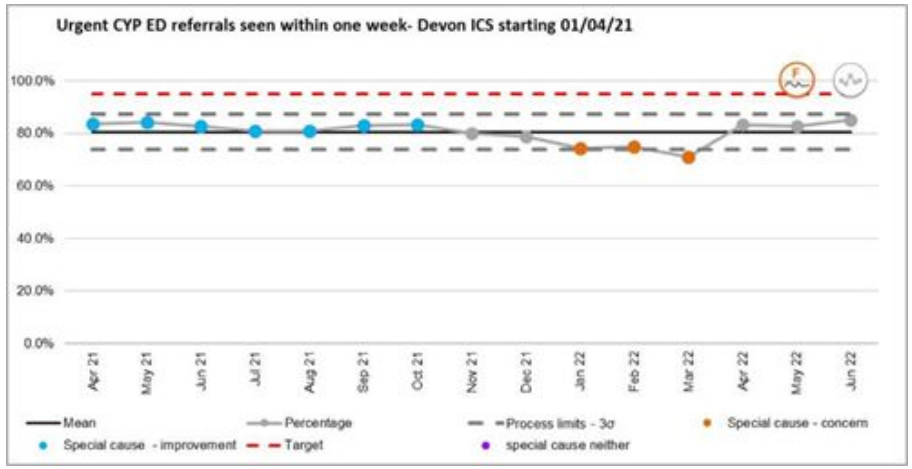
Mental Health: CYP Eating Disorders Urgent

Key Performance Indicator	Target (National)	Target (System)	Latest Period	Actual	Variation	Assurance
Children & Young People Eating Disorders urgent cases	95%	91.4% (Q2)	Jun-22	85.0%		

KPI Description

The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment. Rolling 12-month target.

Statistical Process Control Chart



NHS England request that monthly data points are calculated as a rolling average of the preceding 12 months activity as opposed to activity within the month itself. For example, August 2021 80% rate is calculated as the average of all referrals seen within a week between September 2020 – August 2021).

Analytical Commentary

This KPI is within common cause variation with an upward trend. Devon and Torbay have not been able to report since June 2022. Plymouth had no urgent referrals in September.

Operational Summary

NHS England identify a target of 95% of children and young people with 'urgent' needs receiving treatment for eating disorders within 1 week of referral. ICS Devon submitted a trajectory to reach 95% by the end of quarter 3.

As of June 2022, nationally performance against this deliverable is at 68.1%, regionally performance against this deliverable is at 35.9%. ICS Devon's performance against the national target is 85.0% (rolling 12 month target – (July 2021- June 2022).

Since November 2021, both providers have achieved 100% referrals seen within a week (on a month by month basis). However, due to the rolling average calculation this will not yet be visible on the chart as the reported data period is June 2022.

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

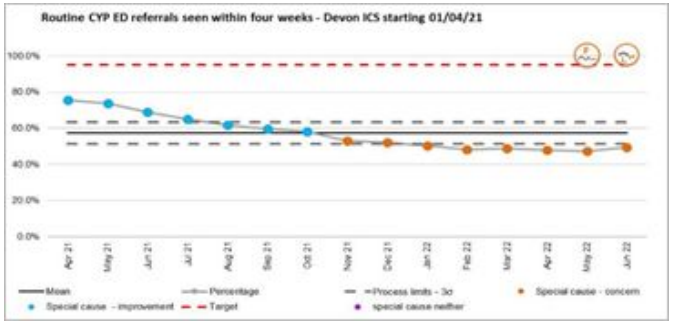
Mental Health: CYP Eating Disorders (ED) Routine

Key Performance Indicator	Target (National)	Target (System)	Latest Period	Actual	Variation	Assurance
Children & Young People Eating Disorders routine cases	95%	48% (Q2)	Jun-22	49.5%		

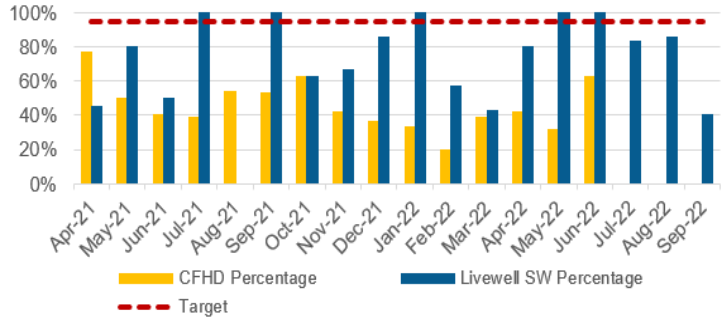
KPI Description

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



(NHS England request that monthly data points are calculated as a rolling average of the preceding 12 months activity as opposed to activity within the month itself).



Analytical Commentary

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

Operational Summary

NHS England identify a target of 95% of children and young people with 'routine' needs receivingtreatment for eating disorders within 4 weeks of referral. ICS Devon submitted a trajectory to reach 95% by the end of quarter 4 22/23.
As of June 2022, nationally performance against this deliverable is at 68.9%.
As of July 2022, ICS Devon's performance against the national target is 50.36% which exceeds the quarter 1 and quarter 2 trajectory expectations.

Actions and Assurance

Plans to support achievement of these deliverables are monitored through the CYP EHWB Programme Board and individual provider contract review meetings to monitor and assure delivery and improved performance proceeds as planned. A deep dive has been requested for the December Quality and Performance committee.

***** No data is available at system level after June-22 due to national patient records outtage. *****

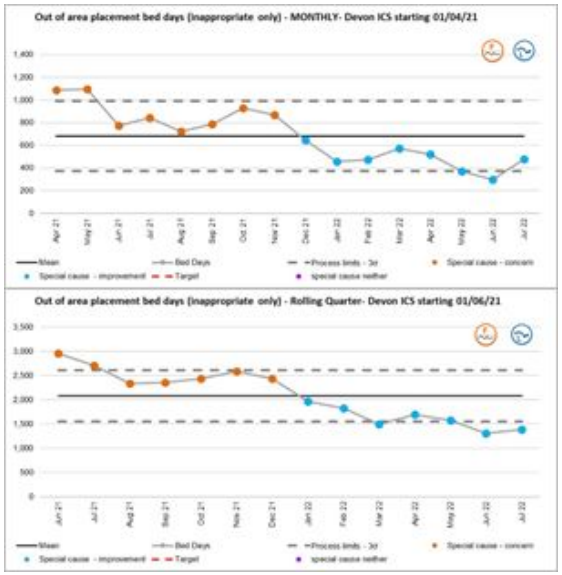
Mental Health: Out of Area Placements/Bed days

Key Performance Indicator	Target (National)	Target (System)	Latest Period	Actual	Variation	Assurance
Inappropriate out of area bed days	0	0 (Q2)	Jul-22	1,385 (Rolling Quarter) 479 (monthly)		

KPI Description

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

Statistical Process Chart



Data Source: Monthly inappropriate OAPs stocktake

Analytical Commentary

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

Operational Summary

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.

Actions and Assurance

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

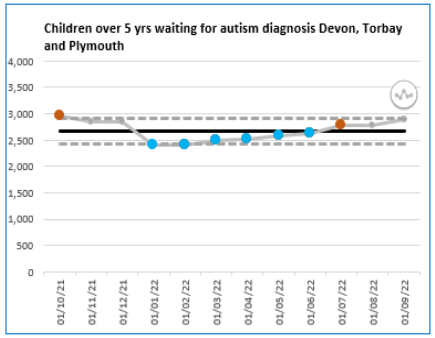
- Implementing peer/senior clinician reviews at length of stay trigger points in DPT. To reduce average length of stay and increase the number of patients accessing the service.
- Evaluating (complete Q3) the model ward pilot (aligning local beds to local people). Findings implemented in Q4.
- Initiating a 'Right to Reside Review' in the Plymouth footprint
- In addition, supplementary bed-based capacity is being introduced in the Winter period to manage demand.

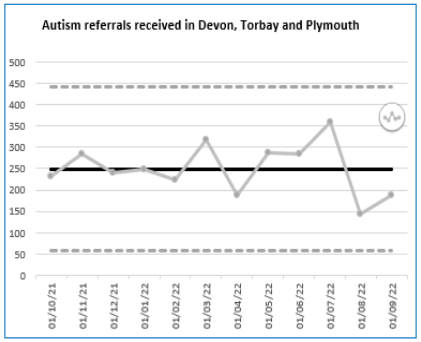
Children & Young People (CYP): Autism Diagnosis waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Autism Diagnosis (Waiting)	> 18 wks.	Sept 2022	76.6 wks.		

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

Statistical Process Charts – Devon, Torbay and Plymouth





Longest wait = 114.8 weeks

(Referral data unavailable from LSW).

Analytical Commentary
The metric is currently experiencing Common Cause Variation, however average wait times are over four times greater than target. Process/delivery change is required for improvement.

Operational Summary – Devon, Torbay & Plymouth

What are the causes?
Staffing levels remain below full establishment and recruitment into posts was unsuccessful.

Actions

- Meetings with providers to review trajectory – there is a dependency on workforce numbers – realistic targets set based on previous experience by providers to recruit.
- Short & medium term: new model for Neurodiversity – first workshop held November 22.
- Proposed use of key workers to support families on waiting list.
- T&SD Paediatrics implement 'First Steps' – parent workbook of resources whilst waiting as well as Joint clinics with therapies for pre-school age children.
- Agency staff have their contracts extended to March 2023.

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

- Requests for Help' are triaged to identify children at risk and prioritise as appropriate. Families have access to telephone support where needed.
- Continued pressure for ADHD assesment in North Devon. Service cost identifed £288k

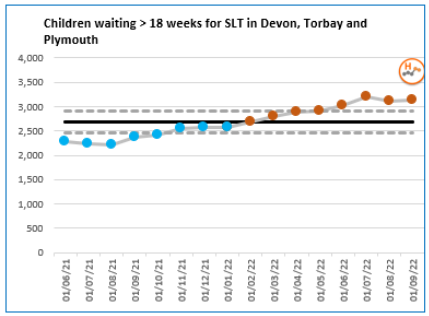
When will we see an improvement?
Forecasting within the Strategic long term Neurodiversity improvement plan projects a 39% reduction in children waiting in Devon (1959 to 1189) by September 2023.

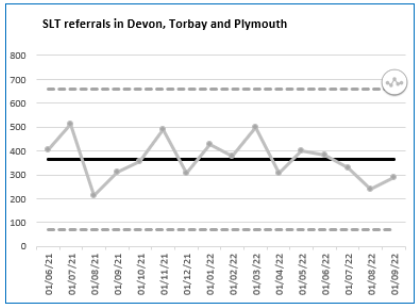
Children & Young People (CYP): Speech & Language waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Speech and Language waiting times	< 18 wks	Aug 2022	33.9 weeks	H	F

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

Statistical Process Control Charts – Devon, Torbay and Plymouth





Devon System:
Average wait - 33.9 weeks
Longest wait - 103.35 weeks (Excludes LSW).

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

Operational Summary – Devon, Torbay and Plymouth

What are the causes*?*
Continued workforce vacancies reduce clinical capacity.
Increased Requests for Help at Getting Advice and Getting Help stage impacting on capacity to complete assessments.

What are we doing/what are the challenges*?*
Livewell business case for 4WTE additional SLTs decision due end of November.
CFHD additonal non recurrent funded staff still being recruited so not at full compliment.
Training programmes specfic to Speech Language Needs/ Social Emotional Mental Health for wider workforce, available and promoted online.
Mapping of workforce, demand, demographics using the Better Communicaiton CiC Balanced System (national evidence toolkit).

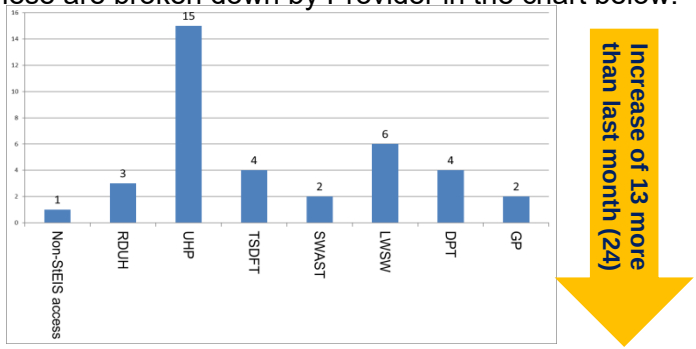
Is there any risk/harm caused to children by waiting longer*?*
Referrals are triaged to ensure urgent requests are prioritised. Telephone support and advice available to waiting families.

When will we see an improvement*?*
CFHD 12 month action plan to bring waits down to under 20 weeks by August 2023.
Livewell additional Speech and Language Therapists recruited to the workforce will make a planned improvement over a 12 month period. Already they have made a steady monthly reduction in children waiting since August 2022 to latest data for October 2022.

Quality

Serious Incidents

During October 2022 there have been **37 serious incidents** reports, these are broken down by Provider in the chart below:



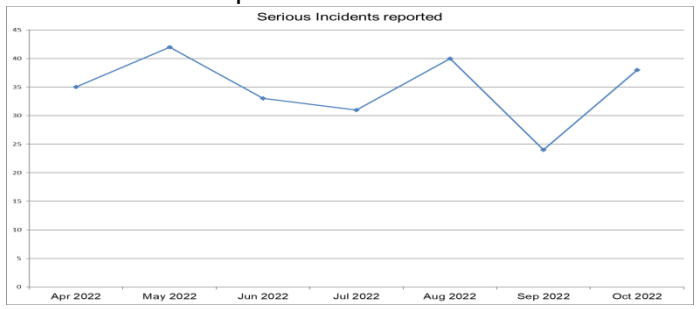
There were 2 Never Events reported in October 2022. Since April 2022 there have been **13 never events reported**, which is a significant increase compared to the same period last year (3). These will continue to be monitored by the SST.

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

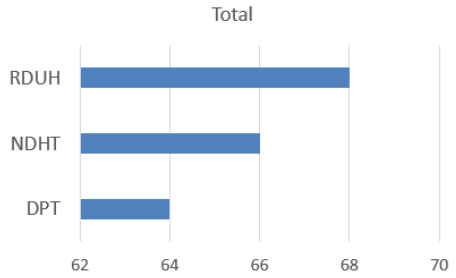
- Medication incident (5)
- Slips/trips/falls (5)
- Maternity/Obstetric (4)
- Pressure Ulcer (4)
- Pending review for category (4)

There are currently 17 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.

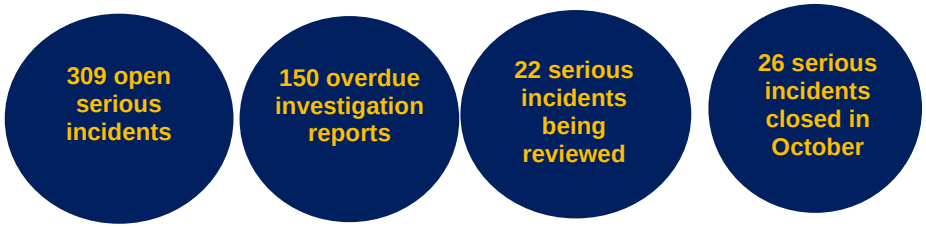
The below chart shows the total number of **reported serious incidents** since April**:**



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



Current SI status.

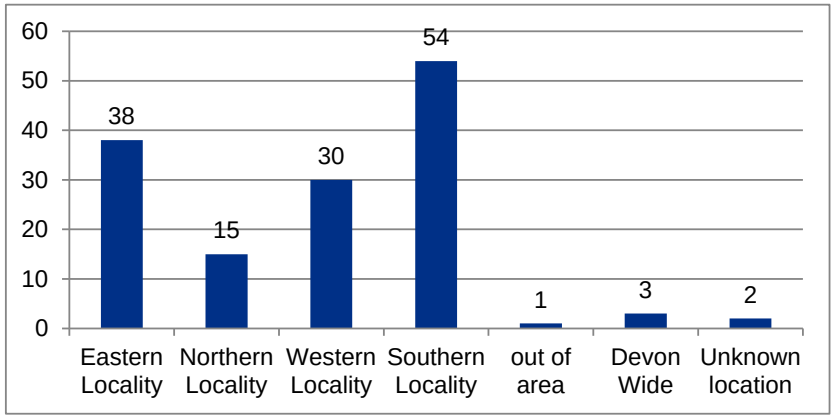


November 2022

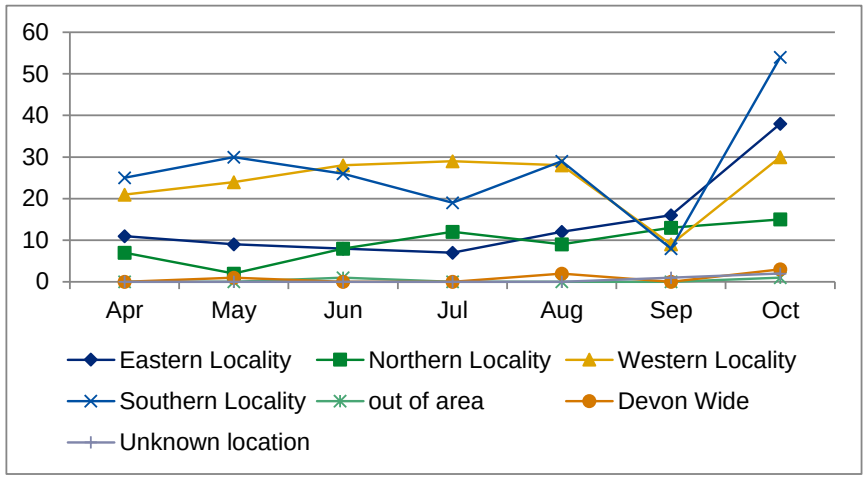
One Devon

Peer Improvement Tips for Care and Health (PITCH)

During October there were **143 PITCHs** reported, these are displayed by locality in the chart below:



The chart below shows **reported PITCHs** since April **by locality:**

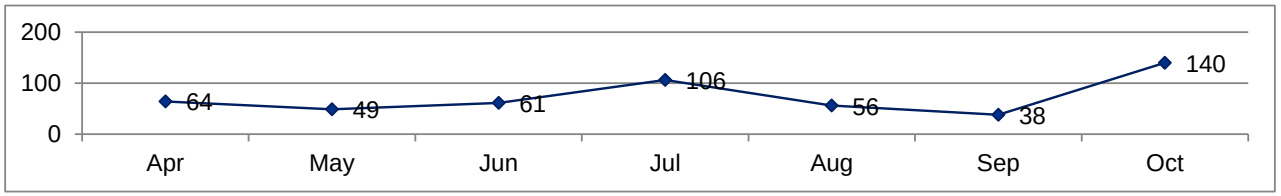


The **top three PITCH concerns received in** October were:

- Access to Services (45)
- Referrals (23)
- Procedure or Process (18)

High submissions relating to PPG,111 wait times and response after triage. Where patient information was available, PPG are investigating concerns raised. PITCH has identified a number of GP practices incorrectly referring patients to the Urgent Treatment Centre in Newton Abbot. Patients are being referred for services that are not available at the UTC, or for conditions/symptoms that may be more appropriately managed by ED. Patient Safety and Quality are working with local UTC to explore the issues further.

During October 140 PITCHs were closed compared to 38 last month. The below chart, illustrates the number of closed PITCHs per month since March 2022:



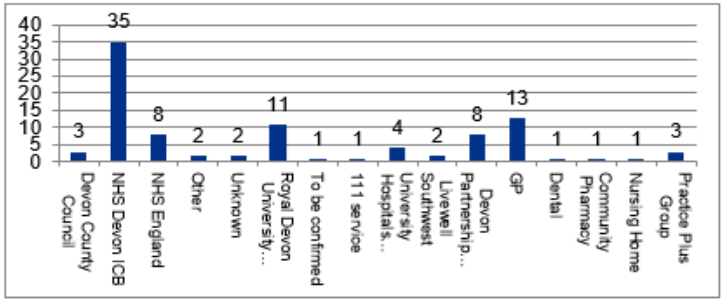
69 open PITCHs remain open

Priority next month – Understanding themes of concern with PSQ

One Devon

Patient Experience (NHS Devon): Patient Contacts

During October there were **96 new patient experience** feedback and concerns to manage, these are broken down by Provider in the graph below:



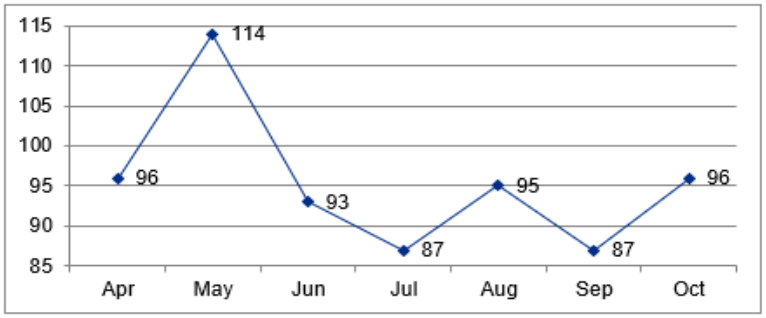
The **top three patient experience concerns received in** in October were:

- Quality of Care **(29)**
- Access to Services **(18)**
- Vaccinations **(11)**

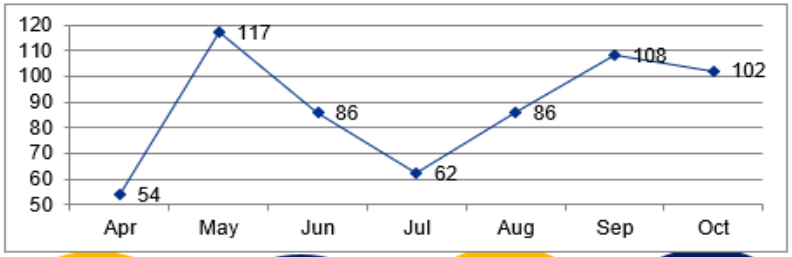
Continued focus on ADHD/Autism services, particularly care after 'right to choose'. Continue to receive concerns and complaints relating to Continuing Healthcare in particular the outcome of eligibility and associated processes.

- There has been **6 new formal complaint** raised during October for NHS Devon.
- There have been **3 contractual reviews received** and in progress, which are required and form part of Primary Care complaints which are managed by NHS England.
- There are **2 requests for information** from the **Parliamentary Health Service Ombudsman (PHSO)**

Patient experience informal concerns remain stable over the last 5 months to a monthly average of 95 cases however remains higher than 2020/2021 at 69 per month and 2021/2022 at 79 per month.



The team have made significant progress in **closing** patient experience concerns in recent months. The number of cases closed are illustrated below:



Safeguarding: Adult Enquiries

Issue: Safeguarding Adult Enquiries (Section 42.2) are undertaken when concerns about abuse and neglect within health care settings are raised. The statistics below are in relation to new S 42.2's caused out by the 3 Local authorities in Devon for the month of October 2022 and the primary themes of the concerns.

Data	Underlying cause
<table><tr><th></th><th>August</th><th>September</th><th>October</th></tr><tr><td>Total number of S42.2 enquiries</td><td>5 ↓</td><td>6 ↑</td><td>10 ↑</td></tr></table>	**Themes:** The top issues identified within new S42.2 enquiries in October 2022 related to: - • A slight increase in those relating to poor quality of care across a range of setting including residential and inpatient settings. • An increase in the number of pressure ulcers identified in inpatient settings that met the Care Act criteria to proceed to an enquiry. • An enquiry relating to a person (staff) in a position of trust (PiPoT) featured for the first time since July 2022.

Initial learning from new safeguarding enquiries, closed safeguarding enquiries and safeguarding adult reviews:	Assurance
• Initial learning from the PiPoT enquiry highlighted the importance of raising concerns to the local authority teams as well as to internal HR teams. • Some recently closed PiPoT cases have highlighted the need for more in-depth training regarding professional boundaries.	• The provider safeguarding lead has included a reminder about the allegations process in the safeguarding newsletter and provided support to individual practitioners. • Training is being delivered by the provider and individual practice is being monitoring.

Actions for next month/s	Intended impact	Date impact will be realised
Torbay and Devon Safeguarding Adult Partnership (TDSAP) will be publishing publish several Safeguarding Adult Reviews (SAR).	Each SAR will have recommendations and associated actions for providers that should improve care	Each action plan with completion dates will be monitored by TDSAP

Safeguarding: Children in Care (CIC)

Issue: The inconsistencies in provider reporting across the system, means NHS Devon 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

1. Ongoing late notifications from all three Local Authorities (LA). Includes requesting health assessments without consent and correct paperwork. Children's health needs remain unidentified and unaddressed
2. All providers have their own paperwork and have different data flows and routes into the ICB. This prevents a clear oversight of the experience of children receiving their health assessments.

Increase of unaccompanied asylum-seeking children (UASC) via two routes. a) children within the emergency hotels and b) the national transfer scheme

AUTHORITY	Numbers of UASC 16 November 2022
Devon	19
Plymouth	13
Torbay	33

	TSDFT	RDUH - Eastern	RDUH - Northern	UHP	LIVEWELL	CFHD
Percentage of CIC receiving RHA's within statutory timescales (this is 6 monthly for U5s and annually for Over 5s)					42.90%	62.50%
Percentage of CIC receiving IHA's within statutory timeframe of 20 working days of coming into care.	46%	33%	25%	60%		

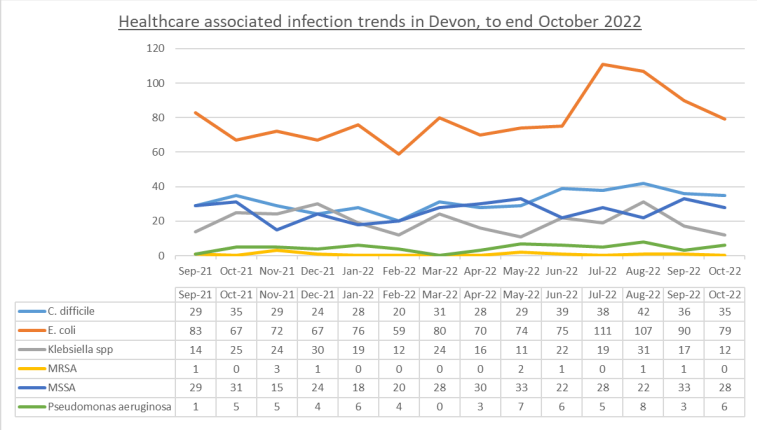
Actions undertaken in last month	Impact
1. Meetings with the three LA to improve notification process through collaborative working. 2. Designated Doctors have devised a form that all Named Doctors can complete monthly. Revised Outcome Framework awaiting community providers agreement, which includes a consistent reporting method. 3. Planning meeting held to ensure adequate resources to review and meet the health needs of UASC 4. Designated doctors are writing a business plan for medical resources to undertake the increased workload.	Requests for initial health assessments would be timelier. Consistent reporting method across Devon UASC would have their health needs assessed and supported in a timelier and child friendly way. Adequate resources within the acute teams to manage the increased volume and complexities of the UASC IHA's.

Actions for next month/s	Intended impact	Date impact will be realised
Named Doctors to use agreed form to report IHA activity. Complete business plan regarding medical capacity to complete health assessment of CIC and UASC	Robust data of health assessment activity Children receive timely health assessments	January 2023

Infection Prevention and Control

Theme: Healthcare associated infections trends and national ambitions

Data



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
C. difficile	29	35	29	24	28	20	31	28	29	39	38	42	36	35
E. coli	83	67	72	67	76	59	80	70	74	75	111	107	90	79
Klebsiella spp	14	25	24	30	19	12	24	16	11	22	19	31	17	12
MRSA	1	0	3	1	0	0	0	0	2	1	0	1	1	0
MSSA	29	31	15	24	18	20	28	30	33	22	28	22	33	28
Pseudomonas aeruginosa	1	5	5	4	6	4	0	3	7	6	5	8	3	6

Infection Highlights

The *E. coli* increase over the summer has now reduced, consistent with a seasonal fluctuation.
There have been recent cases of diphtheria in the Devon system, reflecting a national increase and linking in with a national incident concerning diphtheria.

Influenza (seasonal and avian)

The vaccination programme for seasonal flu is under way, and weekly monitoring meetings identify emerging vaccine rollout issues.
There has been a national data issue around incorrect recording of those in the under 65 age group who have comorbidities; this has resulted in some primary care providers being asked to review their dataset.
A change of provider for antiviral prophylaxis in flu outbreak situations is underway, with a new contract in train and a bridging process in place.

Actions undertaken in last month	Impact
Antiviral prophylaxis recommissioning.	Antiviral prophylaxis contract near completion, with bridging process in place.
Engagement of care & residential home staff with infection prevention education.	Workbooks being delivered to staff in care homes to support community infection management service educational role.

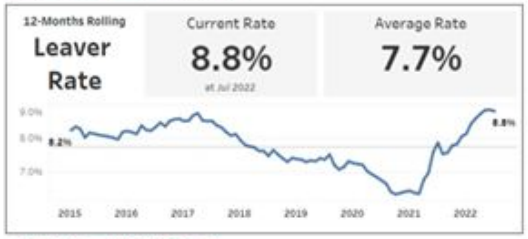
Actions for next month/s	Intended impact	Date impact will be realised
Infection control and antimicrobial resistance system meetings	Sharing of good practice, dissemination of national requests and information, system assurance.	November 2022.
Tuberculosis commissioning pathway evaluation	Consistent provisioned service for tuberculosis video observed therapy and directly observed therapy.	February 2023
Support to asylum seeker & refugee hotels	Improved health outcomes and reduced outbreaks in these settings.	December 2022

Workforce

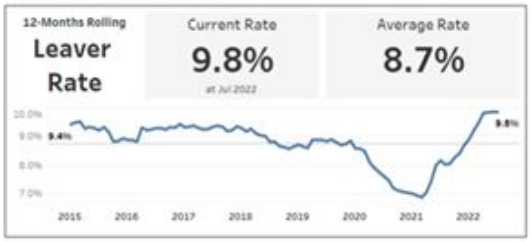
Workforce: Metrics

Leaver rate (leavers outside the NHS)

Devon – July 22 (HEE data – inc LSW)

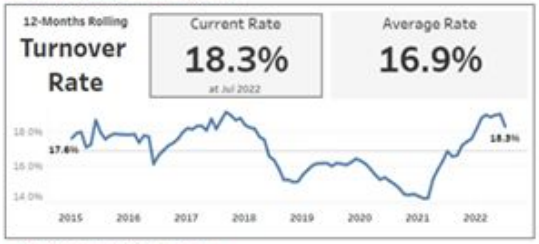


South-West – July 22 (HEE data)



Turnover rate (leavers including to other Trusts)

Devon – July 22 (HEE data – inc LSW)



South-West – July 22 (HEE data)

Absence

Devon (HEE data)

National (HEE data)

Sickness Absence Rate by Month and 12 Monthly Rolling Rate

Vacancies

Sept 22 (inc LSW) – local data

Total vacancies for ICS – Sept 22				
This month vacancies	Previous month vacancies	Last year vacancies	Vacancies as a % of funded establishment	Substantive WTE
2,195	2,213	1,610	6.44%	31,827

Consultant: 75 wte ↓

Nursing 626 wte ↓

AHP 323 wte ↑

HCA 436 wte ↑

Trust data (not inc Primary or Social Care)

Spend £ against operational plan 22/23

April 22 – Sept 22 – local data

	Plan YTD	Actual YTD	Variance	M12 plan
Agency	£14,378	£25,662	(£11,284)	£28,034
Substantive	£688,572	£712,769	(£24,197)	£1,380,176
Bank	£39,282	£44,138	(£4,856)	£73,308

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

WTE against operational plan 22/23

Sept 22 – local data

	Plan M6	Actual M6	Variance
Substantive	30,035 wte	29,559 wte	476
Bank	1,514 wte	1,545 wte	(31)
Agency	380 wte	529 wte	(149)

Workforce: Workforce Strategy

Strategic Workforce Planning

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

- Options and costings presented to co-sponsors on 16th November 2022 with associated timescales.
- Final internal meeting planned 18th November 2022 for ICB co-sponsors for decision on two options if to proceed to a business case to develop the Strategic Workforce Planning tool.

Further Strategic Workforce Planning activity:

- South-west Planners Special Interest Group held on 15th November 2022 with offer of courses to upskill staff in workforce planning capacity.
- WITNe (Workforce Intelligence & Transformation Network) meeting held on 17th November 2022 with detailed presentation delivered on Scenario planning in Devon in collaboration with HEE and Staff College.

Workforce Strategy

- To be delivered by the end of March 2023 and progress on track.
- Devon 2035 Workforce vision developed from Future Facing workshops output and interviews with senior system leaders.
- Live microsite for resources currently being updated to support next phase
- Ongoing weekly meetings with HEE and Staff College during the design phase to develop an organisational readiness template, conduct a rapid test pilot in social and health care settings and finalise by the end of November.

Workforce: Learning, Education and Strategy

Learning and Education Strategy: Principals shared across the system, complete timelines end of March 2023.

- **Placement expansion:** Working alongside our providers to better enhance their data.
- **CPD Strategy:** A funding position of Devon CPD is being worked through incorporating HEE funding
- **ICS Learning Academy:** First meeting held in November; governance framework altered to reflect SOG.
- **Community Upskilling Funding:** Successful system bid, currently identifying key priority areas (By Dec 2022).

Workforce: Best Place to Work (BPTW)

- **Inclusive Health and Wellbeing (HWB) Strategies:** Wellbeing Strategy paper will be issued to HR Directors in Dec 2022.
- **HWB bid**: Recommendation to continue Employee Assistance Programme for Primary Care and Adult Social Care staff.
- **Cultural and wellbeing dashboard**: Recommendation to share the dashboard in a public Committee.

Workforce: Workforce Capacity

- **International recruitment (IR):** 600th Nurse (in 15 months) arrives this month. Funding for 6 midwives in North Devon approved. Social Care Pilot underway and progress on track.
- **Network/System First:** Consideration given to posts 8C+ following internal VCP's and agreement to be made between Trusts. No joint appointment opportunities identified as yet.
- **Collaboration of banks:** T&F Group set up to increase usage of SW Collaborative Locum Bank which is a more cost effective supply route than agencies.
- **Bank and agency spend:** Framework live from 1st Nov to help standardise rates and formalise agency tiering for Nursing.
- **Attraction:** Strategy work began in November to develop a plan of events across the year for 2023.
- **Medical Recruitment Campaign**: website live, marketing approach in final stages of agreement.
- **Prince's Trust:** Campaign to fill a small number of roles offered to those from a disadvantaged background, beginning next year.

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.
- As at month 7 the Devon ICS is reporting year to date £20.9m deficit against a planned deficit of £15.9m – an adverse variance of £5m (M6 £4m).
- The reported forecast is a deficit of £18.2m which delivers to plan.
- As at month 7 the Devon ICS had made efficiency savings of £52.5m (M6 £43.2m) This is £18.2m adverse to plan (M6 £14.2m).
- Forecast savings are averse to plan by £33.3m. (M6 £16.4m).
- At the planning stage net risks of £95.9m were identified to delivery of a break-even plan. At the end of month 7, this has improved by £39.4m and stands at £56.5m (£38.3m against plan) against an expectation of break-even. (M6 £61.5m).
- In addition to continuous drive to reduced CIP shortfall, the ICS is committed to delivering further mitigation through a Financial Recovery Plan, consisting of 10 workstreams.

Summary Financial Position as at 31st October 2022

Organisation	Year to date			Forecast		
	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000
Devon ICB	0	0	0	0	0	0
Royal Devon University NHS FT	(8,433)	(8,433)	0	(18,263)	(18,263)	0
University Hospitals Plymouth Trust	(4,240)	(4,240)	0	0	0	0
Torbay and South Devon NHS FT	(2,596)	(7,618)	(5,022)	69	69	0
Devon Partnership Trust	(581)	(581)	0	0	0	(0)
Total	**(15,850)**	**(20,872)**	**(5,022)**	**(18,194)**	**(18,194)**	**(0)**

- As at month 7 the Devon ICS is reporting a year to date £20.9m deficit against a planned deficit of £15.9m – an adverse variance of £5m (M6 £4m variance)
- 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 Saving 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	18,953	13,995	(4,958)	36,525	36,525	0
Royal Devon University NHS FT	18,415	9,247	(9,168)	33,935	15,190	(18,745)
University Hospitals Plymouth Trust	12,935	15,103	2,168	29,592	29,592	0
Torbay and South Devon NHS FT	15,586	10,714	(4,872)	28,452	15,300	(13,152)
Devon Partnership Trust	4,874	3,453	(1,421)	10,358	8,932	(1,426)
Total	**70,763**	**52,512**	**(18,251)**	**138,862**	**105,539**	**(33,323)**

- As at month 7 the Devon ICS had made efficiency savings of £52.5m (M6 £43.2m) This is £18.3m adverse to plan. (M6 £14.2m).
- Forecast savings are adverse to plan by £33.3m (M6 £16.4m).

Risks and Mitigations

Description	Net Weighted Risks & Mitigations						Net Risks at Plan
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000	£000
CIP shortfall	(13,967)	(18,751)	(6,000)	(10,446)	(2,300)	(51,464)	(47,817)
Planned Surplus/(Deficit)		(18,263)		69		(18,194)	(18,194)
Increase in inflation		(2,700)	(4,000)	(1,500)	(874)	(9,074)	(6,950)
Integrated care contract				(7,500)		(7,500)	(6,000)
Hospital discharge	0					0	(2,500)
High cost drugs not met by income		(3,711)	(2,500)	0		(6,211)	(2,314)
Clinical excellence awards			0	(809)		(809)	(1,665)
Pay inflation shortfall		(1,251)	(1,800)			(3,051)	
IFRS 16			(1,200)			(1,200)	
Specialist commisioning rebase					0	0	(1,500)
Prescribing prices	(3,900)					(3,900)	(1,500)
OOA and staffing support					0	0	(1,300)
IPP service growth					(509)	(509)	(1,250)
MHIS and SDF income risk					0	0	(1,200)
Other		(1,557)		(1,381)	(1,661)	(4,599)	(5,545)
Total Risk	**(17,867)**	**(46,233)**	**(15,500)**	**(21,567)**	**(5,344)**	**(106,511)**	**(97,735)**
Non-Recurrent flexibility	10,367	22,850	0	2,944	5,344	41,505	14,076
s256 funds/Other	7,500					7,500	2,500
Further Excess inflation funding						0	1,375
Total Mitigation	**17,867**	**22,850**	**0**	**2,944**	**5,344**	**49,005**	**17,951**
Net Risk	**0**	**(23,383)**	**(15,500)**	**(18,623)**	**0**	**(57,506)**	**(79,785)**
ERSF risks		(1,503)	(2,500)			(4,003)	
ESRF s256 mitigation	5,000					5,000	
Net risk including ESRF	**5,000**	**(24,886)**	**(18,000)**	**(18,623)**	**0**	**(56,509)**	
Month 6	**5,000**	**(26,588)**	**(20,500)**	**(19,432)**	**0**	**(61,520)**	
Movement	**0**	**1,702**	**2,500**	**809**	**0**	**5,011**	

Risks and Mitigations

- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of a break-even plan. In addition, there were £16.1m of ESRF related risks giving a total net risk of £95.9m. As at Month 7 the net risk has reduced to £57.5m. (M6 £50.7m).
- As at Month 7 the net risk has reduced to £56.5m. (M6 £61.5m). This is a risk of £38.3m against planned deficit of £18.2m.
- The main risks to be mitigated (in addition to the planned deficit of £18.2m) are:
    - Shortfall on planned CIP delivery £51.5m (month 6 £40.7m).
    - Excess inflation costs above funded level £9.1m (month 6 £10.3m).
    - Integrated care contract increased costs £7.5m (month 6 £0m).
    - High-cost drugs above funded level £6.2m (month 6 £5.4m).
- There has been an improvement against ESRF risk around clawback and a change of ESRF productivity now categorised as a CIP shortfall.

NHS Devon

NHS Devon Integrated care board meeting

Finance Committee Chair report

Date of board meeting	Dates of committees covered in this report
21 December 2022	7 December 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 and reviewed, noting impact to date of the £24m winter response funding allocated throughout the system in August. Noted additional capacity of 197 beds impacting on a reduction in hospital patients awaiting package of care. The committee noted further work underway to align financial and workforce data to the operational performance metrics. Noted the importance of learning from 22/23 operational performance in shaping the operational plan for 23/24.

ICS Finance report. Position to end of October 2022 and Forecast.
Report received. Identifies adverse variance to plan at end October of £5m. Year-end forecast remains that financial plan target will be met, but this requires mitigation of significant identified risk which puts pressure on delivery. Further work being undertaken for report to the January 2023 meeting of the committee.

Operational Financial Plan 23/24
The committee received assurance that work on operational plan 23/24 is on track. Receipt of detailed planning guidance from NHSE is expected in the week before Christmas.

ICB Finance Report. Position to end of October 2022 and Forecast.

Report received and assurances received relating to delivery of 22/23 financial plan for ICB. Further assurance required relating to mitigation of risk to delivery. This will be reported to next meeting.

Devon ICS Long Term Financial Model
The Committee received progress report of work to align financial challenge to transformation programmes. Concern reported relating to pace of delivery of the strategic work programmes and the Committee asked the Executive Finance Group to consider what further support is needed to the work programmes. The Committee thanked Devon CFOs for their work on this. The committee agreed that the next stage of work on this will commence after the completion of 23/24 financial planning round.

Report of the Estates Director
The Committee received an overview of the work of the Estates Function, noting significant work required to develop the ICS Infrastructure Strategy by December 2023 for submission to NHS England. It is expected that NHS capital financial allocations will be driven by these strategies from mid 2020s, rather than by the current allocation formula.

Fair Shares in Allocations
The Committee received further analysis relating the work on fair shares in allocations and spend across Devon.

Reports received and noted

The Committee noted the **quarterly report on contracting and procurement**, including single action tenders.
The Committee noted the output of a recent exercise applying the **HFMA financial sustainability checklist** to the work of the ICB finance function. Noted assessment and actions for improvement.

Risk register review updates

Deferred until Board Assurance Framework is determined in December 2022.

Committee decisions

None

Items of concern to be escalated to the board

Significant challenge to mitigate risk to delivery of ICS financial plan. Board discussion in January/February 2023.

Recommendations for the board

N/A

Recommendations for other committees

N/A

Terms of reference or other committee effectiveness issues

The Committee has introduced the good practice of a meeting observer who provided positive feedback and also some issues for consideration relating to further committee development.

Management of conflict of interests:

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

3

NHS Devon Integrated Care Board meeting

NHS Devon (ICB) Finance Report Month 7

Date of committee	Date report produced
21st December 2022	29th November 2022

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	Bill Shields Director of Finance
Phone:	07825 027569	**Date:**	29th November 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 Board's (ICB's) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICB for the year ended 31st March 2023. This report details the ICB financial position as at 31 October 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
None

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

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

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

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

NHS Devon Integrated Care Board

Finance Report

Month 7 – 2022/23

Contents

Appendices

1. Executive Summary

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

This report details the ICB financial position as at 31 October 2022.

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

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

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

Financial Position

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

As at 31st October 2022	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Total Net Expenditure	1,447,154	1,447,154	0	2,511,488	2,519,558	(8,070)
Resource Allocation	(1,447,154)	(1,447,154)	0	(2,519,558)	(2,519,558)	0
Additional Roles Reimbursement Scheme	0	0	0	0	(8,070)	8,070
Total Commissioned Services	**0**	**0**	**0**	**(8,070)**	**(8,070)**	**(0)**

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

As at month 7 some service lines are currently exceeding budget including some acute services, continuing healthcare, individual placements and primary care prescribing. These variances are currently being covered by contingencies held in reserves.

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

Savings Plan

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

The delivery of savings and efficiencies is off plan at month 7 by £5m, driven by a slower than expected delivery of savings linked to prescribing, placements and targets associated with the recovery programme.

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

Risk

The ICB has identified risk to delivering a breakeven position of £17.9m at 31st October 2022 including risks relating to delivery of the savings target and increases in prescription drug prices. Actions including release balance sheet flexibilities and use of non-recurrent funding streams have been identified that fully mitigate the identified risk.

Conclusion

As at 31st October 2022 the ICB is expecting to deliver its target of break even for the year.

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

2. Detailed Financial Performance

The year to date and outturn by main service heading as at 31st October 2022 is as follows.

Service	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Acute	722,556	724,983	(2,427)	↓	1,239,497	1,241,945	(2,448)	↓
Mental Health	158,168	158,172	(4)	↓	271,230	272,867	(1,638)	↓
Community Health	175,287	175,415	(128)	↓	303,872	304,716	(844)	↓
Continuing Care	85,553	86,914	(1,361)	↑	146,684	149,181	(2,497)	↑
Primary Care	263,453	266,295	(2,842)	↓	451,474	463,353	(11,879)	↓
Other Programme	21,598	20,455	1,144	↑	37,384	36,918	466	↑
Total Commissioned Services	**1,426,615**	**1,432,233**	**(5,618)**	↓	**2,450,141**	**2,468,981**	**(18,840)**	↓
Running Costs	13,511	13,769	(258)	↓	22,919	22,919	(0)	→
Net Expenditure	**1,440,126**	**1,446,002**	**(5,876)**	↓	**2,473,060**	**2,491,901**	**(18,840)**	↓
Reserves/Contingencies	7,028	1,152	5,876	↑	38,428	27,658	10,770	↑
Total Net Expenditure	**1,447,154**	**1,447,154**	**0**	↑	**2,511,488**	**2,519,558**	**(8,070)**	↑
Resource Allocation	(1,447,154)	(1,447,154)	0	→	(2,511,488)	(2,511,488)	0	→
Additional Roles Reimbursement Scheme	0	0	0	→	0	(8,070)	8,070	→
Total Commissioned Services	**0**	**0**	**0**	↑	**0**	**0**	**(0)**	↑

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

2.1 Acute Services

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

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

The majority of the overspend in this is due to patient transport costs, linked to increase journeys as a result of COVID and the discharge to assess policy. There is also an increasing pressure in relation to out of area non-contracted activity where patients are receiving treatment that is recharged to the ICB on a case by case basis.

Both of these overspending areas are subject to reviews with the lead commissioners to understand the drivers and seek mitigating actions where possible.

2.2 Mental Health Services

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

The main area of overspending within mental health relates to individual patient placements driven by increasing numbers of placements receiving care under s117 of the mental health act. A review of potential mitigating actions is being explored.

There are also pressures emerging relating to addressing ADHD waiting lists and SMI physical health checks that indicate a potential forecast overspend. Funding solutions are being explored but cannot be guaranteed at this stage.

2.3 Community Health Services

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

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

The forecast overspend relates to a small number of high cost individual placements which are subject to a high cost case review process that has expanded the savings plan in this area.

2.4 Continuing Care

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

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

Some examples of other risks include:

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

The YTD and FOT overspend is largely a result of a small number of high-cost cases at circa £4m full year effect which emerged in months 4 and 5. The CHC team are working on mitigating plans for these cases.

The CHC control centre will continue to provide senior oversight to manage the financial position.

2.5 Other Programme

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

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

2.6 Primary Care Services

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

Prescribing

The prescribing position is being impacted by a cost pressure due to unavailability of the lowest priced stocks of medicines, an issue known as Price Concessions or No Cheaper Stock Obtainable (NCSO). The £3.8m forecast is being driven entirely by this cost pressure having set budgets on a flat cash basis which required savings of £5.7m.

A plan to deliver this savings target has been created which aims to deliver £6.1m of savings. As of month 7 the plan is on track to deliver and the medicines optimisation team have been challenged to go further than the initial plan and increase delivery in order to mitigate the NCSO cost pressure described above.

Delegated Commissioning

The remaining forecast overspend in primary care is driven by an £8m anticipated cost in relation to additional primary care roles which is reimbursed on a retrospective by NHSE.

Other Primary Care

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

2.7 Running Costs

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

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

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

2.8 Resource Allocation

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

Allocation Description	Year to date		
	CCG M1-3 £000	ICB M7 £000	Total £000
Core allocation	520,549	1,538,927	2,059,476
Primary care commissioning	49,960	148,548	198,508
Ockenden maternity review	365	1,093	1,458
Running costs	5,645	16,933	22,578
Core - Additional Inflation Funding		22,720	22,720
Primary Care - Additional Inflation Funding		1,331	1,331
Recurrent Allocation	**576,519**	**1,729,552**	**2,306,071**
Health Inequalities Funding	931	2,794	3,725
COVID funding	11,828	35,482	47,310
Running cost pension contribution	340		340
Service development fund (SDF)	9,073	29,124	38,197
Elective Services Recovery Funding (ESRF)	9,874	29,623	39,497
CCG to ICB Transition Adjustment	(12,248)	12,248	0
Core - Additional Inflation Funding		7,123	7,123
New Allocations M4		3,891	3,891
New Allocations M5		14,183	14,183
New Allocations M6		48,564	48,564
New Allocations M7		2,587	2,587
Non-Recurrent Allocation	**19,798**	**185,619**	**205,417**
Total Allocation	**596,317**	**1,915,171**	**2,511,488**

The new allocations from month 4 to month 7 include £30m relating to the changes in pay inflation and £23.9 demand and capacity funding to increase bed capacity over winter as well other know service development funds.

3. Savings And Efficiencies

The delivery of savings and efficiencies as at 31st October 2022 is as follows:

Scheme	RAG Status	Rec/ Non-Rec	% of Budget	Year to date			Forecast		
				Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000	Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000
Prescribing		R	2.7%	3,325	3,279	(46)	5,704	5,704	0
Running Cost Inflation		R	2.3%	308	308	0	525	525	0
Placements		R	3.7%	2,303	1,934	(369)	3,945	3,945	0
Primary Care Commissioning Review		R	0.8%	1,169	1,169	0	2,000	2,000	0
Commissioning Review		R	0.8%	1,750	1,750	0	3,000	3,000	0
Covid Reduction		NR	78.0%	2,100	2,100	0	3,600	3,600	0
Acute		R	1.4%	455	455	0	784	784	0
Unidentified		NR		1,320	0	(1,320)	2,967	2,967	0
SDF		NR	11.1%	2,668	3,000	332	6,000	6,000	0
Workstream stretch		NR		3,556	0	(3,556)	8,000	8,000	0
Total				**18,954**	**13,995**	**(4,959)**	**36,525**	**36,525**	**0**
Recurrent				9,310	8,895	(415)	15,958	15,958	0
Non-Recurrent				9,644	5,100	(4,544)	20,567	20,567	0
Total				**18,954**	**13,995**	**(4,959)**	**36,525**	**36,525**	**0**

The majority of identified savings plans are delivering to plan as at Month 7.

The Placements year to date savings plan is reported as being off plan, although currently actions taken to date are forecast to deliver the £3.9m savings target. The savings plan in this area focuses on reviews of high cost placements, timely post discharge assessments and reviews of personal health budgets. In addition the ICB is in the process of engaging external assessment resource which is expected to realise financial benefits.

Savings linked to prescribing, placements and SDF have seen improved delivery from the previous month.

The unidentified savings and workstream stretch target are linked to the recovery plan actions.

4. Risks

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

Headline	Description	M6 £000	M7 £000	Movement £000	Risk at Plan £000
CIP shortfall	Non-delivery of workstream stretch efficiency	8,000	8,000	0	8,000
CIP shortfall	Non-delivery of unidentified CIP	2,967	2,967	0	2,967
CIP shortfall	Partial delivery of SDF Review efficiency	3,000	3,000	0	3,000
Hospital discharge	Unable to manage costs of hospital discharge within budgets set	0	0	0	2,500
Prescribing prices	Increases in prescription drugs prices	3,900	3,900	0	1,500
Total Risk		**17,867**	**17,867**	**0**	**17,967**
Non-Recurrent flexibility	Release of balance sheet accruals	7,376	7,376	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	7,992	7,992	0	0
Total Mitigation		**17,867**	**17,867**	**0**	**9,876**
Net Risk		**0**	**0**	**0**	**8,092**

The ICB has identified risk to delivering a breakeven position of £17.9m at 31st October 2022 including risks relating to delivery of the savings target and increases in prescription drug prices. Actions including release balance sheet flexibilities and use of non-recurrent funding streams have been identified that fully mitigate the identified risk.

5. Other Financial Information

5.1 Statement of Financial Position

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

The ICB's position at 31 October 2022 is shown in appendix 1.

5.2 Capital

The ICB has spent no capital in the period ended 31 October 2022.

5.3 Better Payment Practice Code

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

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

Better Payment Practice Code	M7	
	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

5.4 Cash

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

7 Recommendations

The Finance Committee is requested to:

Consider, review and discuss the ICB's performance and position as at the period ended 31 October 2022.

Appendices

Appendix 1: Statement of Financial Position

Statement of Financial Position	M7 £000
Property Plant & Equipment	2,918
Intangible Assets	199
Non Current Assest	**3,118**
Inventories	896
Trade & Other Receivables - NHS	630
Trade & Other Receivables - Non NHS	10,729
Cash & Cash Equivalents	1,128
Current Assets	**13,382**
Total Assests	**16,500**
Trade & Other Payables - NHS	(2,275)
Trade & Other Payables - Non NHS	(131,894)
Other Liabilities	(3,730)
Borrowings / Cash in Transit	(7,109)
Current Liabilities	**(145,008)**
Total Assets Employed	**(128,508)**
General Fund	(128,508)
Total Taxpayers Equity	**(128,508)**

Appendix 2: Cash

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

Measure	Month 7
ICBs must operate within their Cash Drawdown Requirement *The cash drawdown requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,903m for Devon ICB for the period ended 31 March 2023 (excluding the 3 months relating to Devon CCG).*	45.6% of the Cash Drawdown Requirement has been utilised as at month 7 (44.4% is expected based on a straight-line trajectory at month 7). The additional cash required was to cover payments made in April to June 2022 for late allocations received in March 2022.
ICBs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against ICBs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the ICB has not yet been confirmed.	Notional charges amount to £14,341 for October.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The ICB has met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

Appendix 3: Operating Expenditure

The detailed financial position as at 31st October 2022

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
NHS Royal Devon & Exeter Foundation Trus	206,848	206,730	118	355,882	355,881	0
NHS University Hospitals Plymouth NHS Tru	186,199	186,944	(745)	322,517	322,517	0
NHS Northern Devon Healthcare Trust	91,630	91,778	(148)	158,087	158,087	(0)
NHS South Devon Healthcare Foundation Tr	149,124	149,134	(9)	257,277	257,277	(0)
NHS Taunton and Somerset	5,959	5,959	0	10,215	10,215	0
NHS South Western Ambulance Trust	37,080	37,299	(219)	63,565	63,784	(219)
Independent Sector	22,964	22,880	84	39,367	39,176	191
Patient Transport	5,629	6,477	(848)	9,650	11,182	(1,533)
Other Acute	17,123	17,783	(661)	22,938	23,826	(888)
Acute	**722,556**	**724,983**	**(2,427)**	**1,239,497**	**1,241,945**	**(2,448)**
Devon Partnership NHS Trust	96,867	96,583	283	165,956	165,957	(0)
Livewell MH Services	3,656	3,655	0	6,302	6,302	0
University Hospitals Plymouth MH	23,973	23,972	1	41,122	41,121	1
Children and Families Health Devon	8,946	8,901	45	15,398	15,376	22
Individual Patient Placements	7,784	7,826	(42)	13,360	13,421	(62)
Section 117	12,105	12,778	(673)	20,855	21,905	(1,050)
Other Mental Health	4,838	4,456	382	8,236	8,784	(548)
Mental Health	**158,168**	**158,172**	**(4)**	**271,230**	**272,867**	**(1,638)**
Livewell Southwest	(174)	(82)	(92)	(167)	(59)	(108)
Royal Devon and Exeter Community	37,039	36,962	77	63,495	63,496	(1)
Northern Devon Healthcare Community	19,087	19,087	(0)	32,721	32,722	(1)
South Devon Healthcare Community	40,996	40,996	0	70,171	70,171	0
University Hospitals Plymouth Community	33,227	33,228	(0)	57,601	57,601	0
Children and Families Health Devon	7,524	7,480	44	12,958	12,925	34
Individual Patient Placements	500	749	(249)	834	1,284	(450)
Integrated Urgent Care Service	9	8	1	9	8	1
Hospices	4,821	4,775	46	8,264	8,171	94
MIU Contracts	470	421	49	806	751	54
Better Care Fund_Plymouth CC	2,978	2,978	(0)	5,878	5,878	(0)
Better Care Fund_Devon CC	17,045	17,045	0	29,220	29,219	1
VCSE S256	0	(144)	144	0	8	(8)
Other Community Services	11,764	11,911	(147)	22,081	22,541	(460)
Community Health	**175,287**	**175,415**	**(128)**	**303,872**	**304,716**	**(844)**
Continuing Healthcare	77,113	77,874	(760)	132,187	133,684	(1,497)
Funded Nursing Care	8,439	9,040	(601)	14,497	15,497	(1,000)
Continuing Care	**85,553**	**86,914**	**(1,361)**	**146,684**	**149,181**	**(2,497)**

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Prescribing	122,113	124,151	(2,038)	210,109	213,950	(3,841)
Enhanced Services	6,069	6,069	(0)	11,529	11,529	(0)
Delegated Commissioning	115,757	116,258	(501)	199,733	207,878	(8,145)
GP Out Of Hours	7,089	7,573	(483)	11,544	11,305	240
GP IT	2,435	2,452	(18)	4,199	4,216	(18)
Other Primary Care	9,991	9,793	198	14,359	14,475	(115)
Primary Care	**263,453**	**266,295**	**(2,842)**	**451,474**	**463,353**	**(11,879)**
NHS 111	5,705	5,146	559	9,741	9,844	(103)
Better Care Fund Torbay	2,138	2,138	0	3,665	3,665	0
Chime Audiology	2,256	2,303	(47)	3,867	3,913	(46)
All Other Commisionned Services	11,500	10,867	632	20,111	19,496	615
Other Programme	**21,598**	**20,455**	**1,144**	**37,384**	**36,918**	**466**
Total Commissioned Services	**1,426,615**	**1,432,233**	**(5,618)**	**2,450,141**	**2,468,981**	**(18,840)**
Pay	10,199	10,997	(799)	17,240	18,046	(805)
Non Pay	3,380	3,069	312	5,795	4,990	805
Income	(68)	(297)	229	(117)	(116)	(0)
Running Costs	**13,511**	**13,769**	**(258)**	**22,919**	**22,919**	**(0)**
Net Expenditure	**1,440,126**	**1,446,002**	**(5,876)**	**2,473,060**	**2,491,901**	**(18,840)**
Reserves/Contingencies	7,028	1,152	5,876	38,428	27,658	10,770
Total Net Expenditure	**1,447,154**	**1,447,154**	**0**	**2,511,488**	**2,519,558**	**(8,070)**
Resource Allocation	(1,447,154)	(1,447,154)	0	(2,511,488)	(2,511,488)	0
Additional Roles Reimbursement Scheme	0	0	0	0	(8,070)	8,070
Total Commissioned Services	**0**	**0**	**0**	**0**	**0**	**(0)**

NHS Devon

NHS Devon Integrated Care Board Meeting

NHS Devon (ICS) Finance Report Month 7

Date of committee	Date report produced
21 December 2022	29 November 2022

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	Bill Shields Director of Finance
Phone:	07825 027569	**Date:**	29 November 2022
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary (250 words max)

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

The report details the ICS financial position for the period ended 31st October 2022 against the finance plan submitted on 20th June 2022, setting out the year to date and forecast financial position as well as the risks to delivery of an expected break-even position at system level.

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

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

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

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

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

NHS Devon ICS Finance Report

Month 7 – 31st October 2022

One Devon

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

Executive Summary

- 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.
- As at month 7 the Devon ICS is reporting year to date £20.9m deficit against a planned deficit of £15.9m – an adverse variance of £5m (M6 £4m).
- The reported forecast is a deficit of £18.2m which delivers to plan.

Executive Summary

- As at month 7 the Devon ICS had made efficiency savings of £52.5m (M6 £43.2m) This is £18.2m adverse to plan (M6 £14.2m).
- Forecast savings are adverse to plan by £33.3m. (M6 £16.4m)
- At the planning stage net risks of £95.9m were identified to delivery of a break-even plan. At the end of month 7, this has improved by £39.4m and stands at £56.5m (£38.3m against plan) against an expectation of break-even. (M6 £61.5m)
- In addition to continuous drive to reduced CIP shortfall, the ICS is committed to delivering further mitigation through a Financial Recovery Plan, consisting of 10 workstreams.

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	(8,433)	(8,433)	0	(18,263)	(18,263)	0
University Hospitals Plymouth Trust	(4,240)	(4,240)	0	0	0	0
Torbay and South Devon NHS FT	(2,596)	(7,618)	(5,022)	69	69	0
Devon Partnership Trust	(581)	(581)	0	0	0	(0)
Total	**(15,850)**	**(20,872)**	**(5,022)**	**(18,194)**	**(18,194)**	**(0)**

- As at month 7 the Devon ICS is reporting a year to date £20.9m deficit against a planned deficit of £15.9m – an adverse variance of £5m (M6 £4m variance)
- 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 2022/23

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	18,953	13,995	(4,958)	36,525	36,525	0
Royal Devon University NHS FT	18,415	9,247	(9,168)	33,935	15,190	(18,745)
University Hospitals Plymouth Trust	12,935	15,103	2,168	29,592	29,592	0
Torbay and South Devon NHS FT	15,586	10,714	(4,872)	28,452	15,300	(13,152)
Devon Partnership Trust	4,874	3,453	(1,421)	10,358	8,932	(1,426)
Total	**70,763**	**52,512**	**(18,251)**	**138,862**	**105,539**	**(33,323)**

- As at month 7 the Devon ICS had made efficiency savings of £52.5m (M6 £43.2m) This is £18.3m adverse to plan. (M6 £14.2m).
- Forecast savings are adverse to plan by £33.3m (M6 £16.4m).

Risks & Mitigations

Description	Net Weighted Risks & Mitigations						Net Risks at Plan
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000	£000
CIP shortfall	(13,967)	(18,751)	(6,000)	(10,446)	(2,300)	(51,464)	(47,817)
Planned Surplus/(Deficit)		(18,263)		69		(18,194)	(18,194)
Increase in inflation		(2,700)	(4,000)	(1,500)	(874)	(9,074)	(6,950)
Integrated care contract				(7,500)		(7,500)	(6,000)
Hospital discharge	0					0	(2,500)
High cost drugs not met by income		(3,711)	(2,500)	0		(6,211)	(2,314)
Clinical excellence awards			0	(809)		(809)	(1,665)
Pay inflation shortfall		(1,251)	(1,800)			(3,051)	
IFRS 16			(1,200)			(1,200)	
Specialist commisioning rebase					0	0	(1,500)
Prescribing prices	(3,900)					(3,900)	(1,500)
OOA and staffing support					0	0	(1,300)
IPP service growth					(509)	(509)	(1,250)
MHIS and SDF income risk					0	0	(1,200)
Other		(1,557)		(1,381)	(1,661)	(4,599)	(5,545)
Total Risk	**(17,867)**	**(46,233)**	**(15,500)**	**(21,567)**	**(5,344)**	**(106,511)**	**(97,735)**
Non-Recurrent flexibility	10,367	22,850	0	2,944	5,344	41,505	14,076
s256 funds/Other	7,500					7,500	2,500
Further Excess inflation funding						0	1,375
Total Mitigation	**17,867**	**22,850**	**0**	**2,944**	**5,344**	**49,005**	**17,951**
Net Risk	**0**	**(23,383)**	**(15,500)**	**(18,623)**	**0**	**(57,506)**	**(79,785)**
ERSF risks		(1,503)	(2,500)			(4,003)	
ESRF s256 mitigation	5,000					5,000	
Net risk including ESRF	**5,000**	**(24,886)**	**(18,000)**	**(18,623)**	**0**	**(56,509)**	
Month 6	**5,000**	**(26,588)**	**(20,500)**	**(19,432)**	**0**	**(61,520)**	
Movement	**0**	**1,702**	**2,500**	**809**	**0**	**5,011**	

Risks & Mitigations

- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of a break-even plan. In addition there were £16.1m of ESRF related risks giving a total net risk of £95.9m.As at Month 7 the net risk has reduced to £57.5m. (M6 £50.7m)
- As at Month 7 the net risk has reduced to £56.5m. (M6 £61.5m). This is a risk of £38.3m against planned deficit of £18.2m.
- The main risks to be mitigated (in addition to the planned deficit of £18.2m) are
  - Shortfall on planned CIP delivery £51.5m (month 6 £40.7m)
  - Excess inflation costs above funded level £9.1m (month 6 £10.3m)
  - Integrated care contract increased costs £7.5m (month 6 £0m)
  - High cost drugs above funded level £6.2m (month 6 £5.4m)
- There has been an improvement against ESRF risk around clawback and a change of ESRF productivity now categorised as a CIP shortfall.

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	17,450	13,822	3,628		33,306	33,306	0	
University Hospitals Plymouth Trust	9,881	8,065	1,816		24,080	24,080	0	
Torbay and South Devon NHS FT	13,040	11,167	1,873		18,371	18,371	0	
Devon Partnership Trust	3,929	2,193	1,736		7,448	7,448	0	
Total	**44,300**	**35,247**	**9,053**		**83,205**	**83,205**	**0**	

- System Capital spend is under plan at month 7 by £9.0m (M6 £8.7m)
- Forecast system capital spend is on plan as at M7.

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	26,951	21,225	5,726	50,562	52,559	(1,997)
University Hospitals Plymouth Trust	19,435	12,140	7,295	88,480	90,733	(2,253)
Torbay and South Devon NHS FT	15,091	15,657	(566)	27,007	33,451	(6,444)
Devon Partnership Trust	3,929	2,195	1,734	7,448	9,988	(2,540)
Total	**65,406**	**51,217**	**14,189**	**173,497**	**186,731**	**(13,234)**

- Total capital plan includes impact of IFRS16 - leases
- Total capital spend is under plan by £14.2m as at month 7. (M6 £8.7m)
- The forecast spend on capital by end March 2023 is over plan by £13.2m. (M6 £18.1m)
- The plan is fixed at submission and not updated as subsequent schemes are approved and PDC awarded. These schemes then show as an overspend.

Recommendation

- The Finance Committee is requested to consider, review and discuss the ICS's performance and position as at the period ended 31 October 2022.

NHS Devon

NHS Devon Integrated care board meeting

Memorandum of Understanding (MoU) with NHS England

Date of committee	Date report produced
21 December 2022	9 December 2022

Author(s)		Report approved by	
Name and title:	Ann Cooper, Interim Strategic Governance Adviser	**Name and title:**	Andrew Millward, Chief Communications and Corporate Affairs Officer, NHS Devon
Phone:		**Date:**	8 December 2022
Email:	Ann.cooper19@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 Board is presented with the final draft of the MOU with NHS England.

The MoU is designed to provide:

- the principles that underpin how NHS Devon and NHS England will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services
- the delivery and governance arrangements across the ICB and its partner organisations

- how NHS England, NHS Devon and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risks and support needs
- how NHS Devon and NHS England will work together to address development-specific needs in the ICS and across the region.

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

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. Approve the MoU with NHS England.

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

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	All parts of the NHS, including ICBs, have a statutory duty to ensure that the quality of NHS services is maintained and improved.
Health inequalities	CORE20Plus5 remains the focus of our combined health inequalities and prevention plan, with plans to strengthen leadership and system-wide awareness of health inequalities through a range of activities, including our 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.

Workforce	None
Resources and finance	Financial delegation of resources will be determined by NHS Devon's finance committee at an individual level with collective delegation to either LCP's or Provider Collaboratives coming on stream as those arrangements reach appropriate maturity.
Legal	The MOU should set out how NHS England, NHS Devon and system partners will work together to implement the requirements set out in the Oversight Framework taking into consideration system maturity, risks and support needs – this includes mitigating and managing quality risks/ concerns, in accordance with NHS England's Guidance on Quality Risk Response and Escalation
Digital and Data	NHS Devon actively promotes the digital option for our patients across the system.
Involvement, Engagement and consultation	None

Classification: Official

Publications approval reference: xxxxxx

Memorandum of Understanding NHS Devon Integrated Care Board and NHS England

NHS Devon
December 2022

Classification: Official

Contents

Classification: Official

Introduction

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.

The four key aims of an ICS are to:

- improve quality of services and 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.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

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

ICSs are led by both an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB). The ICP is a statutory committee bringing together all system partners to produce the ICSs integrated care strategy. The focus of this MOU is with the ICB as the statutory body with responsibility for NHS functions and budgets.

Purpose of this agreement

This MOU is between the NHS Devon Integrated Care Board, and NHS South West region, on behalf of NHS England. It is effective as of [insert date]. It sets out:

- the principles that underpin how the ICB and NHSE will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services
- the delivery and governance arrangements across the ICB and its partner organisations
- how NHSE, ICBs and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risk and support needs
- how the ICB and NHSE will work together to address development-specific needs in the ICS and across the region.

This MOU is not a legally binding agreement, and it does not change the statutory roles and responsibilities or functions of either party. NHSE will continue to exercise its statutory role

and powers in relation to regulatory action under legislation, including to address individual organisational issues in line with the principles set out in this MOU. The accountabilities of individual NHS organisations also remain unchanged.

Ways of working

The following principles will inform how the ICB and NHSE will work together:

1. **Effective partnership working** based on compassionate leadership behaviours, openness and transparency.

2. **Clear roles and responsibilities**, taking into consideration system maturity, risks and support needs.

3. **Build on what works** – leveraging and learning from existing arrangements and ways of working.

4. **'System first'** – encouraging actions and decisions to be made by, with and through the ICB rather than bilaterally between NHSE and individual provider organisations

5. **Improvement focused**, building a learning culture across local and regional level. Identifying opportunities and working together to address concerns / risks in a timely and proactive way; ensuring that the approach to oversight and, where necessary intervention, is proportionate and supports improvement.

6. **Improve performance and provide tailored support** by considering how best NHSE and the ICB and its stakeholders can use and respond to System Development Plans and the System Oversight Framework to ensure each ICB has the tools to improve performance of challenged organisations and the wider system.

7. **Reduce the total regulatory oversight activity** by ensuring that, where possible, oversight and monitoring are proportionate to risk. Oversight will be strategic and targeted based on comprehensive and dynamic risk assessments.

8. **Support and enable innovation** by working to ensure that arrangements do not restrict innovation, but rather identifies it and incentivises the ICB to take risk in a controlled way in line with the system's risk appetite and share any evidenced effective practice more widely.

System priorities and deliverables

National

National priorities of the NHS are set out in the Long Term Plan and on the publications section of the NHS England website. Key pieces of operational planning guidance for ICBs include elective recovery, people planning, oversight framework, and the quality framework. Further guidance relevant to the establishment and system development of Integrated Care Systems can be found on the ICS Guidance section of the FutureNHS platform.

System and place level

The NHS Devon leadership team developed a Vision, 6 Ambitions and 12 strategic objectives to be viewed as system wide. The publication of the NHSEI 2022/23 Priorities and Operational Planning Guidance (December 2021 and February 2022) means that the 5 key priorities need to integrate these “must dos”. The delivery of priorities will be monitored through a newly designed IQPR report and through the assurance committees using a balanced scorecard approach involving metrics from SOF, constitutional standards and deep dives into priority areas.

There is a golden thread from the 14 strategic objectives, through to the 5 key priorities. Given the current risks within the system, our focus for 2022/23 will be on 5 priority areas:

1. Urgent and Emergency Care (UEC) resilience – this also includes social care, mental health, community pathways and primary care access. Includes engagement with the public regarding UEC choices
2. Planned Care – reduction in long waiters, through delivery of accelerator and Targeted Investment Fund (TIF) schemes
3. Diagnostics - networks and community centres
4. Children and young people – including mental health, transition to adulthood and pathways
5. Digital – ensuring that we continue to get the benefits of digital working. Need to link work on pathways. Building on the success of Your Shared Care Record

These priorities are reflected in the 2022/23 operating plan, along with the key national requirements and key metrics for monitoring of the above are in development.

Classification: Official

Devon ICS's vision & ambitions

'Equal chances for everyone in Devon to lead long, happy and healthy lives'

At its core Devon has **six ambitions**, with an aim to shape services around the needs and preferences of the Devon population, while improving outcomes, tackling health inequalities unwarranted variation, being financially sustainable and a great place to work.

AMBTIONS	
1. Effective and efficient care	**Collaborate across the system to address quality (safety, effectiveness, experience) and productivity** Health and care organisations will work together to provide the best possible services. They will use Devon taxpayers' money to deliver best value for the population by reducing waste, tackling unwarranted clinical variation and improving productivity everywhere.
2. Integrated Care	**Systematic delivery of integrated care for children and adults across Devon** Primary care, community, mental health and social care working together with the Voluntary and Community Services to provide a more timely and consistent offer of care and support within every community, reducing growth in demand for acute urgent care, improving access to primary care and enabling more people to be cared for at or closer to home.
3. Community and people led change	**A citizens-led approach to health and care** A new approach will be adopted to reduce variations in life expectancy and health inequalities across Devon. There will be a shared way of working with people and communities to identify priorities and tackle the root causes of problems such as poverty, homelessness, substance misuse, domestic abuse and sexual violence, and mental ill-health. Information and intelligence across services will be used to target resources in the most effective way.
4. Children and young people	**Working together with children, young people and their families** All children and young people in Devon will have the best start in life and to be healthy and safe. Children, young people, their families and carers and communities will have access to a personalised, sustainable and coordinated system of care and support which meets needs early and improves their quality of life so that they can live well throughout life and make the most of the choices and opportunities available to them.
5. Digital Devon	**Invest in a digital Devon: tell your story once, first contact will be digital, secure, digital connectivity** Digital advances are continually creating possibilities for new ways of enabling people to stay well, preventing ill-health, and providing care. The ability to share information across all of our services will improve quality and in particular the safety of services and transform the ways we work. Building on the "Digital Citizen" and adopting a 'digital first' approach where appropriate across the whole system to access and deliver care, and, critically, ensure support for everyone in Devon to be able to access care through these new routes.
6. Equally well in Devon	**Work together to tackle the physical health inequalities for people with mental illness, learning disabilities and autism** The physical health of some people with mental illness, learning disabilities, and/or autism is significantly worse than the health of Devon's population as a whole. Health and care providers, commissioners, professional bodies, service user and carer organisations, and charities in Devon are committed to working together to bring about equal physical health for all.

Together for Devon

NHS Devon interim Strategic Objectives 2022/23

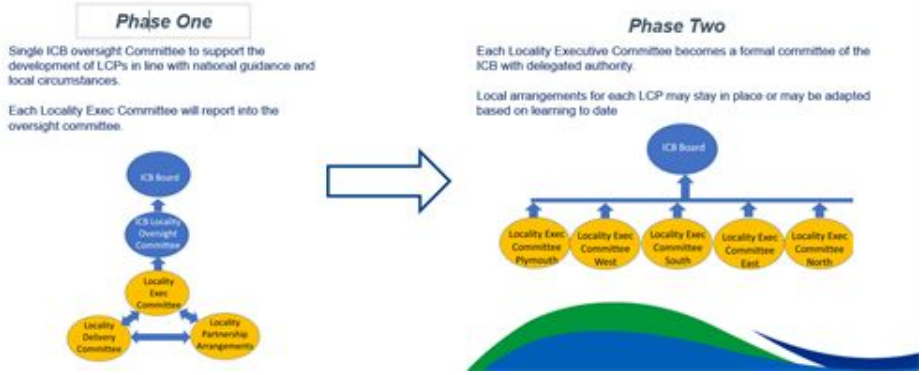
Improve population health	Improve services and reduce unwarranted variation	Make more efficient use of our resources	Develop our culture and how we operate
Work in partnership with community and 'anchor' organisations (such as education and police) to address the social determinants of health (1)	Deliver safe and effective urgent and emergency care services that better meet people's needs (4)	Move out of System Oversight framework (SOF4) – including delivery of a balanced system financial plan (9)	Develop and embed a new culture for the 'One Devon' system and create stronger relationships built on integration and trust (13)
Reduce health inequalities through public health and mental health support (2)	Reduce the number of people waiting for elective care – with a specific short term focus on 104-week waits (5)	Develop a workforce strategy to ensure resilience of key services (10)	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)
Enable a greater shift from treatment to prevention (3)	Improve the capacity of primary care – with particular attention to challenged areas, such as Plymouth (6)	Maximise the use of digital technology and data so it is evidence based and outcome focused (11)	
	Improve the quality of mental health, learning disability and neurodiversity services – particularly for Special Educational Needs and Disabilities services (7)	Minimise our negative impact on the environment and ensure services are green/sustainable (12)	
	Support and treat more people in their own homes and communities to help them live healthily and independently (8)		

Enablers to delivering our Strategic Objectives:
(i) Digital; (ii) Workforce; (iii) Estates; (iv) Good governance; and (v) Communications and engagement

Locality Priorities

Each LCP has developed its own set of priorities to focus on in the year 2022/2023 based on the understanding of local population needs. Following the refresh of the NHS Devon Board Strategic Objectives, these priorities are being reviewed to ensure they are aligned with the wider system objectives. Once finalised, these priorities can be shared with regional colleagues.

There is a plan to develop LCPs in a manner that is consistent across Devon. The plan is set out across two phases, with phase one commencing in alignment with the national ICS 'go live' date, and phase two commencing from 1st April 2024 at the latest.



Partnership and place arrangements

NHS Devon contains 5 individual LCPs which covers the geography of the fourth largest county in the country. The LCPs cover; North, East, South, West and Plymouth. As well as the LCPs NHS Devon will be supported by provider collaboratives overseeing Acute and Mental Health services.

LCPs and Acute Provider Collaboratives will hold delegated responsibility the identification, delivery, and monitoring of priorities within their localities. Issues that require system support/resolution or notification will be escalated to system level via the System Quality & Performance Group. LCPs and Provider Collaboratives will hold a monthly forum to review quality & performance, including all partners, holding each other to account and agreeing action for improvement. In this forum, quality, performance, activity, and finance will be triangulated. LCPs will receive support from quality, performance, finance, and BI teams to enable this.

The Performance and Assurance Team will support LCPs and Provider Collaboratives to develop locality Quality and Performance Reports and agree the narrative to feed into the report for locality or collaborative Executive meetings. LCP Executive Groups will agree the exceptions that comprise the narrative for escalation to SQPG via the system Integrated

Quality & Performance Report. The Integrated Quality and Performance Report will be developed to align to the provisions set out in the NHS System Oversight Framework and exit from Segment 4. It will focus on place and system wide performance, rather than each of the individual organisations. The document will include a suite of metrics that under-pin the ICS priorities and focus on achieving transformation rather than routine assurance of what is a “high performing” system.

LCPs have their own local priorities which will link to the system priorities via the Operating Model which have been identified in the section above.

Health Inequalities

CORE20Plus5 remains the focus of our combined HI and Prevention plan, with plans to strengthen leadership and system-wide awareness of health inequalities through a range of activities, including our 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 our system will be delivered through a number of actions, including:

- Working closely with our workforce programme, we will aspire to deploy Health Inequalities awareness to all staff. This will ensure our 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; and
    - 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 we 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 our revised **Quality and Equality Impact Assessment** (QEIA) will be launched across Devon to ensure HI is fully considered in all change. A “soft launch”

within the ICB 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.

- We will also 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.

- Alignment with the Health Inequalities work led through the Transformation Board

- Explore the establishment of HI Dashboard to underpin our HI Narrative, build knowledge, support priority setting and measure impact

Net Zero

To achieve net zero healthcare in line with the Greener NHS programme we want to develop greener health and social care systems which strive to deliver high quality services and improve the health and wellbeing of the population. NHS Devon's 'Green Plan', is a plan that will align itself with the NHS Long-Term Plan. As part of the NHS, we must play our part in reducing the environmental impact and carbon footprint of our operation. The inaugural Green Plan is a high level, strategic document that should be viewed as a 'living' document. As the ICS and Integrated Care Board (ICB) develop, and work programmes become clearer, the areas of focus of this Green Plan will be developed, and sustainability will be seen as business as usual.

In order for the NHS to reach net zero carbon emissions by 2040 for the emissions it controls directly, and 2045 for those it can influence, we are aiming to achieve the following:

WORKFORCE AND SYSTEM LEADERSHIP

- Support our staff to become carbon champions.
- Encourage our staff to be green innovators.
- Create an environment that promotes a highly motivated, engaged green workforce.

SUSTAINABLE MODELS OF CARE

- Consider carbon reduction principles when delivering care across the whole system.

DIGITAL TRANSFORMATION

- Increase the options for staff to work flexibly.
- Actively promote the digital option for our patients across the system.

TRAVEL AND TRANSPORT

- Actively support and promote travel that does not use petrol and diesel powered vehicles.
- Promote home working where possible.

ESTATE AND FACILITIES

- Purchase our energy supply from renewable energy sources.
- Ensure all new and future developments are green positive.
- Reduce gas, electric and water usage to cut carbon emissions.

MEDICINES

- Optimise the use of carbon friendly medical gases where possible.
- Prioritise the prescribing of lower carbon inhalers.
- Reduce the use of single use plastics.

SUPPLY CHAIN AND PROCUREMENT

- Apply the Social Value Act in all procurement processes.
- Buy locally where possible.
- All suppliers of goods and services to be aligned to the NHS Net Zero Target.

FOOD AND NUTRITION

- Offer healthier lower carbon options for all – staff, patients and visitors
- Buy locally where possible.

ADAPTATION

- Ensure we and our patients are prepared for future extreme weather conditions.

Operating Model

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**
- **Enhancing productivity**
- Helping the NHS support wider **social and economic development**

Classification: Official

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 development journey required to implement the new operating mode, 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 exhaustive 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 a new system operating model **will not in any way impinge on the statutory duties of the individual organisations** that were operating in the system before the implementation of the **Health and Care Act 2022**

Governance and oversight

The NHS Oversight Framework details the NHS oversight arrangements for 2022/23, which reflect the legislative changes enabled by the Health and Care Act 2022, including the formal establishment of ICBs.

The legislative changes do not provide additional regulatory powers to ICBs, and these will not be delegated by NHSE. ICBs will, however, lead oversight and support in their systems, as supported by NHSE, should regulatory intervention be required. This MOU reflects how NHSE, ICBs and system partners will work together to implement the requirements set out in the Oversight Framework.

Across **One Devon**, we have redesigned our **Oversight and Assurance approach**, the aim of which is to create an environment of **mutual accountability** and process that allows us to **hold ourselves to account** for delivery of the ICS strategic ambition and to use the process to **facilitate service and performance improvement.**

The **One Devon** Oversight and Assurance Framework is designed to dovetail with the national **NHS Systems Oversight Framework (SOF)**; and ensure that the **ICB has accountability to oversee and assure** systems within Devon for delivery, maintaining quality, driving a greater degree of autonomy, access to resources for the ICS and clear triggers for escalation and regional intervention.

The aim of the framework is to support delivery of improved health outcomes, reduced inequalities, improved service quality and standards (not just constitutional) and financial performance as we move into the COVID 19 recovery phase, 2022/23 and beyond.

The Devon Assurance framework will **respond to the requirements of the national NHS Systems Oversight Framework (SOF).** Our aim is that our **One Devon** approach to performance improvement and assurance will be different and add value and underpinned by the following set of principles:

- A focus on improving performance that benefits the citizen and the community.
- A single framework of governance that enables and supports all parts of the system collaboratively to drive improvement to delivery and outcomes and provides clear line of sight on performance and risk at system level.
- Building our understanding of performance across all services, encompassing prevention, primary care, secondary care, mental health, social care and community, developing new metrics where necessary, to drive service improvements and outcomes and supporting the reduction in health inequalities.
- Provision of integrated, timely, appropriate information, aligned across quality, performance, outcomes, workforce and finance, and expressed at place and at system.
- Ambition to deliver a fully integrated data set with an agreed central version.
- A forward look approach to anticipate risks to performance and inform collaborative solutions and action plans (e.g.: mutual aid).
- Enable a culture of continuous performance improvement, through benchmarking and adoption of best practice and innovation.
- Enable a culture of support, not blame, that focuses on getting better every day and assurance at Place level.

NHS Devon will lead the oversight of the integrated care system of:

- University Hospitals Plymouth NHS Trust
- Royal Devon University Healthcare NHS Foundation Trust
- Torbay and South Devon NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- Devon Partnership NHS Trust
- Primary Care Networks - covering 130 GP practices
- Devon County Council
- Plymouth City Council
- Torbay Council
- Livewell Southwest
- VCS colleagues
- Social care providers
- Hospices

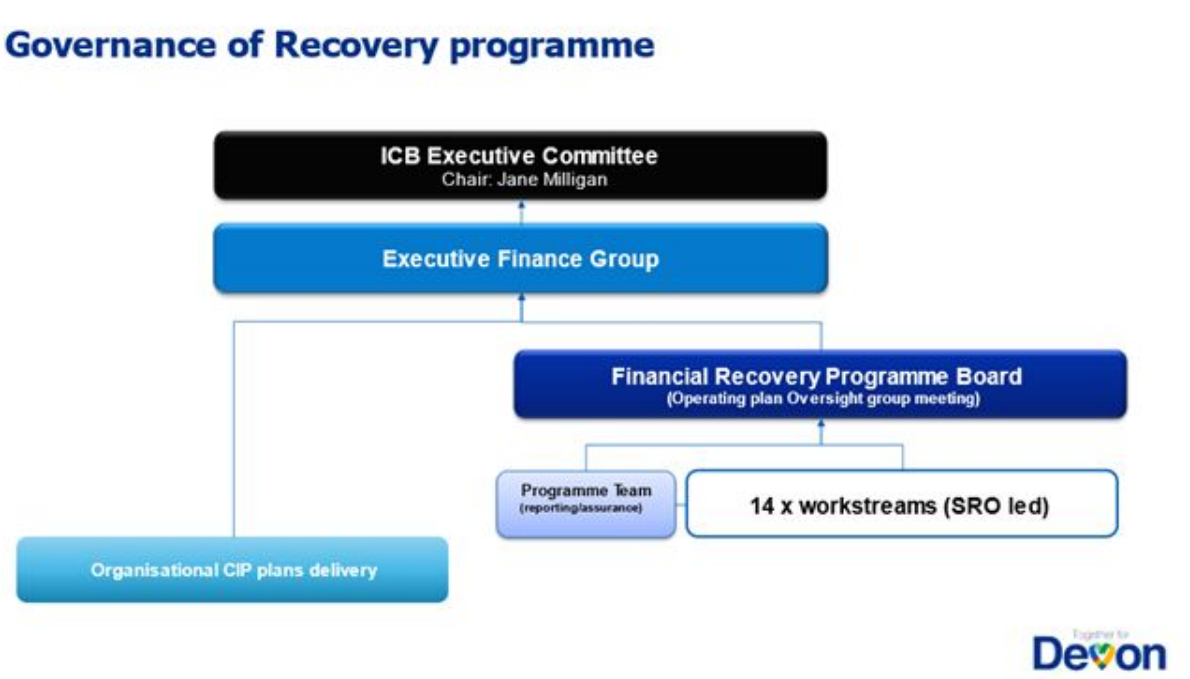
NHS Devon will agree and co-ordinate any support and support and/or intervention to provider organisations carried out by NHSE South West, other than in exceptional circumstances.

NHS Devon will provide assurance on place-based systems and provider Trusts within Devon to NHSE South West. **NHS Devon** will undertake the least number of formal assurance meetings as possible with individual organisations.

The Finance Working Group is responsible for system financial management and resource allocation. The NHSE regional team are attendees at Devon's Finance Working Group. System partners are committed to transparency on financial decision-making, performance, and drivers of deficits via the System Transformation & Efficiency Committee.

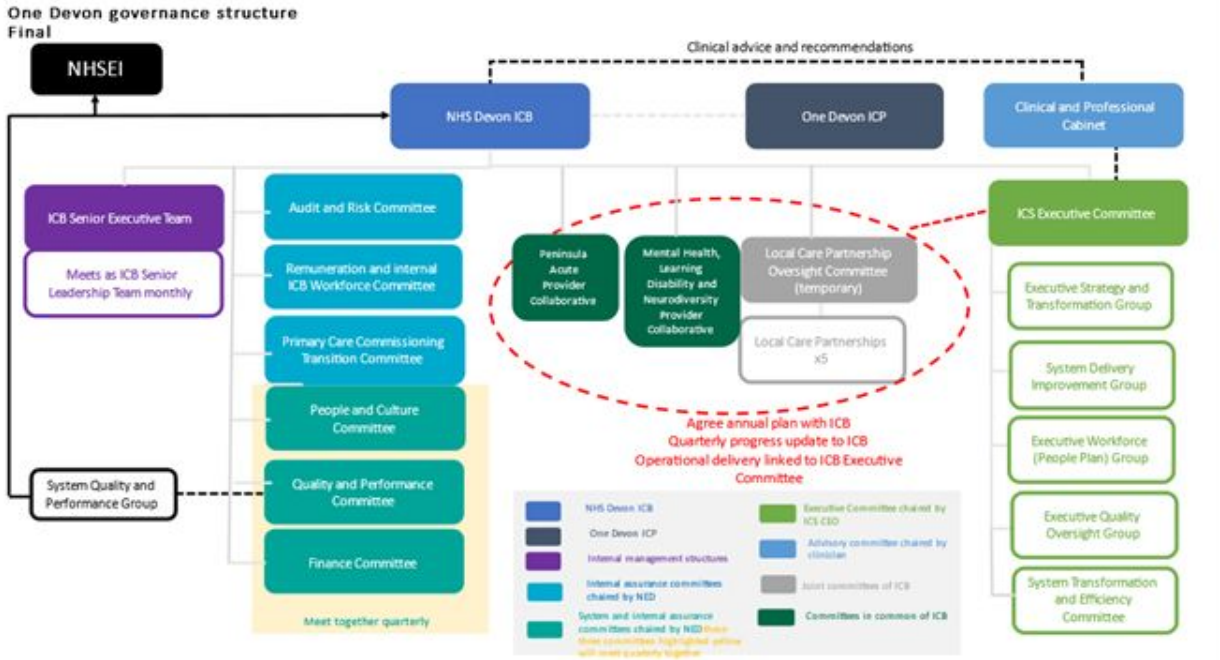
Classification: Official

A risk management framework is being developed across the Devon system to ensure that an overall breakeven position is achieved at system level.
Monthly monitoring of the financial position of the ICS including risks associated with delivery of a breakeven position will be reported to NHSE via the new Integrated Financial Reporting process as well as being reported and scrutinised by the ICB Finance Committee.



Financial delegation of resources will be determined by the ICB finance committee at an individual level with collective delegation to either LCP's or Provider Collaboratives which will come on-stream as those arrangements reach appropriate maturity. **One Devon** finance, performance and quality assurance will be delivered through the following architecture

Classification: Official



Roles and responsibilities in performance improvement

As the ICS matures, LCPs and Acute Provider Collaboratives will hold delegated responsibility the identification, delivery, and monitoring of priorities within their localities. Issues that require system support/resolution or notification will be escalated to system level via the System Quality & Performance Group. LCPs and Provider Collaboratives will hold a monthly forum to review quality & performance, including all partners, holding each other to account and agreeing action for improvement. In this forum, quality, performance, activity, and finance will be triangulated. LCPs will receive support from quality, performance, finance, and BI teams to enable this.

Currently there is a need for greater oversight and scrutiny and NHS Devon will lead on system oversight of performance management by introducing an integrated performance meeting with the three acute providers, the mental health provider, community services, and ICB directly delivered services. Including ICB directly delivered services will provide a consistent approach to performance oversight and maintain the principles of system working. These meetings will be provider-specific on a 2 monthly basis, with a locality meeting including LCPs and Providers in that Locality Partnership on alternate months. These meetings will be chaired by the Chief Delivery Officer (CDO) with support from the Director of Performance and Assurance and the ICB Executive Lead for the relevant LCP will also be in attendance. Further consideration will need to be given to how other system Directors and leads participate in these meetings as required.

The meetings will follow a standard agreed agenda and will provide specific scrutiny of performance including but not limited to; RTT, Cancer, Diagnostics, Urgent Care including ambulance handover, Criteria to Reside, and any further metrics related to SOF. 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. It is proposed that we use the individual providers IPR as the data source for these meetings as they will be focussed on current and future actions to improve performance in the domains stated above. The outcomes of this process feed to the ICB Executive Finance Group, which will now also include performance as the Chief Finance Officer (CDO) will hold overall responsibility for integrated performance.

Monitoring serves both a strategic and operational focus via defined Recovery Metrics, Integrated Quality and Performance Report and an Outcomes Framework. Progress in the delivery of service transformation and developmental programmes is via exception, escalation, and progress reporting of programmes.

NHSE membership or attendance at groups forming part of Devon's architecture will be agreed in advance and can be requested by the ICB or region. A relationship between the ICB and regional performances will be maintained to ensure mutual understanding throughout the oversight themes on an ongoing basis. NHSE are partners in the exceptional oversight arrangements currently in place in the Devon system.

NHS Devon will maintain an open, honest and transparent relationship with the regional team ensuring any issues with system performance or quality are escalated at the earliest opportunity. NHS Devon expects the regional team to respect its accountability for delivery of priorities and performance and will ensure that any regional intervention with NHS Devon or individual providers will be agreed in advance with a clear rationale for intervention provided.

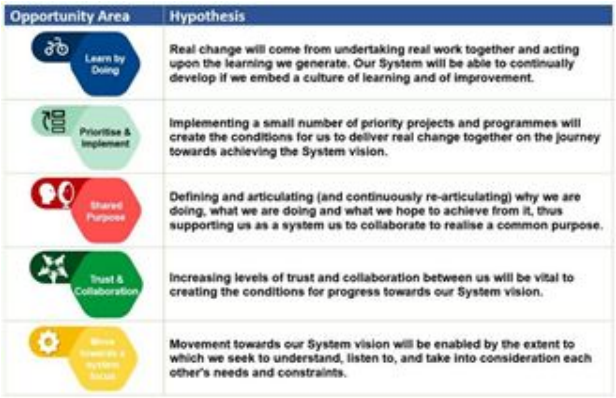
ICS Development

The Integrated System Development (ISD) Programme commenced in November 2021 and is comprised of two phases: Design and Implementation. The Design Phase was completed by end of April 2022 with the findings of a System Diagnostic and the ICS Maturity Framework commended, and the scope and focus for the Implementation Phase endorsed by c.50+ senior system leaders (including NHSE).
The need for Devon to deliver sustained transformational change and performance improvement is fully recognised. To deliver this change successfully will require Devon to work in a different way as an ICS and this, in turn, will require support from the NHSE Team. The way in which Devon needs to change is set out in *'the way we do things together in*

Classification: Official

Devon' narrative with broad agreement across all partner organisations to the principles outlined. Colleagues also acknowledge the scale of change to be delivered and that this will require significant cultural change.

The purpose of the ISD Programme is to support Devon to strengthen a collaborative and integrated way of working which enables improved experience and outcomes for the citizens of Devon. Underpinning all work undertaken by the ISD Programme will be the five opportunity areas outlined here.



There is strong correlation between this purpose and the principles of how Devon and NHSE will work together.

Over a c.12-18 month period, the following work will be undertaken. This work has been aligned to the wider ICS plans and, for some activities, aligned to the NHSE agenda (for example: the co-production of the Devon Joint Forward Plan and the co-design of the Devon Operating Model).

Programme Focus	2022/23			2023/24			
	Qtr 2	Qtr 3	Qtr 4	Qtr1	Qtr 2	Qtr 3	Qtr 4
Strengthening senior System Leadership: a programme of development for Executive Teams and above							
Devon Joint Forward Plan: co-production of the Integrated Care Strategy and overarching strategic delivery plan – creating a shared purpose					Delivery of the Devon Plan		
Devon Operating Model: co-design of the future Operating Model, and embedding it across the ICS to drive a different way of working			Adoption, and continuous improvement, of the Devon Operating Model				
Urgent Emergency Care Programme: embedding OD within the approach to enable successful delivery of sustained performance improvement							

Value Based Approach: support to completing research into VBA, and commencing the co-production of a business case			Co-production of VBA business case, pending approval in Nov 22				
Education, Communication & Engagement							

This describes the key priorities of the ISD Programme which the Executive Strategy & Transformation Group will have oversight of – in essence the Programme will enable *'creating the conditions for success'*. Devon, and NHSE, will assess the impact and value of the ISD Programme through an evaluation approach which the SW AHSN will support to enable objective assessment.

NHSE and NHS Devon need to work together to drive a different way of working. The NHSE Team can support this work in a variety of ways including:

- **Adopting a 'System First' approach:** (as per the principles mentioned earlier)
- **Shared Priorities:** consistently reinforcing 'one version of the truth' which balances a focus on the 'here and now' challenges with that of 'developing the future'
- **Creating the Conditions for Success:** adopting mindsets and behaviours which role model the new way of working; supports innovation and encourages 'learning by doing'
- **Learning from Others:** where Devon can rapidly adopt learning from others in and outside of Devon to drive pace of improvement, make best use of resources and avoid duplication of effort etc

The Chair and Chief Executive Officer of the ICB (with their equivalents at the other South West ICBs) will continue to work in collaboration with NHSE South West's Senior Leadership Team to agree and implement a "South West Compact" for their working together as a leadership body.

Reviewing, amending, and monitoring of the MOU

This MOU relates to an ongoing relationship between the ICB and NHSE and will run indefinitely. The ICB and NHSE agree to review the agreement every 12 months to assess whether it is still accurate and fit for purpose.

Changes to the MOU required outside of the proposed review period can occur at any time, if agreed by both parties.

Signatures

The ICB and NHSE, as represented by the below officers, agree to honour the aspirations and commitments made in this MOU.

[insert name/title of representing officer of the ICB]

[insert name/title of regional NHSE representative]

[insert effective date]

NHS Devon Integrated care board meeting

Committee chair report – People & Culture Committee

Date of board meeting	Dates of committees covered in this report
21 December 2022	30 November 2022

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

Reports discussed and assurances received

- Paul Renshaw presented the Director of Strategic Workforce report to the group with updates on:
    - agency spend - the system will not hit its target of £28m agency spend and is on trajectory to also exceed last year's £38m spend, with current forecast more than £42m. Work has been completed to ensure director/ finance sign off all spend. Supply and demand issues for workforce are driving this spend. Work is proceeding well to move significant levels of nursing agency to internal bank spend for next year.
    - The work to agree a workforce strategy work is ongoing and will be finalised by the end of the financial year for ICB review/approval
    - Work has begun on the operational plan for 2023/24.
    - Work also continues to produce a workforce planning tool for implementation in 2023/24
    - International recruitment is proceeding well with the 600th international nurse joining Devon in November since the start of the

Devon-wide alliance 15 months ago. Very high levels of retention and pastoral care satisfaction were reported.

- The Integrated System Development Programme was presented to the group by Tracey Cottam, where the group were updated on the work completed during the first year of the programme.
    - Devon operating model has been worked up with system providers during July and August and this has now been signed off and is in the adoption phase.
    - Integrated care strategy work is underway for the five-year plan to be published by December 2022.
    - Work to agree the Devon Joint Forward Plan is also underway and this will be published by the end of March 2023.
- Paul Renshaw provided an update on the work within the Readiness to Operate framework and focussed on the elements that remain RAG rated amber or red (workforce strategy / workforce planning/ recruitment / leadership development and driving wider social- economic impact). It is expected that the workforce elements of the framework will be rated as green by Q1 2023, but it was highlighted that more work is required on the leadership development and the social economic impact elements via the HR Director (leadership) and Local Authority colleagues for the social economic improvements.

Reports received and noted

- Director of Strategic Workforce Report was presented to the group and noted.
- Integrated System Development report were presented to the group and noted.
- Readiness to operate framework was presented to the group and noted.
- Workforce Productivity and Efficiency Group update was provided to the group and noted.

Risk registers review updates

Nil

Committee decisions

- The committee agreed to have a deep dive into the international recruitment hub to the January committee meeting.
- The committee agreed to have a deep dive into the retention work at the February committee meeting.
- The committee agreed for the workforce strategy to be brought to February committee for approval

Items of concern to be escalated to the board

The committee raised at the October meeting the need to discuss at the December ICB Board the issue of how we view risk when transforming services and workforce

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:

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

NHS Devon Integrated care board meeting

Committee chair report – Primary Care Commissioning Transitional for Public meeting of ICB, from private meeting of PCCTC

Date of board meeting	Dates of committees covered in this report
21 December 2022	24 November 2022

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

Reports discussed and assurances received

- The committee reviewed the monthly report from NHS England of **Dental, optometry, and community pharmacy services** in which a regional dental event was emphasised as important to the new Devon Dental Framework as a starting point for strategic management of the service and as part of the overarching community care offer.

- PCCTC reviewed and discussed the **Quality Report** which focused on:
  - An example of improved incident reporting making a difference to the escalation and resolution of issues
  - CQC inspections: There have been remote reviews but no full inspections for 9 practices since 2015 and 15 since 2016. The Quality team are going to run through those practices for CQC to share intelligence and data.

    - The handing over of some General Practice Nursing programme workstreams to the Devon Training Hub

- PCCTC were given a presentation on the operational processes appropriate to primary care, which is part of the new **Patient Safety Framework,** especially that of the learning from patient safety events policy.

- The PCCTC reviewed the **metrics** for measuring the impact and delivery of the new primary care strategic framework. It was noted that in September activity: 47.5% of appointments happened within one day which is very commendable and is well above the target of 35% and the national GP access data position of 38.9%.

- The committee was given a more in depth understanding of the **Community Pharmacy workstream** which will be one of the new delegations to NHS Devon.

Reports received and noted

- PCCTC was updated on **contractual, and resilience matters** in a high-level overview report. This drew the committee's attention to updates on the CQC registration, contractual issues and a partnership change request
- PCCTC received the **finance report** for month 7
  - The continuing cost pressure from a contract in Plymouth on contingency and this practice is routinely reporting financial position against plan in monthly meetings with NHS Devon staff.
  - Present levels of service development funding money and a new process which reviews allocations before releasing them to service areas. In future years, NHS Devon may need to reallocate some primary care SDF funds if organisationally appropriate.
  - A £2million underspend in the ARRS budget due to recruitment problems in some localities. PCNs have been asked to bid for more ARRS money and £1.3m in extra bids have been received.
  - Prescribing for noting, as PCCTC do not oversee this area of expenditure– a national pricing issue, due to unavailability of less expensive drugs, is making a £6m price pressure on the prescribing budget which had been working well within original reduced budget parameters. The Medicines Optimisation team are exploring more ways of saving, over and above current efforts.

- The **Deputy Director's Report** highlighted the constantly changing and intensive work in place for asylum seeker and refugee settlement healthcare and the closing of a risk around remote access system concerns, which have now been resolved.

Risk register review updates

- None

Committee decisions

- The national GP **Patient Survey results** were reported to the committee with recommended next steps. It was noted that at county level, Devon exceeds national average across all indicators.
  The **Recommendations,** to note the contents of the report, take the work forward with locality GP commissioners, at a strategic level give consideration to the establishment of an overarching access dashboard and initiate the workstream in Spring 2023 to complete by Autumn 2023, were **approved by the meeting.**

Items of concern to be escalated to the board

- Cost of locums in primary care and impact on this of different systems of delivery.

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 Integrated care board meeting

Remuneration and Internal ICB Workforce Committee

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

Chair	
Name and title:	Kevin Orford, Chair

Reports discussed and assurances received

Very Senior Manager (VSM) pay uplift report

On 26th September 2022, the Minister's recommendation on 2022/23 annual pay increases for VSMs was confirmed.

The guidance within the report recommends:

An across-the-board increase of 3.0% for all VSMs is to be applied and backdated to 1st April 2022.

A further 0.5% at the discretion of the Remuneration Committee may be applied to VSMs on salaries to resolve differentials). This is aimed at facilitating the introduction of the new VSM pay framework over the course of the coming year.

Risk register review updates

N/A

Committee decisions
The Committee applied the pay award in accordance with the Minister's recommendation and the accompanying guidance.

Items of concern to be escalated to the board
N/A

Recommendations for the board
N/A

Recommendations for other committees
N/A

Terms of reference or other committee effectiveness issues
N/A

Management of conflict of interests:

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NHS Devon

Integrated Care Board Meeting - Action Log								
Action Number	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**OPEN/CLOSED**
3	21.09.22	Share Dr Hooper's report on long waits during covid	Oct-22	Simon Tapley	24.11.22 - Report shared with board members for information. Request to close 12.10.22 - Report is not ready to share yet as it won't be going to the relevant Board meeting in Urgent and Elective Care until November now (17 November) therefore this will be circulated with the minutes of the November ICB meeting.			**Request to close**
19	19.10.22	Liaise with regional colleagues to provide feedback of the inappropriate timelines for developing and implementing the BCF plans and inform that the plans from our organisation will be submitted at a later date to ensure these are in line with the Devon operational plan.	Nov-22	Simon Tapley	14.12.22 - This has been discussed with Jane Milligan and raised with the regional team, however the submission will need to be in line with the regional timelines. Request to close 01.11.22 - Simon Tapely to discuss with Jane Milligan			**Request to close**
23		Add a freedom to speak up session to the forward planner	Nov-22	Jodie Howland	07.12.22 - Kevin Orford to update Jodie on an appropriate time for this item to be included on the agenda 26.10.22 - Request to FTSU Guardians to understand what they wish to cover to ensure the forward planner is updated and scheduled appropriately. KO responded and will update following FSTU next meeting.			**In progress**
24	16.11.22	Investigate the points raised by the patient relating to his experience whilst waiting for treatment of NDHU and follow up with the patient and the Chair	Dec-22	Darryn Allcorn	08.12.22 - Darryn Allcorn has raised some concerns with NDUH N and had some responses. Darryn will write to the patient and copy in the Chair once a couple of points have been clarified.			**In progress**
25		Maternity voice development session to be scheduled	Feb-22	Jodie Howland	25.11.22 - Added to forward planner, request to close			**Request to close**