Integrated Care Board Meeting - Public

21 September 2022 12:30 - 21 September 2022 15:30

AGENDA

#	Description	Owner	Time
1	**Welcome and Apologies** Apologies - none received	Chair	12.30
2	**Declaration of Interest** For information 02. DOI Integrated Care Board Meeting @08.09.20... 5	Chair	12.35
3	**Minutes of the previous meeting and action log** For approval 03. NHS Devon - ICB Board Minutes - Public 20.07.... 8	Chair	12.40
4	**Former CCG Annual Report sign off** To acknowledge the approved former CCG Annual Report and signpost to publication on the public website (separate attachment)	Chair	12.45
5	**Citizen involvement story**	Mrs Duran	12.50
6	**Chairs report** For information 06. Chair's report (final draft 3).docx 14	Chair	13.25
7	**Chief Executive report** For information 07. CEO report (final draft 2).docx 22	Chair	13.35
8	**ICS Executives report** For information 09. ICS Executives' report (final draft 2).docx 30	CEO	13.45
9	**One Devon Integrated Care Partnership committee chairs report** For information 08. NHS Devon - ICP chairs report 04.08.22.docx 38	Cllr James McInnes	13.55

#	Description	Owner	Time
10	BREAK		14.00
11	Finance Report NHS Devon ICS Finance Report M4 (FINAL for ICB... 40	Chief Finance Officer	14.05
12	ICB Priorities and draft Strategic Objectives For decision NHS Devon - Strategic objectives 2022-23 - DRAF... 59	Chief Communications and Corporate Affairs Officer	14.15
13	Assurance Committees - updates and escalations		
13.1	Audit and Risk Committee, including risk management For Information 01. NHS Devon - Audit and Risk Committee chair r... 60 01. Appendix 1 - Risks Reporting to Audit and Risk... 62	Committee Chair	14.25
13.2	Primary Care Commissioning Transition, including refreshed NHS Devon Primary Care Strategy (General Practice) For Information 02. NHS Devon July PCCTCommittee chair report.... 73	Committee Chair	14.35
13.3	People and Culture Committee, including workforce strategy For Information 03. NHS Devon People and Culture committee Rep... 76	Committee Chair	14.45
13.4	Quality and Performance Committee, including ambulance handovers For Information Chair's report- Quality and Performance committee... 79 Devon IQPR report FINAL August 22.pdf 82	Committee Chair	14.55
13.5	Finance Committee, including Plymouth Health and Well Being Centre Business Case For Information 04. NHS Devon Finance Committee chair report Jul... 179	Committee Chair	15.05

#	Description	Owner	Time
14	Public Questions	Chair	15.15
15	AOB	Chair	15.25
16	Close	Chair	15.30

Declaration of Interests Register - ICB Board
Register updated and generated by the Governance Team - 08 September 2022

Register last updated 08 September 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	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	Director of H Smith Safety Associates Patron of the FORCE cancer charity in Exeter Wife works as an associate with the South West Academic Health Science Network Relatitive consultant Dermatologist at the Royal Devon University Hospital In-law is a GP partner in the Woodbury Practice Director on the board of the South West Academic Health Science Network		05/10/2018		12/05/2022				NHS Devon ICB
	Allcorn	Darryn	Chief Nurse	Quality and Performance Committee System Quality and Performance Group ICB Board Audit and Risk Committee (If Required) Quality and Risk Group ICS Executive Committee	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 Partner runs a research consultancy specilising in the integration and analysis of large data (inc NHS) 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 Plymout		10/03/2022		10/03/2022				NHS Devon ICB
	Brown	Steven	Director of Public Health (DCC)	STP Directors ICS Partnership Board ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group	No interests declared		19/11/2020		19/11/2020				Devon County Council
	Clarke	Graham	Independent Non Executive Director of Audit and Risk	ICB Board Audit and Risk Committee NHS Devon Finance Committee Primary Care Commissioning Transitional Committee	Non-Executive Director of Medicine Discovery Catapult Non Executive Member at the Deparment of Health & Social Board Chair of HUC (East of England 111 and Urgent Care Provider) Trustee and Treasurer of the Cornwall Community Foundation	Spouse is CEO of Cornwall Partnership Foundation Trust and a Board Member of Cornwall & Isles of Scilly ICB	01/01/2020		04/08/2022				NHS Devon ICB
	Davenport	Liz	Chief Executive Torbay and South Devon Trust	A & E Delivery Board ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Integrated Care Partnership Committee	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	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015		20/10/2020	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	Hara	Thandiwe	Independent Non Executive Director of Inequalities and Population Health	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee People & Culture Committee	Trustee of Plymouth and District Racial Equality Council, a voluntary organisation that work to promote race equality. member on the NIHR SW Clinical Research Network Board.		16/03/2022		16/03/2022			There should be no conflict of interest in current circumstances, but this may arise if, they became a provider during the course of time. I will declare my interest at any meeting that may result in them being considered for service provision and leave the meeting if necessary. This should not raise any conflict, that I can foresee except that it is research related. There is no commissioning involved, but thought to mention it anyway. I will declare my interest at any meeting that may result in them being considered for service provision and 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 Integrated Care Parernship Committee Audit and Risk Committee Building Coordinators Green Team Integrated Care Partnership Committee			11/02/2020		08/08/2022		Indirect	Any shift allocation that I am supporting with will be agreed and approved by a third party	NHS Devon ICB

Prof	Khalil	Hisham	Independent Non Executive Director of Quality and Performance	ICB Board Audit and Risk Committee Quality and Performance Committee	Practising Consultant in Derriford Hospital Limited Private Practice in Nuffield health Plymouth Director for Private Practice- Dormant Company Trustee of the Peninsula Medical Foundation		01/09/2004	24/02/2022				NHS Devon ICB
	Lee	Tracey	Chief Executive for Plymouth City Council	ICB Board	Chief Executive for Plymouth City Council		27/06/2022	27/06/2022				Plymouth City Council
	Lou Glover	Sarah	Ordinary Member for the Devon Integrated Care Board for Mental Health	ICB Board	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
	Milligan	Jane	CEO ICS for Devon	Senior Executive Team Meeting Senior Leadership Team (SLT) Audit and Risk Committee (If required) ICB Board NHS Devon Finance Committee ICS Executive Committee Executive Workforce Committee People & Culture Committee	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	Senior Executive Team Meeting Staff Partnership Forum Senior Leadership Team (SLT) Audit and Risk Committee (If Required) Vacancy Control Panel Equality, Diversity and Inclusion Group ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group ICS Executive Committee Executive Workforce Committee People & Culture Committee	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, ICB Devon nominated director		19/06/2018	14/04/2021	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	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		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	Partner of Management Consultancy – Linea Consulting Provide advice and guidance to Devon Doctors, Head of HR on 2 specific issues. 1.The staffing challenges for their frontline 111 service and their modelling of the impact of increasing their clinical validation resources. 2.I meet with Sam Fraser fortnightly for up to an hour to assist with his development and attend on an ad hoc basis a clinical resourcing meeting on a Monday so I can help spot where opportunities.		2017	23/09/2021	Partner	Direct	Will declare at relevant meetings / any potential procurement In order to manage the declared conflict of interest, the conflicted individual providing support to Devon Doctors must do the following: •Declare the interest at the start of all meetings •State clearly in meetings their role and the limits of their involvement •Remove themselves from any meeting or conversation where content pertains in any way to any element of the IUCS procurement •Ensure that representatives of the provider understand the nature and importance of the conflict of interest and are encouraged and supported to request the conflicted individual's exclusion where required •Ensure that they are not in receipt of papers for meetings that contain (or could reasonably be expected to contain) information relating to the IUCS or any other procurement in which Devon Doctors is participating	NHS Devon ICB
	Snaith	Ginny	Associate Director of Governance	Senior Executive Team Meeting Working with Industry and Sponsorship Group System Restoration and Transformation Group Audit and Risk Committee ICB Board One Devon Parternship	No interests declared		22/03/2019	25/08/2022				NHS Devon ICB
	Tapley	Simon	Chief Transformation and Strategic Planning Officer	Senior Executive Team Meeting Senior Leadership Team (SLT) Audit and Risk Committee (If Required) Vacancy Control Panel ICB Board NHS Devon Finance Committee Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee Eastern LCP Executive Group South LCP Executive Group ICS Executive Committee		Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon ICB Step-son is a Receptionist at Albany Surgery	01/11/2016	05/05/2021	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB

Dr	Wollaston	Sarah	Chair for ICS Devon	ICB Board Audit and Risk Committee (If Required) NHS Devon Finance Committee (If Required) Remuneration & Internal ICB Workforce Quality and Performance Committee People and Culture Committee Primary Care Commissioning Transition Committee	Trustee of Landworks, a Dartington based charity that works with ex offenders and people at risk of going to prison to support them into employment and reduce the risk of reoffending	Spouse is president of the Royal College of Psychiatrists and a consultant forensic psychiatrist employed by Devon Partnership Trust Relative is a registrar in Obstetrics and Gynaecology on the South West training scheme (currently on maternity leave) but will be returning to RD&E in late 2022. Relative is a registrar in Anaesthetics on the south West training scheme and currently based at Derriford	26/11/2021	27/06/2022	Non-Financial Personal Interests	Indirect	Where a piece of ICB/ICSD work or an item on a Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB

NHS Devon

INTEGRATED CARE BOARD, BOARD MEETING (Public)
MINUTES

Date: 20 July 2022 Time: 09.00am – 11.25am

Location: Via Microsoft Teams

Item	Discussion	*Decision taken by Organisation*
1	**Welcome and Apologies** SW extended a warm welcome to all in attendance. An apology was extended for the meeting being held virtually due to rising numbers of Covid 19. Apologies were noted from Simon Tapley, Nigel Acheson, Cllr James McInnes.	
2	**Declaration of Interests** Updates from KO and JH within the report were noted. No new declarations were offered. SW shared that all declarations of the interest could be found on the NHS Devon website.	The Board **noted** updates to the declarations of interest report
3	**Overview of integrated care and how we will work together** JM provided an overview of pressures within the system. Covid 19 still being present which has exacerbated issues in health and care services in Devon including within the workforce. There are over 18,000 people waiting more than a year for care with 800 of those waiting over two years. This has been identified as having both a physical and mental health impact. Ambulance delays are acute in this part of the country. It was noted that Cornwall and the Isles of Scilly Integrated Care Board also share the same pressures which has a knock-on effect to both counties. Delays have increased by over 2 ½ times since 2020. Emergency services are very challenged. The numbers of people attending Accident and Emergency have stabilised, however less than 40% of people are being treated within the four-hour target compared to the national target of 95%. Pressures within community and primary care services were noted. There have been significant increases of between 8-10%, for appointments in primary care services and in increase in demand for social care, with the	

	impacts of Covid 19 outbreaks within care home still causing concern. Along with the increase in mental health referrals both in adults and children. Children's services, whilst good in many areas, are significantly under pressure, particularly in relation to the special educational needs and disability services. Workforce challenges underpin many of the challenges. There are currently 5000 vacancies across the health and care system in Devon. With the high turnover, 35%, in some parts of social care coupled with an aging workforce and the reduction in the number of people coming forward to train as nurses, this will have a significant impact on delivering services. It was shared that the Board alongside the One Devon Partnership would be looking at working differently to address the significant and very complex challenges. Over the next six to nine months, a forward plan will be developed to tackle these areas.	
4	**Service user experience** Mr Peter Washburn kindly joined the meeting to share his experiences of ambulance waits and urgent emergency care, which included non-arrivals, poor customer service from the call operator, being sent home and being asked to return for emergency care. The most distressing element being the long wait for an ambulance and the lack of compassion from the call operator. He has been left with a fear of calling an ambulance again and being sent home from A&E whilst in pain. The Board felt that Mr Washburn's experience had illustrated just why the system needs to work in a collaborative way. SW and members of the Board thanked Mr Washburn for his account and apologised for his poor experience. Mr Washburn thanked the Board for the invite and shared that he felt cared for and that it showed people actually cared.	
Programme of works		
5	**Outline of the NHS Devon approach to support change across Devon** DA presented the report to set the foundations of where the service has come from, where it is now and the ambitions for the future. Challenges in Devon have been long standing going back to those seen in 2015 and 2016. With a risk of a £440 million deficit by 2020 forecast a requirement for transformation was identified and brought about a review of the approach to support the changes needed. It was acknowledged that there are some good foundations to build on and it was explained that moving forwards a collaborative approach will focus on working with our population and workforce to meet the needs of everyone. Value based approaches as well as other national models will be reviewed and built on and that transitioning to a new approach, moving from a fragmented number of services to a service that is less acute dominated	The Board **noted** the report.

	and works within our communities will positively serve the whole population of Devon. DA shared that the integrated quality and performance report has seen several iterations and will see further improvement with the use of a national model around Statistical Process Control (SPC) charts to enable a much clearer to read document. It was highlighted that there remains a system oversight framework (SOF) in place at level 4 which highlights the inability to deliver a balanced plan. All pathways are stretched not least the non-surgical pathways such as autism, speech and language and mental health. Covid 19 was reiterated as a challenge which has seen over 300 patients this week within hospital bed bases which impacts urgent care pathways. Vaccination uptake in Devon is exceptionally positive, which will be the main line of defense into Winter and moving into a combined vaccination program of flu and COVID. There are significant challenges around 111 and GP out of hours services with a current call answered within 60 seconds target of 45% which should be at 95%. As the new provider takes over there will be several areas to seek improvement around. Social care referrals have continued to increase particularly as we come out of the pandemic seeing 130% above where we were pre pandemic. New collaborative ways of working were shared which will draw on expertise across the system. The ICP will work to reduce duplication, reduce complexity and make sure the services are safe, effective and provide the best experience. A focus on equally well in Devon will tackle the physical and mental health inequalities combined with learning disabilities and autism to ensure a holistic approach to our communications. *Discussion* SW acknowledged the extreme pressures and the impact these have on both the population of Devon but also the staff within health and social care services and extended a heartfelt thank you to those staff who continue to work together to tackle the issues and provide a service. There were detailed discussions of improvement requirements and solutions for moving forwards from members of the board which included strategic dashboard, workforce strategies, theory of change model, the understanding of pathways as well as digital advancements, research, utilising assets more imaginatively and looking at pathways as a whole. It was acknowledged that focusing on delivering areas to unlock some of the challenges faced is key as well as making tough decisions and that workforce is a high priority. It was also acknowledged that improved qualitative data is required and the ability to break down some areas to bring about change rather than trying to tackle the overarching issue. KS shared that Cornwall and the Isles of Scilly share the issues that Devon has in terms of workforce and referenced the True North report and event which took place recently that saw hard challenges from	

	provider organisations and voluntary, community and social enterprise (VCSE) sector and offered to work with Devon to develop an evidence-based approach to workforce. It was recognised that information governance has been difficult across Devon and that having trusted research environment status would support this.	
6	**System Integrated Quality and Performance Report - overview/ challenges and next steps** Discussed within section 5	The Board **noted** the report.
7	**Minutes of the Devon Clinical Commissioning Group Governing Body – 16 June 2022** The minutes of the meeting were agreed as an accurate account.	The Board **approved** the minutes of the CCG Governing Body Minutes
8	**System Finance Operating Plan 22-23** JD provided highlights, risks and mitigation relating to the operational plan that has been put together for this financial year. It was shared that given the change of statutory bodies in the middle of the financial year that two sets of final accounts would be presented to the board later in the year. *Discussion* KO congratulated the finance team in the hard work during a very challenging year. And highlighted that the challenge of the £142m and £122m of that not yet fully developed represents a significant risk which will be monitored in the Finance Committee. SA requested to understand the spread of allocation between the acute hospitals and the savings expected of the acutes. JD responded that as a system we are judged above the fair shares this has been replicated for the five local care partnerships. The savings are a product of the acutes own plans as the system develops there will be more consistency.	The Board **approved** the opening budget for the ICB
Assurance Committees		
9	**Audit and Risk Committee** GC introduced the committee, who met on 13 July 2022. GC explained the committee was a statutory committee which is also supported by both internal and external audit. Forward plans will include work on the relationship with the ICB Audit Committee and other bodies as well as how the committee can support the Accountable officer and the Board. It was escalated that the External Auditors have not yet been reappointed. Grant Thornton, the outgoing auditors, have requested a two-year contract which will be reviewed in further detail. GC requested the Board approve to reappoint Grant Thornton. The Internal audit programme was discussed and possible future development moving into more of a focus on value added work, which was supported by members.	The Board **delegated** to the audit committee the appointment of the external auditors.

10	**Primary Care Commissioning Transition Committee** JH introduced the committee explaining that the committee has not yet met. JH explained the reasons there was a specific commissioning committee for Primary care was due to recent changes to delegations. The committee will be focusing on the transition of dental, pharmaceutical and optical services towards the end of the year, transitioning those services into a new way of working and the overall transition of these services.	
11	**Remuneration and Internal ICB Workforce Committee** KO introduced the committee which met on 1 July 2022. The two functions of the committee are to make decisions on pay and remuneration, including the adoption of national pay for all employees, and that includes executive and non-executive board members and seek assurance on internal workforce indicators, for example assurance on the organisational response to the staff surveys, assurance and inclusion, including gender equality, race equality and change processes.	The Board **noted** the report
12	**People and Culture Committee** TH introduced the committee which has not yet met. The role is to provide oversight and direction on people issues which includes the population of Devon and workforce. The Devon People Plan will be used to create a strategy around involvement and engagement. There will be links made to ensure work in train is not duplicated and supported.	
13	**Quality and Performance Committee** HK introduced the committee, which met on 13 July. HK explained the committee was a statutory committee with the main function being to provide assurance to the board in aspects of quality, performance and outcomes across the system and that the membership of the committee had been strengthened to ensure appropriate expertise.	The Board **noted** the report
14	**Finance Committee** KO introduced the committee which will meet 21 July. The committee going forwards will review areas such as system performance, patient experience, access, health outcomes and have a clear link to addressing system health inequality as well as howe the digital strategy will impact productivity and financial positions.	

Minutes approved	Date:	Signed by chair:

Members (attended** / apologies [A])	
Name and initials	*Title and organisation*
Andrew Millward (AM)**	Chief Communications and Corporate Affairs Officer, NHS Devon
Darryn Allcorn (DA)**	Chief Nursing Officer, NHS Devon
Frank O'Kelly (FOK)**	Primary Care Representative, NHS Devon
Hisham Khalil (HK)**	Non-Executive Director, Quality and Performance, NHS Devon
Cllr James McInnes (JMc)**	Co-Chair Devon Integrated Care Partnership
Jane Milligan (JM)**	Chief Executive Officer and Accountable Officer, NHS Devon
John Dowell (JD)**	Chief Finance Officer, NHS Devon
Judy Hargadon (JH)**	Non-Executive Director, Primary Care, NHS Devon

Kate Shields (KS)**		Chief Executive Officer, Cornwall and Isles of Scilly ICB
Kevin Orford (KO)**		Non-Executive Director, Finance and Remuneration, NHS Devon
Jo Turl (JT)**		Director of Commissioning Primary, Community and Mental Health Care, NHS Devon
Liz Davenport (LD)**		Chief Executive Officer, Torbay and South Devon NHS Trust
Nigel Acheson (NA) [A]		Chief Medical Officer, NHS Devon
Paul Renshaw (PR)**		Director of Strategic Workforce, NHS Devon
Sarah-Lou Glover (SLG)**		Mental Health Representative, NHS Devon
Dr Sarah Wollaston (SW)** Chair		Independent Chair, NHS Devon
Sheena Asthana (SA)**		Non-Executive Director,
Simon Tapley (ST) [A]		Chief Transformation & Strategic Planning Officer, NHS Devon
Steve Brown (SB)**		Director of Public Health, Devon County Council
Thandiwe Hara (TH)**		Non-Executive Director, People and Culture, NHS Devon
Tracey Lee (TL)**		Director of Public Health, Plymouth City Council
Attendees		
Ginny Snaith (GS) [**]		Board Secretary, NHS Devon
Jodie Howland (JH)** Minutes		Governance and Facilities Business Manager, NHS Devon
Mr Peter Washburn		Member of the public
Sam Cush		Communications Manager, NHS Devon
Sam Furniss		IT Project Manager, Delt
Minutes approved	Date:	Signed by chair:

Report of the ICB chair

Integrated Care Board

Date of committee	Date report produced
-	September 8, 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:**	September 9, 2022
Email:	Nick.pearson@nhs.net		

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

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

The document represents the chair's report and includes updates on the latest developments, including a message on behalf of the NHS Devon and the One Devon Partnership, reference to the establishment of the ICB and ICP, cost of living crisis, quality and performance reporting, brief details of recent engagements, elective recovery and recognition for our system.

The report is for information only.

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

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Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. For information only
2.
3.
4.
5.

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

Integrated Care Board

8 September

1) Message on behalf of NHS Devon and the One Devon Partnership

We at NHS Devon and the One Devon Partnership are profoundly saddened by the passing of Her Majesty Queen Elizabeth II.

On behalf of the NHS and partners in Devon we send our deepest sympathies to His Majesty and to the Royal Family.

We join the people of Devon in grieving Her Majesty's passing but take solace in her legacy of achievements and her great and faithful service to this country.

Her Majesty Queen Elizabeth led our country through faithful and humble service. She has been a beacon of faultless public service. We join the people of Devon and of the entire country in mourning her passing.

2) NHS Devon, ICB and the One Devon Partnership, ICP, established

Over the last 18 months, we have engaged in a number of recruitment processes in preparation for the establishment of NHS Devon ICB; this has included recruitment of the Chair, Chief Executive and all other senior executive and board posts.

After appointment of the Chief Executive and Chair, a period of design work established the new ICB Board structure requirements. Subsequently, NHS Devon CCG began Phase 1 of the ICB transition process in December 2021 with the wider executive. This phase included consultation with executive and director colleagues whose roles were affected by the creation of the new ICB Board and the process that would be followed to appoint to each role. Roles were therefore appointed to following one of the appropriate processes below:

External recruitment process

Full external recruitment process with support from head-hunters, where required. Most assessments included both stakeholder panel/s, which involved a wide range of system stakeholders, and formal interview with a diverse panel which often included NHSE representative. The stakeholder panel exercise has received very positive reviews from participants and NHSE, contributing to a robust assessment process.

Similarity assessment

In line with the agreed Phase 1 organisational change process, where appropriate, robust similarity assessment processes were completed for director/executive posts. The assessments took place in instances where two conditions applied; it was identified that the current incumbent's role was significantly similar to the proposed ICB role, and they had been appointed into their current role following a robust and significant selection and interview process. NHSE (including the relevant regional specialist lead) reviewed the similarity assessments to confirm their agreement with the determination made. Resultantly, 6 individuals were "slotted in" to ICB roles.

Partner member

Partner members were appointed through robust processes which were set out in the NHS Devon ICB constitution, and which followed the processes set out in the national model constitution for ICBs.

Chair Appointment

My role as chair was an interim appointment which will run until December. This will be subject to an open recruitment process in the coming months.

We are delighted to have successfully filled all posts within the ICB Board; this is a fantastic achievement. Latest appointments include Bill Shield (Director of Finance) and Anthony Fitzgerald (Chief Operating Officer) who will be joining us in early November.

The One Devon Partnership, ICP.

The One Devon Partnership is also now fully established with the latest appointment made to the role of Primary Care Member. The successful candidate is Rachael Lankshear who is a Practice Manager at Brunel Medical Practice and the lead Manager for the Torquay Primary Care Network.
We also welcome 3 representatives from the VCSE sector, Samantha Goff, Jasmine Allen and Julia Boas as well as Stephen Walford, Chief Executive of Mid Devon District Council

Full details of the appointments are shown over.

NHS Devon Board (Integrated Care Board)

One Devon Partnership (Integrated Care Partnership)

3) Co-ordinating the response to the cost of living crisis in Devon

Colleagues in the three upper tier local authorities in Devon have been examining ways to help people through the cost of living crisis.

There are concerns about increasing demand at food banks, and the impact of rising poverty. This will inevitably have an impact on individuals and communities across Devon and our wider One Devon System.

We have seen the Government step in with support – and no doubt will see more announcements on this in the coming months – but it is our council colleagues, local communities and the voluntary sector that will be providing the practical support that is needed locally.

Chairs and leaders across the One Devon System have started discussing their plans for the coming winter to understand what practical measures were being put in place and how each of the councils and the NHS can support each other.

It was felt that coordinating role would be helpful and that the new Integrated Care Partnership (ICP) could be the vehicle to do this.

To be clear the ICP would not be responsible for the delivery of the plans, nor would it seek to replace the local planning taking place. Rather it would undertake a pan-Devon coordinating role, sharing good practice and helping to identify gaps in services.

Devon is a huge county and bringing together the coordination in one place should also help to ensure that plans are aligned and connected into the work of our Local Care Partnerships.

In addition, such an approach might also make it easier for the county to apply for additional funding from Government – including in the form of pilots.

All partners agreed they would discuss the proposal with their organisations and when we meet again, we would look at the practical aspects.

4) Integrated Quality and Performance reporting (IQPR)

There was discussion at our last Integrated Care Board about IQPR reporting and what was or was not appropriate to come to board.

It was a very useful discussion and I'd like to briefly clarify where this left the reporting process.

In line with the new Performance Management and Oversight Framework, plus the existing governance structures, it was always planned that the IQPR would be included in the board pack appendices.

This would mean that they could be read by board members outside of the meeting or referred to in specific areas of escalation as identified below.

The current IQPR is currently more than 100-pages and having a summary of the report as its own standing agenda item appears not only to have caused some potential duplication but also a lack of focus on the key areas requiring escalation to the board for noting, discussion or decision.

It is therefore proposed that the IQPR will be discussed at the Quality and Performance Committee and the Finance Committee, and this is where in-depth interrogation of the report will initially take place including deep dives guided by the data.

The committee will agree on any areas for escalation to the board and the committee chair will include these in their report and verbal update.

Such an approach will allow us to ensure that the board discussions are focussed on areas of greatest concern with in-depth discussions regarding assurance having already taken place.

5) Representing our system

One of the joys of my role as independent chair is that I am often asked to undertake visits or speak on behalf of the Devon system.

These are an opportunity to reflect on our shared purpose and the aspirations we have for our communities and colleagues across Devon, our great staff, volunteers, clinicians, managers and wider partners. These events are also an opportunity to listen.

In the past few months, I've visited a wide range of acute and community settings listening to their experiences and hearing views on what needs to happen to help our system to work more coherently to improve the outcomes, access and experience for those who rely on our services.

Every part of our system is under pressure, but I hear a clear message that teams want to be able to think and act beyond the here and now, to look over the horizon and to tackle prevention and inequalities.

6) Green shoots of elective recovery

There is some good news in terms of elective recovery this month.

I am pleased to report that Devon has been ranked as joint fourth best in the country for the number of elective procedures carried out – compared with before the pandemic.

This is a huge achievement given the pressures within our system and is a testament to the hard work of staff and clinicians throughout the system.

Accelerator sites at Nightingale Hospital Exeter and the repurposing of the Royal Eye Infirmary at the Derriford site in Plymouth have undoubtedly helped to achieve this, as did protected elective wards in some areas and other important measures.

Devon completed 97 per cent of its pre-pandemic procedures in the first quarter of the year. A total of 46,930 elective inpatient procedures were carried out between April and June 2022. This compares to 48,535 in the pre-covid period.

In other words, despite the pandemic still being with us and the additional pull on the NHS, we are close to pre-pandemic levels of activity.

Nationally, 1.9 million procedures were completed between April 2022 and June 2022, compared to 2.1 million in the comparable pre-covid period.

There is clearly still much to do, and Devon remains an outlier for unacceptably long waits but real progress is being made including nationally recognised work on length of stay following surgical procedures.

7) Recognition for our system

Good news this month as multiple projects within our system have been shortlisted for Health Service Journal awards.

The Journal is the pre-eminent news outlet for the health service and its awards are much sought after.

I am pleased to report that University Hospital Plymouth NHS Trust's vaccination team has been nominated for the COVID-19 Vaccination Programme Award. Their approach has seen them build vaccine confidence while working collaboratively to safely provide reassurance in rolling out the programme.

The NHS Nightingale Hospital Exeter's ambulatory orthopaedic centre is shortlisted in the Acute Sector Innovation of the Year category for their revolutionary collaborative approach to tackling the backlog of patients waiting for care.

The South West Provider Collaborative, which includes Devon Partnership NHS Trust and Livewell Southwest, is nominated for the Provider Collaboration of the Year award. This is for their work to transform outcomes for people with mental health conditions by working collaboratively and at-scale.

And One Northern Devon is shortlisted in the Place-based Partnership category in recognition of its innovative approach to reducing health inequalities.

The winners will be announced on Thursday 17 November.

Good luck and thank you to everyone involved.

Report of the chief executive

ICB report

Date of committee	Date report produced
-	September 8, 2022

Author(s)		Report approved by	
Name and title:	Nick Pearson, chair and chief executive's office	**Name and title:**	Nigel Atcheson, Chief medical officer
Phone:	-	**Date:**	September 8, 2022
Email:	Nick.pearson@nhs.net		

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

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

The document includes summary updates on system winter planning, the acute services sustainability programme, a value-based approach, investments in hospital services, consultations with staff and engagement with LGBTQ+ communities.

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

-

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. The board is requested to note the report
2.
3.
4.
5.

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

Integrated Care Board

8 September

1) Winter planning

Challenging winter ahead

It cannot have escaped anyone's attention that this winter is expected to be extremely challenging, with some commentators saying it could be the toughest winter on record.

Planning for winter began earlier this year and in a more integrated way at locality level to make sure we are prioritising any additional funding to services that will make a positive difference.

National forecasts indicate that we could experience two more COVID waves this year with peaks in December and March, potentially higher than we have seen during the last two waves.

Staffing is also likely to be hit by increased staff absence as a result and significant hospital bed pressure and high demand for social care is expected.

Since 2019/20, there has been a near 25 per cent increase in demand for acute hospital beds and bed occupancy remains high at all hospitals in Devon, with all consistently above 90 per cent – and Derriford and Torbay Hospitals regularly above 95 per cent. This is well above the national average of 85% and makes it more difficult for hospitals to manage peaks in demand.

In the social care sector, on-going COVID outbreak management support continues, including Business Continuity Planning Support for providers to ensure plans are in place so that they can continue providing their service with minimal disruption.

NHS England letter

Earlier this month NHS England wrote to all systems in the country, setting out their expectations for increasing capacity and operational resilience in urgent and emergency care this winter.

It makes it clear that our collective task is to:

1) Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.

2) Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.

3) Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers across the country.

4) Target Category 2 (for serious conditions such as stroke or chest pain, which may require rapid assessment and/or urgent transport) response times and ambulance handover delays, including improved use of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.

5) Reduce crowding in Emergency Departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.

6) Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.

7) Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.

8) Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs

Additional funding for beds

In recognition of the challenges and pressures in Devon, the system has secured funding from NHS England which will be used to create more than 300 additional beds (or 'bed equivalents'), some of which will be in hospitals, some in the community and some 'virtual beds'.

As one of the six most challenged hospitals nationally, £5 million of this funding has been ringfenced to radically reduce ambulance handover delays at Derriford Hospital in Plymouth from September 2022, including new ways of working and additional hospital and community bed capacity.

The remaining funding will be focused on high impact services across Devon to provide additional capacity over winter.

Each Local Care Partnership (LCP) in Devon is leading the development of plans for their local population in partnership with their local acute hospital and mental health providers. As well as proposed additional 'escalation' beds in our hospitals, we will be treating more patients at home through 'virtual wards', which allow patients to get acute/inpatient-level care at home (their usual place of residence) safely and conveniently, rather than being in hospital.

In a virtual ward, support can include remote monitoring using apps, technology platforms, wearables and medical devices such as pulse oximeters. The technology captures observations such as blood pressure, heart rate, respiratory rate etc, and also provides a platform to allow remote communication between the person and their clinical team.

There is also additional capacity for mental health and is in addition to the NHS mental health allocation. Nationally, mental health has been allocated £10 million for winter preparations, equating to £219,000 across Devon (covering Devon, Plymouth and Torbay).

It is anticipated this winter requires significant response to increased mental health needs and will also help to prevent use of accident and emergency departments, ambulance and police services. Further opportunities to increase the mental health funding from the wider system allocation for winter are also being explored and considered.

Workforce

One of our biggest challenges, and that of the wider NHS of course, is workforce.

To address shortages in workforce one of the things we are doing is working differently at a system level to align resource across organisations to improve productivity and expand skills across staff cohorts.

We are also working with third sector partners to expand areas that are already delivering or more able to extend quickly.

Additionally, there is scope to test different approaches alongside offering staff additional hours especially those who work part time.

It almost goes without saying that it is essential that we maintain staff wellbeing throughout the winter. Therefore, staff wellbeing hubs will remain in place for the time being for all care staff.

Improving integrated urgent care services

Finally, in this section, October sees Devon's integrated community urgent care services transferring to a new provider.

The service, which include NHS 111 and GP out-of-hours, will be delivered in future by Practice Plus Group.

Vocare have been supporting the existing service, providing call handling support for prior to Practice Plus Group taking on the service. This will continue until 10 October.

Our sincere thanks to Devon Doctors Ltd, their staff and clinicians, who have provided the service for many years.

2) Value-based approach

Following the presentation from Rob Dyer at the Board Development session the Exec Strategy & Transformation group received and approved details of the next steps for this work including the formal sign off by statutory boards in November

3) Acute Services Sustainability Programme

Earlier this year, the four acute trusts* across Devon and Cornwall agreed that they need to work much more closely together, and with their Integrated Care Boards, to deliver improvements in the health and care of people living in the two counties.

Building on the joint work that has previously been undertaken through the Acute Services Review (2017) and the Peninsula Clinical Services Strategy (2019), success is dependent on strong clinical leadership, staff involvement and citizen engagement.

I am pleased to report that each of the trust boards has formally signed-up to being part of the Peninsula Acute Provider Collaborative – where the Chairs, Chief Executives and Medical Directors will jointly commission and oversee programmes of work that aim to address some of the very real quality, performance and workforce challenges we face as a system.

A programme board is being established. This will be led by Liz Davenport (Chief Executive Officer, Torbay and South Devon NHS Partnership Trust) and include senior clinical leaders from all of the partner organisations.

Over the next few months, this group will be developed then share the plan that will outline how this work will be done. There will, of course, be wide discussion with clinical teams and ongoing involvement of clinicians in the process.

We believe that the people of Devon and Cornwall deserve the very best and we are determined to take decisive action now to ensure their health and care services are sustainable going forward.

We'll provide further updates as the programme develops.

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

4) New provider collaborative

Devon's Mental Health, Learning Disability and Neurodiversity (MHLDN) Provider Collaborative began in July; with providers working closely together.

Its aim is to commission and deliver high quality, consistent care across the county, reducing duplication of effort and driving improvement.

Among many other things, it will create much closer planning and working between Devon Partnership NHS Trust (DPT), which is the lead organisation for the Collaborative, and Livewell Southwest (LSW) in Plymouth.

Its creation is very timely, with mental health referrals across the country up by around 26% on pre-pandemic levels.

The collaborative's role, structure and governance are being designed with partners

People with lived experience of services and colleagues from the voluntary, community and social enterprise sector.

As the collaborative is established, this single partnership will be well placed to support the design, planning, commissioning, delivery and monitoring of mental health services across the county.

5) COVID and the vaccination programme

The National COVID Alert Level has now been reduced to Level 2, which means 'COVID19 is in general circulation in the UK, but direct COVID19 healthcare pressures are low and transmission is declining or stable'

Routine asymptomatic testing has been paused in hospitals and care homes as COVID-19 cases continue to fall.

Testing for individuals with symptoms in these settings, including health and social care staff, will continue.

Immunocompromised patients in hospitals and people being admitted into care homes and hospices will also continue to be tested.

Currently around one in every 40 people in the south-west have COVID-19 – but the expectation is that they are likely to rise again this autumn and winter.

This year there will be a careful coordination of autumn booster for Covid-19 and Flu vaccine messaging to reinforce protective behaviours for both. Details will be included in a detailed communications plan, which will align with the operational plan for winter and system objectives.

The autumn booster rollout started on September 5, with care home residents, staff and people who are housebound first in line to receive their top up ahead of winter.

Around four million people who are at highest risk, including the over 75s and those with weakened immune systems, are eligible to book a vaccine through the National Booking Service, with the first appointments available from about mid-September.

6) Services at Torbay Hospital to benefit from almost £5 million capital investment

Endoscopy services at Torbay Hospital will benefit from a £4.99million capital investment to increase capacity and help reduce local waiting lists.

There are currently three endoscopy rooms at Torbay Hospital and the new funding will increase this to four, and in addition pay for a training facility – treating more people and improving their experience and outcomes.

The service carries out around 200 procedures each week and demand continues to grow.

Early detection is really important to give people the best possible outcomes.

Building is scheduled to begin on site in January 2023 and is expected to take nine months. A mobile endoscopy unit will shortly be in place to provide additional capacity and also to support the safe and effective delivery of services during construction. This is due to start receiving its first patients from 12 September 2022.

7) Pride in our work

We were proud to be at the latest of the Devon Pride festivals when we attended Totnes Pride Festival (Saturday 3 September) to talk to LGBTQ+ communities.

Senior leads, involvement and equality, diversity and inclusion staff attended the event to understand the experiences and needs of our LGBTQ+ communities in Totnes and how the NHS can be more inclusive.

Members of the system across Devon have been out in force this year at events to celebrate diversity, with a presence at events in Torbay, Plymouth and Exeter.

I have managed to get to some of these, as have other CEOs and their teams in the system.

All staff attend the events in their own time and it's great to be showing our support for such an important group of people.

ICS Executives' report

ICB report

Date of committee/s	Date report produced
August 2022	September 8, 2022

Author(s)		Report approved by	
Name and title:	Nick Pearson, chair and chief executive's office	**Name and title:**	Simon Tapley, chief transformation and strategic planning officer
Phone:	-	**Date:**	September 8, 2022
Email:	Nick.pearson@nhs.net		

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

-

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

The following report summarises the discussions and outputs from the groups reporting to the Integrated Care System executive committee.

This includes:

- Executive Strategy and Transformation Group
- System Delivery and Improvement Group
- Mental Health, Learning Disability and Neurodiversity Provider Collaborative
- Peninsula Acute Provider Collaborative
- Local Care Partnership Oversight Committee

The report contains reports from the groups that have formed and have met. There are a number of groups, however, that are at a formative stage and expect to meet shortly.

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

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. To note the contents of the report
2.
3.
4.
5.

Impact on NHS Devon objectives	
Objective	**Impact**
Objective 1	Contribution
Objective 2	Contribution
Objective 3	Contribution
Objective 4	Contribution

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	Improvement
Health inequalities	None
Workforce	Improvement

Resources and finance	None
Legal	Comply
Digital and Data	None
Engagement and consultation	Engaging communities and stakeholders in our work

ICS Executives' report

Integrated Care Board

September 8, 2022

Introduction

The following report summarises the discussions and outputs from the groups reporting to the Integrated Care System executive committee.

The report contains reports from the groups that have formed and have met. There are a number of groups, however, that are at a formative stage and expect to meet shortly.

These are:

- Executive Finance Group – due to meet 16 September
- Executive Quality and Risk Management Group – expected October

There are therefore no reports from these groups, nor is there a report from the Executive Workforce (People Plan) Group which did not meet in August due to reduced member attendance. Reports from these groups will begin from next month.

Executive reports

Executive Strategy and Transformation Group
Executive lead: Simon Tapley

- Executive Strategy and Transformation Group have formally requested from ICS Executive Committee a mandate to act. This includes to:
    - Act as the strategy and transformation arm of the ICS Executives Group to support development and delivery of the Devon Plan, Acute Sustainability Plan, and to respond to the Health & Care Strategy.
    - Set an ambitious vision and outcomes for how services in Devon will be delivered, and;
    - Create an environment and culture which sets the right tone and supports successful delivery of the Devon Plan and prioritised programmes of work. Senior Leaders will adopt the principle to "leave behind the organisation" for the greater good of Devon;
    - Provide a forum for Senior Leaders from each health and social care partner organisation to take a forward look over the next 2-5 years and

to plan strategic health and care priorities which require collaborative working across the ICS footprint;
  - Take a leading role in the development of collaborative and trusted relationships which integrates partner organisations, local care partnerships and provider collaboratives around a shared purpose outlined in the Devon Plan
  - Take a leading role in developing the strategic relationship between the ICS and NHSE/I Regional and National teams in relation to continued ICS development and transformational change;
  - Monitor and understand the impact of work commissioned to evaluate success.
- It was agreed by the group on 16 August 2022 that we will embark on public engagement, in an Appreciative Inquiry format, in relation to Community Urgent Care and broader services.

- Primary Care Strategy and Community First Strategy are both requiring significant further work before they can be recommended to the Integrated Care Board for sign off.

- The Terms of Reference for the Assurance Group which will report into the Executive Strategy and Transformation Group will be signed off by the Group at the meeting on 20 September.

- Views are being sought in relation to the potential creation of a Community Health and Social Care Provider Collaborative. Simon Tapley as Chair will gather these views and report back to ICS Executive Committee at the next meeting.

- There are plans in place for a facilitated joint development session for the Executive Strategy and Transformation Group and the Clinical and Professional Cabinet. An initial scoping discussion is being held on 23 September 2022.

- An update on the Integrated System Development Programme will be provided to the ICS Executive Committee on 20 September

- An approach for a stocktake on strategies under Executive Strategy and Transformation Group's remit is being developed

System Delivery and Improvement Group (SDIG)
Executive lead: Mairead McAlinden

The remit of SDIG is to oversee in-year system performance through daily UEC monitoring and organisation of mutual aid when available, and progress to improvement priorities as set by System Chief Executives in April 2022 which are included in the ToR. The membership has been revised to include Jacquie Mowbray-Gould as the Mental Health Provider Collaborative representative.

A key system priority is to reduce hospital inpatients with no continuing right to reside (NCR2R) to no more that 5% of each hospital's General and Acute (G&A) bed base.

A non recurrent allocation of £23.919 has been made to Devon NHS to create capacity over winter and SDIG has been leading on the development of investment proposals primarily aimed at reducing NCR2R numbers in Devon hospitals with the aim of moving closer to the 5% G&A target as a system. High level priorities for spend were endorsed by System Chief Executives with the caveat that mental health capacity should equally be prioritised.

At the most recent SDIG meeting on 1 September, the system proposals for the investment of this funding were discussed and finalised for approval by the Operating Plan Oversight Group (OPOG).

Work is underway to explore any flexibility within Better Care Funds (BCF) to align to this investment and join up our Devon system funding streams to support patients out of hospital and into social care. Proposals for BCF flexible investment will be developed by Locality Directors and considered at SDIG on 15 September.

The timeline for the submission of Winter Plans and BCF is summarised below.

Review of Winter Planning Assurance Framework & BCF at SDIG	15/09/2022
Sign off for Winter Planning Assurance Framework & BCF at Oversight	20/09/2022
Sign off BCF at ICS Chief Executives	20/09/2022
Better Care Fund submission	26/09/2022
Submission of UEC Action Plans and operational self-assessment good practice checklist.	w/c 26/09/2022

Mental Health, Learning Disability and Neurodiversity Provider Collaborative (MHLDN)
Executive lead: Sonja Manton

Building on the longstanding and successful partnership working across the Devon system and wider SW region to support MHLDN needs of our population, Devon Partnership NHS Trust was asked in 2021 to become the lead provider in MHLDN provider collaborative for Devon. It was also asked to develop a Partnership Collaborative Board to oversee these arrangements, working with Livewell Southwest, primary care, the voluntary sector (VCSE), local authorities and other key partners to deliver this very exciting change.

To achieve the maximum benefit from this collaboration, NHS Devon will delegate its responsibility for the commissioning of mental health, learning disability and neurodiversity services for adults, children and younger people.

This is an integral part of our new way of working in the ICS. The provider collaborative executive board is established and met this summer to take forward the national and local priorities.

Our vision is to work together with an expert led, co-produced, evidence and value based approach focused on population health outcomes.

Our aim will be to promote prevention, working with partners on improving the social determinants of health as well as re-focusing care so it is delivered closer to home and support more people closer to their homes and earlier in their recovery journey. We will have to do this is in the context of socio-economic changes, workforce and financial challenges which all amplify the needs of our population. It will require us to strengthen our partnership working to do even better together.

Last year, we focussed on implementing the new national community mental health model in Devon and developments in urgent and crisis care in addition to the national long term plan expectations, with good success and impact.

We have now agreed further additional workstreams that demonstrate the benefits of a new way of working including key developments in Early Intervention in Psychosis, Eating Disorders, Physical Health monitoring and support for people on anti-psychotic medication, and Dementia: all of which involve collaboratively working with local care partnerships and/or other collaboratives in the system.

We have agreed to dedicate some focussed time as an ICS executive in October on our changes in meeting the needs of those with learning disabilities and neurodiversity.

We are pleased to continue to be on track with the agreed development timeline for the provider collaborative and will focus in coming weeks on formalising the underpinning partnership agreements and governance arrangements, aligned to our overall ICS development and the development of our 5-year sustainability plan.

Peninsula Acute Provider Collaborative
Executive lead: Allison Williams

In the July meeting of the Peninsula Acute Provider Collaborative, a 4-phased approach to the work programme was approved with agreement reached to establish the Acute Services Sustainability Programme to drive the detailed work on service redesign.

Liz Davenport, Chief Executive, Torbay and South Devon NHS Foundation Trust, has been confirmed as the lead Chief Executive and will chair the Programme Board which is scheduled to meet for the first time on 16th September.

A general communication was issued to staff in August, via the usual team briefing channels, to advise that this work is commencing and that there will be wide engagement over the coming months. Initial discussions have also taken place with the Communications leads across the acute Trusts and both ICBs with a view to developing a comprehensive communications and engagement plan to be approved and implemented within this calendar year.

Work has commenced with Medical Directors from the acute Trusts in Devon and Cornwall, together with other key Executives, to confirm:

- the route in to service transformation
- key clinical interdependencies
- the methodology, key questions and core data sets to inform specialty workshops
- the process for addressing fragile services in parallel with the wider strategic work

The output of this work will be presented to the Peninsula Acute Provider Collaborative at its next meeting on 12th September together with the outline timeline to commence the detailed workshops which, if agreed, will be presented to Trust Boards for approval in October.

NHS Devon board meeting

Committee chair report – Integrated Care Partnership

Date of board meeting	Dates of committees covered in this report
21 September 2022	04 August 2022

Chair	
Name and title:	Cllr James McInnes – Joint Chair Dr Sarah Wollaston – Joint Chair
Phone:	
Email:	James.mcinnes@devon.gov.uk Sarah.wollaston@nhs.net

Reports discussed and assurances received

- Updated integrated care strategy guidance has been published by NHS England the committee were assured that the forward plans for the development of the strategy covered most areas.
- The working group developing the Devon plan and Integrated care strategy will consist of those with expertise in a particular field and that understand the data as well as those who can support the engagement process. There has been clear commitment that the whole of the One Devon Partnership will be represented in the development.
- The first task of the working group is to put together a work plan so that the Integrated Care Strategy is completed by December and the overall plan by March 23.
- The Devon Joint Strategic Needs Assessment (JSNA) was presented and noted by the committee

- Plymouth, Torbay and Devon Health and Wellbeing strategies were shared which highlighted similar key themes across the local authorities which can be used to develop the Integrated Care Strategy.

- Engagement mapping - It was acknowledged that there are groups which had not been identified in the Integrated Care Strategy guidance who would be useful to engage with such as higher education and research groups, ethnically diverse communities and that the next step would be to develop a comprehensive stakeholder map looking at those and anyone else and then align the various different involvement approaches.

Reports received and noted

- N/A

Risk register review updates

- N/A

Committee decisions

Full minutes of this meeting are available from the chair.

- The committee agreed to ensure Healthwatch were involved in the working group developing the Integrated Care Strategy
- The committee agreed that involvement and the integration of health and social care would be included in the strategy.

Items of concern to be escalated to the board

- None

Recommendations for the board

- For information only

Recommendations for other committees

- None

Terms of reference or other committee effectiveness issues

- None

NHS Devon ICS Finance Report

Month 4 – 31st July 2022

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

Executive Summary

- On 20th June 2022, Devon ICS submitted a deficit plan of £18.2m. There is a requirement that the system achieves a breakeven outturn by year end.
- For 22/23 the system has received a reduced COVID envelope from 21/22. Some COVID funding will be reimbursed on top of the system envelope, this includes spend on testing and vaccinations.
- Efficiency savings of £138.9m are required to meet the June plan.
- Elective Services Recovery Fund (ESRF) funding has been received by the system to deliver 104% of 19/20 elective activity. Delivering more / less than 104% will result in additional funding / clawback at 75% PBR value. (Outsourced activity is reimbursed at 100% subject to meeting 104% target).
- As at month 4 the Devon ICS is reporting break even against a planned deficit of £9.6m (M3 £0m)
- The reported forecast is a deficit of £18.2m which delivers to plan.

Executive Summary

- As at month 4 the Devon ICS had made efficiency savings of £23.8m (M3 £16.0m) This is £6.8m adverse to plan (M3 £6.5m).
- Forecast savings are adverse to plan by £12.5m. (M3 £0m)
- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of the deficit plan.
- As at Month 4 the net risk has remained at £79.8m. (M3 £78.2m)
- Although no data is available from central sources to confirm performance against ESRF, systems have been informed to assume no clawback for month 4 reporting.
- April and May internal ESRF data shows that although the system is not reaching the required 104% of 19/20 activity, ICB commissioned activity is ahead of plan as at May 2022 by £2.2m but NHSE commissioned activity is behind plan by £2.8m leaving a potential shortfall from plan of £0.6m. We have not received M3 data as yet.
- The month 4 position identifies risks and issues to be managed totalling £90.7m against an expectation of break-even. (M3 £94.3m)

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 CCG	0	0	0	→	0	0	0	→
Royal Devon University NHS FT	(1,960)	(1,958)	2	↑	(18,263)	(18,263)	0	→
University Hospitals Plymouth Trust	(3,864)	(3,864)	0	→	0	0	0	→
Torbay and South Devon NHS FT	(2,884)	(2,884)	0	→	69	69	0	→
Devon Partnership Trust	(648)	(648)	0	↑	0	0	0	→
Total	**(9,356)**	**(9,354)**	**2**	↑	**(18,194)**	**(18,194)**	**0**	→

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

Efficiency Plan 22/23

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

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

Efficiency Plan 22/23

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

Efficiency Plan 22/23

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

Efficiency 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 CCG	8,406	6,687	(1,719)	36,425	36,425	0
Royal Devon University NHS FT	10,141	5,938	(4,203)	33,935	33,935	0
University Hospitals Plymouth Trust	5,418	6,591	1,173	29,592	29,592	0
Torbay and South Devon NHS FT	7,929	5,178	(2,751)	28,452	15,923	(12,529)
Devon Partnership Trust	2,216	1,045	(1,171)	10,358	10,358	0
Total	**34,110**	**25,439**	**(8,671)**	**138,762**	**126,233**	**(12,529)**

- As at month 4 the Devon ICS had made efficiency savings of £25.4m (M3 £16.0m) This is £8.6m adverse to plan. (M3 £6.5m).
- Forecast savings are adverse to plan by £12.5m (M3 £0m). We are working through with providers a consistent approach to forecasting in this area (as the Torbay and Sothern Devon forecast under achievement of CIP is considered a risk rather than a certainty).

Risks & Mitigations (Excluding ESRF)

Description	Net Weighted Risks & Mitigations						Net Risks at Plan £000
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000	
CIP shortfall	(13,967)	(2,725)	(12,500)	(17,829)	(5,360)	(52,381)	(47,817)
Planned Surplus/(Deficit)		(18,263)		69		(18,194)	(18,194)
Increase in inflation		(2,800)	(4,000)	(2,500)	(1,000)	(10,300)	(6,950)
Integrated care contract				(6,000)		(6,000)	(6,000)
Hospital discharge	(2,500)					(2,500)	(2,500)
High cost drugs not met by income		(2,900)	(1,500)	(657)		(5,057)	(2,314)
Clinical excellence awards			(900)	(170)		(1,070)	(1,665)
Specialist commisioning rebase					0	0	(1,500)
Prescribing prices	(1,500)					(1,500)	(1,500)
OOA and staffing support					(1,300)	(1,300)	(1,300)
IPP service growth					(1,250)	(1,250)	(1,250)
MHIS and SDF income risk					(1,200)	(1,200)	(1,200)
Other		(2,367)		(2,865)	(1,180)	(6,412)	(5,545)
Total Risk	**(17,967)**	**(29,055)**	**(18,900)**	**(29,952)**	**(11,290)**	**(107,164)**	**(97,735)**
Non-Recurrent flexibility	7,376	12,200	750	2,000	2,500	24,826	14,076
s256 funds	2,500					2,500	2,500
Further Excess inflation funding						0	1,375
Total Mitigation	**9,876**	**12,200**	**750**	**2,000**	**2,500**	**27,326**	**17,951**
Net Risk	**(8,092)**	**(16,855)**	**(18,150)**	**(27,952)**	**(8,790)**	**(79,839)**	**(79,785)**

Risks & Mitigations (Excluding ESRF)

- At the planning stage risks of £97.7m (excluding ESRF) were identified along with £18.0m of mitigations, leaving a net risk of £79.8m to delivery of the deficit plan.
- As at Month 4 the net risk has remained at £79.8m. (M3 £78.2m)
- CIP risk is distinguished from other risks unrelated to the delivery of the £138.9m savings plan.
- The movement in M4 is as a result of representing ESRF mitigations as opposed to a real deterioration from the M3 assessment.
- ESRF risk is described in the next slide

ESRF Performance/Risk

Cumulative Activity/£000 Compared to Target	ICB Year to date	
	April	May
Planned activity	98%	97%
Actual activity	98%	101%
Planned £000	(1,485.0)	(3,553.0)
Actual £000	(1,322.0)	(1,346.0)
Total	**163.0**	**2,207.0**

NHSE Year to date	
April	May
88%	88%
60%	60%
(800.0)	(1,807.0)
(2,271.0)	(4,654.0)
(1,471.0)	**(2,847.0)**

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

- Although no data is available from central sources to confirm performance against ESRF, systems have been informed to assume no clawback for month 4 reporting.
- April and May internal data show that although the system is not reaching the required 104% of 19/20 activity, ICB commissioned activity is ahead of plan as at May 2022 by £2.2m but NHSE commissioned activity is behind plan by £2.8m leaving a potential shortfall from plan of £0.6m.
- The differential earning potential in the plan by provider is why the risk appears skewed.

Summary Of Total Risks To Breakeven

Organisation	Summary Of Risks To Breakeven						
	Reported Surplus/ Deficit £000	CIP Risk £000	Other Risks £000	Mitigation £000	Variance Pre ESRF Favourable / (Adverse) £000	ESRF Risk £000	Variance Favourable/ (Adverse) £000
Devon CCG	0	(13,967)	(4,000)	9,876	(8,092)	5,000	(3,092)
Royal Devon University NHS FT	(18,263)	(2,725)	(8,067)	12,200	(16,855)	(9,733)	(26,588)
University Hospitals Plymouth Trust	0	(12,500)	(6,400)	750	(18,150)	(5,000)	(23,150)
Torbay and South Devon NHS FT	69	(17,829)	(12,192)	2,000	(27,952)	(1,136)	(29,088)
Devon Partnership Trust	0	(5,360)	(5,930)	2,500	(8,790)	0	(8,790)
Total	**(18,194)**	**(52,381)**	**(36,589)**	**27,326**	**(79,839)**	**(10,869)**	**(90,708)**

- The month 4 position identifies risks and issues to be managed totalling £90.7m against an expectation of break-even. (M3 £94.3m).
- The improvement from M3 is largely as a result of a re-evaluation of ESRF risk.

Capital (CDEL)

Organisation	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Royal Devon University NHS FT	10,410	7,721	2,689		33,306	33,306	0	
University Hospitals Plymouth Trust	3,735	1,502	2,233		24,080	24,080	0	
Torbay and South Devon NHS FT	10,517	7,080	3,437		18,371	18,371	0	
Devon Partnership Trust	2,488	1,123	1,365		7,448	7,489	(41)	
Total	**27,150**	**17,426**	**9,724**		**83,205**	**83,246**	**(41)**	

- System Capital spend is under plan at month 4 by £9.7m (M3 £3.5m)
- Forecast system capital spend is on plan as at M4.

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	16,835	13,966	2,869	↑	50,562	50,562	0	→
University Hospitals Plymouth Trust	6,634	2,065	4,569	↑	88,480	89,313	(833)	↓
Torbay and South Devon NHS FT	10,938	9,735	1,203	↑	27,007	33,505	(6,498)	↓
Devon Partnership Trust	2,488	1,123	1,365	↑	7,448	8,114	(666)	↓
Total	**36,895**	**26,889**	**10,006**	↑	**173,497**	**181,494**	**(7,997)**	↓

- Total capital plan includes impact of IFRS16 - leases
- Total capital spend is under plan by £10.0m as at month 4. (M3 £4.3m)
- The forecast spend on capital by end March 2023 is over plan by £8.0m. (M3 £0.1m)
- The plan is fixed at submission and not updated as subsequent schemes are approved and PDC awarded. These schemes then show as an overspend.

Conclusion and Next Steps

- The operational financial plan submitted on 20th June 2022 recognised a significant delivery risk against the NHSE break-even expectation, valued at £95.9m.
- At the end of month 4, this has not moved materially and stands at £90.7m
- The most material items are shortfall against required CIP (£52.4m), eliminating the residual deficit at plan (£18.3m) and shortfall against ESRF required earnings (£10.9m)
- In addition to continuous drive to mitigate CIP and ESRF shortfall risks, the ICS is committed to delivering further mitigation through a Financial Recovery Plan, consisting of 14 workstreams, as set out in Appendix 1 of this report.
- The ICB has recently appointed a small team (funded by the Recovery Support Team) to instil pace and traction to the recovery plan and improve on the in-year financial benefit.

Appendix 1 – 2022/23 Financial Recovery Programme

Recovery Workstreams and SRO's

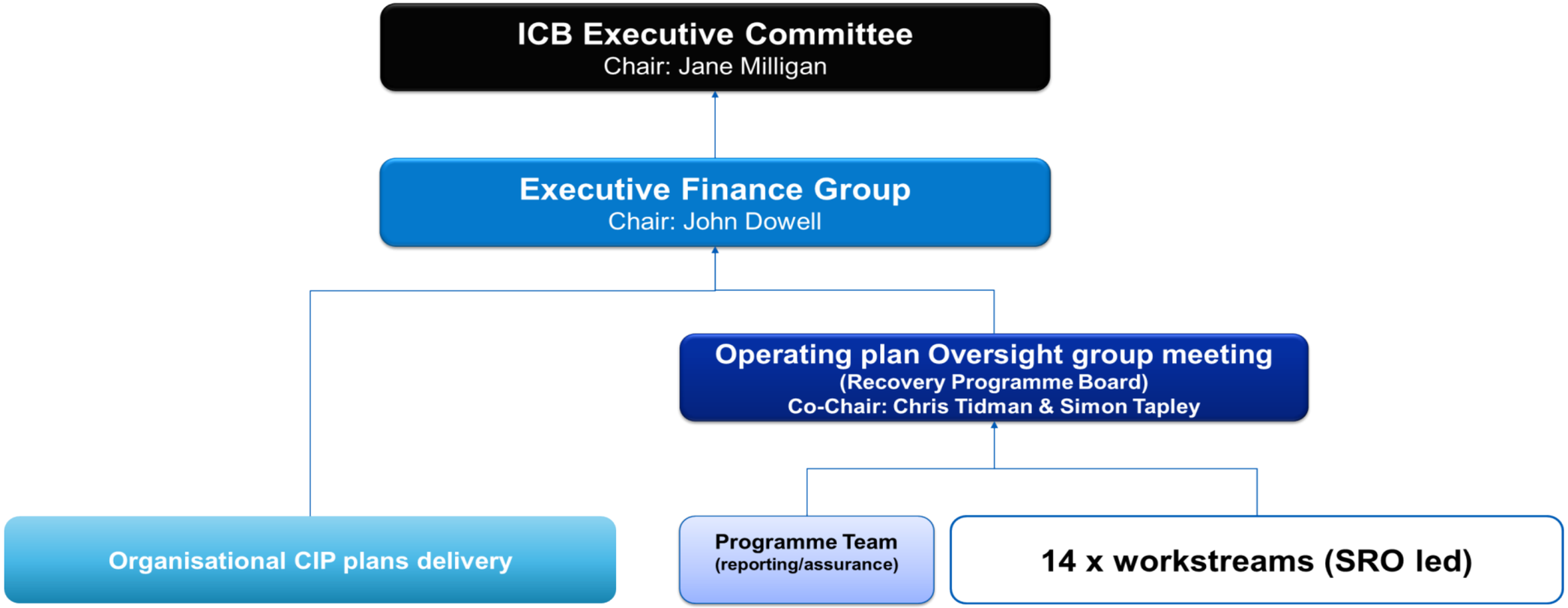
Workstream	Areas of Focus	SRO
Workforce	Grip and control Agency reduction Payroll merger Headcount increase (providers and ICB) Vacancies – network first Reducing sickness	Paul Renshaw
Meds Management	Meds optimisation opportunities High cost drugs	Nigel Acheson - Meds Mgt lead
Procurement	Grip and control Contract alignment/consolidation Decontamination services	Sarah Brampton
Digital	Data centres Telecoms/data bundles Alignment of contracts	Malcolm Senior
Finance	Grip and control Business case process/expenditure review process Liaison transaction reviews	Dave Stacey
Torbay pharmaceuticals	Maximise the commercial opportunity	Dave Stacey

Workstream	Areas of Focus	SRO
Pathology	Opportunities for standardisation Opportunities for combining operations across the system	Simon Tapley
Diagnostics	Reducing insource and reporting costs	Nigel Acheson or nominated CMO
Estates	Identification of surplus estate Estate strategy Contract alignment	Bill Shields (John Dowell)
MH Placements	Reduce use of private sector by both DPT and ICB	Phil Mantay
CHC	Hospital discharge programme S256 Torbay arrangements	Simon Tapley
ERF	Deliver 104% Eliminate 104 weeks Maximise income Minimise financial risk	John Finn
Covid 19 spend	Identify opportunities for standardisation and reduction	Darryn Allcorn
Clinical pathways	GIRFT opportunities Commissioning list	Nigel Acheson - Warwick Heale

Recovery Workstreams and SRO's

- The 10 workstreams, System enablers and Commissioning list have been reviewed resulting in one list. The proposed list is captured in the tables on the previous slide. The focus of the workstream is more clearly articulated and any obvious duplication has been removed. The SROs have mostly remained the same.
- Each SRO will be approached to advise what support maybe needed, we anticipate this will be across;
  - BI
  - Finance
  - Clinical expertise
  - Delivery support
- With an aim to source this from within the system.
- A small programme team will be convened to help secure and deploy the requested support as well as track progress of the workstreams.

Recovery Programme Governance (Phase 1 – now until end October 2022)



NHS Devon: Strategic Objectives for 2022/23

Improve services

- Deliver urgent and emergency care services that better meet the needs of people in crisis (1)
- Increase the volume of elective activity in line with national operating plan to reduce number of people waiting for elective care – with a specific short-term focus on 104-week and 78-week waits (2)
- Improve the capacity of primary care – with particular attention to challenged areas such as Plymouth (3)
- Improve the quality of services for children and young people with Special Educational Needs and Disabilities (4)

Rebalance our priorities

- Reduce health inequalities at local and system levels (5)
- Make a bigger shift from treatment to prevention (6)

Make more efficient use of our resources

- Move out of System Oversight framework (SOF4) – including delivery of a balanced system financial plan (7)
- Develop a workforce strategy that can ensure resilience of key services (8)
- Maximise the use of digital technology; as well as data so that it is evidence based and outcome focused (9)
- Minimise our negative impact on the environment and ensure services are green/sustainable (10)

Develop our culture and how we operate

- Create a new identity for the ‘One Devon’ system and create stronger relationships built on trust (11)
- 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 (12)

NHS Devon board meeting

Committee chair report – Audit and Risk Committee

Date of board meeting	Dates of committees covered in this report
21 September 2022	10 August 2022

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

Reports discussed and assurances received

- Terms of Reference System Audit Chairs – The committee feels there are benefits to having a system audit chairs meeting, while there needs to be caution in determining respective roles. Whether two separate committees is ultimately appropriate will be evaluated in due course.

- Risk Report –The corporate risk register is reported to the Audit and Risk Committee and to the Board through the Chairs report and awaits a major refresh.

- Internal Audit progress report – The committee were assured that work is underway on the 2022/23 audit plan and this will be reviewed in October 2022 to ensure it remains fit for purpose.

Reports received and noted

- The committee noted the risk report, albeit requiring a refresh
- The committee noted the Terms of Reference for System Audit Chairs
- The committee noted the Internal Audit progress report

Risk register review updates

- Two risks with a score of 25 and which have the approval of the accountable officer these are risks:
  Risk 100 - SWASFT Call Stacking.
  Risk 153 - Planned Care System Capacity.
- One new risk has added Risk 163 – Mayflower Longer Term Procurement.

Committee decisions

- The committee agreed to escalate the update requirement around risk management processes
- The committee approved the Internal Audit Plan
- The committee approved the process of deep dives although acknowledged this should not duplicate and perhaps provide an oversight of the organisation deep dives rather than undertaken them.

Items of concern to be escalated to the board

- External Audit contract has not been renewed to date. Grant Thornton have proposed a fee per year for a two-year contract. This figure is in line with other ICBs and although high, going out to market may not be successful.
- The committee request to escalate they are not assured that risk is being managed appropriately across the ICB and support the work to review and improve this.

Recommendations for the board

- Board workshop on risk management

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.

DEVON CCG
Custom Risk Register Export

Date produced: 28-07-2022 - 01:06

Produced by: james.maslen1@nhs.net

ID	Risk Description	Previous Risk Score	Risk Score	Risk Opened	Committee Reported to	Exec Lead	Risk Owner	Last Reviewed
153	There is a risk to patient safety and experience within commissioned acute trust services, due to long waiting times for elective care, including diagnostics, across Devon (adult and child). The risk to safety is greater for patients that fall into the Priority (P) 1, 2 and 3 categories, but risk also includes1 a) Not yet seen' patients referred by their GP but yet to be seen by acute secondary care services b) Patients waiting for a follow up appointment for acute services beyond their 'time critical' date In addition, there is CCG and System reputational risk, due to long waiting lists for elective care across Devon. Not in scope for this risk is adult and child community or mental health services. The impact of this risk is; • Patients poor experience of a long wait for definitive treatment • Patients may experience physical symptoms, for example increased pain / reduced mobility as a result of waiting longer • Patients clinical condition may deteriorate (physical harm), further impacting of safety and experience, but also potentially the complexity of the case. Subsequently this may lead to: • Increased level of intervention at the point of procedure, and increased length of stay • Increased support from the wider system, including Health and Social Care. For example, community nursing and social care support if unable to self-care and/ or medication support from primary care for pain control • Increased system support and communication to patients; Primary care activity has increased, due to concerned long waiting patients. Additional work by primary care and Communication teams is required, as patients seek to understand their individual waiting time experience – • Those providing care may suffer burn out due to the level of intensity required to manage lists, but also more complexity as risk grow. This may also impact on • Successful recruitment and retention across the system. • Increased Carer burden for those whose physical and mental health deteriorates as a result of the long wait (HISTORIC ID: Na)	25	25	19/10/2021	Commissioning Committee	John Finn	Jane Sangoor	01/03/2022

151	There is a risk that the activity relating to CHC assessments and reviews, and requests for joint funding is impacting upon the ability of both the provider CHC and ICB Complex Care teams to undertake their wider responsibilities around quality assurance and effectiveness. The impact of this will likely be: • clinical risks not being exposed and mitigated - a reactive service only presenting when risks are escalated to the team • escalating costs of packages of care & placements with no scrutiny and no oversight or ability to contribute to the quality assurance or improvement agenda within the independent sector • poor patient and family experience. An individual's care needs could unnecessarily escalate without the correct clinical intervention/oversight • remaining staff working within the team at risk of burn out possibly increased sickness levels • reduced number of staff with the right skills, competencies • limited capacity to ensure new staff receive the correct support and upskilling which will further impact on them functioning fully (Risk 151 to supersede risks 135 and 136) (HISTORIC ID: Na)	20	16	13/07/2021	Quality Assurance	Darryn Allcorn	Jo Shill	09/06/2022
149	There is a risk that adults with Eating Disorders are not able to access the necessary physical health checks. There is no commissioned service either within Primary Care or within the Specialist Eating Disorder pathway, for patients who require frequent monitoring, and Primary Care is increasingly not able to support them. The impact is that vulnerable patients are exposed to a very significant risk of compromised health states that can cause impairment or death. (HISTORIC ID: Na)	20	16	05/05/2021	Commissioning Committee	Jo Turl	Adam Carrick	28/06/2022
100	There is a risk that the population of Devon will not receive timely access to 999 emergency ambulance care when needed. The impact of this is upon patient experience and safety; public and professional confidence in the system and associated reputational impact. (HISTORIC ID: Na)	20	16	21/01/2019	Quality Assurance	Darryn Allcorn	Russell Cooke	22/07/2022
108	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand, capacity and impact of COVID) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system, including patient safety, could be affected. It is acknowledged that the risk will vary from locality to locality over time, with the need to focus resources where need is identified. This risk replaces risk 09 (SDT) and 68 (NEW Devon) Risk 117 closed 27 May 21 and merged into Risk 108 (HISTORIC ID: Na)	20	12	29/05/2019	Primary Care Commissioning	Jo Turl	Paul Green	07/07/2022
121	There is a risk that the Mental Health Inappropriate Out of Area trajectory, agreed by MH providers (Devon Partnership Trust and Livewell Southwest), is not met. The impact of this for patients is poorer outcomes, poorer experience, increased cost and damage to the CCG's reputation due to not meeting the nationally derived target to eliminate OOA placements by 20/21. (COVID Wave 2 Risk 45) (HISTORIC ID: Na)	16	16	13/07/2020	Commissioning Committee	Jo Turl	Adam Carrick	28/06/2022

157	There is a risk that combined historic workforce challenges, changing national and regional requirements including the requirements around continuity of carer, changes to thresholds for induction of labour, personalisation etc and the impact of the ongoing Covid-19 Pandemic will impact on safe delivery of maternity services and maternity services ability to implement national directives. The impact of this is • Potential for increased harm to baby • Potential for increased harm to mother • Increased staff absences due to stress and burnout • Potential for reduced retention for newly recruited staff • Reduced system-wide ability to deliver on maternity outcomes • Reputational risk due to non-delivery of national transformation agenda • Financial risk to non-delivery of Devon Game Changer schemes (HISTORIC ID: Na)	16	16	24/11/2021	Quality Assurance	Darryn Allcorn	Hannah Pugliese	22/07/2022
159	There is a risk that the start of the system wide PHM implementation plan will be further delayed due to low numbers of Primary Care GP practices signing & returning information sharing agreements to enable data sharing. The impact of this is an inability to provide full PHM data packs to LCP's and PCN's to support population analysis, stratification & segmentation to support PHM as a Long Term Plan priority. It will also impact on a range of other LTP priorities and operational plan work programmes e.g. Anticipatory & Integrated Care, Health Inequalities & Prevention. Without 90-100% PCN sign up we will have incomplete data to support strategic intelligence and commissioning activity also. (HISTORIC ID: Na)	16	12	07/01/2022	Primary Care Commissioning	Jo Turl	Todd Chenore	28/07/2022
146	There is a risk that University Hospitals Plymouth NHS Trust is unable to deliver safe and effective services, due to a lack of robust clinical oversight and risk management in the ED - as highlighted during the CQC inspection (8th March 2021) and subsequent Section 31 letter (15th March 2021). Concerns include: ambulance handover delays, IPC concerns, poor flow through the hospital, in part due to ED, but also the wider hospital and the Trusts ability to ensure mitigation under pressure. The impact of this is that the delivery of patient care may be negatively impacted upon, both in potential harm and poor patient experience. In addition, there is a risk to wider System reputational damage. (HISTORIC ID: Na)	15	20	26/03/2021	Quality Assurance	Darryn Allcorn	Vanessa Crossey	25/07/2022

156	There is a potential risk that there will be a delay in DRSS being able to identify 'red flags' within 'routine' referrals, due to a sizeable and growing backlog of referrals awaiting administrative and clinical review. Whilst not a specific service specification, DRSS has assumed this 'gatekeeper' role to provide referring clinicians with the opportunity to raise the referral status from 'routine' and expedite as 'urgent'. The risk is as a result of: - A reduced operational referral management workforce (i.e., Band 3, Patient Choice Facilitators) due to redeployment of some staff to other priority workstreams (i.e., Oximetry@home & patient Outsourcing/ Validation work programmes) - Reduced productivity levels resulting from remote/ home working (e.g., poor internet/ network connections) - An increased number of new staff (not sufficiently trained/ skilled) and the need to use existing staff to provide necessary training - Outstanding vacancies yet to be filled (4 WTE as of 05/10/2021) The impact of this risk is: - Poor referral experience for patients - Delay in supporting referring clinicians with the identification of referrals raised as routine but which may need expediting due to identified 'red flags' - Potential for increasing individual service line workloads within Provider landscape, due to fluctuating onward referral volumes - Potential increase patient demand for GP Practices with patients querying referral progress - Reputation damage for Devon Referral Support Service and Devon CCG - Low staff morale within DRSS Not in scope for this risk are urgent referrals, including specific time framed pathways (e.g., 2WWs and Mental Health referrals), which remain a priority for processing each working day. (HISTORIC ID: Na)	15	6	05/11/2021	Commissioning Committee	John Finn	Steve Matson	01/03/2022
133	There is a risk that decisions to make changes to services commissioned by the ICB through providers are done so without full cognoscente, clinical oversight and agreement whilst responding to the COVID 19 outbreak and management of capacity and resource. The impact: a) decisions made in isolation may impact on other services or capacity in system b) inequitable access for patients to services (HISTORIC ID: Na)	15	10	27/10/2020	Quality Assurance	Darryn Allcorn	Sara Wright	20/06/2022

134	There is a risk that Children and Family Health Devon do not recover the current position of increased waiting times and deteriorating RTT positions for CAMHS; Occupational Therapy; Speech and Language; Autism Assessment services. The risk score has again been reviewed (17.06.2021) and remains at 20. Initial trajectories were provided by CFHD December 2020 and Update March 2021. There has been some improvement in the OT service performance as well as Autism Assessment however services overall continue to struggle to make an impact on waiting list numbers and times. The impact of this is that children experience delay in accessing assessment, support and services for their physical, mental and communication development needs which may experience poorer quality and outcomes. CFHD are not yet achieving contracted service standards and NHS Devon cannot be confident that they will deliver the service improvements and transformation as set out in the contract agreed with NHS Devon CCG. There continues to be a lack of operational clarity in terms of service management and different service offer between Devon and Torbay, increasing wait times, regular queries and comments from families and schools, together with concerns regarding leadership and workforce capacity within the services that indicate CFHD are not yet achieving contracted service standards. The issues have been further intensified by the pause in a number of services as a result of COVID 19 and services are not currently being provided at the standard expected with increased wait times and reduced access to services(COVID Risk wave 2 risk ID 18)The CCG were notified 16.06.2021 that CFHD were starting their 'Roadshows' with staff to present their finalised clinical pathways, senior leadership structure and service/workforce models. The detail of this is still to be shared with the CCG and therefore remains unclear of improvements, impact and if risks remain in relation to workforce capacity and gap to deliver contract. (HISTORIC ID: Na)	15	20	27/10/2020	Quality Assurance	Jo Turl	Siobhan Grady	15/07/2022
139	There is a risk that there is insufficient capacity within the ICB infection control workforce to meet both the duties of the COVID-19 pandemic and those of normal Infection Prevention & Control (IPC) business. The impact of this is on: * Normal business; reduced focus on prevention & monitoring functions, including rates of notifiable hospital-acquired infections, reduced ability to attend and gain assurance from provider infection control meetings, change in focus of IPC sub teams due to COVID-19 support and reduction in capacity to monitor and support the Devon flu vaccination programme * COVID-19 business; potential to fail to gain assurance on COVID-19 outbreaks, programmes of work and overall status within the Devon footprint and potential to not provide operational advice in a timely fashion when requested (HISTORIC ID: Na)	12	9	21/12/2020	Quality Assurance	Darryn Allcorn	Alastair Harlow	15/06/2022
130	There is a risk that the CCG does not respond effectively to the COVID-19 pandemic. The impact of this is that the CCG may delay or disrupt the pandemic response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and perception of the CCG. COVID Risk Register Wave 2 risk ID 14 (HISTORIC ID: Na)	12	12	17/09/2020	Audit	Andrew Millward	Phil Coutie	25/04/2022

132	There is a risk that until robust reporting processes are embedded in general practice that there will be reduced assurance to fully understand how the learning from incidents will be shared and actions implemented. Additionally, there is an associated risk that until comprehensive and robust systems are in place to monitor quality and patient safety that only limited surveillance will be able to be implemented. The impact of this is that a failure to recognise the need for reporting incidents, completing a robust report in a timely manner and learning from incidents will be lost and the incident may therefore reoccur. That until the learning is embedded in practice the risk of the same incident reoccurring is not reduced and could occur repeatedly. (COVID Risk wave 2 risk ID16) (HISTORIC ID: Na)	12	12	22/09/2020	Primary Care Commissioning	Jo Turl	Paul Green	11/07/2022
106	There is a risk to the CCG delivering a medium to long-term financially sustainable plan which achieves breakeven within the Financial Recovery Plan timeframe. The Financial Recovery Timeframe will be reset with the allocations in 2022/23, when the Financial Improvement Trajectory is indicated to be retired. The allocation for 2022/23 will be a one year allocation, with a further two years to be issued later in the year. The long-term Financial Plan was developed in the Autumn as a response to the NHS long-term plan. The high-level view submitted to NHS England as part of the Operational Plan for 2020-21 highlights that following the CCG maintaining the pre-CSF outturn recorded for 2018-19 in 2019-20 and then a return to financial balance in 2022-23 with the delivery of surplus in 2023-24. This plan needs to be refreshed in light of the change in allocations and system control total process, along with the Strategic Oversight Framework 4 exit criteria, which includes an LTP based on 19/20 to 21/22 exit run rate (HISTORIC ID: Na)	12	12	08/05/2019	Finance and Performance	John Dowell	Ben Chilcott	06/04/2022
38	There is a risk that decisions will be made by the ICS which impact negatively on delivery of CCG functions As the ICS increasingly takes responsibility for decision making there is a risk that it will make decisions which a) have not had appropriate input/scrutiny from the CCG b) do not consider the CCG statutory functions c) are not supported by the CCG Governing Body These decisions may mean that the CCG may fail to adhere appropriately to one or more of its statutory duties or internal governance requirements, thus potentially failing in one or more of its legal duties. (HISTORIC ID: 319)	12	6	10/10/2016	Audit	Simon Tapley	Ginny Snaith	25/04/2022

162	Personal Health Budgets (PHBs) /Direct Payments can be used to pay for Personal Assistants (PAs) to provide care and support to individuals in receipt of Continuing Healthcare Funding. The PAs are employed by the Budget Holder. There is a risk that PHB Holders do not know the tasks they need to complete when they employ PAs, including: *Ensuring the PAs are adequately trained, to include core skills training and Delegated Healthcare Tasks (DHTs) and * Understanding their roles and responsibilities as a legal employer The impact of this is: *Potential patient harm – due to untrained staff caring for complex individuals, *Potential for sub-optimal care being provided by PAs, *Potential risk of safeguarding issues/abuse – for untrained staff taking advantage of budget holders, *Potential litigation to the ICB/financial compensation – due to harm to patients (above) and potential harm to PAs who are working and not sufficiently trained, eg Manual Handling incidents causing PA long term injury and *Potential reputational damage to the ICB – due to poor care provision; funding care with non-adherence to recommended mandatory/statutory training; budget holder's complaints and potential litigation for budget holders who have not fulfilled their responsibilities as an employer, which could result in budget holders personally being sued for damages (HISTORIC ID: Na)	**12**	**12**	05/04/2022	Quality Assurance	Darryn Allcorn	Jo Shill	30/06/2022
163	The limited duration of the new interim contact (18 months) will provide a challenge in terms of meeting the timeline for a new procurement exercise. There is a risk that procurement of a longer term contract for Mayflower may not be successful. The success of this is dependent on several factors, including the ability of the interim contract holder to move to a sustainable resilient position. The impact of this is that the delivery of primary care services to patients may be adversely affected. It may also impact other GP practices in Plymouth and the wider system. (HISTORIC ID: Na)	**12**	**12**	20/07/2022	Primary Care Commissioning	Jo Turl	Siobhan Cambridge	20/07/2022
147	There is a risk that NHS Devon does not currently employ the services of a designated doctor for safeguarding children. The impact of this risk is that NHS Devon will not meet the statutory requirement laid out in Working Together 2018 and Section 11 of the Children Act 2004, and will therefore be compromised in its responsibility to promote the health and wellbeing of children and young people of Devon (HISTORIC ID: Na)	**12**	**12**	26/03/2021	Quality Assurance	Darryn Allcorn	Michelle Thornberry	24/06/2022

148	There is a risk that Devon Doctors is unable to deliver a safe and effective service to the population of Devon. This includes their 111 and Integrated Urgent Care Service (Out of Hours). The CQC and ICB have identified this is due to a lack of appropriate workforce, a poor organisational culture and issues within the leadership team. These issues run throughout the organisation, including Clinical Assessment Service (CAS) Hubs, treatment centres, and home visit provision. Their largest issue with workforce relates to call answering and telephone assessments. This workforce issue is caused by high attrition rates, high sickness levels and lack of clinicians willing to do shifts. The impact of this is delayed assessment, advice, referral, treatment and care to patients. This may result in harm and/or poor patient experience. This may be resulting in patients using other, less appropriate services, impacting the Devon system. There has been poor clinical oversight and governance processes putting patients at risk and a lack of organisational learning and an increased risk that the organisation does not learn from adverse events. There is a risk this continues with temporary and vacant positions within the governance structure. There could be an impact on reputation for the ICB with public and professional confidence in Devon Doctors deteriorating. Supersedes risks 105 and 126. (HISTORIC ID: Na)	12	16	26/04/2021	Quality Assurance	Darryn Allcorn	Russell Cooke	22/07/2022
150	There is a risk that the Mayflower group is unable to deliver safe and effective services due to a lack of workforce capacity and embedded governance processes putting patients at risk. There is currently limited assurance that patients have a fair, equitable and safe access to appropriate appointments. The impact of this is: * delayed assessment, advice, referral, treatment, and care to patients which may result in harm and/or poor patient experience, This may also be resulting in patients using other less appropriate services, impacting the Devon system or not receiving appropriate treatment at all, * that the delivery of patient care may be negatively impacted upon, both in potential harm and poor patient experience, In addition, there could be an impact on the reputation for the ICB with public and professional confidence in the Mayflower group deteriorating. (HISTORIC ID: Na)	12	16	07/05/2021	Primary Care Commissioning	Darryn Allcorn	Vanessa Crossey	25/07/2022

141	Due to the Covid 19 pandemic there is a risk that the Primary Care Nursing and Quality team, cannot fulfil all their functions in providing assurance on provider quality and safety. The reduction in team capacity is emphasised with members being redeployed to support high intensity workstreams such as PPE / IPC and Vaccination Program resulting in the equivalent of 2 Band 7 FTE posts vacant. The impact of this is; • The ICB are unable to gain appropriate levels of consistent quality and safety assurance to improve the quality of commissioned services for the population of Devon through Primary Care • Some areas of work will not be routinely managed • The inability to appropriately inform and support the Commissioning cycle across Primary Care and maintain positive relationships • Limited engagement/support with providers • Unable to proactively manage and support improvement work-streams • Business as usual workstreams such as clinical supervision, HCSW workforce programme and GPN workforce planning have been temporarily ceased, this may have long-term operational impacts • There is a considerable risk to the delivery of the CARE Programme • Remaining staff working within the team at risk of burn out • Maintaining staff retention due to reduced motivation/job satisfaction • Reduced resilience within the team should there be long term staff sickness/unplanned absences • Reduced number of staff with the right skills, competencies (HISTORIC ID: Na)	12	6	11/01/2021	Primary Care Commissioning	Darryn Allcorn	Vanessa Crossey	24/05/2022
152	There is a risk that when colleagues return to offices following the relaxation of government restrictions related to the Covid-19 pandemic, that there will be the potential for office outbreaks of Covid-19 or impact on staff through social interactions outside of the workplace. The impact of this is would be potential staff shortages across all directorates due to the need for self-isolation or actual sickness. Potential for serious illness or death with a communicable disease. (HISTORIC ID: Na)	12	12	14/07/2021	Audit	Andrew Millward	Ginny Snaith	25/04/2022
129	There is a risk that a disruption to the availability of staff, IT and/ or telecoms, critical information, premises, supplies or suppliers/ contractors, may prevent the CCG from delivering its essential functions as set out in Directorate BCPs The impact of this is that CCG essential functions may be delayed or stopped with a knock on impact upon statutory functions, finance of CCG and Provider service delivery, and perception of the CCG is impacted by patient outcomes. (HISTORIC ID: Na)	9	9	17/09/2020	Audit	Andrew Millward	Phil Coutie	25/04/2022
120	There is a risk that COVID-19 outbreak may lead to the possible work transference from secondary care into General Practice, impacting on GP practices ability to undertake routine work The impact of this is that the delivery of general practice is compromised and there may be funding implications if additional funding is sought. (COVID Risk wave 2 risk ID 09) (HISTORIC ID: Na)	9	12	13/07/2020	Primary Care Commissioning	Jo Turl	Paul Green	07/07/2022

109	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: • Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention • There is reputational impact due to potential patient harm or perception of the CCG is impacted by patient outcomes. • Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (COVID Risk wave 2 risk ID 02) (HISTORIC ID: Na)	9	16	06/06/2019	Audit	John Finn	Karen Barry	25/04/2022
160	There is a risk that the operational plan for 2022/23 is not deliverable within the resources allocated to the system and this jeopardises the wider system plan. The impact of this is that the ICB will fail one of its key financial duties resulting in reputational damage, adverse assurance rating and need to cut expenditure in an unplanned way, jeopardising other key deliverables in its corporate objectives. This will have an impact on the Strategic Oversight Framework exit plan from level 4. (HISTORIC ID: Na)	9	12	03/02/2022	Finance and Performance	John Dowell	Ben Chilcott	06/04/2022
161	Two sub-contracted providers of Devon Special Allocations Scheme have handed back their contracts to main contractor Access Health Ltd. (Fremington Health Centre (North) and St Levan Surgery (West)). There is a risk that we may see a domino effect of other sub-contracted providers handing back their contract. Access Health Ltd may be unable to secure new sub-contracted providers for patients previously managed by Fremington Health Centre (North) and St Levan Surgery (West). Access Health Ltd may not be able to deliver the contract. The impact of this is that patient experience of these patients may be negatively affected in the meantime. Patients may need to travel further. In the interim may not be receiving full level of service. Potentially a vulnerable group of patients not able to access services if service can't be provided. (HISTORIC ID: Na)	9	12	08/03/2022	Primary Care Commissioning	Jo Turl	Paul Green	18/07/2022
127	There is a risk that Devon CCG may be subject to increased fraudulent activity during and following a pandemic or similar major incident The impact of this is potential , Financial loss to the CCG Phishing / Cyber attack Fraudulent staff absence / leave requests Information Governance Breaches Damage to CCGs integrity (HISTORIC ID: Na)	6	6	09/09/2020	Audit	John Dowell	Ginny Snaith	25/04/2022
128	There is a risk that CCG data will be compromised by unauthorised/accidental disclosure due to shared work areas with non-CCG organisations. This may be via data visible on desks and/or screens or telephone conversations. This also includes homeworking where area shared with other persons. The impact of this could be the CCG's ability to maintain patient, staff and/or corporate confidentiality. (HISTORIC ID: Na)	6	6	10/09/2020	Audit	Andrew Millward	Matt Spry	30/06/2022

131	There is a risk that the CCG will be unable to respond effectively in the event of an emergency or business continuity incident, through not meeting its statutory and policy obligations to be prepared to respond to emergencies and disruptive incidents. The impact of this is that the CCG may delay or disrupt an emergency response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and the perception of the CCG. (COVID Risk Register Wave 2 risk ID 15) (HISTORIC ID: Na)	6	6	17/09/2020	Audit	Andrew Millward	Phil Coutie	25/04/2022

NHS Devon board meeting

Committee chair report – Primary Care Commissioning Transitional Committee

Date of board meeting	Dates of committees covered in this report
September 21st 2022	July 2022

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

Reports discussed and assurances received

- Assurance was given to the committee of how the Primary Care Team are working towards the **delegated commissioning** of dental, optometry, and community pharmacy services. During the transitional period NHSE are providing a commissioning hub to discharge commissioning responsibilities whilst ICB becomes increasing involved in strategic decisions effecting our system.
- PCCTC reviewed and discussed the **Quality Report** in which the meeting was updated on the relaunch of the Peer Improvement Tips for Care and Health (PITCH) scheme. Initial results show some important themes: work shift, prescribing, discharge summaries, patient assessments, and referrals. There has been a large spike in issues of work shift relating to local authority and safeguarding – which is being escalated and investigated. The Quality team are supporting practices with PITCH reporting, CQC inspection report and significant incident report action plans.

Reports received and noted

- PCCTC received an update on the new **NHS Devon Primary Care Strategy (General Practice).** The final draft of this document has been approved by NHS Devon Senior Executive team and is in the socialisation stage before sign-off at PCCTC in the September meeting.
- PCCTC was updated on contractual, and resilience matters in a high-level overview report which drew the committee's attention to the consistent high levels of operation escalation in Primary Care across the county.
- PCCTC were informed of the final 3-year programme internal audit report findings. Overall, the audit conclusion was positive, stating that the CCG had robust arrangements in place surrounding commissioning and procurement functions. All areas were within parameters of good practice with 2 small recommendations, one of which has already been implemented and the other to be completed by the September meeting.
- PCCTC received the first finance report of the ICB. Budget setting, forecasting, contingency, and possible areas for savings were discussed. Concerns were noted that, with much of the Primary Care budget being ring-fenced for general practice, the weight of saving will be on prescription budgets which, in turn, will be difficult due to issues; lacking staff to work with practices on savings areas and greater need for additional prescribing for patients waiting in Primary Care due to Secondary Care COVID backlogs.
- The **Deputy Director's Report** highlighted the positive news brought by the 2022 patient survey for which Devon has the 2nd best set of results in the Country and is higher than the national average in all areas.

Risk register review updates

- PCCTC reviewed the risk register. It was debated whether one risk, (149 - physical health checks for adults with eating disorders), which has not previously been held by Primary Care, should be included for oversight by this committee.
  The Commissioning Committee actions show that a monitoring group has been established to ensure the mitigation of the risk. The Primary Care Team will discuss with the current risk holder the appropriate future placement of the risk.

Committee decisions

-

Items of concern to be escalated to the board

-

Recommendations for the board

-

Recommendations for other committees

-

Terms of reference or other committee effectiveness issues

PCCTC reviewed the **Committee Terms of Reference,** noting the inclusion of different and updated areas of transition, accountability, and assurance. The diversity of representation in the membership of PCCTC was discussed with decisions and invitations to new members to take place over the next 2 months. The PCCTC's part in assurance oversight of good budgetary planning and use was highlighted, with the chair undertaking to assure herself and the committee of where correct governance of finance management will be placed.

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Management of conflict of interests:

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

NHS Devon board meeting

Committee chair report – People & Culture Committee

Date of board meeting	Dates of committees covered in this report *Minutes of these committee meetings to be available as an addendum*
21st September 2022	31st August 2022

Chair	
Name and title:	Thandiwe Hara, Non-Executive Director for Citizen involvement and Engagement
Phone:	07888712327
Email:	Thandiwe.hara@nhs.net

Reports discussed and assurances received

- Terms of Reference – it was highlighted that there is no Deputy for the NEDs and therefore if a NED was unable to attend there would be no additional person to send to vote. It was agreed as an action to have a conversation with the Governance team to understand if other committees have had this highlighted and what the solution would be.
- Workforce Statistics, challenges, strategy Principles and People plan were discussed, the data was provided, and the group were updated that the data doesn't yet include social care or primary care, but assurance was given that work is to be started to include periodic data for this part of the system.
- Forward Plan was discussed and agreed that the committee members will input into this forward plan and each agenda.
- Having a sufficient workforce within our budgets is a significant challenge and is the reason why we need to swiftly find new ways of working to deploy our people in different ways and to reduce workforce growth in the future. Action asked of the system Medical Director to bring forward to the October committee our plans for system wide service redesign work

Reports received and noted

- People & Culture Committee Summary Report
- NHS Devon ICB People & Culture Committee Terms of Reference
- Workforce Report August 2022
- Workforce Strategy – Finance Scenarios
- Workforce Strategy – Themes, Principles, and socialisation

Risk register review updates

- None

Committee decisions

- The committee agreed that the meeting would meet monthly until they are established with the view to review and moved to quarterly.

Items of concern to be escalated to the board

- None

Recommendations for the board

- None

Recommendations for other committees

- To ensure workforce issues are discussed across all committees

Terms of reference or other committee effectiveness issues

- None

Management of conflict of interests:

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GOVERNING BODY

Report title: Committee Chair Report – Quality and Performance Committee

Date of Governing Body: 21st September 2022

Dates of Committees covered in this report: 10th August and 7 September, 2022

Chair's Name and Title: Professor Hisham Khalil, Non-executive Director NHS Devon ICB (Chair)

Contact Details: hisham.khalil2@nhs.net

Reports discussed and assurances received

The Committee received updated reports as detailed below

1. **System Quality Risk and Assurance Report** including Risk Register
   There is a piece of work currently underway that the governance team is leading on to look at the current risks on the corporate risk register to identify where these sit. The Board Assurance framework is currently being drafted with the hope to be available at the end of August/beginning of September. This will inform the QPC of those more strategic risks. The committee would like the actions taken to mitigate risks to be clearly highlighted. This would include 'example risks' and following them through. The 'highest' risks will need to be addressed promptly.

2. **Never Events(NE)** There has been a significant increase in NE in planned care this financial year which are not specific to a particular provider. The Head of Patient Safety reported the set up of a Patient Safety specialist forum with sub-group of the Patient Safety Specialist meeting. To include membership from all four major hospitals to review NE. The forum will focus on sharing the actions and learning of NE and reviewing local practice against national guidelines. The QPC committee will review collated themes of NE.

3. **Ambulance Handover and Transfers** The Director of Performance presented data on Ambulance handover. Most KPI are not met and it was highlighted thsi is a multi-faceted problem. The committee was appraised on the negative impact this is having on patients and the public and that the system is looking into actions that will have the greatest impact on improving this situation.The Learning related UHPNT & RDEFT Transfer Incident in January 2022 was discussed in detail in the September meeting. Work is underway to look into changes that may be required into diverts and transfers between hospitals.

   NB. After recent discussions between the Chair with the Executive Team, it was agreed that the outputs of a summit led by the Medical Director on Urgent and Emergency Care including Ambulance Handover will be presented in the October meeting of the QPC Committee for assurance and scrutiny.

4. **Infection Prevention and Control** The merger of the RDUH and NDHT with combined reporting by the National system has resulted in a less accurate picture of what is happening in the northern and eastern section. Assurance was received that this should be addressed.
   There is a rise of C Difficile infections in UHPNT and SFT possibly due to overuse of antibiotics. Assurance was received that this is being monitored and addressed.
   There are SOP for managing Monkey pox infections.

5. **Integrated Quality and Performance Report** The Director of Performance provided a 'preview' on the new formatof the IQPR in Power BI and details of the cover sheet. The patient/user stories will be aligned to items on the IQPR. From October, 2022 the new IQPR will be scrutinised by the QPC and Finance committees ahead of the ICB meeting.
   The Urgent and Emergency Care data and the Elective Care data will move into the SPC from September. This will enable the committee to be clear on what the root cause analysis is of the position, what is being done about it and when it will be resolved.

6. **Position Statement Devon ICS CQUIN Schemes Q1** The Commissioner, Quality and Innovation (CQUIN) Schemes Q1 Position Statement was presented to the QPC. There were issues with RDUHFT not reporting non-selected CQUINS in line with the national requirement. This has been discussed with the provider

7. **Final draft report Mr S- Full report and Executive Summary** The Committee was presented with the second of the reviews commissioned by NHSE.

Reports received and noted

1. Redress Policy
2. Learning related UHPNT & RDEFT Transfer Incident in January 2022
3. SBAR Patient Group Direction Virtual Review Panel report

Risk Register Review Updates
System Quality Risk and Assurance Report including Risk: No change in risks from the July 2022 report
Committee Decisions
1. The committee accepted the report on Mr. S and approved the action plan.
Items of concern to be escalated to the Governing Body
The Committee would appreciate a discussion around where the Commissioning risk should reside in the long term
Recommendations for Governing Body
To note the reports received and positions of assurance by the Quality and Performance committee
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
• 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 and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.

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

Integrated quality, performance and finance report (IQPR)

Table of contents

Executive Summary

This report provides a consolidated update on key strategic issues and measures of outcomes, performance, quality, finance, recovery and activity to provide the necessary assurance to the ICS, at both place and system level that issues are being 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 £18m 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 (EDs) performance and ambulance conveyancing targets have continued to decline with the continued stepping down of some planned procedures.

Planned Care 104 week waits continue to reduce, but NHS Devon is forecasting 889 patients waiting above 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 COVID 19 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.

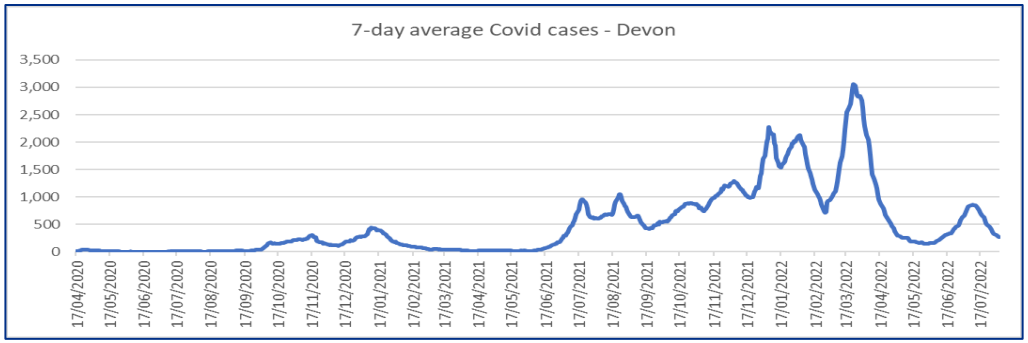
Key risks and priorities

Quality	Performance
• Planned Care: risk to patients, due to long waits. Mutual aid and other workstreams in place to mitigate risk. • Urgent & Emergency Care: risk of long waits across whole pathway; 111, 999, ambulances through to EDs. Including risk due to discharge delays and long waits for packages of care in community. • Primary Care: impact on primary care workforce and capacity, i.e. GPs undertaking additional care tasks. • IPC: Increasing numbers of COVID-19 positive cases, impacting on communities, but also NHS workforce.	• Planned Care: Although improving position, approx. 1000 patients above 104 weeks expected to be waiting at the end of July 2022 (target of zero) for elective procedures. Cancer 62 day target delivery unmet at 56%. • Urgent & Emergency Care: Emergency Department 4 hour under-performance and declining (64%). 60 minute handover delay breaches at all four acute hospitals with loss of 8,822 hours in June. • Discharge: delays continue to impact on flow through the entire system & No Criteria To Reside targets unmet. • IUCS: 111 and Out of Hours service seeing continued capacity problems and performance standards unmet. • Children's & Mental Health: improvements relating to urgent access to eating disorder services. Deteriorating position for children awaiting autism and speech and language assessments.
Workforce	**Finance**
• Challenged staffing position across the whole healthcare sector in June 2022. • Provider sickness rates are between 5.6% (TSDFT) – 6.7% (LSW). • Provider vacancy rates are between 4.7% (TSDFT) – 12.1% (LSW). • Provider turnover rates are between 11.95% (UHP) – 15.82% (LSW) YTD agency spend £12.078m compared to £8.946m previous YTD	• As at month 3 (June 2022) the Devon ICS has a deficit of £7.8m which is £0.1m adverse variance to plan. • The forecast is a deficit of £18.2m which is £0.4m adverse to plan. • The system is required to deliver a breakeven position by the year end.

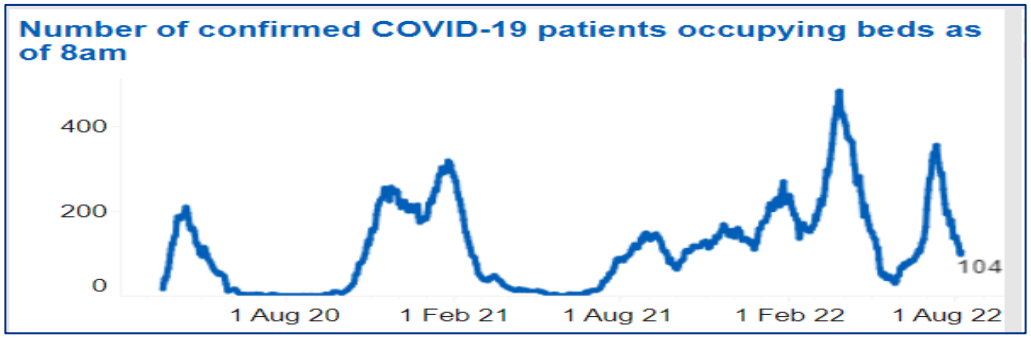
Performance & Quality Context

Covid Update

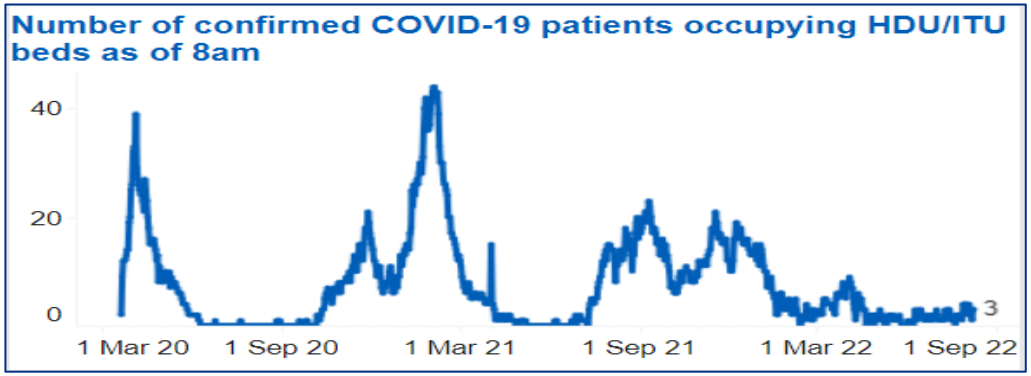
Covid infections have continued to fall, reflecting the decrease seen nationally. Cases peaked in early July although changes in testing processes mean actual cases were likely to be significantly higher than the reported position.



The number of Covid patients in hospital beds has quickly reduced since the peak of 353 at the beginning of July, mirroring the fall in community prevalence. Further Covid increases are expected in early Autumn and at the start of Winter.

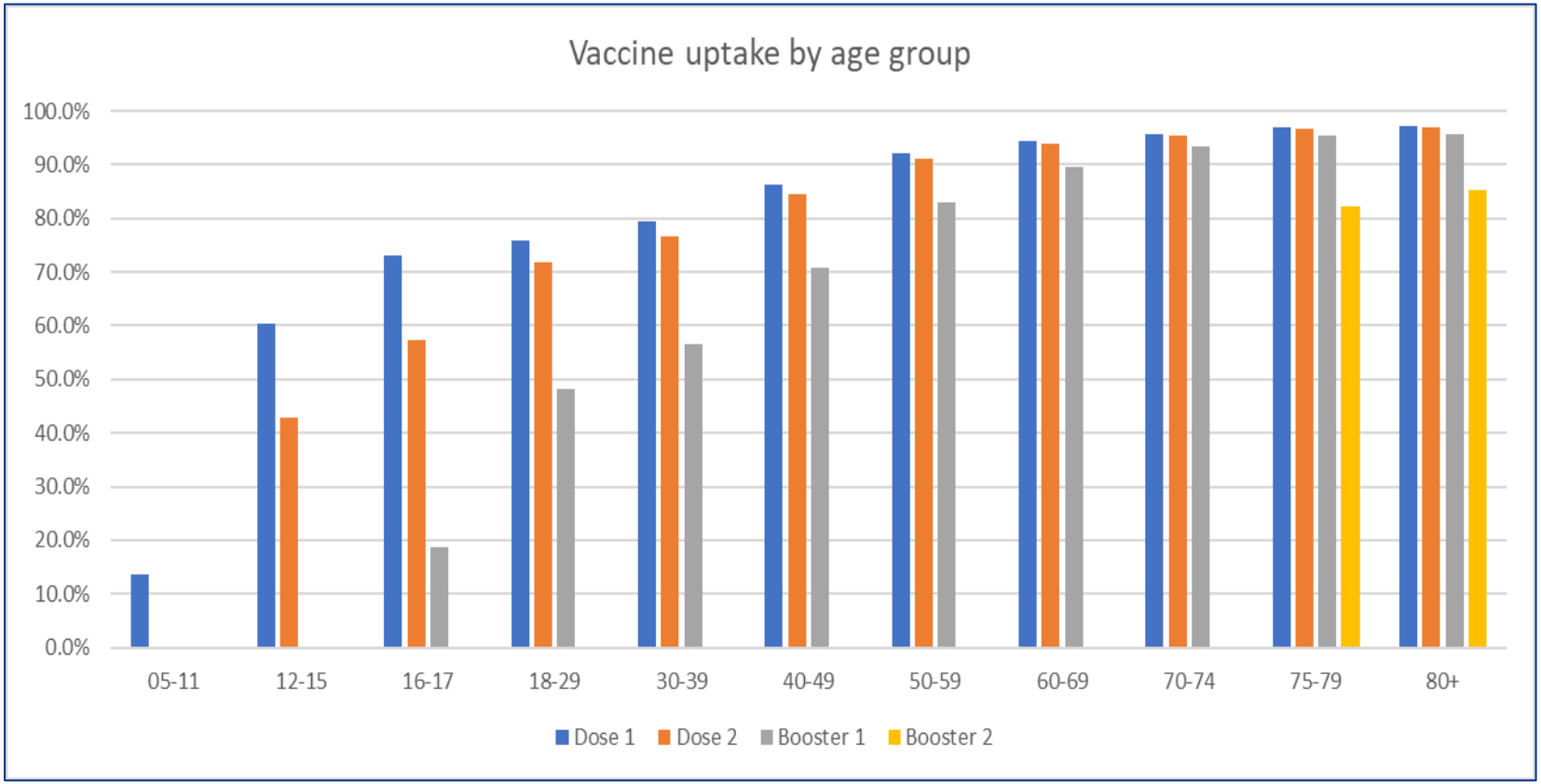


Covid patients in ICU continue to remain low. As of 8th August, there were 3 patients with Covid occupying an ICU bed.



Covid Update: Vaccinations

80.6% of the eligible Devon population have received one vaccination dose and 83.2% both doses. 60.4% of 12-15 year-olds have received at least one vaccination and 13.6% of 5-11 year-olds. 83.9% of eligible people have received a second booster (all figures as of 7th August)



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 in order 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 back log is not readily quantifiable.

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

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

Primary Care: Clinical Activity

Actions undertaken in last month:	Impact:
Primary Care completed action to access BI Team to review quantification of activity data that could be utilised to monitor accumulation of delayed work, for example QOF, Public Health screening metrics, immunisation rates and referral activity. Further work to develop and present this data is planned.	Potential data sources identified to help identify backlogs. Once available, this data will be used to assess the extent of delayed services and plan improvement.
Following release of the initial tranche of Devon Spring Action Fund (DSAF) funding in May (£641,000), a practice-specific activity assurance template has been developed in readiness for reconciliation purposes to evidence spend on additional staffing. Each practice has now been sent a template to complete and return with supporting evidence to enable the balancing payment, or clawback if necessary, to be made. Once all information has been received the Primary Care Team will be in a position to provide detail on the number and type of additional sessions that have been provided under this fund.	Additional financial support will enable practices to secure extra clinical sessions, from both existing staff providing additional sessions and locum practitioners.

Actions for next month/s:	Intended impact:	Date impact will be realised:
Continued work with BI to quantify outstanding practice and provision of services.	Will support a system-wide understanding of the impact of COVID on clinical backlog in partner organisations; and identify the interdependencies and potential impact of system wide provision on other partners.	Ongoing, work will continue during June/July 2022

Practices will be issued with templates to complete to provide evidence of their investment in additional staffing. Completed templates will be reviewed as part of a reconciliation and assurance process. This will trigger payment of the remaining 50% of the funds allocated, to be paid in September. DSAF will come to an end on 31st July 2022. The deadline for claims to be received with supporting evidence is 02/09/22 with payment/clawbacks being processed in month	Additional capacity in general practice will support an increase in clinical activity	Additional sessions to be funded from May to July 2022. Final funding payments to be made during September 2022. Evaluation of impact to be undertaken in the next quarter.

Integrated Urgent Care Service: NHS 111

Theme: Delivery of key NHS 111 service standards in relation to call handling and call abandonment

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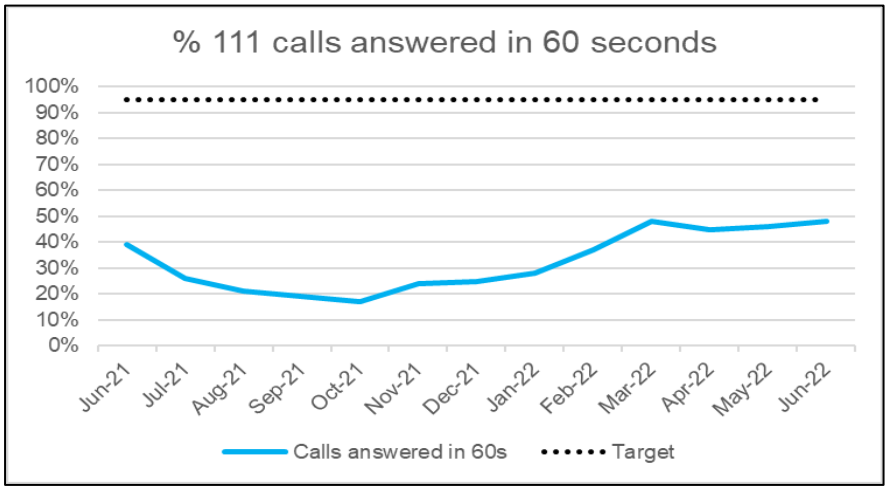
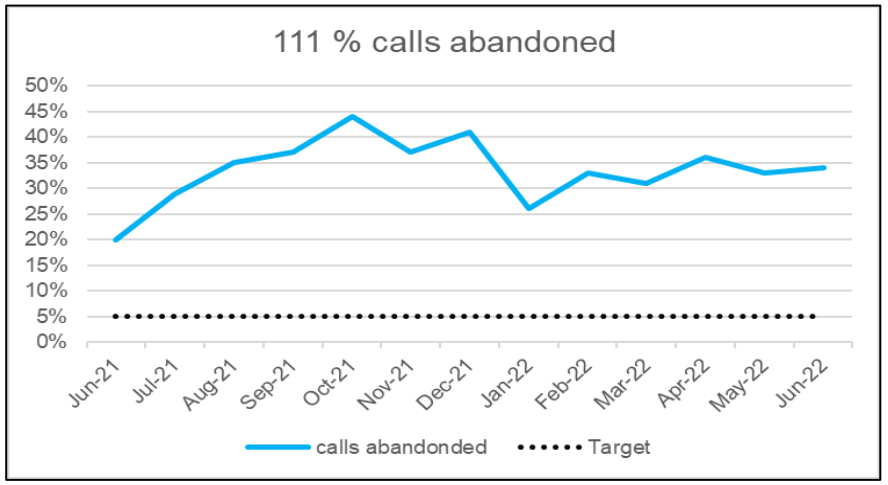
- Call answering remains distant from target of 95% at around 50%. Weekday performance has improved but weekend performance is still very challenging with poor rota fill and continued attrition.
- Call abandonment remains significantly adrift from target at 35% compared to a target of 5%. Compared to national average, Devon Doctors remain one of the lowest performing providers for call abandonment.

As a result of long waits to speak to a call handler, many patients abandon calls. It is difficult to know the pathway they then take, but it could impact on patient safety and experience, as well as the wider system, including use of Emergency Departments. As no assessment / contact is made it is impossible to identify if harm is occurring due to failed contacts and use of alternative service.

Underlying cause: Overall, poor performance due to low call answering capacity because of unplanned absence and insufficient weekend establishment. In addition, there are high volumes of “Patient Safety Calling” during busy periods which non-clinical call handlers are required to support.





Actions undertaken in last month	Impact
Recruitment for non-clinical call handlers.	Incumbent provider working with incoming provider to ensure continual recruitment and training available. Posts have been recruited to but this is matching the rate of attrition
Work with incumbent provider and NHS England to utilise call handling capacity from other IUCS providers.	Level of protection being provided for incumbent provider during pressured periods, including weekends and evenings, with calls being taken by other providers including 'National Contingency'. Whilst not reflected in data shown, performance metrics such as time to answer and the abandonment rate has improved.

Actions for next month/s	Intended impact	Date impact will be realised
Continue to review recruitment for non- clinical call handlers	To ensure recruitment and training does not stall during transition to new provider.	ongoing
Continue to review utilisation of call handling capacity from other IUCS providers.	Improvement of performance metrics such as time to answer and the abandonment rate.	ongoing

Integrated Urgent Care Service: GP Out of Hours

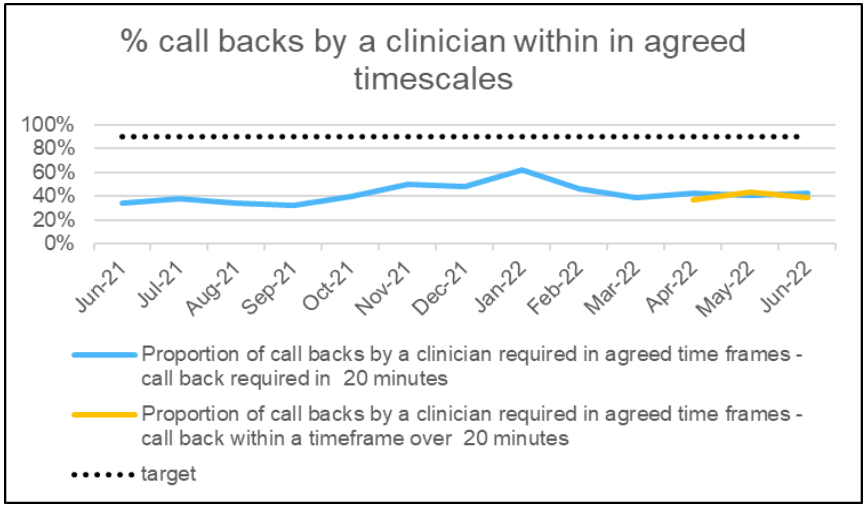
Theme: The GP Out of Hours is currently not meeting the following service standards:

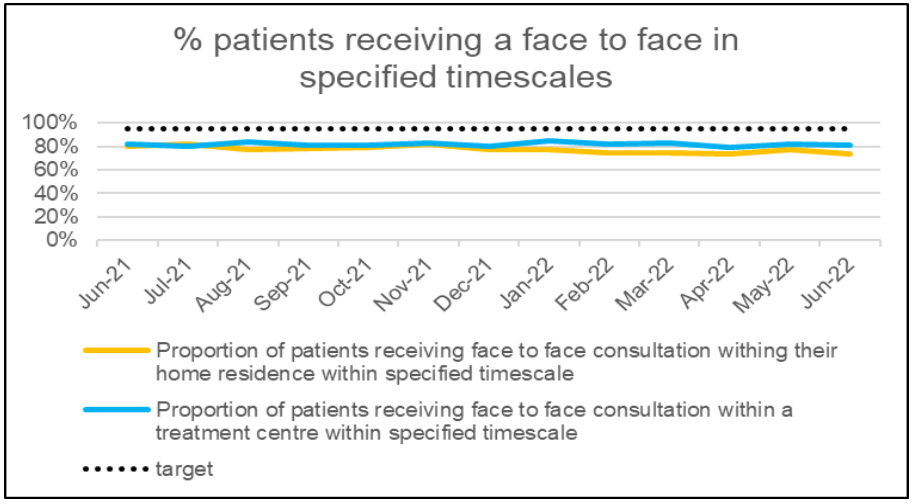
- 90% of patients who receive telephone advice or have their call triaged within a clinically defined timeframe (determined by the disposition from NHS Pathways). Performance is currently around 40% due to poor rota fill.

- 95% Patients receive a 'face to face' appointment, either within their home or at a treatment centre within clinically defined timeframes. The standard for 'face to face' service is measured from a combination of timeframes determined by the disposition from NHS Pathways. Overall, the service remains circa 80%.

There are patient safety impacts as a result of delays with telephone and / or face to face contacts. These include a delay in assessment and potential deterioration in a patient's condition, in particular in time critical circumstances; there have been increasing numbers of reported safety incidents as a result of delays across Devon Doctors work streams.

Underlying cause: Fluctuating poor performance is due to low rota fill. Reduced fill / low pick up rates are due to a number of reasons including competing demand on limited workforce.





Actions undertaken in last month	Impact
Continued clinical communications to ensure clinicians are kept up to date during the transition period between providers including engagement events led by Practice Plus Group.	To connect local clinicians with who may wish to pick up shifts in the integrated urgent care service, with the incoming provider.

Actions for next month/s	Intended impact	Date impact will be realised
Continued clinical communications to ensure clinicians are kept up to date during the transition period between providers including engagement events led by Practice Plus Group.	Reduce the number of unfilled shifts.	June 2022 and beyond as part of mobilisation process

Emergency Department: 4 hour waits and Ambulance Handover delays

Themes:

- Increasing ambulance handover delays. Total hours lost to ambulance handover delays (of over 15 minutes) in June across Devon was 8,822 hours.

- No trust in Devon is meeting the target for 95% of patients attending the Emergency Department (ED) should be admitted, transferred or discharged within four hours. In June Devon wide performance was 64%.

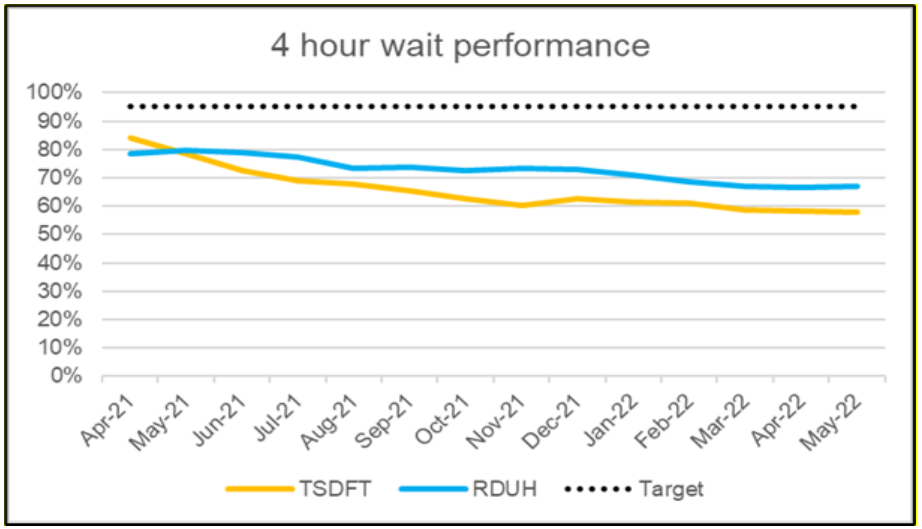
It should be noted that while ambulance handover delays are increasing the number of ambulance incidents (calls) and conveyances to ED have been reducing. There has also been a reduction in ED attendances.

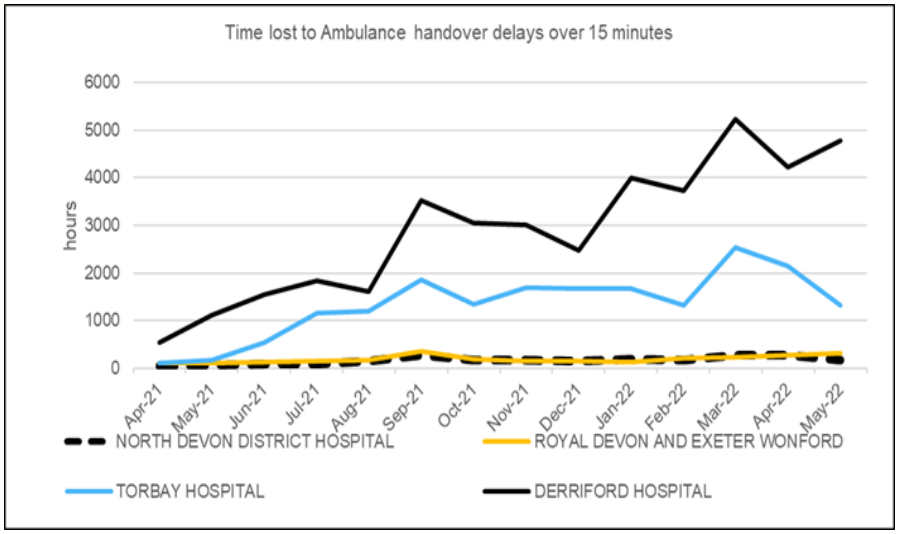
When patients wait for long periods in ED there have a poor experience of the service, patient safety may be compromised, due to of delayed assessment and intervention. This is a risk for all long waits, from 4 to 12 hours plus. There have been patient safety reports of patients coming to harm in cramped, busy ED's, over a long period.

There is risk to patients waiting in ambulances for extended periods. While care is provided in the vehicle, and ED clinicians often also attend, there may be delays in onward assessment, diagnostics, treatment and appropriate ward admission. Experience, including comfort and pressure care can also be affected. Multiple patient safety incidents have been reported relating to patients waiting in the ambulances outside ED's for a long period of time.

With ambulances held outside EDs, there is a risk to clinically undifferentiated patients waiting an ambulance response to attend them in the community, particularly for emergency conditions in category 2 such as stroke, sepsis and heart attack.

Underlying cause:
Delays caused by flow through the hospital being compromised due to delays to discharge. Performance also been impacted by winter and covid pressures, staffing challenges and crowding in ED.





Note: UHP do not report against this standard as they are part of a pilot for new metrics. Also RDUH site data is now combined

Actions undertaken in last month	Impact
UHP: Continuation of work to increase Same Day Emergency Care (SDEC) activity by 10% and capacity to reduce SDEC conditions seen in ED and increase ambulance referrals	10% Reduction in SDEC appropriate cases being seen in ED and directed to SDEC, currently identified as 4 patients per day from within ED, further work on pathways for direct admission to SDEC underway.
UHP: Continuation of work to deliver and report on Falls Pilot (referrals of clinically appropriate cases from SWASFT to Urgent Community Response (UCR).	Reduction in number of long layers and conveyance to ED.

Actions undertaken in last month	Impact
UHP: Continuation of work to Achieve nurse staffing establishment & fill rate in ED to 90% of hours required v hours available	Increase in ability to triage and treat patients within timeframes and increase flow through ED
TSD: Increase in acute medical inpatient capacity at T&SD for the last 4 weeks	This has not had the impact that was hoped but has given a greater opportunity to flex.

Actions for next months	Intended impact	Date impact will be realised
UHP to provide agency staff to release ambulance crews from cohorting areas	Reduce number of vehicles queuing	August 2022
Implementation of “full capacity” protocol at T&SD. This is currently not in place and has been escalated to the Trust Senior Ops Team	Reduced waiting in ED	August 2022
UHP: Remodel existing Livewell Southwest Complex Needs and High Impact Team to focus on frequent ED attenders from complex lives cohort	Reduction in number of inappropriate frequent attenders	September 2022
UHP: Work with and support 26 GP practices which create 80% of ED attendances through refocused capacity of Livewell MDT	Reduction in ED attendances from identified practices	September 2022
UHP: Enhanced care homes offer – a more targeted response to care home attendance, extension of Care Home Liaison Team to provide focused interventions into highest 999/ ED referring care homes	Reduction in 999 calls and ED attendances from identified homes	September 2022

UHP: Fallers' service – extend current Urgent Care Response Team offer to include 'pick up' and 'sitter' service to avoid long waits and ambulance conveyance	Increase number of fallers who are referred from 999 to UCR Reduce the number of long waiters (non-injury falls)	September 2022

Ambulance Service Response

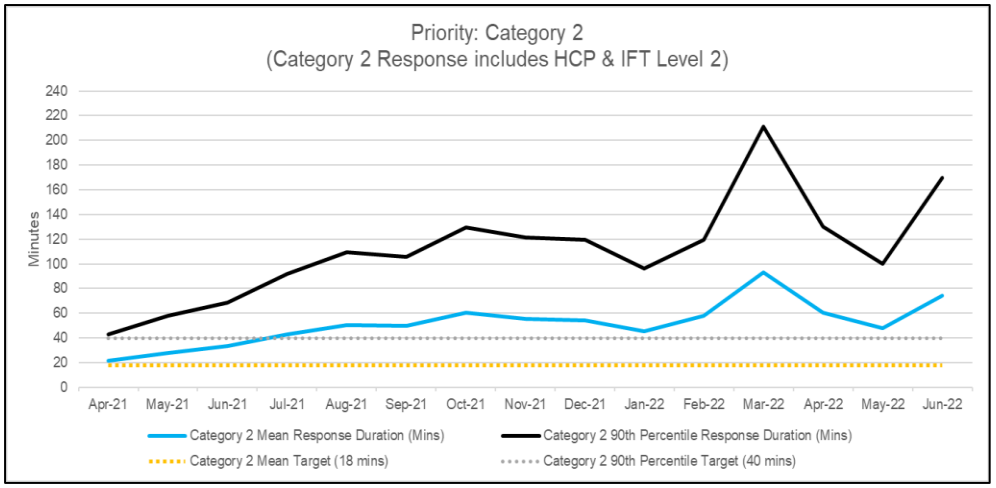
Theme: Delays to delivery of emergency care: 999 call answering, ambulance response (particularly category 2 which is an emergency response excluding immediately life threatening conditions) and hospital handover delays. SWASFT call response, ambulance response and resources lost to handover delays are the worst in England.

The decline in response time performance, has occurred at the same time as there has been statistically significant downward shift in the number of 999 calls and conveyances to the ED. In June 2022 there were 18,488 calls compared to 21,1164 in June 2021 and 6535 conveyances to ED compared to 9304 in June 2021.

Ambulance response delays have a positive correlation with hospital handover delays, particularly in South and West Devon; category 2 performance aligns to other key metrics such as ambulance handover times and long waits in ED. SWASFT have completed a system patient safety incident investigation report. It records 49 cases across the SW region (6 in Devon) of patients coming to severe harm as a result of waiting for ambulances in the community. All are caused by the lack of available ambulances to respond as a result of long handover delays and staffing levels.

Approximately 60% of SWASFT conveyances are category 2 and these will include some of the sickest patients hence the national priority to address this. Through June, 50% of 999 calls were answered in 60 seconds (target 95%) a reduction from May (63% answered within target).
SI investigations show 4 cardiac patients accessing heart attack treatments at UHP have suffered severe harm due to ambulance delays in reaching them in the community.

Underlying cause: Delays in call answering times relate to challenges recruiting enough emergency medical dispatchers, attrition and abstractions of existing workforce.



170 minutes 90th centile response in June across Devon (target is 40 minutes).

75 minutes mean response in June across Devon (target is 18 minutes).

Actions undertaken in last month	Impact
On-going recruitment and training of Emergency Medical Dispatchers (EMDs). Increase in training room capacity. Complete review and refresh of recruitment strategy for the role. Retention payments being offered to EMDs.	Increase in trained call takers and improvement in call answering times. Call answering times have improved but are not yet being sustained as June saw a drop in answering times from May. Training places continue to be only filled to 50%, short notice withdrawals an issue.
Clinical resourcing in hub to maintain hear & treat rates, including dedicated mental health practitioners, and additional crew and private ambulance resources to improve response times.	Hear and treat rates of 25%, increase on May rate of 21%. Ambulance response times have increased in all call categories from May.
On-going development of handover improvement plans and trajectory as part of 2022/23 contracting arrangements.	Agreement to aim for a step change decrease in handover delays by October, towards 2019/20 levels based on impact of virtual wards and same day emergency care programmes at UHP and Torbay

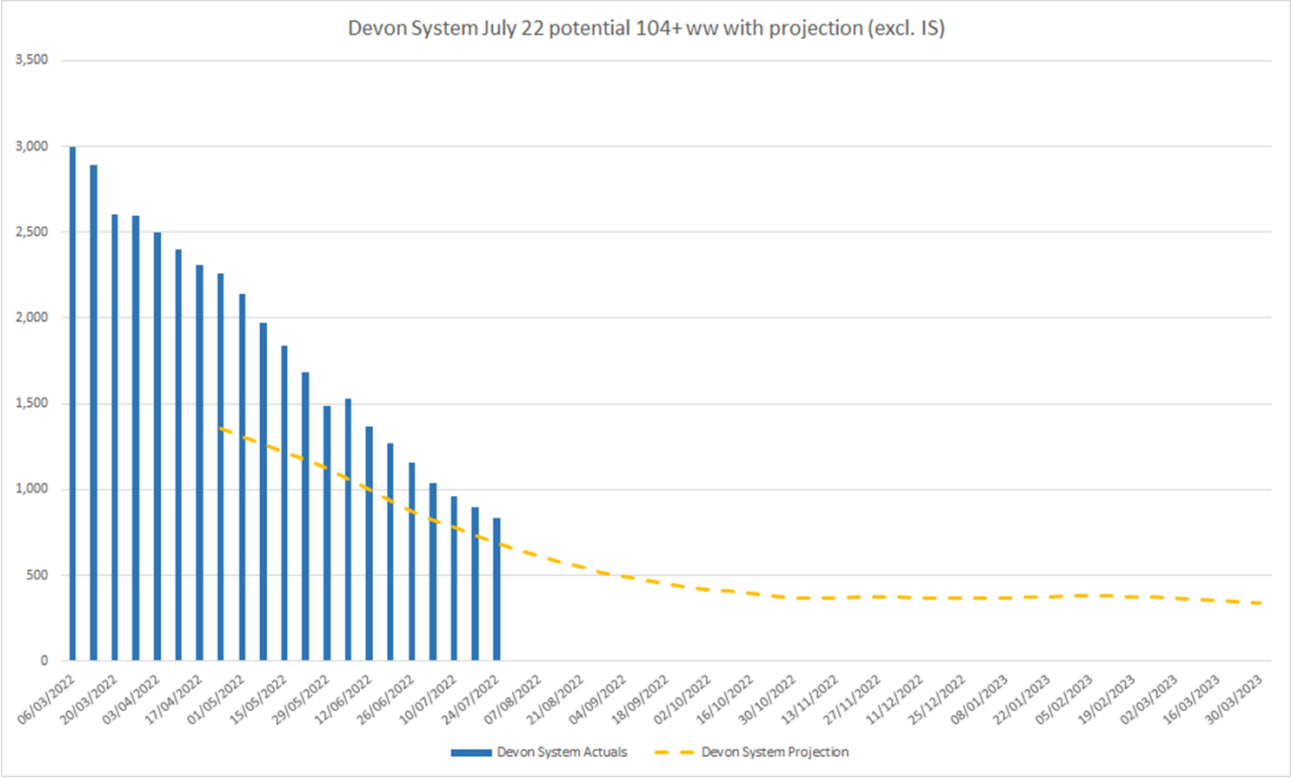
Actions for next month/s	Intended impact	Date impact will be realised
Continued recruitment and training of Emergency Medical Dispatchers	185 WTE trained call takers in place, 250 by September. Significant improvement in compliance with calls answered in 5 seconds.	September 2022.
UHP handover improvement plan refreshed following visit from Pauline Philip and Stephen Powis	No handovers >30 minutes at UHP	September 2022
Review of SWASFT system SI recommendations and action plan development around them	Reduce handover delays	On going
Refinement of Devon handover plans and trajectories, including implementing findings from SW thematic review and revised assumptions for trajectories	Significant reduction in average handover times	September-October 2022

Planned Care: 104 week waits

Theme: The number of patients waiting over 104 weeks for elective procedures and number of patients on waiting lists for surgery.

Underlying cause: Backlog in treatment of patients due to impact of pandemic and urgent and emergency care pressures on elective care capacity.

Actions undertaken in last month	Impact
The number of patients waiting 104+ weeks currently 1003 (167 patient reduction from last month). There is considerable system focus on managing this cohort. Mutual aid is in place with seven national providers. Acute providers continue to update plans for 104 ww position. As a system, there is a projected gap of 889 patients waiting above 104 weeks for the end of July 2022 (target of zero). NHSE continue to provide with mutual support.	**For all current, and planned actions:** An improved safety & quality position for patients, positively impacting other services e.g. Emergency Care, fewer patients will switch to urgent care pathways, due to wait time and deterioration of their condition, thus improving the ED patient experience; this impacts Primary care and SWASFT as condition deterioration causes greater demand.



Actions for next month/s	Intended impact	Date impact will be realised
Trusts continue to focus on reducing 104 week waiters to delivery July targets and review/monitoring of plans at specialty levels	Reduction of patients waiting over 104 weeks for treatment ensuring that further condition deterioration is avoided.	Impact each month
Cases of suboptimal experience monitored in various meetings e.g. 104ww check-in call between ICB and Providers to mitigate the patients Harm and suffering	To improve the service in the individual cases highlighted as poor quality and to implement mitigating actions	Impact each month
Work underway to form a One Devon Patient Tracking List	Focus on opportunities for increased productivity in 22/23	Impact by end of March 2023
Trusts are communicating with their long waiting patients to acknowledge and apologise for their wait for treatment	Patients will feel more supported giving them greater confidence in the system	Impact each month
Work with regional/national teams to identify mutual aid from outside of Devon and review any further opportunities within Devon.	Reduction of patients waiting over 104 weeks for treatment whilst ensuring that the patients are happy and safe to move provider through the validation process and phone calls to the patients.	Impact each month
Clear communication regarding the transport offer to patients taking up the Mutual Aid offer is being put in place. The offer of transport and accommodation has been extended to a relative or carer	This may encourage more patients to take up the offer and to ensure that they feel emotionally supported during the mutual aid process.	Impact each month
Continued patient validation exercise across all providers	Reduction in unnecessary waiting on the waiting lists. Reduction in waiting times for the patients remaining on the waiting list Contact support ensuring that patients continue to feel valued	Impact each month

Actions for next month/s	Intended impact	Date impact will be realised
Healthy Waiting initiatives have been adopted to optimise the patients on the waiting lists	To minimise the risk of deterioration of the patient's condition on the waiting list. To give patients more control over their condition whilst they wait.	Impact each month
The Planned care Board is reviewing the 78ww as a standing agenda item as well as the 104ww	This will focus attention on the potential to avoid a further wave of backlogged patients and extended waits. Further deterioration is avoided in patients asT the waiting time is reduced.	Impact each month

78 week waits: Patients within the 78ww cohort will continue to be a pressure on the system and this remains a challenge. The system is focusing attention on those patients who have waited the longest, outside of those requiring priority treatment. An ongoing process of patient validation is underway across all providers and is being coordinated through the system.

52 week waits: Capacity has been diverted from across all providers to assist in managing the longest waiting patients, namely all those who have been waiting over 78 weeks for their procedure. Clinical oversight and validation remain in place.

Planned Care: Protected Elective Capacity (PEC)

Theme: Lack of PEC for complex orthopaedic surgery in acute trusts.

Underlying cause: Pressure on all bed types and risk of protected beds being utilised for other specialty in-liers and non-ortho patients because of:

- Urgent and emergency non elective care pressures on elective (EL) care capacity.
- Backlog in treatment of patients due to impact of pandemic has led to an impact on hospital flow.
- Delayed transfer of care (DTOC) and social care constraints (plus pandemic) have impacted hospital flow

Impact: An increase in waiting and subsequent poor patient experience will result if elective capacity is not protected. Also, seen, and unseen physical harm. PEC will mitigate this risk.

104 Waiting Lists & Highest Priority elective care
RDUHT and Nightingale Exeter (NHE) have successfully opened their protected capacity on time and to plan. c.48 beds in total. NHE has seen their 340th patient, Nightingale has now moved to a 5 day week further plans to operationalise the Nightingale for Orthopaedics to more than the current 5 days a week is ongoing with a substantive ward and theatre staff, it has been challenging to full utilise this capacity due to UEC and COVID impacts of the surgical teams across the region. In terms of Ophthalmology, the 4 imaging lanes are now live which is having a real and positive impact on clearing the backlog of patients. The innovative Surgicube is due to be operational from August 8th delivering cataract surgery.

The Plymouth Royal Eye Infirmary scheme is progressing. Phase 2 has had issues in terms of building planning, however, planning permission has now been approved and this phase can move forward.

Delayed openings.
Jubilee ward in RDUH North opened at the beginning of June 2022 as a separate ring-fenced orthopaedic facility.

Actions undertaken in last month	Impact
Meeting of clinically led orthopaedic working group to confirm that plans are on track to deliver protected elective capacity at each site. Scheduled for the second week July 2022 to start the MSK and Orthopaedic workstream.	Improved governance. Agreement at Clinical Director/Specialty lead and NHS Devon Director level that the Ortho group should oversee all ortho restoration activity in Devon, not just complex ortho.
Each Trust has developed plans to protect beds for complex elective surgery and RD&E site went live with their 26 protected beds on 28th February. No further update though surge planning for Covid is now taking place.	Greater access to orthopaedic treatment for patients. • 104ww/highest priority elective care reduction. EL Protected beds are currently delivering ortho work, to the plan, in RDUH East and Nightingale Hospital Exeter (NHE) • Exec backing. CEO/Exec level agreement on the importance of ringfencing • Clinical leadership. Agreement across all clinical leads in the 4 major Trusts that EL protected beds must only be used for orthopaedic patients
Nightingale is on a 5 day week, Mon -Fri with ad hoc additional weekend sessions.	The increase in session capacity will reduce the outstanding treatment delays quicker, reducing the potential for patients to suffer physically and psychologically
Quality Impact Assessment completed and submitted to Devon clinical leads for ortho	Clinical assurance on the rigor of the operational plan ensures that patients are treated equally and fairly

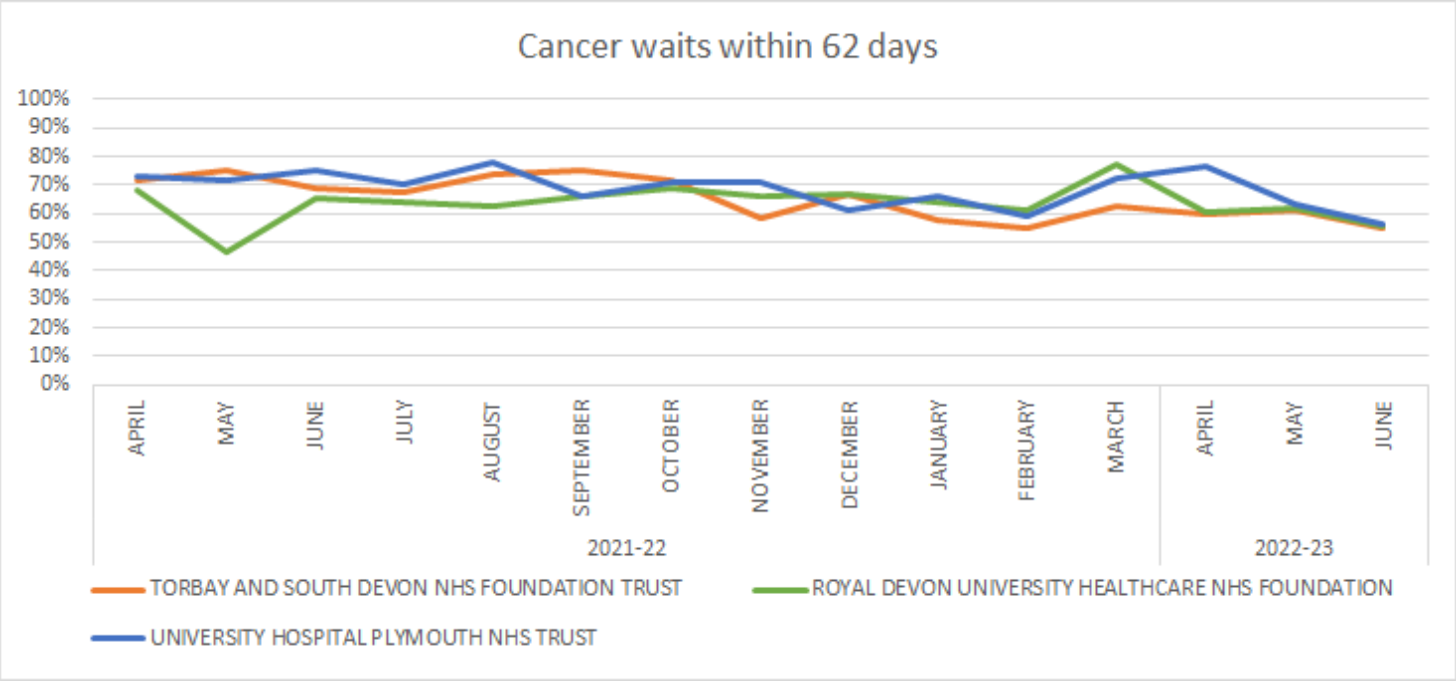
Cancer Performance 62 Day Standard

Theme: Failure to achieve statutory performance standard due to staff and physical space shortages, competing with urgent care pressures for general resources. Performance in June 2022 was 56% against an 85% standard.

Underlying cause: Existing problems alongside impacts of covid and impact of prevalence on both staff and patients. Increased 2ww demand continues (139% - compared to the same period in 2019/20) to increase due to public health awareness campaigns and restoration of screening services. The majority of the 62 day breaches are in the urology and colorectal pathways due to capacity constraints.

Impact: Numbers of patients are not receiving a confirmed diagnosis and starting treatment within 62 days.

62 Day (urgent) (85%)



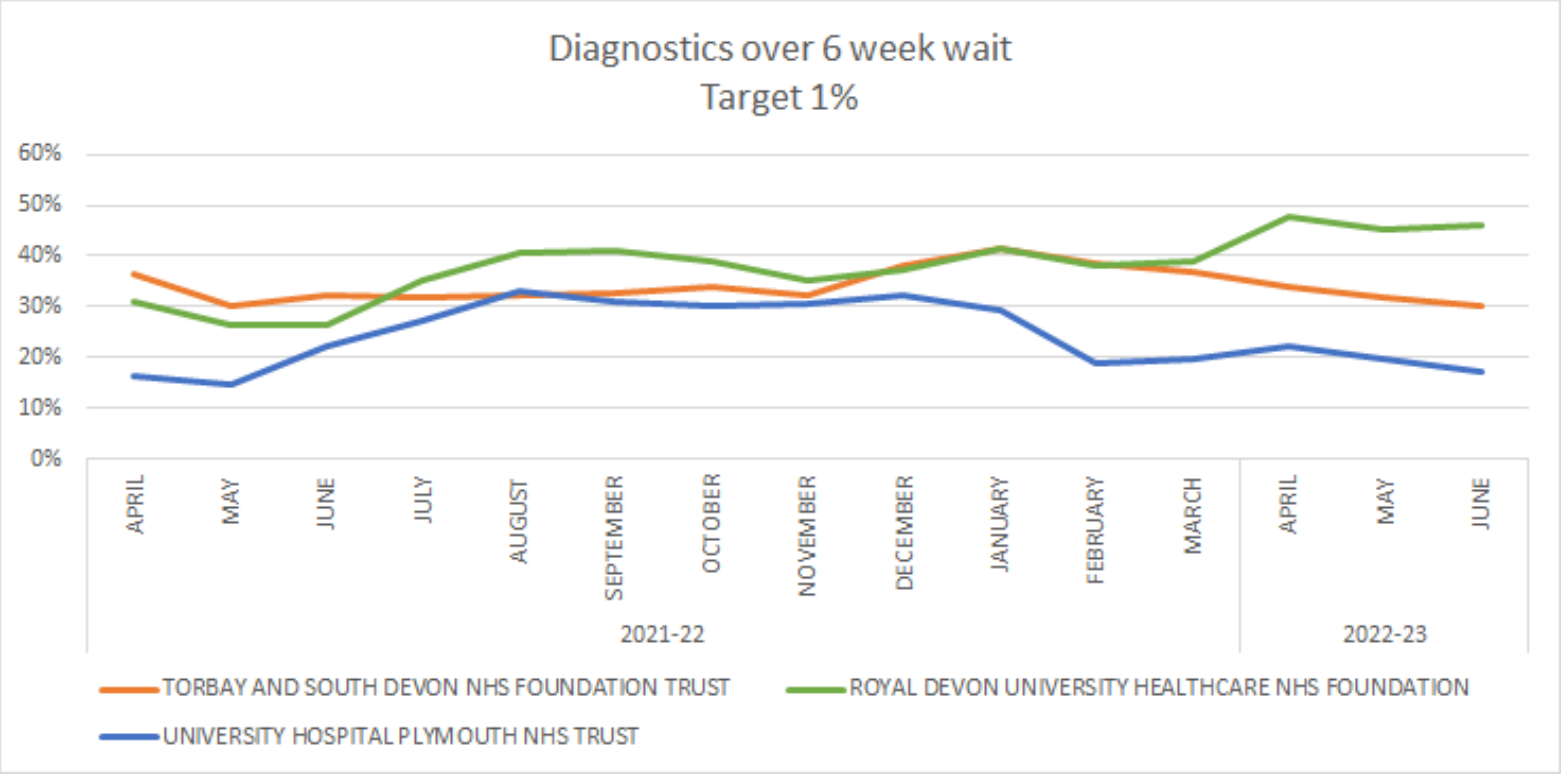
Actions undertaken in last month	Impact
Trusts determined use of Cancer Alliance funding returned MoUs to Cancer Alliance for approval.	Reduction in 62 day breaches and achievement of national cancer strategy objectives.
Ongoing support and monitoring of Trust cancer recovery plans. Identifying opportunities for further recovery.	Reduction in 62 day breaches and achievement of national cancer strategy objectives.

Actions for next month	Intended impact	Date impact will be realised
Development of plans for increasing capacity for Trans Perineal biopsies across the ICS	Reducing the number of 62 day breaches on the prostate cancer pathway.	Tbc when capacity finalised.
Work with NHSE to assign the funding from the decommissioned bowel scope program into capacity to support RDUH in delivery of additional endoscopy capacity.	Reduce the delays on the colorectal cancer pathway due to lack of colonoscopy capacity.	Tbc when capacity finalised.
Development of endoscopist training program with regional support.	Development of additional clinical endoscopist capacity for 2023/24. The training lists will use patients on existing waiting lists so will generate additional capacity from September 22.	Tbc when program agreed.

Planned Care: Diagnostics

Theme: Statutory performance target for Diagnostics not met. June 22 performance was 36% against a 1% target.

Underlying cause: Impacts of covid increasing inpatient and urgent care activity. Previous infection prevention measures constraints reducing capacity which developed longer waiting lists. All sites are struggling for capacity across all the 15 modalities



Recovery plans determined as part of 2022/23 operational planning process.

- Delivery of 120% of 2019/20 activity.
- Diagnostic standard to be at 75% within 6 weeks by end March 2023.
- No 26ww by end March 2023.

Actions undertaken in last month	Impact
Commissioning of mobile endoscopy unit at TSDFT	To be commissioned and in use by September to support recovery and mitigate impacts of works to develop additional endoscopy capacity from January 23.
Reviewing utilisation of Exeter CDC imaging capacity. Meeting with IS provider of radiography staff resulted in an increase in activity through administrative rearrangement of lists. TSDFT revising their use of capacity to release back for other providers to use. Costings for seven day operations complete for if /when required.	Ensure all available capacity is being used across the ICS and appraise opportunities for seven day operations and assess the potential cost and impact.

Actions for next month/s	Intended impact	Date impact will be realised
Development of endoscopy capacity building planning following successful bids for capital from NHSE. Capital allocated to TSDFT for development to be completed in 22/23 and 'seed funding' to start development at UHP.	To address levelling up gap and regain Joint Advisory Group accreditation. Schemes must deliver in 22/23.	March 23

Complete and submit business cases for capital funding for endoscopy development at RDUHT and completion works at UHP.	To address levelling up gap and regain Joint Advisory Group accreditation.	March 23 for UHP March 24 for RDUHT
Procure additional Non-Obstetric Ultrasound capacity through the Increasing Capacity Framework to support UHP & RDUHT North with waiting list clearance.	To commission c 5000 scans at the acute sites to reduce waiting lists that have been increasing due to unforeseen long term staff sickness.	TBC

Community Services/Care Homes

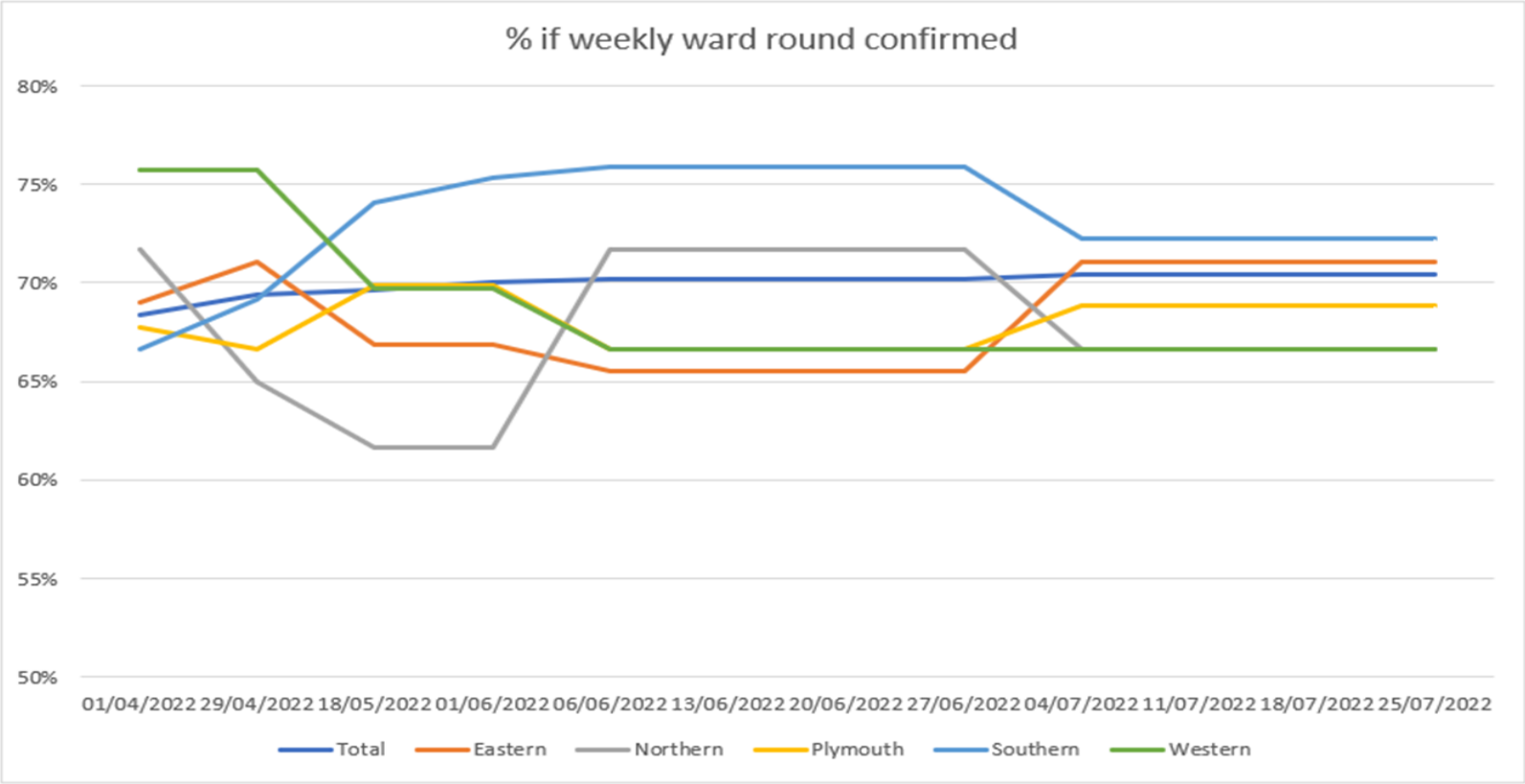
Theme: Within the Enhanced Health in Care Homes Framework there is a requirement for:

- Residents to receive weekly clinical reviews & care homes to report completion of these within the national capacity tracker.
- Early identification of deteriorating residents using RESTORE2. Implementation of training and use of RESTORE2 has been delayed as an impact of COVID

There is a potential risk to safety for care home residents who are not receiving weekly clinical reviews or where early identification of a deteriorating resident's condition is not actioned by care staff. In addition, the care staff will not benefit from the learning and upskilling that the use of RESTORE2 brings.

The chart below shows minimal change in the number of care homes reporting receipt of weekly clinical reviews over the last 4 weeks indicating that homes are not updating the capacity tracker.

Underlying cause: Care homes self-report receiving weekly clinical reviews for residents using the national capacity tracker (CT) however, frequency of updating the information relies on care homes completing and this has been variable. There is no alternative data reporting method available.


% if weekly ward round confirmed
80%
75%
70%
65%
60%
55%
50%
01/04/2022
29/04/2022
18/05/2022
01/06/2022
06/06/2022
13/06/2022
20/06/2022
27/06/2022
04/07/2022
11/07/2022
18/07/2022
25/07/2022
Total
Eastern
Northern
Plymouth
Southern
Western

<table>
<tr><th>Actions undertaken in last month</th><th>Impact</th></tr>
<tr><td>Review of capacity tracker reporting to:
Identify which homes are not reporting weekly clinical reviews understand if these homes are receiving weekly clinical reviews for residents.

Number of Homes consistently reporting 'No' to receiving a weekly ward round:

<table>
<tr><th></th><th>04/07/2022</th><th>11/07/2022</th><th>18/07/2022</th><th>25/07/2022</th></tr>
<tr><td>Total</td><td>64</td><td>64</td><td>63</td><td>66</td></tr>
<tr><td>Eastern</td><td>18</td><td>18</td><td>18</td><td>22</td></tr>
<tr><td>Northern</td><td>9</td><td>9</td><td>9</td><td>3</td></tr>
<tr><td>Plymouth</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Southern</td><td>18</td><td>18</td><td>17</td><td>18</td></tr>
<tr><td>Western</td><td>18</td><td>18</td><td>18</td><td>22</td></tr>
</table>
</td><td>To understand variation in self reporting by care homes and identify those care homes that are not updating CT regularly.
Enable locality commissioners to target those homes not reporting to establish if weekly clinical reviews are in place.

Increase the number of homes updating the tracker
Enable targeting communications of PCN’s that have not undertaken weekly clinical reviews.</td></tr>
<tr><td>Monthly RESTORE2 training dashboard reviewed by Strategic Enhanced Health in Care Home Group.</td><td>Oversight of progress against training trajectories for care homes and GP practices.</td></tr>
</table>

Actions for next month/s	Intended impact	Date impact will be realised
Locality commissioning leads for Enhanced Health in Care Home (EHCH) to review those homes within their locality and identify PCN/practices linked to these homes. Liaise with local social care colleagues to plan joint communications to care homes.	Identify key areas to target proactive communications	End of Q3

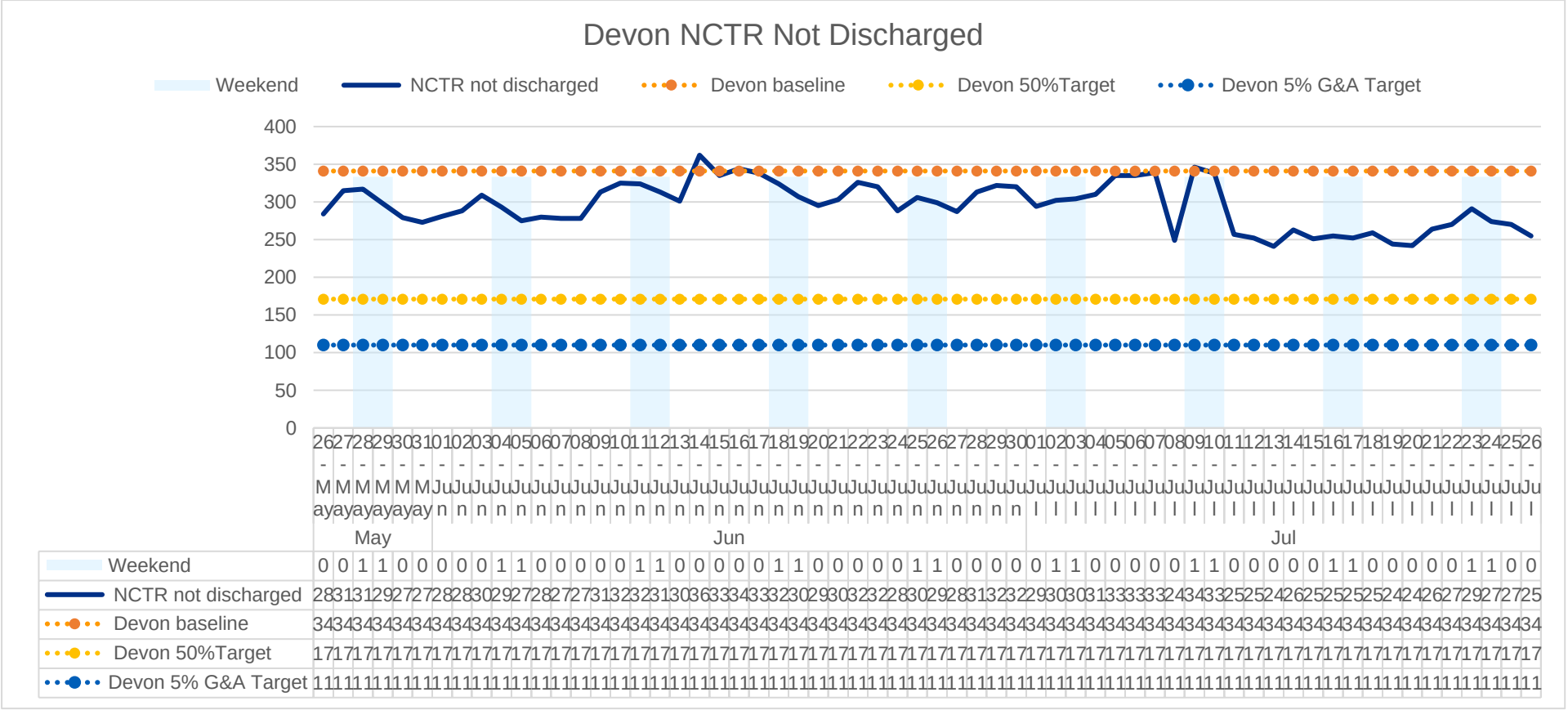
Hospital Discharge

Theme:
NHS England nationally set a requirement for all systems to reduce the number of individuals with No Clinical Criteria to Reside by 50% by 31/3/22, and additionally we have locally agreed a target of reducing NCTR by 5% of GA beds. The Devon System is yet to meet either target and continues to track the baseline.

In addition to the risk of deconditioning and infection for the patients remaining in hospital when able to leave, there is impact on other areas of the System and pathways; patients in ED wait in excess of 4 and 12 hours when waiting for a ward bed to become available, whilst ambulances are unable to hand over their patients to ED staff. Patients waiting for these ambulances, often very sick at home, are left waiting extended periods and at risk of harm.

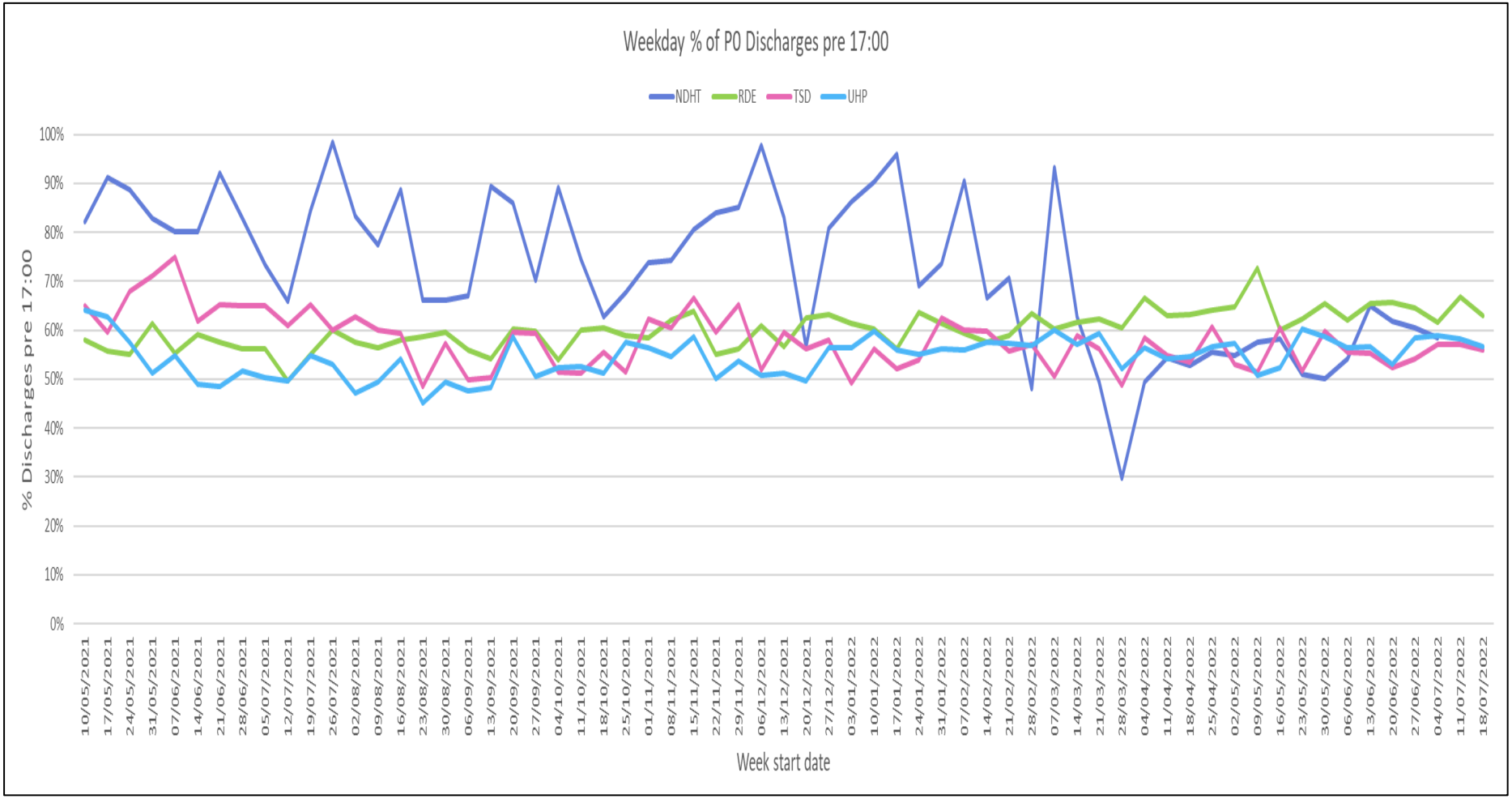
Underlying cause:

- Challenges in capacity to support individuals as a result of continued pressures across the system
- Market resilience and sufficient staffing resource
- Time of discharge – high proportion of discharges (simple and complex) continue to take place after 5pm – impacting on flow



	26-May	27-May	28-May	29-May	30-May	31-May	01-Jun	02-Jun	03-Jun	04-Jun	05-Jun	06-Jun	07-Jun	08-Jun	09-Jun	10-Jun	11-Jun	12-Jun	13-Jun	14-Jun	15-Jun	16-Jun	17-Jun	18-Jun	19-Jun	20-Jun	21-Jun	22-Jun	23-Jun	24-Jun	25-Jun	26-Jun	27-Jun	28-Jun	29-Jun	30-Jun	01-Jul	02-Jul	03-Jul	04-Jul	05-Jul	06-Jul	07-Jul	08-Jul	09-Jul	10-Jul	11-Jul	12-Jul	13-Jul	14-Jul	15-Jul	16-Jul	17-Jul	18-Jul	19-Jul	20-Jul	21-Jul	22-Jul	23-Jul	24-Jul	25-Jul	26-Jul
Weekend	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0
NCTR not discharged	283	313	312	292	272	272	282	283	302	292	272	282	272	273	313	232	313	303	633	343	332	302	293	303	232	283	302	928	313	232	293	303	313	333	333	324	343	325	252	524	262	525	252	524	242	626	272	927	272	725										
Devon baseline	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343	343										
Devon 50%Target	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171										
Devon 5% G&A Target	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111	111										

NB – Due to the implementation of EPIC the RDU – North data is not reflected in the above and has not been included since 10th July 2022. Inclusion of these numbers would take the Devon data to the Devon baseline


Weekday % of PO Discharges pre 17:00
NDHT
RDE
TSD
UHP
% Discharges pre 17:00
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10/05/2021
17/05/2021
24/05/2021
31/05/2021
07/06/2021
14/06/2021
21/06/2021
28/06/2021
05/07/2021
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25/04/2022
02/05/2022
09/05/2022
16/05/2022
23/05/2022
30/05/2022
06/06/2022
13/06/2022
20/06/2022
27/06/2022
04/07/2022
11/07/2022
18/07/2022
Week start date

Actions undertaken in last month	Impact
Launch of National Hospital Discharge 100 Day Challenge – this includes 10 interventions that have been identified as key enablers to improving discharge activity	Each locality has self-assessed against these interventions in order to identify current application within each trust. This is now being reviewed to a) determine an ICB positions b) develop a clear action plan with timeframe for implementation
Development of 'Help Me Home For Lunch' scheme with ward based champions & Criteria Led Discharge	Clear approach to discharging earlier in the day, freeing capacity by 12pm to support flow across the trust. Plans have been developed and continue to be monitored through System Flow calls.

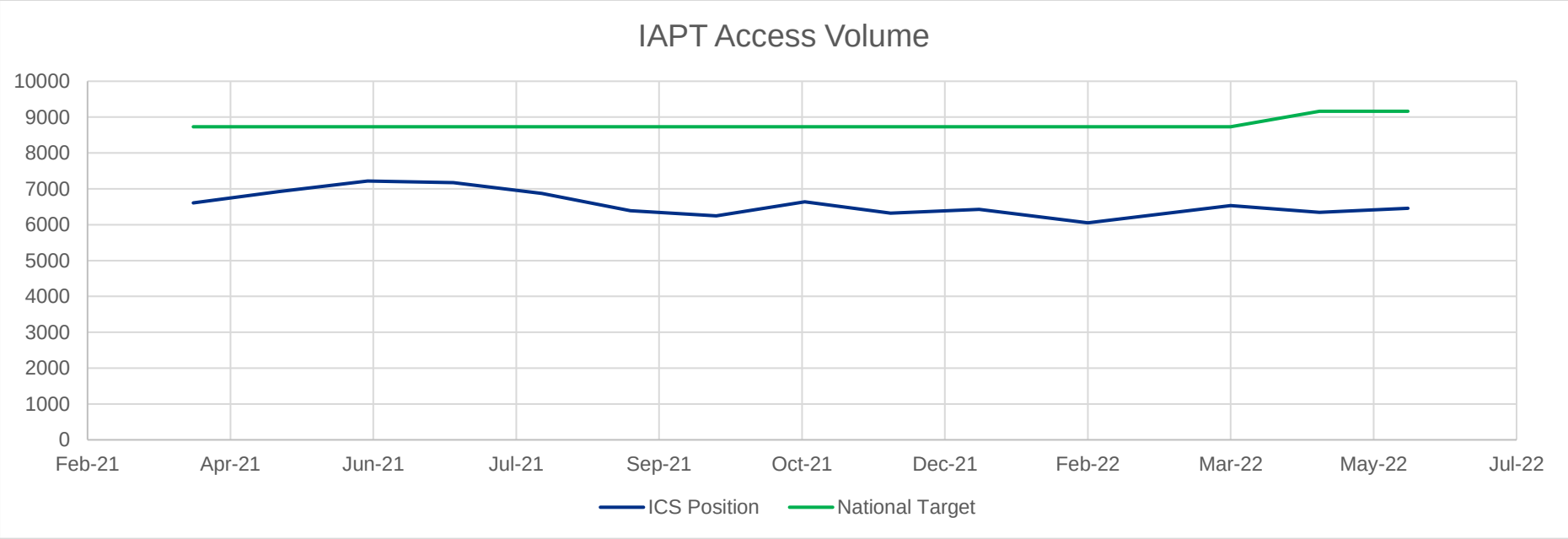
Actions for next month/s	Intended impact	Date impact will be realised
Delivery of Pathway 2 commissioning review underpinned by Demand & Capacity Modelling at a system and LCP level	Clear consistent model for delivery of Pathway 2 service across Devon, consistent outcomes and resource understanding. Sufficiency of capacity to meet current and predicted need.	Commissioning Review to be concluded with implementation plan by September 2022.
Completion of Demand & Capacity Modelling – utilising initial work at a System Level to refine and determine accurate projections of demand for each locality underpinned by a clear action plan.	Development of locality action plan to identify improvement plans to mitigate capacity gap through; pathway optimisation, reduce LoS and appropriate capacity creation	Targeted discussions to refine gap analysis throughout August. Plans to be completed and in delivery September 2022

Mental Health: IAPT Access Volumes

Theme: IAPT Access Volumes
This indicator tracks the national ambition to expand Improving Access to Psychological Therapies (IAPT) services and counts the number of people who receive IAPT in the quarter. This is compared to the ICS Devon requirements set by NHS England and Improvement.

Underlying cause: Access is lower than expected, due to decreased referrals (also observed regionally and nationally).

Data:
National Target for ICS Devon: 9,163 people- updated national target in 2022/23
Local Q1 trajectory for ICS Devon: 6,768 people
Performance in ICS Devon: 6,459 people



Impact: There is evidence to suggest that whilst demand for these services has decreased, need has increased. This means people are less likely to be accessing appropriate support, care and treatment early in the development of a need. Delayed access to treatment can increase intensity of the response needed and reduce the benefit.

Actions undertaken in last month	Impact
In ICS Devon we continue to: • Augment the national promotion of IAPT • Maintain prioritised access for key workers • Target promotion to meet need and address inequalities • Work with primary care/ LCPs to promote referrals Using referral data by GP practice, TALKWORKS, are able to promote the service in a targeted manner. • TALKWORKS launched their professionals referral form online. • Q1 paid marketing for older adults • BAME (Black Asian and Minority Ethnic) data monitored and analysed – equity of access. • Devon Psychological System Review (DPSR) has been initiated and an engagement plan put forward to the Community Mental Health Framework (CMHF) Core Group, DPSR Steering Group and Associated Stakeholders for agreement	The impact of local and national promotion activities should be to increase access to the IAPT service. 2022/23 Q1: NHS Devon has identified achievement of the quarter one local trajectory for IAPT access. The review, of which IAPT is a part, aims to identify the need, good practice, areas for development, duplications and gaps in order to inform recommendations in local Psychological Services.

Actions for next month/s	Intended impact	Date impact will be realised
Marketing and Promotion: Implement the IAPT equality deliverable through targeted marketing towards people from BAME communities and older people. **Promotion in Primary Care** Use PCN level analysis of need and referral to target. Further progress and completion of the Devon Psychological System Review	**Marketing and Promotion:** Equitable access, outcomes and experiences for people from BAME communities and older people. **Promotion in Primary Care** Reduced unwarranted variation in referral across primary care. Increased primary care referrals measured through utilisation of webpage functionality. The review will inform recommendations for Devon Psychological services	**Marketing and Promotion** BAME- improved equity of access rates and paired outcomes- end of Q1 Older People- Q3. **Promotion in Primary Care** Review start Q2 Recommendations presented to VCSE (Voluntary, Charitable, Social Enterprise) and CMHF (Community Mental Health Framework) Boards October 2022

Mental Health: CYP Eating Disorders

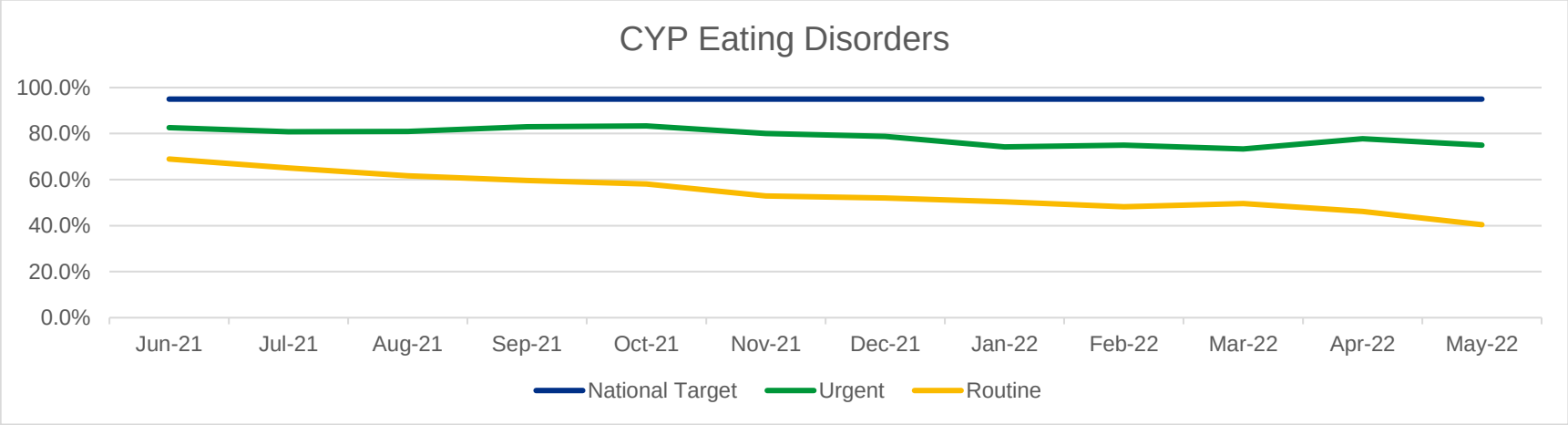
Theme: Urgent and Routine Referral to Treatment Waiting Times for CYP with an eating disorder

These indicators demonstrate performance against the national standards for these services which are part of the Long-Term Plan. The focus is on improved access and on effective treatment at the earliest opportunity in order to improve outcomes, reduce rates of relapse and need for admission.

Underlying cause: There has been increased longitudinal demand (prior to and due to COVID) and average acuity of need at the time of referral has increased. These are also nationally observed trends.

Data: Urgent Access RTT (7 days)
National Target: 95%
Current Performance: 75% (May 2022)
Local Q1 Target: 85.7%
Trend: Variable, over 12 months. Trajectory for achieving target percentage rate is Q3 2022/23.

Data: Routine Access RTT
National Target: 95.0%
Current Performance: 40.41% (May 2022)
Local Q1 Target: 46%
Trend: Deteriorating, resource prioritised to respond to urgent referrals. Improvement against the rolling 12 month national target will be gradual, current trajectory for achievement is for Q4 2022/23.



Impact: Eating disorders are serious mental health problems which can have severe psychological, physical and social consequences; prompt access to evidence-based, high-quality care and support can improve recovery rates, lead to fewer relapses and reduce the need for inpatient admissions.

Actions undertaken in last month	Impact
An improvement plan is in place which includes recruitment, waiting list reviews, enhanced flow and earlier intervention, reducing longer treatment episodes. Additional investment has enabled recruitment of 10.5WTE in a variety of roles; 8.0WTE are in recruitment and recruitment to 2.5WTE posts is delayed because of the CFHD consultation.	To increase service capacity to enable continuous increase in performance against the CYP eating disorder wait time standards for urgent and routine access. Access is expected to improve from the end of Q1. Achievement of CYP eating disorders routine wait time standard (4 week RTT) is expected by the end of Q3 22-23; the urgent standard (1 week RTT) is expected by the end of Q4 22/23.
Mutual support to maximise capacity is being explored.	To increase resilience of service capacity.
Policy is in place to manage access and waits to services, with service specific protocols such as the Keeping Children Safe protocol. Recommendation to audit waiting and access policy. Teams are working with families to ensuring that preparatory work is undertaken, and support is provided whilst people wait.	CYP and families are supported to be safe whilst waiting and are ready to engage. To provide assurance that policy and protocol is meeting intended purpose to safely manage long waits.

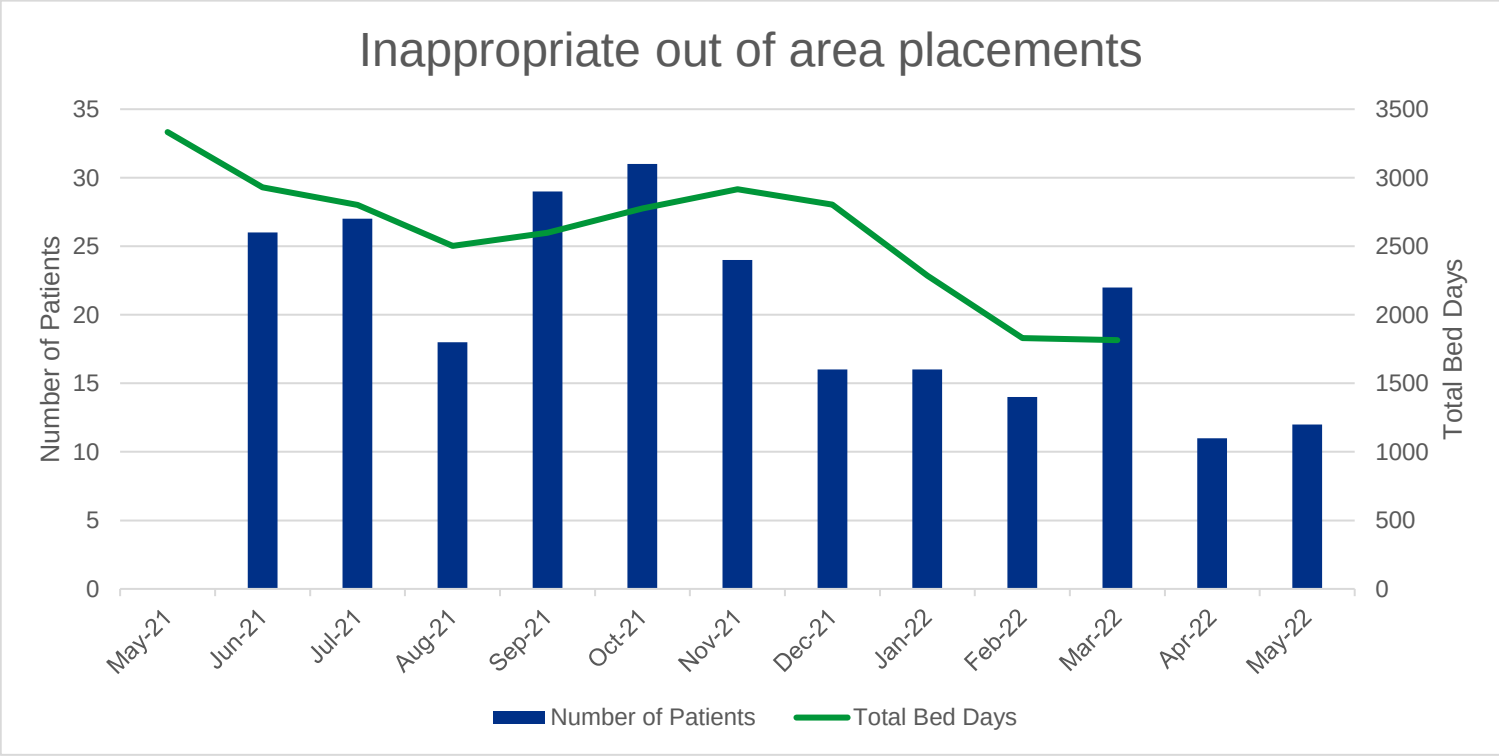
Actions for next month/s	Intended impact	Date impact will be realised
Continuation of the above actions.	As above.	Trajectory targets: Urgent: Q3 2022-23 Routine: Q4 2022-23
Scoping the ARFID (Avoidant Restrictive Food Intake Disorder) pathway. Review local demand and trends to map against national evidence to consider future sustainable development.	Met needs of children and young people. Sustainability of the eating disorder pathway.	Q4 2022-23.
ICB Harm profiling for planned care to include CYP	To understand direct and indirect harm, and the impact on outcomes, for patients waiting for assessment and/or treatment.	October 2022.

Mental Health: Out of Area Placements

Theme: Number of inappropriate out of area placements
The number of people placed out of area inappropriately for acute mental health inpatient care at the end of each month.

Underlying cause: The Devon System has a historical challenge in relation to performance against this metric. This is in part because the volume of bed-based provision for acute mental health in Devon is below the national average. Occupancy rates for inpatient mental health care remain high.

Data: National Target: 0. Current Performance: 12 patient (May 2022), 1815 bed days (March 2022).



Impact: Inappropriate out of area placements are where patients are sent out of area because no bed is available for them locally. This type of placement dislocates them from their friends, families and community and the local health and social care support, care and treatment. Overall, this can delay their recovery, resulting in increased length of stay and reduced long-term outcomes.

Actions undertaken in last month	Impact
Maintaining utilisation of external provision (Elysium) to increase bed based capacity.	Continue planned reduction in inappropriate out of area placements.
Progress on building transfer for Salus Ward, new 16 bed acute ward. Estate transfer scheduled to complete at the end of July.	Additional beds for patients in Torbay. Delay results in continued private contract with Cygnet.
Pilot for 2 step down flats with Elysium Healthcare, completed. Discontinued.	Discontinued due to insufficient impact on patient flow.
Ocean view (rehabilitation ward in Barnstaple) fully operational and running at full capacity.	Additional beds and service for patients in North Devon.

Actions for next month/s	Intended impact	Date impact will be realised
Continued mobilisation for Salus Ward	Additional capacity in system and reduction in procured out of area/private provider beds.	End of Q2 2022-23.
Implement the model ward/locality in South Devon.	Improved therapeutic experience and increased efficiency.	End of Q4 2022-23.

LMNS (Local Maternity and Neonatal System) update

Summary:
Insight visits ongoing until September 2022
Awaiting feedback on LMNS Continuity of Carer Plans (no date provided)
Continued Development of Equity & Equality plan
Wholesale review and refresh of LMNS programme, prioritising governance and reporting in July & August 2022.

Actions undertaken in last month (July 2022)	Impact
1. Equity & Equality engagement workshop undertaken with professionals (18th July 2022). 2. Revision of Pelvic Health Bid submission, working with stakeholders to design an affordable system wide service. 3. Torbay and South Devon NHS FT (TSD) Insight Visit (28th July 2022). 4. Applicants received for Safety & Quality Lead Midwife. 5. No applicants received for Neonatal Lead. 6. Prioritisation of Devon Dashboard development. 7. University Hospitals Plymouth NHS Trust (UHP) Insight visit report completed. IEA (Immediate and Essential Actions) 7 Informed Consent remains partially compliant. 8. All Trusts are undertaking recruitment in line with midwifery staffing establishment plans.	1. Priority areas as perceived by professionals identified as access to information (including in non-English languages), socioeconomic deprivation & rural deprivation 2. Opportunity to receive £119k of funding for Devon for 2022/23 and £238k for 2023/24 3. Updated Ockenden compliance position for TSD, enabling agreement of onward actions 4. Increased capacity within the LMNS to monitor safety and quality in Trusts 5. Delay to planned increased strategic alignment between neonatal critical care activities and LMNS 6. Improved data access and quality at system level 7. Action plan to be put in place to ensure that UHP is compliant with Ockenden IEA7 8. Increase in midwifery staffing establishment to reduce workforce shortfall

Actions for next month (August 2022)	Intended impact
1. Equity & Equality engagement workshop planned with women & families (8th August 2022) 2. Scoping Digital Maturity Assessment and Trust based maternity digital strategies for alignment within LMNS Digital Strategy (Submission October 2022) 3. Development of LMNS Equity & Equality Plan (Submission September 2022) 4. Ongoing revision of LMNS programme plan & structure 5. Focus on development of Workforce plans including Health Education England Maternity Support Worker (MSW) competency framework 6. Ensure that the LMNS has oversight of exception reports/ joint reviews on babies born <27 weeks in a centre without a Neonatal Intensive Care Unit 7. Review Trust engagement in maternal medicine network activities 8. Ensure Trust dashboards are submitted monthly to the LMNS Safety & Governance Group.	1. Information gathering on sources of inequality as perceived by service users, enabling development of equity plans (Submission Sept 2022) 2. Consistent system wide digital strategy for maternity (Submission October 2022) 3. Reducing inequalities and safety of maternity and neonatal care (Plan 2022-2027) 4. Improved LMNS Function & quality of outputs, improved reporting of progress (by December 2022) 5. Improved career pathway and retention of MSWs (December 2022) 6. Improved LMNS oversight of 'born in the right place' ambitions 7. Improved LMNS oversight of Maternal Medicine Network implementation. 8. Improved oversight of Trust performance and compliance with Ockenden actions

Risk/Issue	Impact	Mitigation
1. RISK: Devon wide maternity data sources continue to be of poor quality.	1. Inability to provide data-based reporting across all aspects of the programme (transformational and quality) may impact ability to accurately report on programme progress, quality and safety as required by NHSE'	1. Urgent action to be taken on development of LMNS dashboard and improving accuracy of Maternity Services Data Set data reported within Trusts.
2. ISSUE: As of 1st August 2022 Bristol Hospital will withdraw provision of perinatal pathology	2. Trusts have no provision for specialist perinatal pathologist to undertake perinatal post-mortems and placental histology. Placental histology by specialist pathologist is a requirement of the perinatal mortality review tool reviews and Health Safety Investigation Branch recommendations	2. NHSE have established a buddy system between units with and units without a specialist perinatal pathologist to deliver post-mortem provision. This does not apply to perinatal histopathology (placental histology)

Progress against National targets (under development)

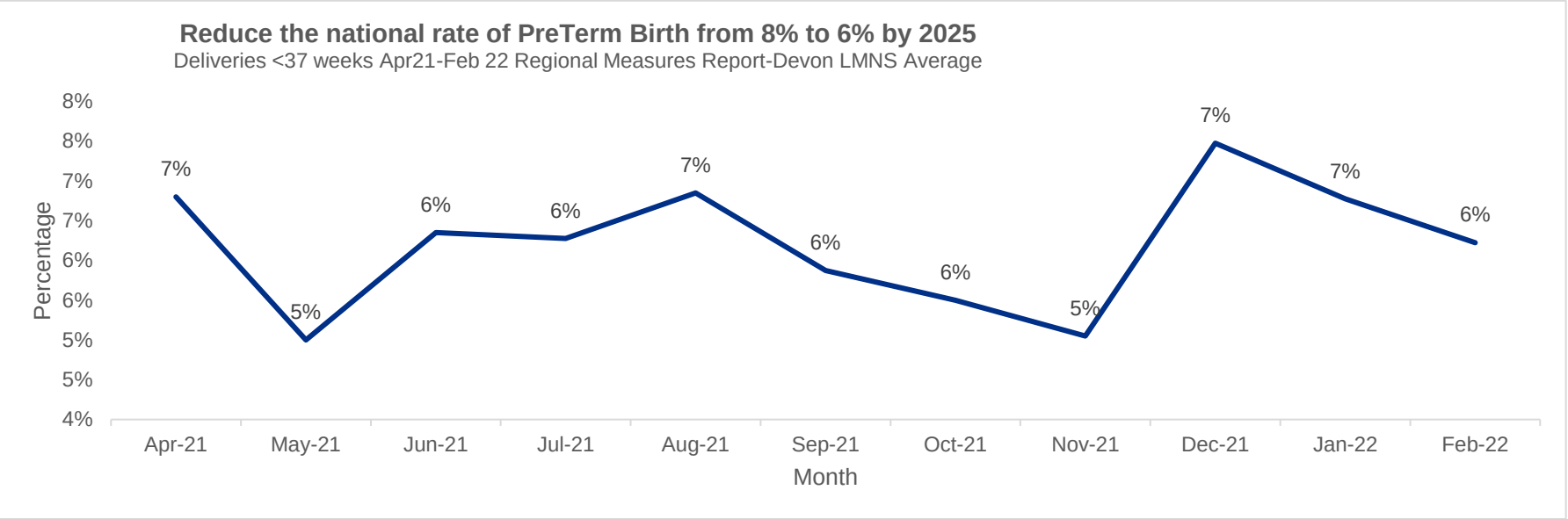


Figure 1: Preterm Birth Rates
Preterm birth rates (%) across Devon are on average +/- 1% the national target of 6% by 2025. At Trust level, preterm birth rates range from 3%-11% in individual months.

Actions to reduce preterm birth include implementation of preterm birth clinics in line with Saving Babies Lives Care Bundles version 2.

Preterm Birth Clinics have been implemented in all 3 Trusts, but not on all 4 sites. RDUHT North does not have sufficient numbers to launch a full clinic, however all women at high risk are seen by Maternal and Fetal medicine consultants.

Funding will be transferred to providers in August 2022 to support implementation of preterm birth clinical pathways. It is likely that this will be used to fund equipment.

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

- A re-inspection of **Devon SEND Local Area** provision by Ofsted and Care Quality Commission (CQC) was undertaken between 23rd- 25th May 2022. The visit was to determine whether the Local Area has made sufficient progress in addressing the 4 areas of weakness identified during the previous inspection in December 2018: The inspection found that, none of the significant weaknesses have improved.
- We are proactively working across the Devon Local Area by working on the Rapid Improvement Plan with the Parent Carer Forum. The plans will align to the Neurodiversity Game Changer LTP Programme and will triangulate with the recommended actions from the Children's Services Review.
- The level of intervention is yet to be confirmed, there are ongoing discussions with Department for Education and NHS England (NHSE).

- The **Plymouth Local Area** was inspected in 2016 they were not issued with a Written Statement of Action. An inspection, under the new framework, is anticipated for the autumn term. In anticipation of the inspection there are plans to learn from Devon and Torbay areas of focus.

- Following the **Torbay SEND Local Area** joint Ofsted and CQC inspection, progress is on track with respective to key milestones identified in the Written Statement of Action.

- The learning and key themes across the Devon ICB have been identified these are informing SEND plans. The development of partnership arrangements is an enabler to the pace and effective of change programmes.

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

Summary: CYP in Devon and Torbay are having to wait longer than 3-months to receive an Autism diagnosis (NICE guidelines). Currently in June there are 2402 CYP, over 5 years old, in Devon and Torbay are waiting for an Autism assessment from Children and Families Health Devon (CFHD). (See Figure 1).

Underlying cause	Impact
1. There is insufficient capacity to process referrals and assess CYP in a sustainable manner. This is impacted by: •Vacancies and recruitment challenges for key clinical roles. •Sickness and long-term absences. 2. Historical backlog and increase in number of referrals during covid (See Figure 2). 3. A complex pathway delivered by multiple services; bottlenecks arise with children awaiting diagnoses.	• CYP are not able to access support and intervention they need to help them achieve their full potential. • Potential for increase cause to CYP of emotional distress and crisis. • Increased risk of family breakdown.

Figure 1 - Children over 5 yrs waiting for autism diagnosis Devon (Excl. Plymouth) June 2021 - June 2022

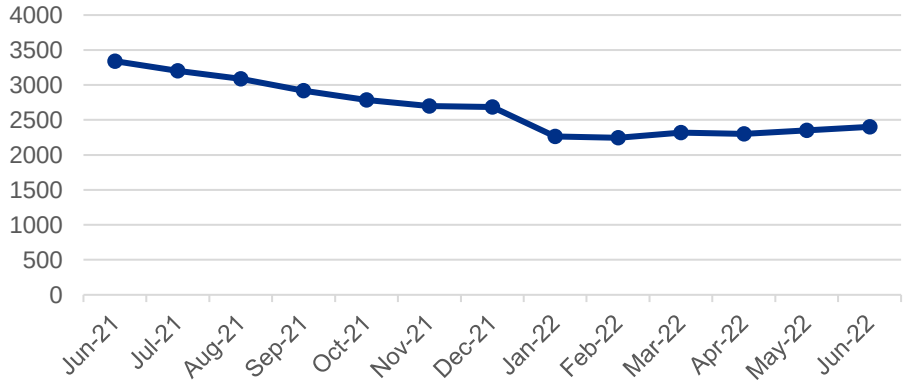
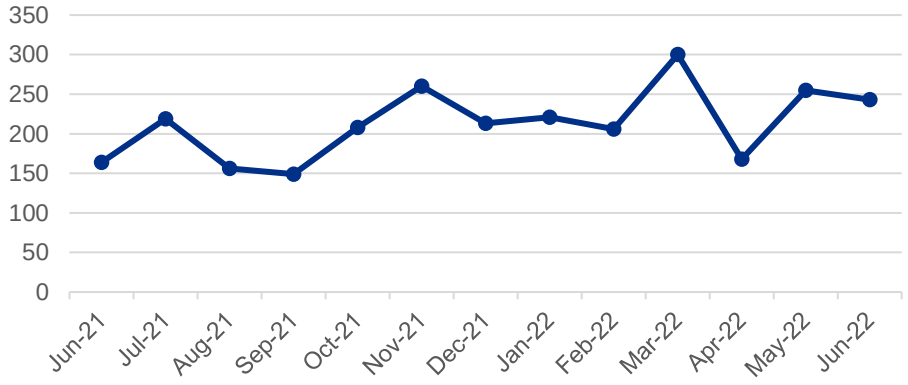


Figure 2 - Autism referrals received in Devon (Excl. Plymouth) June 2021 - June 2022



Children & Young People (CYP): Autism Diagnosis & Neurodiversity LTP Programme

Summary:

- There is insufficient capacity to process referrals and assess children in a sustainable manner and achieve waiting list recovery. This is in addition to a historical backlog as well as an increase in referrals. Referrals and the number waiting is increasing again, this is linked to the ongoing workforce pressures and more complex cases. The provider continues with the recruitment drive with plans for clinical and leadership capacity improvements in Winter 2022.
- The current pathway drives the need for a diagnosis to be able to access support causing; a high number referrals, bottle neck in health services and delays in accessing support from health, education and care services. This will be addressed through the Neurodiversity Transformation programme.
- Data quality and deficit issues, commissioners and the providers are working to improve the data quality and reporting, consistency and monitoring.
- There are known inequalities and problems of fragmentation within the current Autism and Neurodiversity pathways, improvements require large scale and transformational change.

Actions undertaken in last month:

Actions undertaken in last month	Impact
• In line with the Data mapping and Outcomes Framework project timetable, planned meeting held between ICB, CFHD and LSW to review and confirm Autism data and criteria. Further work planned as part of wider Outcomes Framework review work. • Children and Families Health Devon (CFHD) ASD workforce have extended contracts for agency staff in virtual team to end of November 2022. • Outcome of CFHD consultation and impact on staff roles and teams yet to be confirmed by provider. • Develop options to address the non-complex ADHD pathway issues and variation in North Devon for ADHD. • CYP Learning Disability and Autism Programme (LDAP) subgroup has been repurposed and launched as the Neurodiversity Transformation Steering Group.	• Accurate monitoring of need, demand, delivery and performance across ICB. • Neurodiversity assessment pathway ensures timely assessment and diagnosis. • Reliable data and agreed trajectory/action plan ensuring pathway is in accordance with NICE guidance. • Support & commitment from key stakeholders for the Neurodiversity pathway transformation.

Children & Young People (CYP): Autism Diagnosis & Neurodiversity LTP Programme (Cont.)

Actions for next month/s	Intended impact	Date impact will be realised
Data request to Paediatric Service providers to explain pathway assessment waiting times for CYP (0-18 yrs.)	Better understanding of waiting times and issues that will inform improvements and efficiencies.	September 2022
Recruitment of the ICB CYP Clinical Community Paediatrician Post to lead on Neurodiversity Game Changer.	Clinical leadership that can gain support and commitment from the providers and delivery of the programme objectives.	March 2023
Proposal for Expert by Experience Reference Group (ASD) expected in August from Devon Parent Carer Forum which will support the Devon Autism Strategy.	Improved experiences CYP & Families with strategy and transformation plan co-produced and owned.	March 2023
Finalise the action plan for the Neurodiversity Game changer	Partners and stakeholders' agreement and commitment, and Realistic actions and ambition with identified allocation of resources to implement.	October 2022
Develop a plan for the expansion of the Keyworker pilot as part of the Neurodiversity Transformation Programme, aim to secure additional NHSE funding.	Increased support to those on wait list and as part of wider Neurodiversity transformation shift in reduction of those waiting for assessment	September 2022

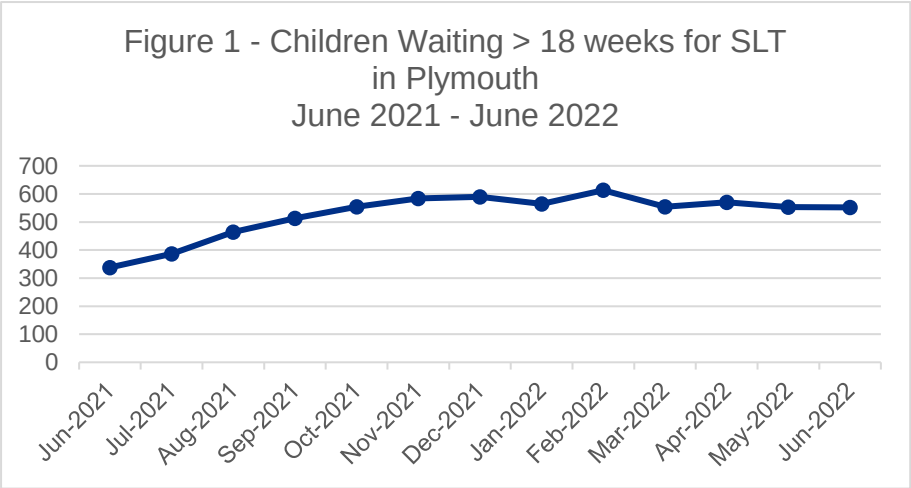
Children & Young People (CYP): Speech & Language waiting times

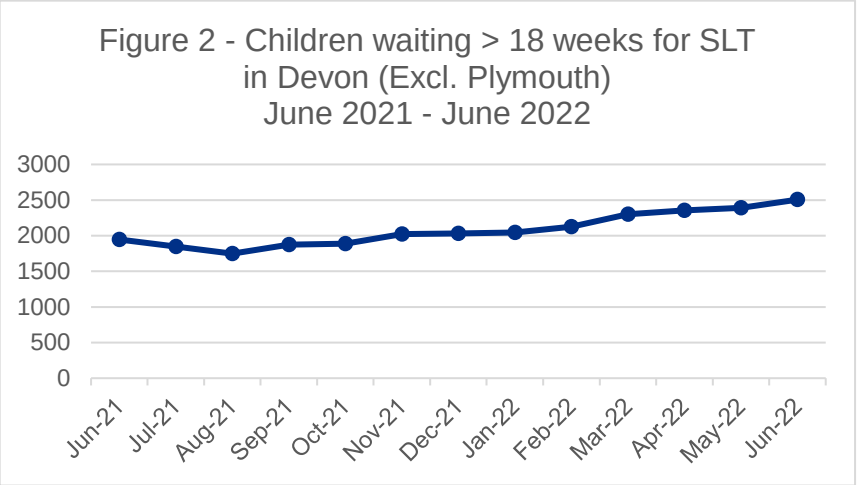
Summary:
CYP in the Devon system are having to wait longer than 18 weeks for a Speech and Language assessment (See Figures 1-4).

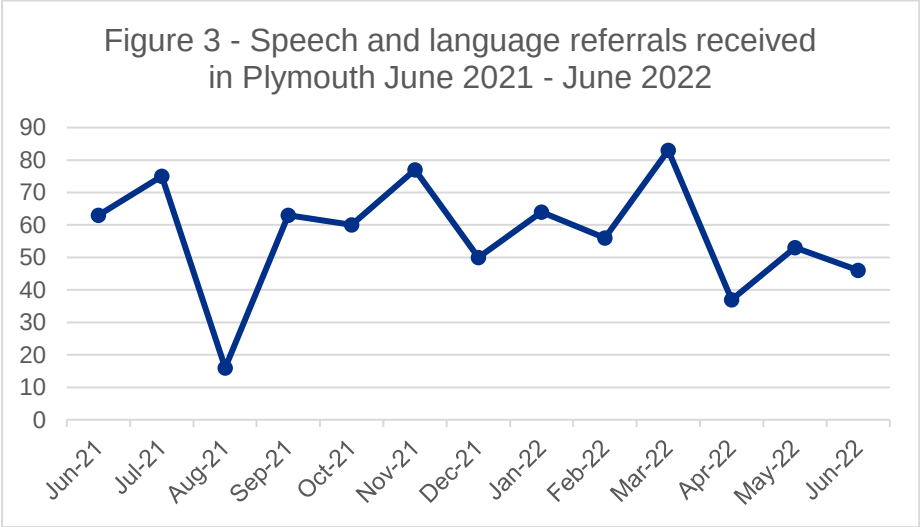
Area	No of CYP waiting over 18 weeks for an assessment
Plymouth (Livewell Southwest – LSW)	552
Devon & Torbay (Children and Families Health Devon – CFHD)	2506

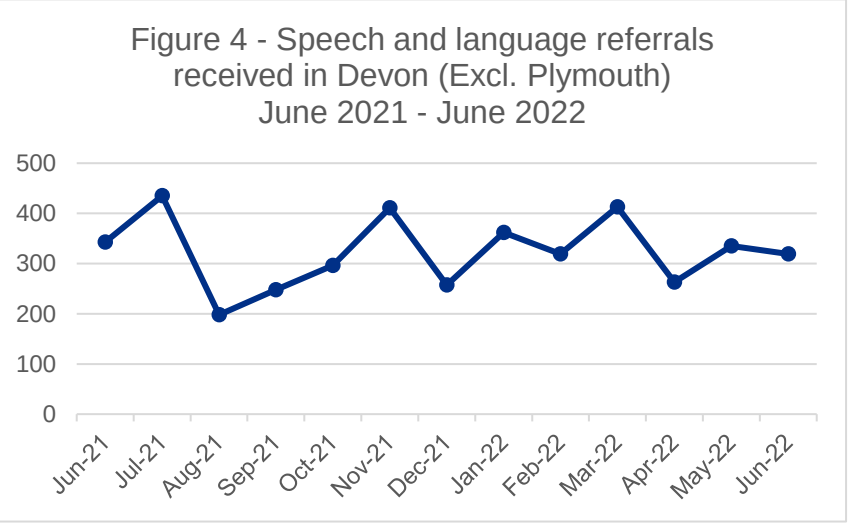
Underlying causes	Impact
1. There is insufficient capacity to process referrals and assess CYP with the pathway waiting time target and to achieve waiting list recovery. This is impacted by: • Vacancies and recruitment challenges for clinical roles. • Sickness and long-term absences within clinical and support staff roles. • Disrupted service restoration. 2. Historical backlog and increased number of referrals during covid: • Waiting lists have worsened due to the pandemic. • Continued fluctuation in referrals, causing bottlenecks on pathway. • Issues within the offer is impacting specialist service referrals. 3. Delays in specialist assessment affects support from health, education and care. • Reduced co-ordination across multiple services/organisations.	• CYP are not able to access support and intervention they need to help them achieve their full potential. • Potential for poor development of language and communication skills, poor outcomes and inequalities. • Delayed care plans can further impact provision of support and outcomes for CYP with SEND.

Children & Young People: Speech & Language waiting times









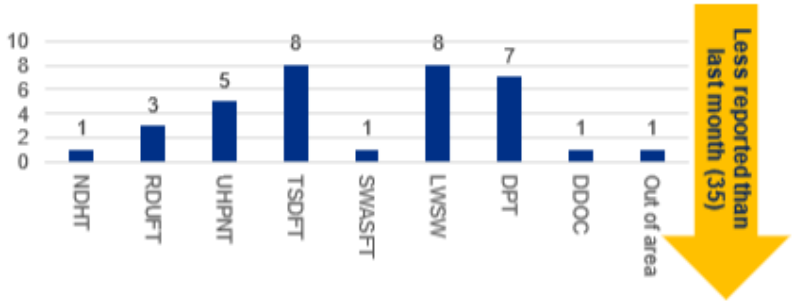
Children & Young People: Speech & Language

Actions undertaken in last month	Impact
• CFHD have successfully appointed an Interim Lead of Speech Language Therapy services, substantive Head of Nursing and Therapies (due to start in October 2022) and are recruiting to Service Development and Quality Improvement lead. There remains vacancies and workforce capacity remains a challenge.	• Increased number of CYP waiting for their first definitive treatment has worsened due to delays in appointments starting
• LSW continue to recruit to vacancies, there has been a challenge from the lack of suitably qualified applicants.	• Reduced capacity and intervention across the pathway.
• Following the Speech, Language and Communication Needs (SCLN) and Social Emotional Mental Health (SEMH) workforce training workshop, key findings and proposals have been identified these are being refined to develop a range of training and literacy resources ranging from Basic Awareness to Specialist. • Developing SEMH modules to be hosted by Marjon's University for Special School teachers.	• Improved workforce skills and competencies and extending training to wider workforce to improve earlier identification of SCLN and SEMH in CYP.

Actions for next month/s	Intended impact	Date impact will be realised
• Scope the Communities of Practice pilot building on the 0-5 years old SLCN examples of good practice. • Options for sub-group activities that align the SLCN and Neurodiversity Game Changers, ensuring the co dependencies and synergy are enabled through reference groups for engagement, co-production and communication. • Meeting re-scheduled between CFHD, LSW and Better Communication CIC to explore shared understanding of focus and agree next steps to commence a light touch needs assessment.	Increase number of Children who are school ready. Improve the knowledge and expertise of communities in addressing SLCN at an earlier and preventive stage. Improve the understanding and support for CYP with complex and comorbid needs that span across SLCN and Neurodiversity. Improve accuracy in identification of needs and understanding of population, that will inform planning.	Transformational programme - work progressing in 2022/23 with benefits being realised across short, medium and longer term with focus on addressing inequalities.

Serious Incidents

During July there have been **31 serious incidents** reports, these are broken down by Provider in the chart below:



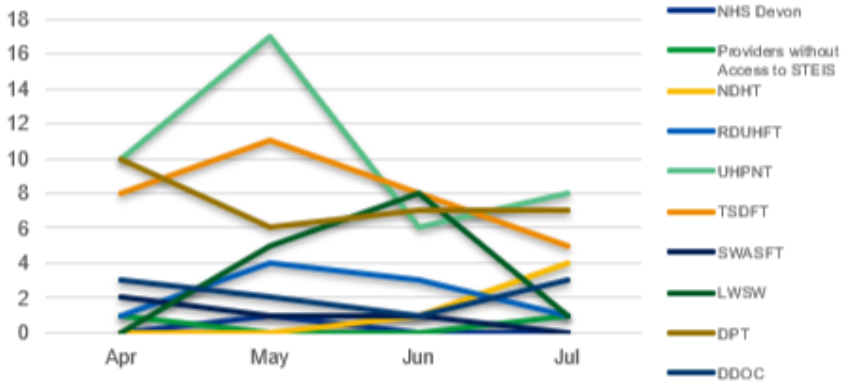
Three never events (wrong site surgery) were **reported** by **RDUFT** during July. Initial reports have been completed and full investigations will follow to identify any learning. Since April 2022 there have been **10 never events reported**, which is a significant increase compared to the same period last year (3).

The **top four incident** types reported in July to date were:

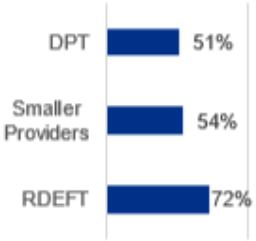
- Apparent/Actual/Suspected self-inflicted harm (8) ⬆
- Slips/Trips/Falls (6) ⬆
- Treatment delay meeting SI criteria (4) ⬇
- Surgical/invasive procedure (4) ⬆

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 number of **reported serious incidents** since April **by Provider:**



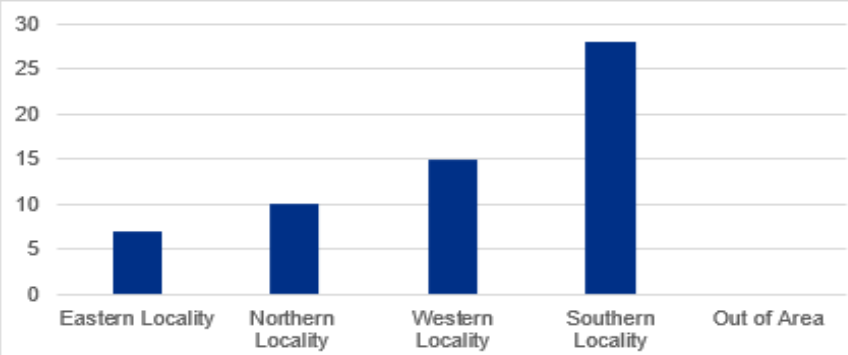
The total number of **overdue investigation reports** that have not yet been completed and submitted to the ICB has **increased** from last month. This remains a concern for the ICB, with the safety systems team working hard to support all Providers in reducing their overdue incidents. The three Providers that need the most improvement this month are illustrated in the chart to the right.



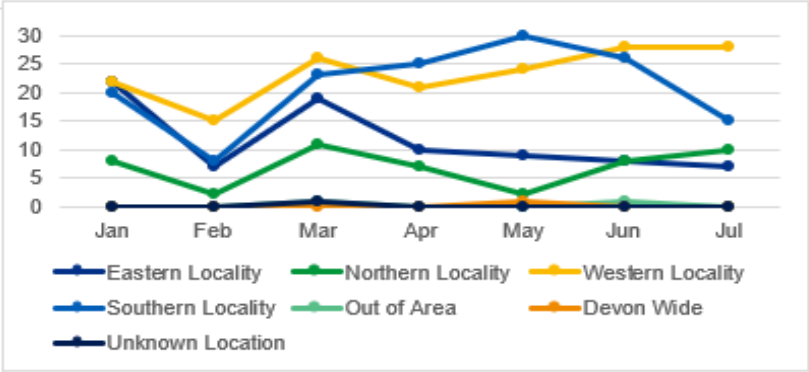
The **SWASFT system investigation report** has been sent to all families who wanted to be involved or requested a copy of the final report. All Integrated Care Boards are to share the report, to review and identify actions.

Peer Improvement Tips for Care and Health (PITCH)

During July there have been **60 PITCHs** reported, these are broken down by locality in the chart below:



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

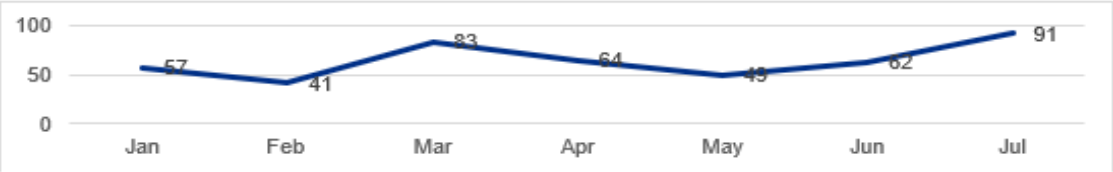


The **top three PITCH concerns received in** July were:

- Procedure or process (9)
- Communication (9)
- Access to services (7)

The team review all PITCHs, escalating to the potential serious incident panel or safeguarding teams if required. During July 4 reported PITCHs were referred to the Safety Systems Team for review if they meet the criteria of a serious incident. Additionally, they are reviewed for themes and trends across specialities and localities.

During July 91 PITCHs were closed compared to 62 last month. The below chart, illustrates the number of closed PITCHs per month since January 2022:

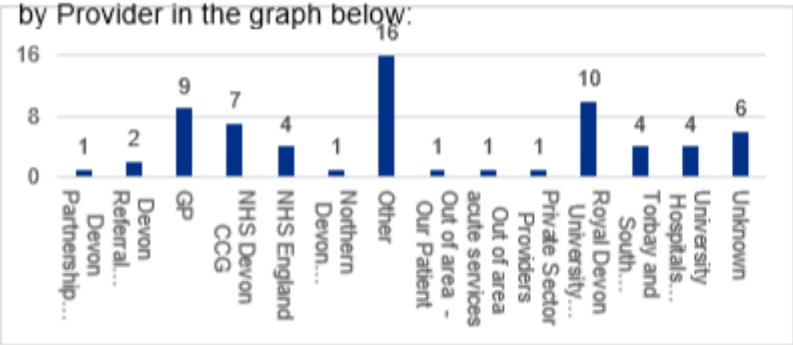


59 open PITCHs remain open

Priority next month – Continue with closing old cases

Patient Experience (NHS Devon): Patient Contacts

During July there were **65 new patient experience** feedback and concerns to manage, these are broken down by Provider in the graph below:



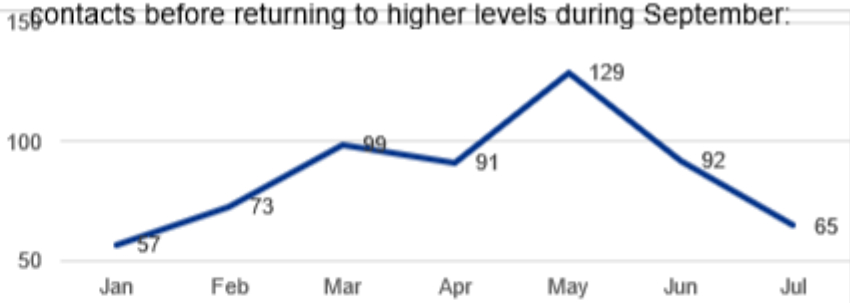
The **top three patient experience concerns received in** in July were:

- Other (under review) (16)
- General Practice (8)
- Dental (4)

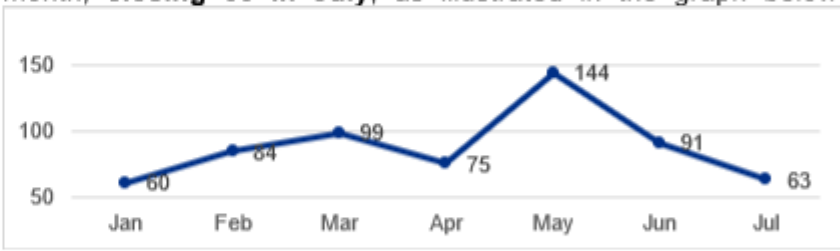
Some data is missing from this month capture due to staffing pressures which have been exceptionally low during July. On-going work continues to improve the sharing of work across the team to support the function

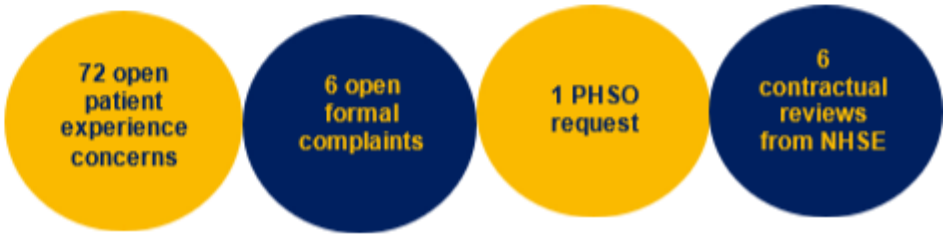
- There has been **1 new formal complaint** raised during June for the CCG.
- There has been **6 contractual reviews received** and in progress, which are required and form part of Primary Care complaints which are managed by NHS England.
- There is **1 request for information** from the **Parliamentary Health Care Ombudsman (PHSO)**

Although the numbers of **patient experience concerns** reported during July have reduced, the number of ongoing case are still significant. Yearly trends suggest July and August can see a dip in contacts before returning to higher levels during September:



The team continue to **close** patient experience concerns this month, **closing 63 in July**, as illustrated in the graph below:





Safeguarding: Adult Enquiries

Issue: The Safeguarding Adult Team has robust internal processes to ensure system oversight of themes and trends arising from Safeguarding Adult Enquiries (Section 42.2) and learning is shared to drive improvement across the health community. Safeguarding Adult Enquiries (Section 42.2) are undertaken when concerns about abuse and neglect within health care settings are raised. Learning will be identified in the process.

Underlying cause: Concerns vary with each enquiry but themes for June 22 include: Discharge – this has seen an increase from 1 to 4. Communication has been identified as an issue, due to the need to maximise bed capacity. There has been a reduction in new Person in a Position of Trust (PiPoT) from 3 to 2.

	Total number of s 42.2 enquires	Discharges	PiPoT	Poor quality of care
Torbay	4	3	1	0
Devon	3	1	1	1
Plymouth	0	0	0	0

Actions undertaken in last month	Impact
Actions undertaken since last report: Providers undertake immediate actions as required when the concern is raised to mitigate risk. Discharge is a known area of concern for the system.	Impact: Identification and sharing of learning from Enquiries to enable improvements in service delivery.

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

Safeguarding: Children in Care (CiC)

Issue: Children in care are not receiving a health assessment within 20 days of coming into care (statutory time scale). Data shows that only approximately 40% of children are seen in a timely way. There are inconsistencies in data reporting across the system. In addition we are aware that the new IT system within PCC has impacted upon the notification process. LWSW CIC nurse team inform us that there were several children and young people that had entered care which they had not been notified of as per statutory requirements, which is being monitored by the Looked After Children team who continue to address these issues to drive through improvement. This presents a risk to LWSW as they are not aware of the cared for population they hold health responsibilities for. For the child and young people, this is creating further delay in initial health assessments which identify their unidentified and or previously unaddressed health needs, with subsequent access to timely treatment/care. This has also been identified as an area of risk for Torbay council. Their transfer to a new IT system last year has created the need for manual notification process to health which creates a single point of failure.

Underlying causes: Health providers not informed by local authority of child coming into care, late or incomplete return of consent and required documents, insufficient clinic capacity to meet peaks in demand and rising number of children coming into care.

Actions undertaken in last month	Impact	
Work is ongoing with the local authorities to improve the notification process. CFHD have the notification risk on their organisations risk register. LWSW have been advised to register this risk with their organisations risk register.	Improvement in number of CIC receiving initial health assessments within 20 days. Timely identification of health needs.	
Actions for next month/s	**Intended impact**	**Date impact will be realised**
Increase in CIC clinic capacity and a flexible resource to meet demands. Implementation of data collection process. Registration of risks on risk register. Meetings continue with LA's to ensure traction on identified risks and assurance improvements are being sought.	Identification of health needs of CIC and met.	September 2022

Safeguarding: Child Protection

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

Underlying causes: Children are subject to child protection plans because of neglect; physical, sexual or emotional abuse.

Data: % children per 10,000 on a child protection plan

Local Authority	Total number of children on a plan	Neglect	Physical	Emotional	Sexual
Torbay	172	108	8	46	6
Devon	586 (40%)	277	54	231	24
Plymouth	247 (46.3%)	114	20	99	14

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

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

Safeguarding: Domestic Abuse and Sexual Violence

Issue: Providers are unable to consistently report on the number of referrals made by their organisation to domestic abuse specialist services

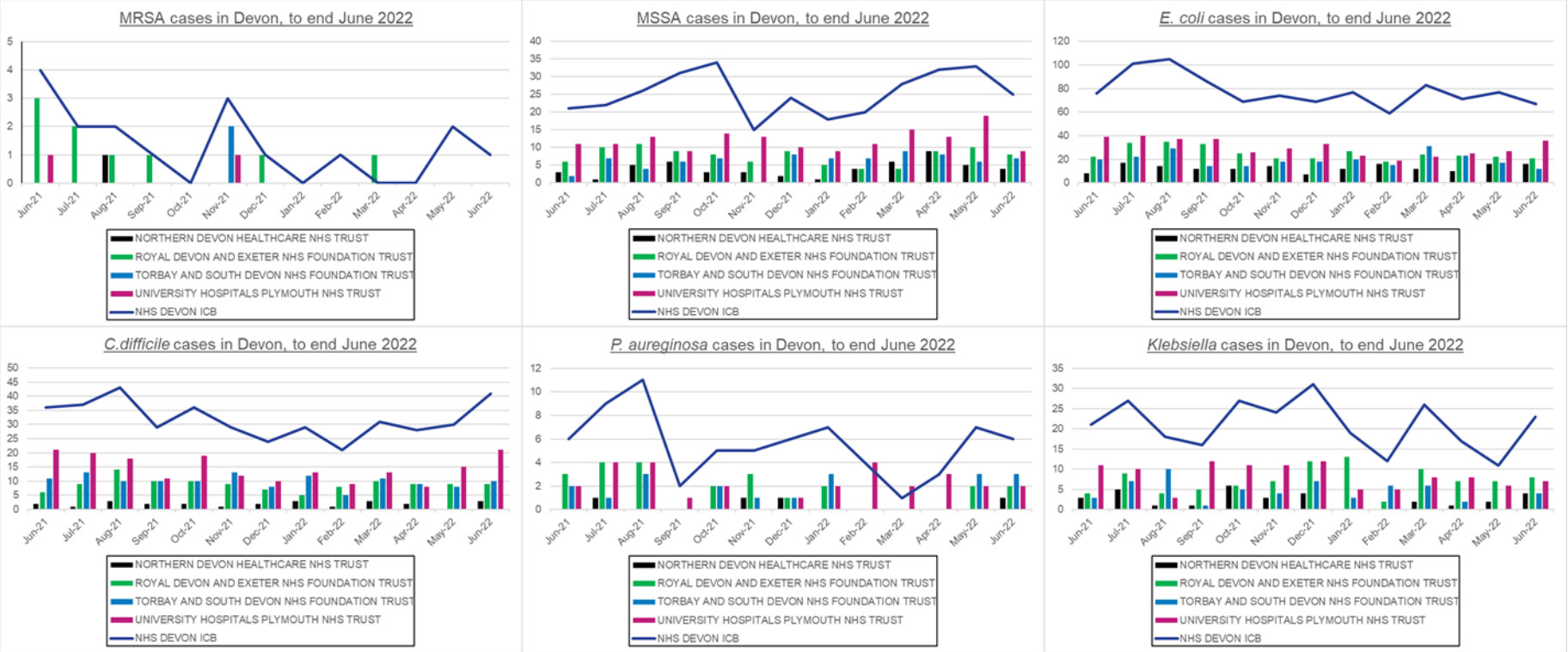
Under lying cause: In consistent data, no single referral point

Actions undertaken in last month	Impact
Communication to all providers with offer of support, added clarity on the requirements. We've approached Domestic Abuse specialist support providers to assist with data collection.	Agreements with a number of providers about data collection - independent domestic violence advisors are being established in providers, this will be the best method of collecting data which is the next stage of this process.
Successful grant bid for Independent Domestic Violence Advisor for Livewell Southwest	Better consistency of data collection

Actions for next month/s	Intended impact	Date impact will be realised
Monitor reporting rates	Increase reporting	ongoing

Infection Prevention and Control

Theme: Healthcare associated infections trends and national ambitions



Each trust has a nationally set threshold for E. coli, C. difficile, Pseudomonas spp. and Klebsiella numbers. These thresholds have been adjusted for 2022-23. Northern Devon (RDUHFT, Northern services) has a slightly higher than expected level of E. coli, and MSSA, which is under review. Of note there has been steady long-term decline in numbers of E. coli reported over the last 12 months while MSSA's are showing the reverse. Each individual episode is reviewed by the IPCT alongside the Consultant Microbiologist and Antimicrobial Pharmacist for themes and trends. Due to workforce capacity and hospital pressures with

significant patient numbers there has been a slight delay in completing this review process. It is expected by the next report this review process will be back on track and a report will be forthcoming

Actions undertaken in last month	Impact
Initial reset meeting of community infection management service to plan new community reduction projects	Community infection management service proactive work enhanced
Improvement of NHS Devon monitoring of healthcare associated infections due to improved team capacity	Faster identification of trends and specific issues within trusts, enhancing learning

Actions for next month/s	Intended impact	Date impact will be realised
Antimicrobial resistance group to restart, with potential joint working with Cornwall	System antimicrobial resistance workstreams, sharing of good practice.	August 2022

Workforce: Workforce Strategy

Strategic Workforce Planning

- The development of a standardised and systemised approach to Strategic Workforce Planning is on-ongoing and work continues on a MVP (Minimum Viable Product) to enable the system to 'build our own' Strategic Workforce Planning tool;
- Engagement with providers has commenced and Workshop 1 held on 20th July 2022 with relevant stakeholders including HEE and Strategic BI lead;
- Requirements and Data Mapping workshops in planning stage and will include SMEs from providers;
- Measures of success responses being collated;
- Workforce Planner interviews scheduled for 4th August 2022.

Workforce Strategy

- Development of the Workforce Strategy is on track. First 'future facing scenario' workshop held on 21st July 2022;
- A further 7 events have been planned between August and October 2022 with c 250 delegates invited across Health and Care;
- Live microsite for workshop bookings and resources https://devon2035.horizonsresearch.org;
- First draft of Workforce Strategy chapter written pending review and templates;
- Executive interviewees have been identified for interviews to be booked in; and
- First draft produced of organisational template designed to capture workforce 'change' ambitions.

Workforce: Learning, Education and Strategy

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

- **Placement expansion:** With collaboration of the group a template has been devised to collect data from providers on Student Placements for last year and capacity for the upcoming academic year. This will allow us to identify gaps and pressure points. Data due in on 31 August 2022.

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

- **Apprenticeships:** A Devon system approach to levy sharing has been socialised with further refinements to be applied, alongside plans to develop a business case for joint health and care apprenticeships for the future especially in job roles with the highest demand across the system.

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

Workforce: Best Place to Work

- **HWB bid**: 'Wellbeing Support Buddies and Champions Programme' to support and equip 300 staff to create peer networks to enable sustainable longer term health improvement and increased resilience across the system is being implemented.
- **Retention**: Continued roll out of excellent retention practice across the ICS including career coaching pilot; stay conversations and guidance for managers; careers on a page guidance; leadership pilot using 360 and development on the people promised statements; use of people's retention stories using a variety of media; Continue to reduce turnover rates for identified groups, recognising the top retention drivers of: Feeling valued/recognised; Work/life balance; Supportive line management; Career/development opportunities
- **Cultural and wellbeing dashboard**: Wellbeing and Culture Dashboard designed and in place with licences for provider organisations obtained to enable organisation and system intelligence to be utilised by individuals, teams and Committees
- **Absence management:** The ICS partners across the Devon System completed a review and is implementing actions using the NHSE/I publication 'Deep dive into factors affecting non covid sickness absence North West NHS Trusts 2020' to focus within their organisation on addressing and improving Sickness Absence.
- **Staff Survey**: Analysis undertaken at organisation and system level with system actions identified (Workforce Capacity; Speaking Up; Appraisal Tools; Respect Campaign).

Workforce: Workforce Capacity

- **Livewell /Social care recruitment pilot:** Meeting end July to discuss how the pilot can now be upscaled following the success of the project. 58 people were recruited in 5 months into 9 social care providers. Many were unemployed and 4 of those had never had a job before.
- **Collaboration of banks**: Plans are being formulated to commence a sharing collaborative of nursing banks across the system to add to the already established medical collaborative bank. This programme of work will span 22/23.
- **Reservists:** Focus between now and Aug is recruiting Reservists – at stage where pre-employment checks are about to commence. Later in the year will determine how programme will move into business as usual.
- **Bank and agency spend**: Plan to standardise agency rates in 22/23 and formalise the approach to the cascade process to agencies whilst adding the use of the NHSP National bank prior to shifts going out to agencies. We are also formulating plans to eradicate the use of non- framework agencies whilst preventing staff level deterioration.

Workforce: Vacancies

Month	Financial Year						
June	2022/23						
		ICS	RDUFT	TSDFT	UHP	LWSW	DPT
Consultant	Substantive Workforce	1334.0	511.9	256.1	458.8	26.8	80.4
	Vacancies	126.8	36.5	15.9	44.6	10.4	19.4
	Vacancy rate	8.68%	6.66%	5.85%	8.86%	27.93%	19.41%
	Trend (ICS rate over 12 months)						
Nursing	Substantive Workforce	7778.1	2899.4	1317.4	2213.6	576.7	771.0
	Vacancies	790.4	302.1	41.9	118.8	155.4	172.2
	Vacancy rate	9.22%	9.44%	3.08%	5.09%	21.23%	18.25%
	Trend (ICS rate over 12 months)						
HCA	Substantive Workforce	3747.185	1387.33	569.19	1270.555	0	520.11
	Vacancies	421.1849	206.46	131.87	107.8649	0	-25.01
	Vacancy rate	10.10%	12.95%	18.81%	7.83%	0.00%	-5.05%
	Trend (ICS rate over 12 months)						
AHP	Substantive Workforce	2471.574	936	515.86	561.0044	253.79	204.92
	Vacancies	357.5486	161.48	79.893	77.34564	29.7	9.13
	Vacancy rate	12.64%	14.71%	13.41%	12.12%	10.48%	4.27%
	Trend (ICS rate over 12 months)						

Note: Percentages are calculated from the reported vacancies in the cells immediately above. Trendline data period runs from July 2021 – Aug 2022.

Overhaul of recruitment & promotion practices to reduce/eliminate diversity gaps: Agreed at Steering Group for EDI leads to agree a few detailed points in the overarching action plan. Agreed to report by exception. First draft of metrics are now within Cultural dashboard.

International recruitment (IR): Meeting end July to discuss how to utilise funding for recruiting into Social Care. Update to follow.

Attraction:

UHP Argyle job fair to be considered for development across the system. Work to scope broader development planned to be discussed at Aug Steering group.

ICS Virtual Fair in planning for 20th and 21st September 2022

Medical Recruitment Campaign – website live. Videos booked in for filming by Whitespace + market research being undertaken. Videos will be added to website from Sept.
Overall attraction strategy and planning to be discussed at Sept Steering Group.

ICS Performance & Quality Outcomes

Strategic Outcomes

Devon ICS Strategic Outcomes Framework

	Domain		latest period	England Latest	England trend	ICS latest	ICS Trend	SW Region Latest	SW region trend	Devon County Council Latest	Devon County Council Trend	Plymouth County council Latest	Plymouth County Council Trend	Torbay County council Latest	Torbay County Council Trend
Health of the Population What is the health	Early Years	Breast feeding prevalence at 6-8 weeks after birth	2020/21 Q4	49.5%						56.0%		41.0%		40.0%	
	Young people	Admission episodes for alcohol-specific conditions - Under 18s (Crude rate per 100,000 population) Rolling 12 month position	June			64.4				60.1		48.1		72.1	
	Older Adults	Admission episodes for alcohol-specific conditions - Over 65s (Crude rate per 100,000 population) Rolling 12 month position	June			1466.7				1219.7		1318.9		1593.2	
Health of the ICS Are people being appropriately and equitably support by the Integrated Care System?	Early Years	Take-up of health visitor checks Proportion of new birth visits completed within 14 days	2021/22 Q4	79.2%				70.2%		4.2%		77.6%		77.9%	
	Younger people	Children and young people accessing mental health services. Rolling 12 Months	April	41%		36%									
		Service users with crisis plans % of people in contact with mental health services	2019/20 Q2	12%		3%									
		Hospital admissions as a result of self harm (10-24 years) Directly standardised rate per 100,000	2020/21	422		519.8		624.9		494.7		499.8		931.0	
	Working Age	Proportion of eligible adults with a learning disability having a health check (%) (target 75%)	April			67.7%									
		Admission episodes for 18 - 65 alcohol-specific conditions (Crude rate per 100,000)	June			1158.4				976.4		905.8		1508.9	
	Older Adults	Bed Occupancy Rates (Acute Hospitals excludes covid beds)	2122 Q4	87%		88%				87%		89%		87%	
		Dementia: Recorded prevalence (aged 65 years and over)	June			56%									
		Emergency admissions aged 65 and over (rate per 1000 population)	2122 Q3			5616.8				5073.2		3960.4		5896.1	

Quality Outcomes

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG		RDU/NorthEastern		RDEFT/Eastern		NDHT/Nothern		UHP/Western		TSDFT/Southern	
Individuals in receipt of funding from the NHS/CCG due to a statutory responsibility	Continuing Healthcare assessment are completed within 28 days	Number of referrals concluded within 28 Days	80%	Q4 2021/22	74%											
	Continuing Healthcare assessments take place within an acute hospital	Less than 15% of Continuing Healthcare assessments take place within an acute hospital	15%	Q4 2021/22	0%											
	Assessment for Continuing Healthcare determination over 12 weeks	Number of assessment for Continuing Healthcare determination over 12 weeks	0	June	2											
Primary care	Asthma RCP assessment	Proportion of GP assesment including Asthma RCP assessment	Higher is Better	2018/19					0.778		0.785		0.729		0.768	
	Mental Health comprehensive care plan	Annual Proportion of GP assesment including Mental health care plan	Higher is Better	2021					0.437		0.513		0.406		0.490	
	Diabetes Blood pressure reading 140/80 mmHg or less	Annual Type 1 Proportion of GP assesment including Diabetes Blood pressure reading	Higher is Better	2020					0.758		0.758		0.720		0.713	
		Annual Type 2 Proportion of GP assesment including Diabetes Blood pressure reading							0.714		0.711		0.708		0.733	
	Needs met at last GP appointment	Annual Proportion of GP assesment including Needs met	Higher is Better	2020					0.964		0.972		0.947		0.955	
	Cancer review within 6 months of diagnosis	Annual Proportion of GP assesment including Cancer reviews	Higher is Better	2021					0.842		0.867		0.841		0.869	
	Females, 25-64, attending cervical screening within target period	Proportion of GP assesment including Cervical screening 25 - 49	Higher is Better	Q2 2021/22					0.734		0.757		0.719		0.746	
		Proportion of GP assesment including Cervical screening 50 - 64							0.775		0.767		0.762		0.762	
	Persons, 60-69, screened for bowel cancer in last 30 months	Annual Proportion of GP assesment including bowl cancer	Higher is Better	2021					0.730		0.715		0.722		0.717	
	Child Imms DTaP/IPV/Hib/HepB (age 1 year)	Proportion of GP assesment including immunisations	Higher is Better	2021					0.944		0.955		0.960		0.952	
	CQC rating	Latest Care Quality Commission rating	Higher is Better							Good (Apr 2019)		Requires improvement (Nov 21)		Requires improvement (Jan 22)		Good (Jul 2020)
ICS	C-Diff Counts of Infection Episodes	Healthcare onset – healthcare associated	Lower is Better	July	16				7		13		4		8	
		Community onset – healthcare associated	Lower is Better	July	5				3		0		2		2	
		Community onset- indeterminate association	Lower is Better	July	0				0		14		3		5	
		Community onset-community association	Lower is Better	July	5											
	MRSA Counts of Infection Episodes	Community onset – healthcare associated	Lower is Better	July	0				0		0		0		1	
		Community onset-community associated	Lower is Better	July	0				1		0		0		1	
	MSSA Counts of Infection Episodes	Healthcare Associated	Lower is Better	July	12				5		5		2		13	
		Community onset-community associated	Lower is Better	July	6				4		5		32		22	

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG	RDU/NorthEastern	RDEFT/Eastern	NDHT/Nothern	UHP/Western	TSDFT/Southern	DPT	Livewell
ICS	E.coli Counts of Infection Episodes	Healthcare associated	Lower is Better	July	14		2	35	15	22		
		Community onset-community associated	Lower is Better	July	10							
	Klebsiella Counts of Infection Episodes	Healthcare associated	Lower is Better	July	11		6	3	2	12		
		Community onset-community associated	Lower is Better	July	6		4	2	3	3		
	Pseudomonas Counts of Infection Episodes	Healthcare associated	Lower is Better	July	1		0	3	0	1		
		Community onset-community associated	Lower is Better	July	3							
	COVID 19 outbreaks	Snap shot of Definite Hospital acquired cases Transferred from another ward on the 1st on the month	Lower is Better	May		2			4	0		
		Staff cases snapshot as at 1st of the month	Lower is Better	July			35.0%	39.0%	43.0%	21.0%		
		Council Snap shot of Care Homes Reporting COVID Cases	Lower is Better	July					7	11	42	
Mental Health	Annual Physical Health Checks for those with Serious Mental Illness	% of completed comprehensive annual Physical Health Checks for those with a Serious Mental Illness	Higher is Better	May	37%							
	Dementia Diagnosis rate	Proportion of patients with dementia, ages 65+	66.70%	June	55.7%							
	% of people discharged from in-patient units who receive follow up at 48hrs	% of people discharged from in-patient units who receive follow up at 72hrs	Higher is Better	April	59.0%						67%	82%
	% of people discharged from in-patient units who receive follow up within 7 days	% of people discharged from in-patient units who receive follow up within 7 days	Higher is Better	July								100%
Childrens	Autism	Mean wait from referral to assessment Childerns number of Weeks data from Chrildren and family Health Devon	Lower is Better	June	76.7							
	Eating Disorders:- routine	Children and Young people Eating disorders waiting times (routine 4 weeks)	Lower is Better	Q4 2021/22	44%						44%	46%
	Eating Disorders:- urgent	Children and Young people Eating disorders waiting times (urgent 1 week)	Lower is Better	Q4 2021/22	54%						65%	40%
	Children and Adolescent Mental Health Services: - Routine	DPT waiting over 18 weeks Livewell within 18 weeks	Lower is Better	June								325
	Children and Adolescent Mental Health Services: - Urgent	Referrals seen within 1 week DPT (local target) Livwell 24hr	Lower is Better	June								100%
	Mean wait for Speech and Language Therapy	Mean wait from referral to assessment	Lower is Better	June								29
Community	End of Life measure Death in place of choice	Proportion of deaths in usual residence	Higher is Better	Rolling annual Q1 2021/22 - Q4 2021/22	58.31							

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG		RDU/NorthEastern		RDEFT/Eastern		NDHT/Nothern		UHP/Western		TSDFT/Southern		DPT		Livewell	
Safety systems	Number of open Serious Incidents	Total number of Open Incidents	Lower is Better	July					22		19		54		50		85		30	
	Number of open Serious Incidents	Total number of Open Serious Incidents (Severe +Death)	Lower is Better	July					0		1		6		1		3		1	
	Number of Serious Incidents that are overdue	Total number of Serious Incidents that are overdue	Lower is Better	July					13		8		6		14		43		9	
	Number of Never events in last twelve months	Total number of Never events withina roling 12 month period	Lower is Better	July					0		3		0		0		0		0	
	PALS: Number of open complaints	Total number of open complaints	Lower is Better	July					0		1		0		0		1		0	
Safeguarding	Number of children receiving CP medicals	Torbay, Devon and Plymouth CC per 10,000		June									46		0		40			
	Domestic abuse and sexual violence victims and perpetrators referred to specialist services.			June					11		2		26				6			
	Percentage of CIC receiving RHA's within timescales (this is 6 monthly for U5s and annually for Over 5s)			June													22%		44%	
	Percentage of CIC receiving IHA's within 20 working days of coming into care.			June					50%		0%		33%		46%					
	Number of safeguarding adult enquiries (S42) regarding the service			June					0		1		1		3		2		0	
Maternity	Breast feeding rates	Proportion First feed breast milk	Higher is Better	March					3%		0%		26%		5%					
	Homebirth rate	Proportion of home births	Higher is Better	March							27%				24%					
	Midwife to Birth ratio		Higher is Better	April			#SPILL!						54%		61%					
	Still births/ Neonatal deaths	Number of still Births	Lower is Better	April			2						2		0					
	C/S rates	Proportion of Elective and emergency Caesarean section births	Lower is Better	March					31%		712.5%		141.1%		596.4%					
People	Sickness rate	Average sickness absence rate	Lower is Better	May			5.62%		0.0%		0.0%		6.5%		5.6%		6.3%			
	Turnover rate	Average staff turnover rate rate	Lower is Better	May			13.63%		0%		0%		12%		14%		13%			
	Bank as share of temporary workforce	Registered nursing, midwifery and health visiting staff	Lower is Better	May			58.60%		0%		0%		93%		33%		53%			
	Consultant vacancies	Total number of vacancies	Lower is Better	May			35.26		0.0		0.0		42.1		9.4		16.9			
	Nursing vacancies	Total number of vacancies	Lower is Better	May			277.24		0.0		0.0		119.3		62.5		162.5			
	HCA vacancies	Total number of vacancies	Lower is Better	May			210.69		0.0		0.0		138.2		140.8					
	AHP vacancies	Total number of vacancies	Lower is Better	May			134.86		0.0		0.0		73.9		80.7					

Recovery & Activity

Performance Key Targets

Performance Key Targets

			ICS			RDUFT			UHP			TSDFT		
Indicator	Date range	Target/Plan	Previous Period	Latest Period	Change	Previous Period	Latest Period	Change	Previous Period	Latest Period	Change	Previous Period	Latest Period	Change
Accident & Emergency type 1&2	JULY 2022-23	95%	49%	45%	▼	56%	49%	▼				34%	37%	▲
Accident & Emergency All	JULY 2022-23	95%	66%	64%	▼	64%	60%	▼				55%	59%	▲
Accident & Emergency 12 hour	JULY 2022-23	0	264	508	▲	86	346	▲				178	162	▼
Referral To Treatment - Incompletes	JUNE 2022-23	92%	54%	53%	▼	52%	52%	▼	60%	59%	▼	52%	51%	▼
Referral To Treatment 52+ week waiters	JUNE 2022-23	0	14383	14666	▲	7664	7763	▲	3169	3240	▲	3880	4275	▲
Diagnostics	JUNE 2022-23	99%	64%	64%	▲	54.7%	53.8%	▼	80.3%	82.7%	▲	68.1%	69.8%	▲
Cancer 2 Weeks	JUNE 2022-23	93%	76%	68%	▼	75%	82%	▲	89%	79%	▼	61%	36%	▼
Cancer breast symptomatic	JUNE 2022-23	93%	52%	53%	▲	38%	82%	▲	47%	20%	▼	76%	42%	▼
Cancer 31 Day First	JUNE 2022-23	96%	93%	93%	▲	88%	85%	▼	94%	94%	▼	94%	97%	▲
Cancer 31 Day Follow-up Drug	JUNE 2022-23	98%	100%	100%	▲	100%	100%	▼▲	99%	99%	▼	100%	100%	▼▲
Cancer 31 Day Follow-up Surgery	JUNE 2022-23	94%	83%	82%	▼	70%	74%	▲	88%	92%	▲	95%	91%	▼
Cancer 31 Day Follow-up Radiotherapy	JUNE 2022-23	94%	98%	96%	▼	99%	96%	▼	97%	97%	▼	95%	96%	▲
Cancer 62 Day Urgent	JUNE 2022-23	85%	62%	56%	▼	62%	56%	▼	63%	57%	▼	61%	55%	▼
Cancer 62 Day screening	JUNE 2022-23	90%	63%	74%	▲	20%	13%	▼	76%	68%	▼	67%	93%	▲
Cancer 62 Day upgrade	JUNE 2022-23	85%	71%	67%	▼	75%	74%	▼	53%	47%	▼	50%	0%	▼

Provider System Oversight Framework: Providers

The approach to the System Oversight Framework in 2021/22 comprises a set of around 100 indicators
This framework describes NHS England and NHS Improvement's approach to oversight in 2021/22, which reinforces system-led delivery of integrated care. This reflects the vision set out in the NHS Long Term Plan, the White Paper: 'Integration and Innovation', and the 2021/22 Operational Planning Guidance.

		NDHT	RDEFT	TSDFT	UHP
Highest performing quartile		18	13	8	10
Interquartile range		6	16	22	19
Lowest performing quartile		6	4	2	4

NHS OF Metric Name	Period	NDHT	RDEFT	TSDFT	UHP
S005a: Daily discharges - as % of patients who no longer meet the criteria to reside in hospital	19/06/2022		41.70%	57.70%	43.50%
S008a: Overall size of the waiting list	2022 04	0	83,271	39,139	43,920
S009a: Patients waiting more than 52 weeks to start consultant-led treatment	2202 04	0	7,645	3,660	3,195
S010a: Cancer - first treatments	2022 04	-	242	172	319
S010b: Cancer - urgent referrals seen	2022 04	-	2,174	1,761	2,404
S011a: Cancer - people waiting longer than 62 days	w/e 05/06/2022	0	356	307	175
S012a: Cancer - % meeting faster diagnosis standard	2022 04	0%	82.40%	76.00%	80.20%
S013a: Diagnostic activity levels - Imaging	2022 04	-	10,773	5,679	10,211
S013b: Diagnostic activity levels - Physiological measurement	2022 04	-	959	792	1,529
S013c: Diagnostic activity levels - Endoscopy	2022 04	-	1,041	575	898
S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation	2022 03	26.5%	23.20%	16.70%	27.10%
S019a: Ambulance handover delays greater than 30 minutes (as reported by NHS Acute Trusts)	2021 03	33	48	118	920

NHS OF Metric Name	Period	NDHT	RDEFT	TSDFT	UHP
S021a: Maternity - % women on continuity of care pathway	2021 12	88.2%			
S022a: Maternity - number of Stillbirths per 1,000 live births	2019	3.13 per 1,000	3.37 per 1,000	2.74 per 1,000	4.07 per 1,000
S023a: Maternity - number of neonatal deaths per 1,000 live births	2019		1.56 per 1,000		1.02 per 1,000
S026a: Proportion of ED patients who turn up unheralded	2022 05	0.00%	61.80%	88.30%	93.60%
S034a: Summary Hospital-Level Mortality Indicator	2022 01	0.00%	98.90%	105.30%	112.80%
S035a: Overall CQC rating (provision of high-quality care)	2022 05		3 - Good	3 - Good	2 -
S036a: NHS Staff Survey Safety culture theme score	2020	6.89/10	6.74/10	6.63/10	6.79/10
S039a: National Patient Safety Alerts not completed by deadline	2022 04	0	0	0	0
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2022 04	0	0	0	0
S041a: Clostridium difficile infections	2022 04	1	5	4	5
S042a: E. coli blood stream infections	2022 04	4	10	3	9
S059a: CQC well-led rating	2022 05		3 - Good	3 - Good	3 - Good
S062a: NHS Staff Survey Health and wellbeing theme score - Health and well-being index	2020	6.36/10	6.19/10	6.06/10	6.08/10
S063a: NHS Staff Survey Safe environment - Bullying and harassment theme score	2020	8.3/10	8.31/10	8.08/10	8.15/10
S064a: Proportion of staff who report that in the last three months they have come to work despite not feeling well enough to perform their duties	2020	39.80%	44%	46.50%	47.80%
S065a: Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	2020	60.70%	52.60%	55.60%	52.20%
S067a: Leaver rate	2022 02	14.4%	15.90%	15.20%	14.00%
S068a: Sickness absence (working days lost to sickness)	2022 01	5.98%	6.45%	6.08%	7.29%
S069a: NHS Staff Survey Staff engagement theme score	2020	7.28/10	7.08/10	6.98/10	6.93/10
S070a: Number of people working in the NHS who have had a flu vaccination	2022 02	70.50%	78.40%	65.60%	62.80%
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	2020	87.60%	87.60%	85.20%	84.80%
S073a: Nursing vacancy rate	2021 12	10.70%	3.34%	9.86%	6.41%

Devon System Oversight Framework: System

		CCG	ICS	MH provider	Provider
Highest performing quartile		3	10	0	2
Interquartile range		11	19	0	8
Lowest performing quartile		1	3	1	2

NHS OF Metric Name	Period	CCG	ICS	MH Provider	Provider
S001a: Appointments in general practice	w/e 03/04/2022	160,920			
S005a: Daily discharges - as % of patients who no longer meet the criteria to reside in hospital	19/06/2022		44.50%		
S008a: Overall size of the waiting list	2022 04		15,834		
S009a: Patients waiting more than 52 weeks to start consultant-led treatment	2022 04		14		
S010a: Cancer - first treatments	2022 04		638		
S010b: Cancer - urgent referrals seen	2022 04		5,725		
S011a: Cancer - people waiting longer than 62 days	w/e 05/06/2022				838
S012a: Cancer - % meeting faster diagnosis standard	2022 04		80.20%		
S013a: Diagnostic activity levels - Imaging	2022 04	25,319			26,663
S013b: Diagnostic activity levels - Physiological measurement	2022 04	3,095			3,280
S013c: Diagnostic activity levels - Endoscopy	2022 04	2,361			2,541
S014a: Cancer - proportion of people that survive cancer for at least 1 year after diagnosis	2018		75.40%		
S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation	2022 03				23.70%
S019a: Ambulance handover delays greater than 30 minutes (as reported by NHS Acute Trusts)	2021 03				1,119

NHS OF Metric Name	Period	CCG	ICS	MH Provider	Provider
S021a: Maternity - % women on continuity of care pathway	2022 02		88.2%		
S022a: Maternity - number of Stillbirths per 1,000 live births	2019		3.43 per 1,000		
S023a: Maternity - number of neonatal deaths per 1,000 live births	2019		1.44 per 1,000		
S026a: Proportion of ED patients who turn up unheralded	2022 05		90.20%		
disability and/or autism	21-22 Q4		38 per 1,000,000		
register receiving an annual health check	21-22 Q4	65.60%			
S031a: Number of personalised care interventions	21-22 Q3		48,894		
S032a: Personal Health Budget	21-22 Q4		8,600		
S033a: Social Prescribing unique patient referrals	21-22 Q4		16,682		
S037a: Patient experience of GP services	2021		87.90%		
S039a: National Patient Safety Alerts not completed by deadline	2022 04				0
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2022 04	0			0
S041a: Clostridium difficile infections	2022 04	28			15
S042a: E. coli blood stream infections	2022 04	71			26
S044a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	Apr 2021 - Mar 2022	82.80%			
S044b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Apr 2021 - Mar 2022	9.20%			
S045a: COVID-19 - % adults vaccinated	w/e 12/06/2022		92.50%		
S046a: Population vaccination coverage - MMR for two doses (5 years old) to reach the optimal standard nationally (95%)	21-22 Q2	92.60%			
S047a: Percentage of people aged 65 and over who received a flu vaccination	2022 02	84.40%			
S050a: Cancer - cervical screening coverage, females aged 25-64, attending screening within target period	21-22 Q3	74.40%			

NHS OF Metric Name	Period	CCG	ICS	MH Provider	Provider
S051a: Number of people supported through the NHS Diabetes Prevention programme	21-22 Q4		46.20%		
S052a: Diabetes patients that have achieved all the NICE recommended treatment targets (adults and children)	2020-21	32.90%			
S055a: General Practice Referrals to NHS Digital Weight Management Programme - Crude Rate/100,000 population	21-22 Q4	56.8 per 100,000			
S067a: Leaver rate	2022 02		13.60%		
S068a: Sickness absence (working days lost to sickness)	2022 01		6.51%		
S070a: Number of people working in the NHS who have had a flu vaccination	2022 02			35.4%	69.3%
S073a: Nursing vacancy rate	2021 12				6.7%
S081a: IAPT access (total numbers accessing services)	21-22 Q4		6,500		
S082a: IAPT recovery rate (%)	21-22 Q4		51%		
S083a: Estimated diagnosis rate for people with dementia	2022 05		55%		
S084a: Children and young people (ages 0-17) mental health services access (number with 1+ contact)	2022 03		12,140		
S085a: People with severe mental illness receiving a full annual physical health check and follow up interventions	21-22 Q4		3,643		
S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (internal or external)	Dec 2021 - Feb 2021		1,830		
S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only)	Jan 2022 - Mar 2022		1		
S087a: Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days	2022 03		7.4 per 100,000		
S087b: Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days	2022 03		6.8 per 100,000		
S088a: Number of women accessing specialist community perinatal mental health services	Apr 2021 - Mar 2022		6.4%		
S089a: Waiting times for Urgent Referrals to Children and Young People's Eating Disorder services	Apr 2021 - Mar 2022		54.3%		
S089b: Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Apr 2021 - Mar 2022		44.2%		

Devon ICS Finance Report Month 3

Financial Framework

•On 20th June 2022, Devon ICS submitted a deficit plan of £18m. 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 £142m are required to meet the June plan.

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

System Surplus/ Deficit Position

Organisation	Measure £'m	Year to date			Forecast		
		Plan	Actual	Variance fav / (adv)	Plan	Actual	Variance fav / (adv)
Devon CCG	Surplus/(Deficit)	0.0	0.0	0.0	0.0	0.0	0.0
Royal Devon University NHS FT	Surplus/(Deficit)	(0.6)	(0.6)	(0.0)	(18.3)	(18.3)	0.0
University Hospitals Plymouth Trust	Surplus/(Deficit)	(3.5)	(3.5)	0.0	0.0	0.0	0.0
Torbay and South Devon NHS FT	Surplus/(Deficit)	(3.1)	(3.1)	0.0	0.1	0.1	0.0
Devon Partnership Trust	Surplus/(Deficit)	(0.7)	(0.7)	0.0	0.0	0.0	(0.0)
Livewell South West	Surplus/(Deficit)	0.1	0.0	(0.1)	0.4	0.0	(0.4)
Total	**Surplus/(Deficit)**	**(7.8)**	**(7.8)**	**(0.1)**	**(17.8)**	**(18.2)**	**(0.4)**

•As at month 3 the Devon ICS had a deficit of £7.8m which is £0.1m adverse variance to plan.
•The forecast is a deficit of £18.2m which is £0.4m adverse to plan.
•The system is required to deliver a breakeven position by the year end.

Efficiencies

Organisation	Year to date £'000 Plan	Actual	Variance fav / (adv)	Recurrent	Efficiency % of operating expenses	Forecast £'000 Plan	Actual	Variance fav / (adv)	Recurrent	Efficiency % of operating expenses
Devon CCG	4,890	5,014	124	3,364		36,425	36,425	0	18,825	
Royal Devon University NHS FT	7,553	4,244	(3,309)	1,107	1.8%	33,935	33,935	0	16,435	3.5%
University Hospitals Plymouth Trust	3,329	3,356	27	578	1.6%	29,592	29,592	0	20,092	3.6%
Torbay and South Devon NHS FT	5,385	2,668	(2,717)	1,698	1.8%	28,452	13,064	(15,388)	10,796	2.2%
Devon Partnership Trust	1,387	686	(701)	590	0.8%	10,358	10,358	0	2,353	2.8%
Livewell South West	828	662	(166)	662	6.7%	3,332	2,264	(1,068)	2,264	2.0%
Total	**23,372**	**16,630**	**(6,742)**	**7,999**		**142,094**	**125,638**	**(16,456)**	**70,765**	

•As at month 3 the Devon ICS had made efficiency savings of £16.6m (M2 £8.6m) of which £8.0m are recurrent (M2 £2.6m). This is £6.7m adverse to plan. (M2 £6.7m)

•Forecast savings are £125.6m which is £16.5m adverse to plan of which £70.8m are recurrent.

In Envelope COVID Spend M1-3

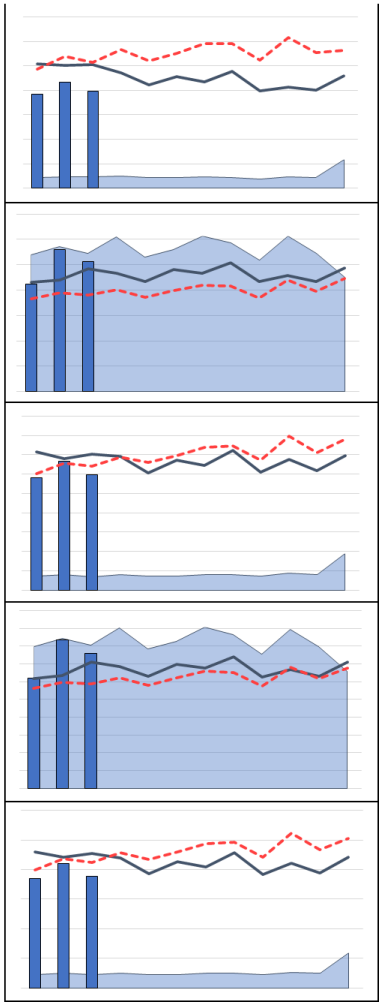
	£'000					
COVID spend category	Royal Devon University NHS FT	University Hospitals Plymouth Trust	Torbay and South Devon NHS FT	Devon Partnership Trust	CCG	Total
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	302	-	-	265		567
Additional Sick pay at full pay for all staff policy - full pay for COVID-related staff absence (for those not normally entitled to sick pay)	35	-	-	-		35
Existing workforce additional shifts to meet increased demand	560	146	59	6		771
Backfill for higher sickness absence	164	875	390	176		1,605
PPE associated costs	87	14	25	4		130
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	75	-	-	-		75
Remote management of patients	46	49	-	164	26	285
Segregation of patient pathways	238	1,481	757	139		2,615
Decontamination	545	101	445	4		1,095
Additional PTS costs	-	-	-	-	134	134
After care and support costs (community, mental health, primary care)	-	-	-	-	- 35	- 35
Long COVID	41	-	-	-		41
Total	**2,093**	**2,666**	**1,675**	**758**	**126**	**7,318**

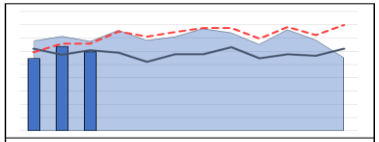
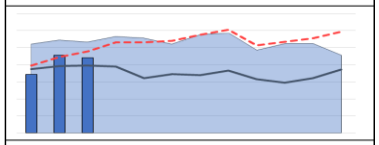
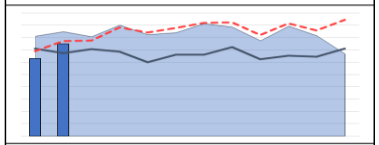
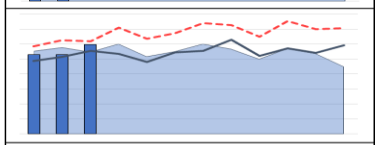
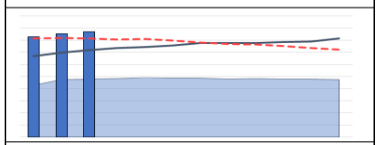
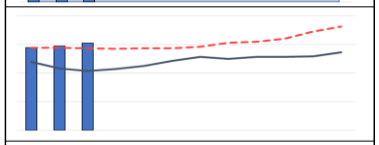
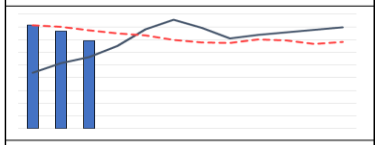
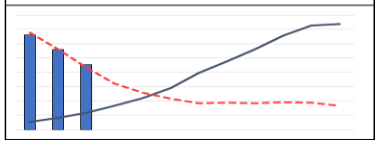
•As at month 3 the Devon ICS had spent £7.3m on in envelope COVID areas. (M2 £4.3m)

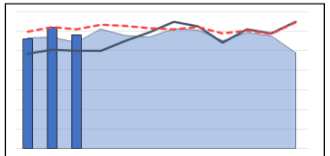
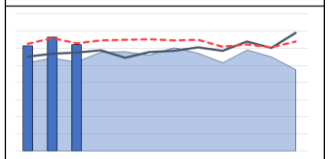
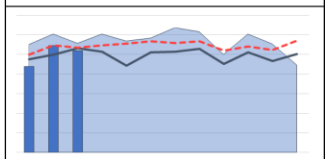
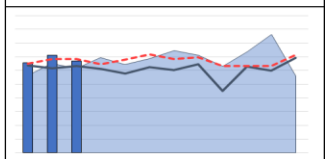
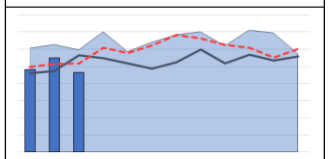
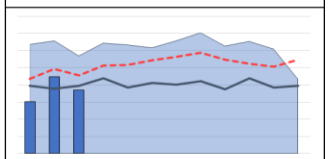
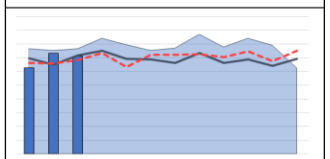
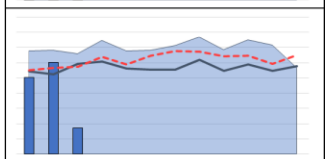
Activity Vs. Plan

			April	May	June	July	August	September	October	November	December	January	February	March			
DEMAND	GP REFERRALS	2019/20	18,912	20,629	19,450	22,588	19,776	19,901	22,943	20,686	18,248	20,411	19,719	16,384	20,629	19,450	▼
		2020/21	8,601	9,461	13,879	17,890	16,960	18,685	18,689	17,602	17,731	16,405	16,512	23,269	9,461	13,879	▲
		2021/22	21,279	20,421	22,128	21,342	18,483	19,684	20,882	21,922	22,327	19,586	20,791	23,253	20,421	22,128	▲
		2022/23	20,164	23,880	21,686										23,880	21,686	▼
		Growth vs 19/20	7%	16%	11%										16%	11%	▼
	OTHER REFERRALS	2019/20	11,851	12,348	11,071	12,844	11,319	11,511	12,703	11,643	10,617	11,900	10,753	8,927	12,348	11,071	▼
		2020/21	4,920	5,951	8,843	9,644	8,592	10,298	9,104	8,352	7,947	8,696	8,456	11,508	5,951	8,843	▲
		2021/22	10,421	10,026	10,623	10,402	9,171	9,420	9,651	10,298	10,067	9,633	9,307	9,964	10,026	10,623	▲
		2022/23	9,028	11,024	9,829										11,024	9,829	▼
		Growth vs 19/20	-24%	-11%	-11%										-11%	-11%	▼
	TOTAL REFERRALS	2019/20	30,763	32,977	30,521	35,432	31,095	31,412	35,646	32,329	28,865	32,311	30,472	25,311	32,977	30,521	▼
		2020/21	13,521	15,412	22,722	27,534	25,552	28,983	27,793	25,954	25,678	25,101	24,968	34,777	15,412	22,722	▲
		2021/22	31,700	30,447	32,751	31,744	27,654	29,104	30,533	32,220	32,394	29,219	30,098	33,217	30,447	32,751	▲
		2022/23	29,192	34,904	19,559										34,904	19,559	▼
		Growth vs 19/20	-5%	6%	-36%										6%	-36%	▼
OUTPATIENTS	Consultant-led first outpatient attendances	2019/20	36,441	38,338	36,220	41,053	35,114	37,152	40,388	38,015	33,381	38,546	34,540	29,527	38,338	36,220	▼
		2020/21	18,043	20,615	25,240	27,697	24,669	29,860	28,582	28,788	28,594	28,899	28,251	33,559	20,615	25,240	▲
		2021/22	32,494	32,709	35,064	32,610	30,037	34,599	33,621	37,545	31,023	33,989	32,019	36,939	32,709	35,064	▲
		Plan	33,439	35,700	35,241	39,234	36,016	39,084	40,585	40,763	36,494	41,563	38,204	42,026	35,700	35,241	▼
		2022/23	31,601	45,051	41,443										45,051	41,443	▼
		Plan vs 19/20	92%	93%	97%	96%	103%	105%	100%	107%	109%	108%	111%	142%	93%	97%	▲
		Actual vs 19/20	87%	118%	114%										118%	114%	▼
	Consultant-led follow-up outpatient attendances	2019/20	75,101	79,912	76,409	84,799	73,215	79,443	86,264	82,621	73,308	87,171	77,107	68,822	79,912	76,409	▼
		2020/21	50,139	56,322	70,452	72,988	63,558	75,018	71,318	74,071	70,146	71,860	70,324	82,120	56,322	70,452	▲
		2021/22	75,227	75,258	81,320	77,752	70,018	79,143	76,097	84,888	70,552	77,185	72,474	80,607	75,258	81,320	▲
		Plan	67,267	72,132	70,589	75,418	69,336	76,378	77,986	78,346	69,576	82,733	73,831	82,546	72,132	70,589	▼
		2022/23	66,863	89,749	82,573										89,749	82,573	▼
		Plan vs 19/20	90%	90%	92%	89%	95%	96%	90%	95%	95%	95%	96%	120%	90%	92%	▲
		Actual vs 19/20	89%	112%	108%										112%	108%	▼
	Total Consultant-led Outpatient attendance	2019/20	111,542	118,250	112,629	125,852	108,329	116,595	126,652	120,636	106,689	125,717	111,647	98,349	118,250	112,629	▼
		2020/21	68,182	76,937	95,692	100,685	88,227	104,878	99,900	102,859	98,740	100,759	98,575	115,679	76,937	95,692	▲
		2021/22	107,721	107,967	116,384	110,362	100,055	113,742	109,718	122,433	101,575	111,174	104,493	117,546	107,967	116,384	▲
		Plan	100,706	107,832	105,830	114,652	105,352	115,462	118,571	119,109	106,070	124,296	112,035	124,572	107,832	105,830	▼
		2022/23	98,464	134,800	124,016										134,800	124,016	▼
		Plan vs 19/20	90%	91%	94%	91%	97%	99%	94%	99%	99%	99%	100%	127%	91%	94%	▲
		Actual vs 19/20	88%	114%	110%										114%	110%	▼
	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance face to face	2019/20	51,475	54,896	51,896	58,785	50,590	53,547	59,012	55,351	47,696	56,151	50,485	41,422	54,896	51,896	▼
		2020/21	16,867	20,837	27,666	33,524	31,916	39,323	35,522	32,841	31,511	31,286	30,983	38,088	20,837	27,666	▲
		2021/22	37,557	38,553	45,507	43,126	39,488	42,993	42,092	45,919	38,749	42,335	39,573	44,746	38,553	45,507	▲
		Plan	38,673	41,386	41,511	44,067	41,413	44,502	47,680	47,174	41,579	48,111	44,105	46,627	41,386	41,511	▲
		2022/23	39,191	54,902	49,063										54,902	49,063	▼
		Plan vs 19/20	75%	75%	80%	75%	82%	83%	81%	85%	87%	86%	87%	113%	75%	80%	▲
		Actual vs 19/20	76%	100%	95%										100%	95%	▼

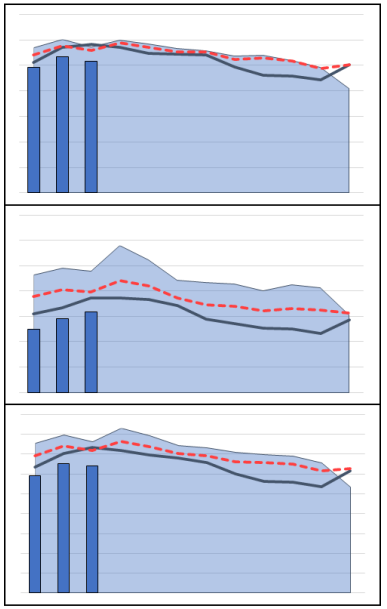
OUTPATIENTS	Outpatient attendances (all TFC; consultant and non consultant led) - First telephone or telemedicine consultation	2019/20	884	934	946	1,019	880	864	936	865	765	937	878	2,356	934	946	▲
		2020/21	9,320	9,497	10,536	9,422	7,101	7,466	8,616	11,106	9,405	10,333	9,402	10,285	9,497	10,536	▲
		2021/22	10,160	10,022	10,112	9,431	8,434	9,123	8,666	9,549	7,966	8,252	7,987	9,177	10,022	10,112	▲
		Plan	9,757	10,751	10,312	11,304	10,419	11,048	11,807	11,815	10,475	12,292	11,079	11,281	10,751	10,312	▼
		2022/23	7,657	8,658	7,917										8,658	7,917	▼
		Plan vs 19/20	**1104%**	**1151%**	**1090%**	**1109%**	**1184%**	**1279%**	**1261%**	**1366%**	**1369%**	**1312%**	**1262%**	**479%**	**1151%**	**1090%**	▼
		Actual vs 19/20	**866%**	**927%**	**837%**										**927%**	**837%**	▼
	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance face to face	2019/20	107,833	114,053	108,967	121,755	105,987	112,094	122,681	117,308	103,605	122,760	109,018	90,300	114,053	108,967	▼
		2020/21	40,354	44,467	60,868	71,409	66,904	80,517	77,558	76,850	73,994	73,452	72,963	88,327	44,467	60,868	▲
		2021/22	86,140	88,166	97,055	93,600	86,754	96,576	93,306	101,852	86,632	91,477	86,539	97,677	88,166	97,055	▲
		Plan	73,508	77,759	75,999	80,413	74,688	79,826	84,015	83,425	73,853	87,962	79,275	88,930	77,759	75,999	▼
		2022/23	84,475	111,826	102,624										111,826	102,624	▼
		Plan vs 19/20	**68%**	**68%**	**70%**	**66%**	**70%**	**71%**	**68%**	**71%**	**71%**	**72%**	**73%**	**98%**	**68%**	**70%**	▲
		Actual vs 19/20	**78%**	**98%**	**94%**										**98%**	**94%**	▼
	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up telephone or telemedicine consultation	2019/20	3,583	3,954	3,506	4,009	3,614	3,723	4,065	4,018	3,677	4,407	4,108	9,503	3,954	3,506	▼
		2020/21	31,546	34,906	36,729	32,833	24,117	26,392	27,995	34,618	31,837	34,724	32,467	36,819	34,906	36,729	▲
		2021/22	35,685	34,111	35,221	34,575	30,276	33,616	32,263	36,177	30,455	33,828	30,858	34,874	34,111	35,221	▲
		Plan	30,105	32,879	32,050	34,454	32,972	34,787	36,960	37,411	33,736	39,902	35,501	39,108	32,879	32,050	▼
		2022/23	29,157	33,412	29,811										33,412	29,811	▼
		Plan vs 19/20	**840%**	**832%**	**914%**	**859%**	**912%**	**934%**	**909%**	**931%**	**917%**	**905%**	**864%**	**412%**	**832%**	**914%**	▲
		Actual vs 19/20	**814%**	**845%**	**850%**										**845%**	**850%**	▲
	Total Outpatient attendances (all TFC; consultant and non consultant led) - Face to face	2019/20	159,308	168,949	160,863	180,540	156,577	165,641	181,693	172,659	151,301	178,911	159,503	131,722	168,949	160,863	▼
		2020/21	57,221	65,304	88,534	104,933	98,820	119,840	113,080	109,691	105,505	104,738	103,946	126,415	65,304	88,534	▲
		2021/22	123,697	126,719	142,562	136,726	126,242	139,569	135,398	147,771	125,381	133,812	126,112	142,423	126,719	142,562	▲
		Plan	112,181	119,145	117,510	124,480	116,101	124,328	131,695	130,599	115,432	136,073	123,380	135,557	119,145	117,510	▼
		2022/23	123,666	166,728	151,687										166,728	151,687	▼
		Plan vs 19/20	**70%**	**71%**	**73%**	**69%**	**74%**	**75%**	**72%**	**76%**	**76%**	**76%**	**77%**	**103%**	**71%**	**73%**	▲
		Actual vs 19/20	**78%**	**99%**	**94%**										**99%**	**94%**	▼
	Total outpatient attendances (all TFC; consultant and non consultant led) - Telephone/virtual	2019/20	4,467	4,888	4,452	5,028	4,494	4,587	5,001	4,883	4,442	5,344	4,986	11,859	4,888	4,452	▼
		2020/21	40,866	44,403	47,265	42,255	31,218	33,858	36,611	45,724	41,242	45,057	41,869	47,104	44,403	47,265	▲
		2021/22	45,845	44,133	45,333	44,006	38,710	42,739	40,929	45,726	38,421	42,080	38,845	44,051	44,133	45,333	▲
		Plan	39,862	43,630	42,362	45,758	43,391	45,835	48,767	49,226	44,211	52,194	46,580	50,389	43,630	42,362	▼
		2022/23	36,814	42,070	37,728										42,070	37,728	▼
		Plan vs 19/20	**892%**	**893%**	**952%**	**910%**	**966%**	**999%**	**975%**	**1008%**	**995%**	**977%**	**934%**	**425%**	**893%**	**952%**	▲
		Actual vs 19/20	**824%**	**861%**	**847%**										**861%**	**847%**	▼

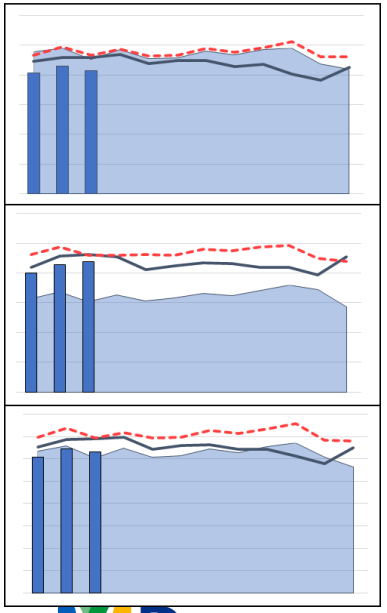


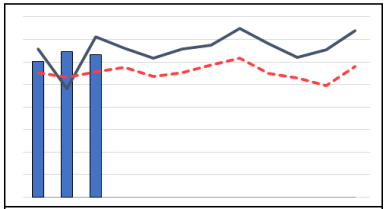
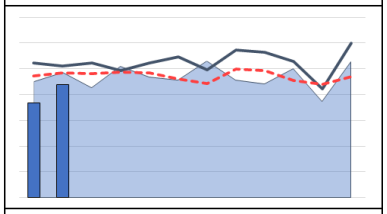
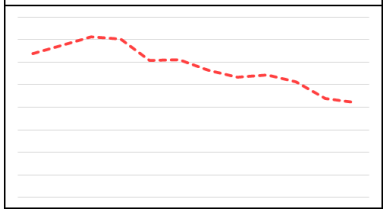
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				
ELECTIVES	DE - Day Case Elective	2019/20	13,574	14,274	13,446	15,181	13,640	14,177	15,353	14,796	13,024	15,202	13,710	11,028	14,274	13,446	▼	
		2020/21	4,125	5,601	8,296	10,726	10,293	11,976	12,084	12,507	12,468	11,268	11,595	13,502	5,601	8,296	▲	
		2021/22	12,379	11,494	12,125	11,782	10,415	11,528	11,536	12,608	10,908	11,554	11,284	12,379	11,494	12,125	▲	
		Plan	11,822	13,172	13,137	14,986	14,218	14,890	15,480	15,471	13,867	15,670	14,409	15,935	13,172	13,137	▼	
		2022/23	10,870	12,691	11,875										12,691	11,875	▼	
		Plan vs 19/20	87%	92%	98%	99%	104%	105%	101%	105%	106%	103%	105%	144%	92%	98%	▲	
		Actual vs 19/20	80%	89%	88%										89%	88%	▼	
	IE - Inpatient Elective	2019/20	2,611	2,723	2,665	2,827	2,791	2,608	2,881	2,926	2,431	2,623	2,622	2,285	2,723	2,665	▼	
		2020/21	801	1,290	1,664	2,054	2,007	2,136	2,032	1,596	1,582	1,361	1,371	1,801	1,290	1,664	▲	
		2021/22	1,873	1,958	1,979	1,955	1,614	1,729	1,692	1,825	1,577	1,476	1,602	1,865	1,958	1,979	▲	
		Plan	1,971	2,235	2,388	2,666	2,657	2,704	2,883	3,032	2,573	2,671	2,779	2,976	2,235	2,388	▲	
		2022/23	1,715	2,279	2,211										2,279	2,211	▼	
		Plan vs 19/20	75%	82%	90%	94%	95%	104%	100%	104%	106%	102%	106%	130%	82%	90%	▲	
		Actual vs 19/20	66%	84%	83%										84%	83%	▼	
	Total Elective Admissions	2019/20	16,185	16,997	16,111	18,008	16,431	16,785	18,234	17,722	15,455	17,825	16,332	13,313	16,997	16,111	▼	
		2020/21	4,926	6,891	9,960	12,780	12,300	14,112	14,116	14,103	14,050	12,629	12,966	15,303	6,891	9,960	▲	
		2021/22	14,252	13,452	14,104	13,737	12,029	13,257	13,228	14,433	12,485	13,030	12,886	14,244	13,452	14,104	▲	
		Plan	13,793	15,407	15,525	17,652	16,875	17,594	18,363	18,503	16,440	18,341	17,188	18,911	15,407	15,525	▲	
		2022/23	12,585	14,970	0	0	0	0	0	0	0	0	0	0	14,970	0	▼	
		Plan vs 19/20	85%	91%	96%	98%	103%	105%	101%	104%	106%	103%	105%	142%	91%	96%	▲	
		Actual vs 19/20	78%	88%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	88%	0%	▼	
	RTT - Clock stops	2019/20	27,642	28,829	27,282	30,093	25,765	27,442	30,035	28,347	25,004	28,514	26,809	22,469	28,829	27,282	▼	
		2020/21	12,638	14,580	18,090	20,192	19,141	22,714	23,082	22,653	20,915	21,422	21,104	25,537	14,580	18,090	▲	
		2021/22	24,456	25,673	27,780	26,725	24,024	27,288	27,769	31,437	26,071	28,606	27,091	29,693	25,673	27,780	▲	
		Plan	29,357	31,242	30,939	35,494	31,850	33,653	37,093	36,293	32,557	37,814	35,069	35,389	31,242	30,939	▼	
		2022/23	26,519	26,519	29,825										26,519	29,825	▲	
		Plan vs 19/20	106%	108%	113%	118%	124%	123%	123%	128%	130%	133%	131%	158%	108%	113%	▲	
		Actual vs 19/20	96%	92%	109%										92%	109%	▲	
	RTT Incomplete pathways	2019/20	85,565	95,238	96,319	96,979	98,176	97,636	97,368	96,283	96,899	95,777	96,157	94,760	95,238	96,319	▲	
		2020/21	90,579	88,030	90,090	94,617	99,428	103,521	108,999	114,168	120,683	121,377	122,332	128,734	88,030	90,090	▲	
		2021/22	133,890	139,801	143,499	147,480	149,026	151,724	155,745	155,489	155,766	156,866	158,188	162,678	139,801	143,499	▲	
		Plan	163,085	163,494	163,258	161,461	161,945	159,492	156,453	154,145	153,011	150,242	147,599	144,889	163,494	163,258	▼	
		2022/23	166,330	171,009	174,161										171,009	174,161	▲	
		Plan vs 19/20	191%	172%	169%	166%	165%	163%	161%	160%	158%	157%	153%	153%	172%	169%	▼	
		Actual vs 19/20	194%	180%	181%										180%	181%	▲	
	RTT 52 Week wait	2019/20	203	195	227	268	368	349	345	328	281	301	237	288	195	227	▲	
		2020/21	618	1,228	2,166	3,124	3,942	4,796	5,972	7,413	8,626	9,856	11,665	12,916	1,228	2,166	▲	
		2021/22	11,918	10,809	10,378	10,705	11,256	12,140	12,829	12,524	12,807	12,808	12,939	13,650	10,809	10,378	▼	
		Plan	14,455	14,422	14,327	14,262	14,353	14,301	14,555	15,288	15,456	15,988	17,241	18,104	14,422	14,327	▼	
		2022/23	14,500	14,713	15,278										14,713	15,278	▲	
		Plan vs 19/20	7121%	7396%	6311%	5322%	3900%	4098%	4219%	4661%	5500%	5312%	7275%	6286%	7396%	6311%	▼	
		Actual vs 19/20	7143%	7545%	6730%										7545%	6730%	▼	
	RTT 78 Week wait	2019/20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2020/21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2021/22	2,191	2,570	2,811	3,246	3,912	4,274	3,971	3,540	3,680	3,794	3,876	3,976	2,570	2,811	▲	
		Plan	4,060	4,013	3,859	3,736	3,666	3,494	3,384	3,378	3,510	3,473	3,323	3,410	4,013	3,859	▼	
		2022/23	4,065	3,839	3,453										3,839	3,453	▼	
		Plan vs 19/20																
		Actual vs 19/20																
	RTT 104 Week wait	2019/20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2020/21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	▼▲	
		2021/22	106	164	237	334	440	582	794	955	1,123	1,318	1,454	1,478	164	237	▲	
		Plan	1,356	1,127	871	645	518	433	368	373	366	380	377	336	1,127	871	▼	
		2022/23	1,327	1,118	907										1,118	907	▼	
		Plan vs 19/20																
		Actual vs 19/20																

			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				
DIAGNOSTIC TESTS	MAGNETIC RESONANCE IMAGING	2019/20	5,655	5,705	5,423	6,099	5,773	5,682	6,128	6,040	5,517	5,939	5,755	4,902	5,705	5,423	▼	
		2020/21	2,281	3,112	4,389	5,491	4,864	4,848	4,982	4,784	4,947	4,701	4,794	5,607	3,112	4,389	▲	
		2021/22	4,856	5,069	5,006	5,010	5,498	5,959	6,475	6,232	5,424	6,103	5,889	6,478	5,069	5,006	▼	
		Plan	5,984	6,218	6,085	6,317	6,278	6,148	6,102	6,200	5,873	6,034	5,862	6,434	6,218	6,085	▼	
		2022/23	5,593	6,192	5,806										6,192	5,806	▼	
		Plan vs 19/20	106%	109%	112%	104%	109%	108%	100%	103%	106%	102%	102%	131%	109%	112%	▲	
		Actual vs 19/20	99%	109%	107%										109%	107%	▼	
	COMPUTED TOMOGRAPHY	2019/20	10,297	10,870	10,368	11,555	11,583	11,179	12,081	11,368	10,281	11,782	10,974	9,500	10,870	10,368	▼	
		2020/21	6,511	9,060	10,047	11,175	10,729	11,008	11,533	10,498	10,238	10,930	10,398	11,643	9,060	10,047	▲	
		2021/22	10,996	11,366	11,526	11,794	10,868	11,528	11,667	12,074	11,721	12,754	12,041	13,770	11,366	11,526	▲	
		Plan	12,528	13,173	12,590	12,934	12,974	13,036	12,903	12,949	12,175	12,422	12,071	12,805	13,173	12,590	▼	
		2022/23	12,281	13,296	12,397										13,296	12,397	▼	
		Plan vs 19/20	122%	121%	121%	112%	112%	117%	107%	114%	118%	105%	110%	135%	121%	121%	▲	
		Actual vs 19/20	119%	122%	120%										122%	120%	▼	
	NON-OBSTETRIC ULTRASOUND	2019/20	11,040	12,078	11,148	12,063	11,398	11,659	12,760	12,334	10,009	12,071	11,095	8,920	12,078	11,148	▼	
		2020/21	4,357	6,111	8,783	9,794	8,249	9,271	9,153	9,005	8,414	8,458	8,314	9,906	6,111	8,783	▲	
		2021/22	9,521	10,006	10,662	10,274	8,883	10,196	10,279	10,592	9,053	10,230	9,353	10,033	10,006	10,662	▲	
		Plan	9,982	10,954	10,684	10,944	11,092	11,347	11,186	11,368	10,407	10,808	10,432	11,398	10,954	10,684	▼	
		2022/23	8,789	10,920	10,363										10,920	10,363	▼	
		Plan vs 19/20	90%	91%	96%	91%	97%	97%	88%	92%	104%	90%	94%	128%	91%	96%	▲	
		Actual vs 19/20	80%	90%	93%										90%	93%	▲	
	CARDIOLOGY - ECHOCARDIOGRAPHY	2019/20	2,818	3,264	3,079	3,480	3,220	3,421	3,727	3,562	3,150	3,675	4,314	2,803	3,264	3,079	▼	
		2020/21	1,075	1,949	2,565	2,987	2,716	2,890	2,482	2,454	3,159	2,810	2,889	3,180	1,949	2,565	▲	
		2021/22	3,181	3,090	3,156	3,057	2,884	3,116	3,025	3,226	2,259	3,148	2,989	3,464	3,090	3,156	▲	
		Plan	3,246	3,422	3,417	3,226	3,395	3,582	3,412	3,481	3,157	3,171	3,158	3,569	3,422	3,417	▼	
		2022/23	3,280	3,545	3,338										3,545	3,338	▼	
		Plan vs 19/20	115%	105%	111%	93%	105%	105%	92%	98%	100%	86%	73%	127%	105%	111%	▲	
		Actual vs 19/20	116%	109%	108%										109%	108%	▼	
	COLONOSCOPY	2019/20	1,215	1,253	1,191	1,400	1,172	1,281	1,372	1,402	1,243	1,423	1,387	1,144	1,253	1,191	▼	
		2020/21	100	138	524	838	757	826	892	903	854	888	1,036	1,158	138	524	▲	
		2021/22	917	945	1,128	1,093	1,037	975	1,047	1,200	1,035	1,137	1,067	1,113	945	1,128	▲	
		Plan	997	1,029	1,035	1,218	1,154	1,242	1,367	1,323	1,253	1,215	1,099	1,201	1,029	1,035	▲	
		2022/23	961	1,096	928										1,096	928	▼	
		Plan vs 19/20	82%	82%	87%	87%	98%	97%	100%	94%	101%	85%	79%	105%	82%	87%	▲	
		Actual vs 19/20	79%	87%	78%										87%	78%	▼	
	FLEXI SIGMOIDOSCOPY	2019/20	635	656	570	642	634	615	656	703	626	653	609	433	656	570	▼	
		2020/21	42	116	281	391	379	361	356	404	381	308	386	483	116	281	▲	
		2021/22	395	377	396	439	386	413	402	423	374	439	385	395	377	396	▲	
		Plan	435	494	454	512	516	544	564	589	548	522	506	548	494	454	▼	
		2022/23	301	446	371										446	371	▼	
		Plan vs 19/20	69%	75%	80%	80%	81%	88%	86%	84%	88%	80%	83%	127%	75%	80%	▲	
		Actual vs 19/20	47%	68%	65%										68%	65%	▼	
	GASTROSCOPY	2019/20	1,534	1,503	1,536	1,688	1,588	1,507	1,539	1,746	1,555	1,680	1,583	1,257	1,503	1,536	▲	
		2020/21	156	257	915	1,044	1,010	1,277	1,166	1,178	1,185	1,129	1,188	1,465	257	915	▲	
		2021/22	1,394	1,298	1,436	1,503	1,383	1,376	1,322	1,465	1,326	1,376	1,286	1,382	1,298	1,436	▲	
		Plan	1,327	1,314	1,369	1,468	1,265	1,444	1,442	1,448	1,410	1,496	1,353	1,503	1,314	1,369	▲	
		2022/23	1,252	1,463	1,423										1,463	1,423	▼	
		Plan vs 19/20	87%	87%	89%	87%	80%	96%	94%	83%	91%	89%	85%	120%	87%	89%	▲	
		Actual vs 19/20	82%	97%	93%										97%	93%	▼	
	TOTAL SCOPES	2019/20	3,384	3,412	3,297	3,730	3,394	3,403	3,567	3,851	3,424	3,756	3,579	2,834	3,412	3,297	▼	
		2020/21	298	511	1,720	2,273	2,146	2,464	2,414	2,485	2,420	2,325	2,610	3,106	511	1,720	▲	
		2021/22	2,706	2,620	2,960	3,035	2,806	2,764	2,771	3,088	2,735	2,952	2,738	2,890	2,620	2,960	▲	
		Plan	2,759	2,837	2,858	3,198	2,935	3,230	3,373	3,360	3,211	3,233	2,958	3,252	2,837	2,858	▲	
		2022/23	2,514	3,005	869										3,005	869	▼	
		Plan vs 19/20	82%	83%	87%	86%	86%	95%	95%	87%	94%	86%	83%	115%	83%	87%	▲	
		Actual vs 19/20	74%	88%	26%										88%	26%	▼	

			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
A&E	TYPE 1 & 2	2019/20	28,522	30,086	28,559	29,922	29,139	28,329	27,862	26,878	26,935	26,021	24,551	20,546	30,086	28,559	▼
		2020/21	14,502	20,922	22,659	26,096	27,714	25,599	23,510	21,040	21,257	18,958	18,367	23,647	20,922	22,659	▲
		2021/22	25,613	28,472	29,187	28,481	27,375	27,163	27,059	24,630	23,143	22,929	22,158	25,177	28,472	29,187	▲
		Plan	27,063	28,885	28,014	29,471	28,476	27,655	27,614	26,239	26,524	25,872	24,375	25,180	28,885	28,014	▼
		2022/23	24,641	26,756	25,783										26,756	25,783	▼
		Plan vs 19/20	95%	96%	98%	98%	98%	98%	99%	98%	98%	99%	99%	123%	96%	98%	▲
		Actual vs 19/20	86%	89%	90%										89%	90%	▲
	TYPE 3 & 4	2019/20	9,256	9,832	9,552	11,599	10,485	8,873	8,681	8,554	8,041	8,524	8,265	6,118	9,832	9,552	▼
		2020/21	2,865	3,958	2,469	6,265	7,230	6,638	6,410	3,504	3,057	2,494	2,431	3,434	3,958	2,469	▼
		2021/22	6,183	6,687	7,451	7,461	7,329	6,864	5,765	5,449	5,044	5,036	4,658	5,714	6,687	7,451	▲
		Plan	7,558	8,119	7,962	8,841	8,382	7,485	6,915	6,784	6,438	6,649	6,514	6,282	8,119	7,962	▼
		2022/23	4,996	5,810	6,332										5,810	6,332	▲
		Plan vs 19/20	82%	83%	83%	76%	80%	84%	80%	79%	80%	78%	79%	103%	83%	83%	▲
		Actual vs 19/20	54%	59%	66%										59%	66%	▲
	TOTAL A&E ATTENDANCES	2019/20	37,778	39,918	38,111	41,521	39,624	37,202	36,543	35,432	34,976	34,545	32,816	26,664	39,918	38,111	▼
		2020/21	17,367	24,880	25,128	32,361	34,944	32,237	29,920	24,544	24,314	21,452	20,798	27,081	24,880	25,128	▲
		2021/22	31,796	35,159	36,638	35,942	34,704	34,027	32,824	30,079	28,187	27,965	26,816	30,891	35,159	36,638	▲
		Plan	34,621	37,004	35,976	38,312	36,858	35,140	34,529	33,023	32,962	32,521	30,889	31,462	37,004	35,976	▼
		2022/23	29,637	32,566	32,115										32,566	32,115	▼
		Plan vs 19/20	92%	93%	94%	92%	93%	94%	94%	93%	94%	94%	94%	118%	93%	94%	▲
		Actual vs 19/20	78%	82%	84%										82%	84%	▲
NON ELECTIVE	+1 LENGTH OF STAY	2019/20	9,562	9,786	9,029	9,693	9,112	9,129	9,602	9,321	9,680	9,820	8,752	8,377	9,786	9,029	▼
		2020/21	5,932	7,400	7,910	8,511	8,620	8,761	9,058	8,153	8,471	8,252	7,853	9,008	7,400	7,910	▲
		2021/22	8,911	9,160	9,168	9,382	8,766	8,956	8,951	8,563	8,692	8,043	7,654	8,491	9,160	9,168	▲
		Plan	9,333	9,872	9,309	9,731	9,270	9,339	9,774	9,513	9,822	10,211	9,213	9,216	9,872	9,309	▼
		2022/23	8,112	8,599	8,258										8,599	8,258	▼
		Plan vs 19/20	98%	101%	103%	100%	102%	102%	102%	102%	101%	104%	105%	110%	101%	103%	▲
		Actual vs 19/20	85%	88%	91%										88%	91%	▲
	ZERO DAY LENGTH OF STAY	2019/20	3,129	3,373	3,032	3,257	3,065	3,167	3,314	3,244	3,421	3,593	3,431	2,865	3,373	3,032	▼
		2020/21	2,087	2,875	3,070	3,537	3,497	3,804	3,546	3,223	3,297	3,008	3,087	3,983	2,875	3,070	▲
		2021/22	4,177	4,563	4,615	4,531	4,109	4,242	4,339	4,305	4,199	4,191	3,930	4,531	4,563	4,615	▲
		Plan	4,610	4,866	4,592	4,588	4,622	4,596	4,806	4,750	4,883	4,923	4,491	4,381	4,866	4,592	▼
		2022/23	4,009	4,285	4,389										4,285	4,389	▲
		Plan vs 19/20	147%	144%	151%	141%	151%	145%	145%	146%	143%	137%	131%	153%	144%	151%	▲
		Actual vs 19/20	128%	127%	145%										127%	145%	▲
	TOTAL NON ELECTIVES	2019/20	12,691	13,159	12,061	12,950	12,177	12,296	12,916	12,565	13,101	13,413	12,183	11,242	13,159	12,061	▼
		2020/21	8,019	10,275	10,980	12,048	12,117	12,565	12,604	11,376	11,768	11,260	10,940	12,991	10,275	10,980	▲
		2021/22	13,088	13,723	13,783	13,913	12,875	13,198	13,290	12,868	12,891	12,234	11,584	13,022	13,723	13,783	▲
		Plan	13,943	14,738	13,901	14,319	13,892	13,935	14,580	14,263	14,705	15,134	13,704	13,597	14,738	13,901	▼
		2022/23	12,121	12,884	12,647										12,884	12,647	▼
		Plan vs 19/20	110%	112%	115%	111%	114%	113%	113%	114%	112%	113%	112%	121%	112%	115%	▲
		Actual vs 19/20	96%	98%	105%										98%	105%	▲





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

NHS Devon board meeting

Committee chair report –finance committee

Date of board meeting	Dates of committees covered in this report *Minutes of these committee meetings to be available as an addendum*
21st September 2022	21st July 2022, 18th August 2022 & 7th September 2022

Chair	
Name and title:	Kevin Orford, Non-Executive Member
Phone:	
Email:	kevin.orford@nhs.net

Reports discussed and assurances received

- **July meeting** - Financial overview – presentation

a) The CFO set out the financial challenge facing the Devon NHS.

b) The CFO outlined the history of the CCG and Devon system finances to set the context for Finance Committee members.

c) Pre-Covid underlying deficit verified by National Intensive Support Team (NIST) was £222 million and that this was analysed into £68.4m "operational", £100.9m "strategic" and £52.5m "structural".

d) The conclusion of the work of the NIST was that NHS Devon needs to address its spending rather than income. The current (unvalidated) underlying deficit is calculated at £173.1m

e) John outlined the Operational plan as submitted to the NHS Region, which has a planned deficit of £18m. Our financial target remains at break-even.

f) The CFO outlined that there is £95m delivery risk in the plan.

g) Devon system is revenue funded 5.59% above "fair share" as calculated by the current NHS revenue allocation funding formula.

- **July meeting** - Long Term Plan convergence model
  The CFO of Royal Devon University Healthcare Foundation Trust attended on behalf of the Devon CFOs. The Committee supported the work on the long-term plan.

- **August Extraordinary meeting**. Plymouth Health and Well Being Centre Business Case. Given the importance of the decision to be taken, the Committee was joined by a number of ICB Board members who were not members of the Finance Committee.

- The Committee scrutinised the Business Case noting:

a) the capital cost of £44m,
b) annual revenue cost of £400k (capped at £750k)
c) the Guaranteed maximum price includes the impact of inflation provided that agreed timelines are met.
d) Cost benefit of 6.4:1 against a requirement of 4:1
e) £13m of social value
f) Contingency Fund of £1.64m

The Committee agreed to recommend to the ICB Board that the Business Case be submitted to NHS England.

- **August meeting** – Revenue Allocations Equity

a) The proposals in the paper are formed to support the ICB in its objective to address health inequity in Devon.
b) It was noted that ICB's have a statutory duty to reduce health inequalities, and that it must be done in a financially sustainable way.
c) It was noted that the finance committee is fully supportive of the funding equity objective but asked for further work to be undertaken on the implementation of the recommendations before presentation to the ICB board.
d) It was stated that key to this is a presentation of the implementation options in order that the ICB can understand the impact of the whole system of each option.

- **September meeting** – ICB Procurement Policy update
  The committee approved the changes to the ICB procurement policy with the caveat that Suze Kay will look into the possibility of increasing the threshold amounts.

- **September meeting** – Revenue Allocations Equity
  The Committee supported and noted the further work which had been undertaken relating to implementation. It was also noted that feedback had been received from some NHS Trusts and the Committee asked that there be a full discussion in the NHS System of the results of this work and proposed implementation before the ICB can be in a position to approve it.

- **September meeting** – Plymouth Health and Well-Being Centre Business Case. It was noted that NHSE had provided feedback on the Business Case and that the project remains subject to confirmation of a funding source. The Committee asked that the feedback be discussed at a future Finance Committee meeting and that the committee receives the ICB responses to the NHSE feedback points in order that we can receive assurance that the scheme is ready for implementation once funding is identified.

Reports received and noted

Each of the main committee meetings has received the monthly Finance Report and monthly Integrated Quality and Performance Report (IQPR), which are presented to Board meetings. It is noted that a review is underway to re-format the IQPR for ICB purposes. The Finance Report is being re-formatted also.
The risk register has been presented to each Finance Committee, but this has been the former CCG risk register and it is accepted that this needs to be re-formatted for ICB purposes. Work on this commences in September 2022 once the ICB Board has developed the Assurance Framework for the ICB.

Risk register review updates

- **July meeting** - None.
- **August meeting** – None.
- **September** – None.

Committee decisions

- **July meeting** - None.
- **August Extraordinary meeting** – The Committee approved the recommendation to the ICB Board that the Business Case for the Plymouth Health and Well-Being Centre be submitted to NHS England.
- **August meeting** – None.
- **September** – None.

Items of concern to be escalated to the board

- **July meeting** - None.
- **August meeting** – None.
- **September** – None.

Recommendations for the board

- **July meeting** - None.
- **August Extraordinary Meeting** - The Committee approved the recommendation to the ICB Board that the Business Case for the Plymouth Health and Well-Being Centre be submitted to NHS England.
- **August meeting** – None.
- **September** – None.

Recommendations for other committees

- **July meeting** - None.
- **August meeting** – None.
- **September** – None.

Terms of reference or other committee effectiveness issues

- **July meeting** - None.
- **August meeting** – The Chair suggested that the ToR's to be reviewed in six months' time – February 2023.
- **September** – 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.