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Published 17 October 2024

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL – SUPPLEMENT PACK

Tuesday 22 October 2024
2.00 pm
Warspite Room, Council House

Members:
Councillor Murphy, Chair
Councillor Ms Watkin, Vice Chair
Councillors Lawson, McLay, Morton, Ney, S.Nicholson, Noble, Penrose, Reilly and Taylor.

Please see enclosed additional information.

Tracey Lee
Chief Executive

Health and Adult Social Care Scrutiny Panel

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	22 October 2024
Title of Report:	**Winter Planning**
Lead Member:	Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Gary Walbridge (Strategic Director for Adults, Health and Communities)
Author:	Chris Morley (NHS Devon ICB)
Contact Email:	democraticsupport@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
To provide the Health and Adult Social Care Scrutiny Panel with an update on the development of plans for managing pressure during the forthcoming winter period, an overview of the Plymouth Healthy Lives Partnership's 'One Plan and the seasonal vaccination programme.

Recommendations and Reasons
1. That the H&ASC Scrutiny Panel supports the plans being developed to respond to pressures ahead of the winter period

Alternative options considered and rejected
1. Not consider the report: Rejected as the H&ASC Scrutiny Panel has a duty to provide overview and scrutiny of local health services, as provided for by the 2013 regulations.

Relevance to the Corporate Plan and/or the Plymouth Plan
Working with the NHS to provide better access to health, care and dentistry;
Keeping Children, adults and communities safe;
Providing quality public services;
Being a strong voice for Plymouth.

Implications for the Medium Term Financial Plan and Resource Implications:
N/A

Financial Risks

N/A

Carbon Footprint (Environmental) Implications:
N/A

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

N/A

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Winter Planning: Presentation (NHS Devon ICB & Partners)							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

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Sign off:

Fin	**N/A**	Leg	N/A	Mon Off	N/A	HR	N/A	Asset s	N/A	Strat Proc	N/A

Originating Senior Leadership Team member: Gary Walbridge (Strategic Director for Adults, Health and Communities)

Please confirm the Strategic Director(s) has agreed the report?

Date agreed: 17/10/2024

Cabinet Member approval: Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care)

Date approved: 16/10/2024

Winter Planning

October 2024

Devon System Approach to Winter Planning

- Winter pressures are a predictable event and form part of local partners business as usual planning cycles.
- However, to maximise robustness and effectiveness of individual plans, it is essential that we coordinate actions and ensure that we are collectively focussed on the key issues that drive the additional pressures that we know winter will bring.
- As in previous years we have worked at both a local Plymouth system level and across wider Devon in development of our plans.
- We have built on learning from what worked well last year, and areas we could improve.
- National guidance on winter planning has also been shared, including self-assessment exercises to assess readiness, the output of this has been incorporated into our planning at all levels.
- Clear communication strategy based on preventing infections (e.g. through effective hand and respiratory hygiene) and staying healthy, encouraging seasonal vaccine uptake, particularly amongst those at greatest risk and those experiencing health inequalities, and knowing which service you need, with a focus on helping to keep the elderly or those with long-term health conditions out of hospital.

Plymouth System Winter Approach

- Joint work between ICB and PCC commissioning team to maximise our ‘Homefirst’ approach to discharge matching reablement capacity along with ensuring availability of long-term domiciliary care, and development of placements for individuals with complex/specialist needs (e.g. complex dementia and people living with obesity)
- Clear approach to local escalation protocols to ensure any issues/delays are escalated in a timely way to enable agreement and delivery of short-term tactical actions across partner organisations.
- Delivery of Urgent & Emergency Care focus areas (Urgent Community Response, Virtual Wards, Falls/Frailty/End of Life, Acute Frailty, Same Day Emergency Care, Urgent Treatment Centres)
- Working alongside GP practices and Community Pharmacies to protect core business operations
- Central to local plans is the delivery of the Healthy Lives Partnership (UHP & Livewell) ‘One Plan’ approach to improve access, quality of care and patient experience of the UEC service offer and pathway - this is summarised on the subsequent slides

Seasonal Vaccinations

- Covid and flu vaccinations are now available to people in at-risk groups.
- Eligible groups include people aged over 65 and those in clinical risk groups.
- You can book your jab using the National Booking Service or by calling 119.
- You may also be contacted by your GP practice.
- For the latest NHS information and advice about coronavirus and vaccinations visit the NHS website.
- People between the ages of 75-79 or those who are pregnant are also able to have the new RSV vaccination this winter and should speak to their GP practice or midwife.
- We have seen good early uptake with people attending their GP, pharmacy or vaccination centre.
- Stay Winter Strong, reduce the spread of viruses and reduce demand on our busy GPs and hospitals.

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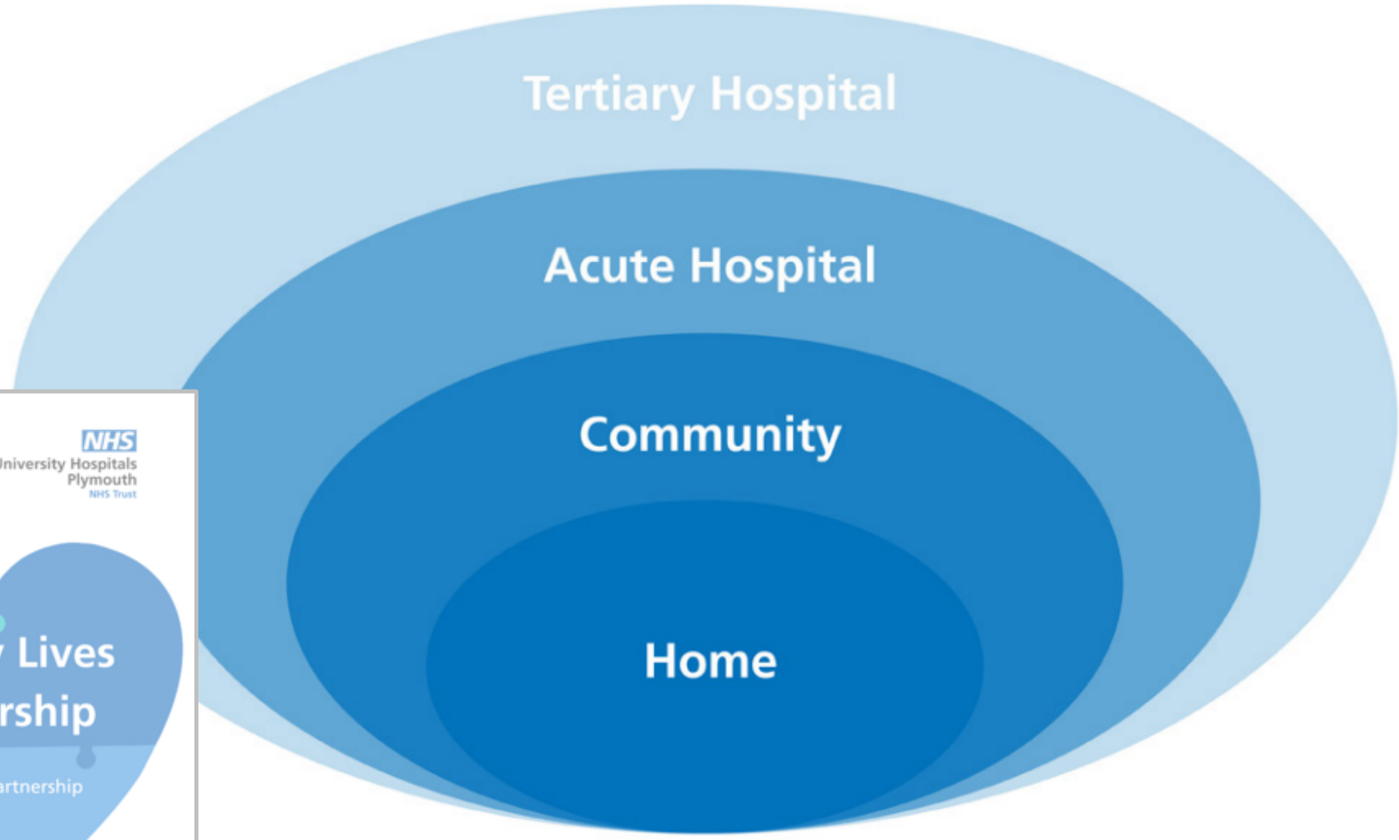
UHP One Plan Overview

Restoring high quality access and care to our UEC services

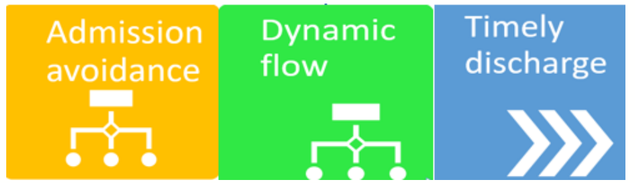
Our Care Model

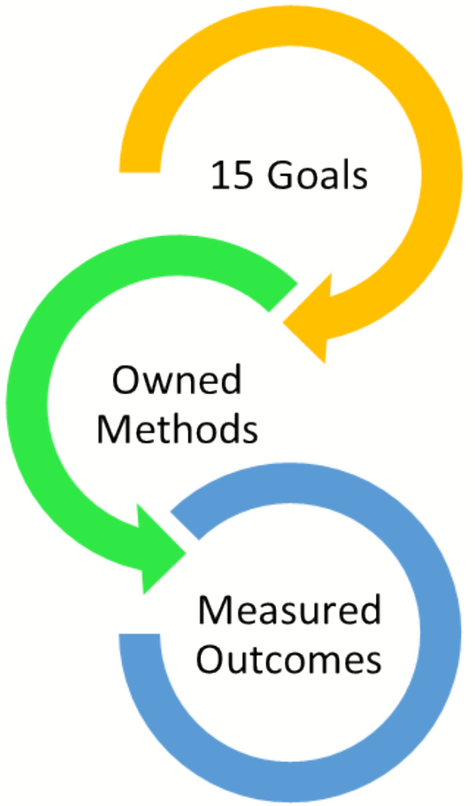


Put people first
Take ownership
Respect others
Be positive
Listen, learn, improve

Introduction

- This is our trust plan for improving access, quality of care and patient experience in our UEC service offer and pathways
- The transformation actions are critical to decompress our ED and reduce and prevent harm as a consequence of overcrowding, also addressing the improvements in quality and safety (section 29a)
- Our plan has three improvement pillars and 4 stages of implementation for resilient, consistent and long-lasting improvement in quality, operational and outcomes to be a high-quality organisation
- Our plan centres upon 15 goals for improvement , with a clear method to achieving the goals and improvements in quality and performance outcomes
- Our plan is clinically led, co-designed and managerially supported
- Our plan has been developed in partnership with our community provider Livewell Southwest
- Seeking a significant move to increasing our community alternatives and supporting care at home





Current State to Future State

Current State

- Worst performing NHS Hospital for ambulance hours lost
- 4 hour standard averaged 54.7% last year
- Section 29a Improvement Notice for our Emergency Department
- Outlier compared to our peers and national averages for higher admissions for frailty, falls, end of life, respiratory, urology, cardiology
- Limited range of alternatives to ED/admission in the community
- Outlier for medicine admissions (37.8%) compared to the median (28.5%)
- ED assessment areas and SDECs too small for the population we serve and to ensure we reduce overcrowding and be more efficient
- ED too small for the activity it now need to provider for on a daily basis, including no collocated UTC
- Lack of integrated front door services with our community provider
- Outlier compared to peers and national average for deaths in an acute bed (palliative care)
- Discharge Delays averaged 12% last year

Future State

- improved performance for ambulance hours lost by March 25 (median England hospitals)
- 4-hour standard to perform at a minimum of 77.9% by March 25
- Section 29a Improvement Notice lifted
- Median range or better for our admissions for frailty, falls, end of life, respiratory, urology, cardiology
- Substantially expanded community alternatives, supported through our community care coordination function, including 125 community Virtual wards beds
- Medical admissions conversion rate in-line with national median
- Rightsized SDEC/ MAU and physician capacity and opening hours reducing admissions by 16 per day
- Collocated UTC open
- Integrated admission avoidance UCR pull team
- Reducing deaths in an acute setting, bringing us in line with peers
- Discharged delays reduced to 5%
- 75% of patients on a complex discharged pathways supported home, reducing further demand for intermediate care bedded capacity

Principles of Our Plan

Enabled By:
- Future Investment
- Capital solutions
- Increased acute medical sessions
- Changes to use of existing capacity and resources

Output:
- Sustained improvements in ambulance waits
- Removal of overcrowding
- Right care, in the right place at the right time

Underpinned by:
Allocative Efficiency
Technical Efficiency
Equity of outcome
Value Propositioning

Put people first
Take ownership
Respect others
Be positive
Listen, learn, improve

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The right care, in the right place, at the right time to meet the needs of the patients and communities we serve

Admission avoidance

Avoiding admission by treating people in the community and as same day emergency care patient reducing the requirement for them to be admitted

- Increasing virtual ward capacity, particularly for the frail elderly
- X-ray car to attend patients with suspected fractures in the community
- Hot clinics for patients to return to
- Direct referral into specialist services e.g. paediatrics, early pregnancy, fractured neck of femur (NOF), urology
- Increase community services particularly for frail patients
- Right sized assessment units

Dynamic flow

Making sure patients get to the right place for their care with the right person

- Right sized Same Day Emergency Care (SDEC) and Medical Assessment Units (MAU)
- Senior decision makers at key points in patient pathways
- Supporting non-operable fracture patients in the community
- Increase alternative ambulatory services
- Increasing community beds for EOL
- Ambulances taking patients direct to SDEC and other areas, e.g. for stroke care and fractured NOF
- Alternative pathways for trauma

Timely discharge

Getting patients home to their place of residence asap

- Increasing the number of complex patients discharged home with appropriate support
- Community IV antibiotics
- Timely clinical review for outlier patients
- Improved management of frail people to improve rehabilitation/recovery
- Enhanced therapy pathways for the assessment and management of patients

Measures of success:

- 70% 4 hour target
- 70% ambulance handovers <15 mins
- Reduced length of stay
- Delayed discharges
- Better patient experience feedback

Visual Summary Future Model- Additional Services
NB- numbers related to business case references

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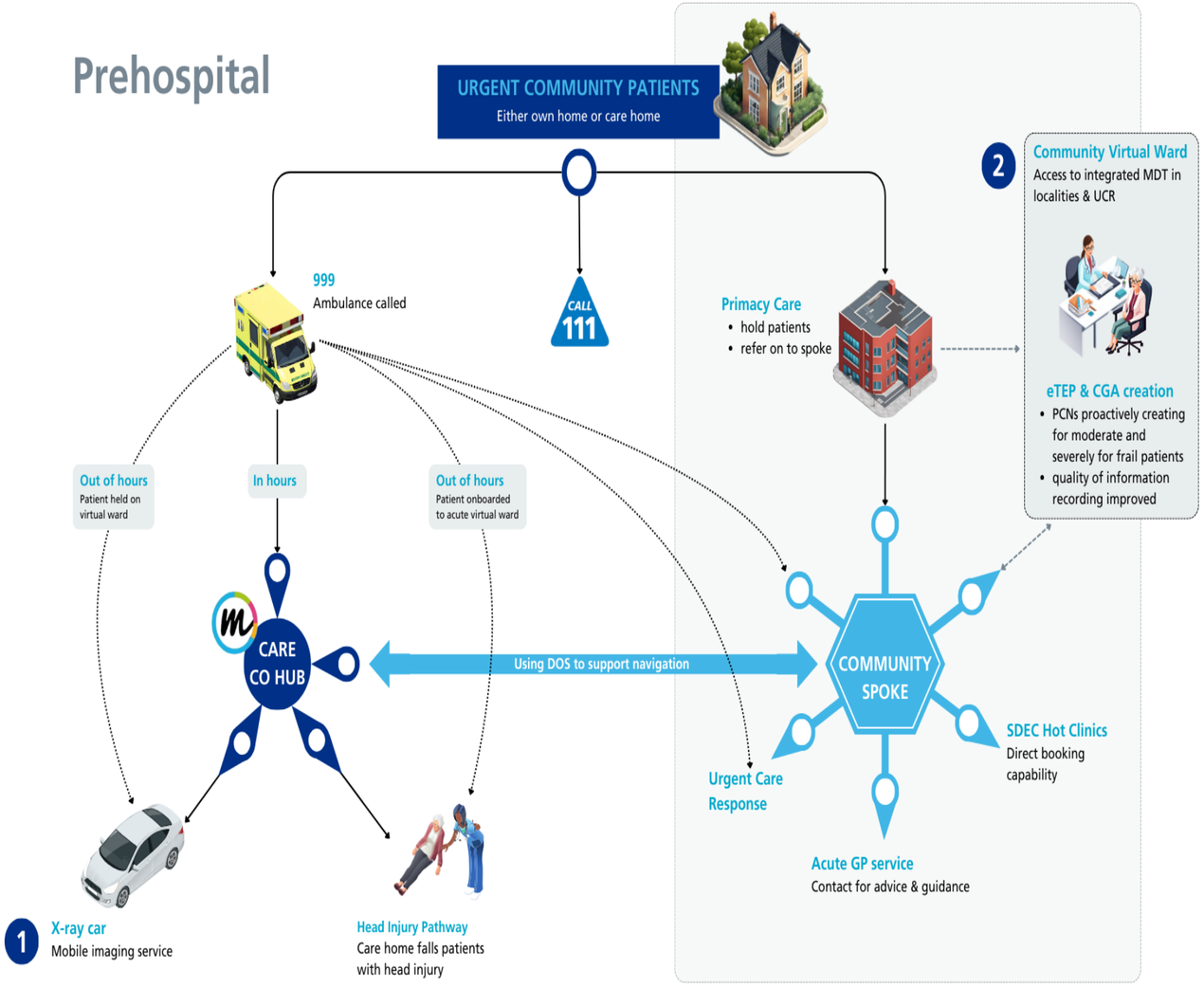

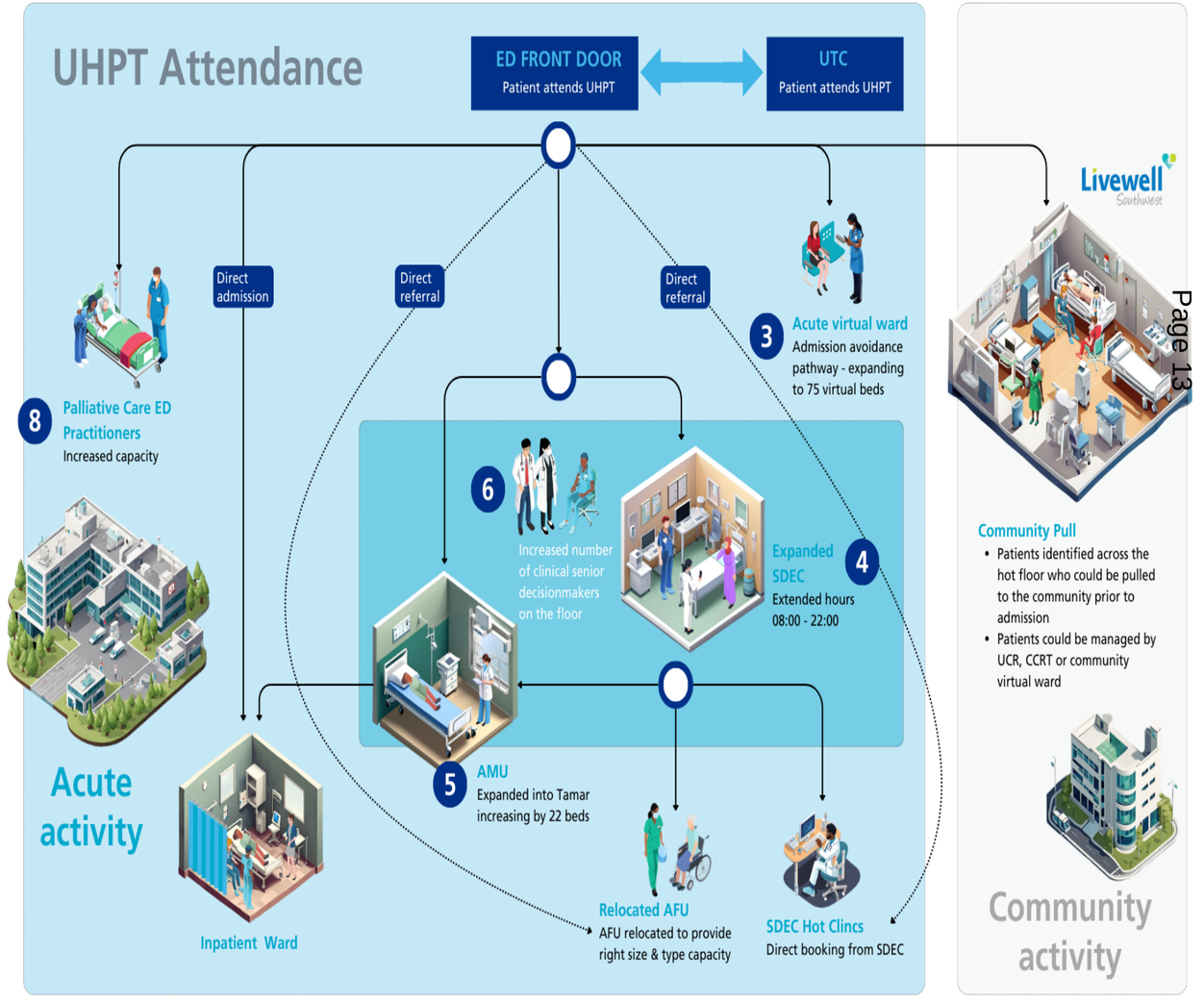

Visual Summary Future Model- Additional Services

University Hospitals Plymouth NHS Trust

Flow & Discharge

WARD BASED CARE
Discharge preparation

8

EOL Patient Identification Clinicians

St Lukes
Specialist Inpatient & Hospice

NOF Bay

Preferred place of death

Discharge Coordination Hub (DCH)
- Management of complex delays and planning
- Demand and capacity management
- of intermediate care pathways

Delay management / increasing **P1**
Capacity and right-sizing **P2**
capacity based on demand

Home

Mount Gould Dove Unit
Expanding from 4 - 12 beds

Acute activity

Livewell Southwest

7

ESD Inreach and Capacity (Stroke)
- Direct pull into ESD community service
- ESD inreach and capacity expansion
- Integrated stroke pathway MDT approach

Livewell Southwest

IV community pull
Identification and pull of appropriate patients to support early discharge into UCR / virtual ward

Community activity

	Overview of One Plan Goals	Business Case Required
	Admission Avoidance	
1	**We will ensure clinical senior decision makers are available in MAU and ED to ensure rapid assessment and development of treatment plans to patients that meets the daily average demand between 0800-2000hrs in MAU and 0800-2200 in ED which will reduce 4hr waits in ED by a further 2.5% in August increasing to 5% from December and time to treatment to an average of 150 minutes and reduce time to transfer to MAU (mean time in department) by 25% by 30th September 2024**	YES BC/oneplan/06 Impacts combined with MAU
2	**We will increase the number of patient treated through streaming to Same Day Emergency Care (SDEC) as opposed to through ED patients by 5% by 31st July 2024 (16 per day), through increased staffing capacity of acute physicians by 5 wte in SDEC, creating new pathways for the top 10 common ambulatory presentations to ED/MAU and increasing direct referral which will improve ED 4hr waits daily by 5%**	YES- SDEC BC/oneplan/04
3	**We will deliver an increased MAU capacity for medical admissions from 51 to 73 beds by 30th July 2024 which will reduce ED waits > 4hr by 2.5% supported by a new acute medical model which will increase zero-day length of stay by 2.5% reduce conversion to specialty admission and reduce conversation to inpatients wards to the national average of 28.6% and reduce occupied beds from 30th September 2024.**	YES BC/oneplan/05
4	**We will introduce alternatives to attendance and ambulance conveyances or conveyances to ED through use of Care Coordination and use of new/existing pathways for direct transfers to streaming or community alternative services which will reduce ED attendances by 168 per month by March 2025 for the following; EPAU (-75 per month from June) / EOL (-11 in Sep'24 rising to –22 from Oct'24) / Falls (–37 in Sep'24 rising to –71 from Nov'24) .**	YES BC/oneplan/01 BC/oneplan/02 BC/oneplan/03
	Dynamic Flow	
5	**We will deliver a re-sized and realigned bed capacity including the opening of the remaining 23 medical beds on Avon and increasing medical beds by 36 to increase the medical bed base from 557 to 596 for specialities to support medical demand by 30th September 2024 Reducing medical outliers and improve medical length of stay by 0.5 days which will deliver improved bed day usage to an equivalent of 30 beds by 30th September 2024.**	
6	**We will deliver an increased Rapid Assessment and Treatment space to 3 cubicles by the 31st July 2024 that will reduce Time to triage for ambulances from 25 minutes to 15 minutes.**	YES BC/oneplan/06
7	**We will expand our community virtual ward offer for the effective planning, assessment and management of patients whom condition deteriorates and/or can be supported back home from our ED and assessment areas. Wrapping around them our**	YES BC/oneplan/03

	Overview of One Plan Goals	Business Case Required
	Dynamic Flow	
8	We will scope and expand a community intravenous therapies and infusions service that meets the demand and capacity of 20 patients a day by 30th September 2024 to reduce 10 in-patient beds per day.	
9	We will deliver improved pathways for Fractured Neck of Femur (NOF) and Non admitted fractures (NAF) avoid 3 admissions per day and admit 2 direct from ambulance 30th June 2024 and reduce occupied bed days by 20 and reduce length of stay by 2 days.	
10	We will deliver an improved ambulatory and diagnostic surgical pathways to SAU which reduces the time to decision to admit and reduce admission by 5 patients per week by 31st December 2024	
	Timely Discharge	
11	We will deliver a reliable and consistent standard ward processes using SHOP principles by the 30th September 2024 that will improve discharges by midday to 25%	
12	We will establish an integrated discharge co-oridnation hub (TOC) for the rapid and effective discharge of patients from hospital beds across UHP for pathways 2 and 3, and supporting a single point of access for pathway 1. It will reduce time of delay for discharge from 52 hours to 24 hours would generate a further 1,172 bed days per year By the 31st July 2024.	
13	We will ensure early supported discharge services have appropriate capacity to support discharge at point the patient is medically fit for stroke pathway patients and deliver a delay of no more 24 hours for referral reducing length of stay by an average of 14 days and support 60% of patients in 24/25, releasing 12 outlier beds by September 2024	YES BC/oneplan/07
14	We will increase the number of patients who are supported to die in their preferred place of death by 1,262 per year, reducing the number of deaths in the acute site by 642 per year. Working with specialist end of life partners to, introduce care professionals (registered and unregistered staff) who will actively identify, facilitate transfer of care and holistically support carers and patients to an alternative location of care (Mount Gould end of life beds, in first phase and bridging for community packages), increasing from 4 to 12 beds by September 2024	YES BC/oneplan/08
15	We will champion that home is best and increase the number of people we are supporting home with or without support following an acute or community stay. Resulting in moving from 42% of patients on complex discharge pathways home with support to 75% within 24 hours of being ready for onward care at home by September 2024.	

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Quality and Safety impact

Implementation of the one plan is expected to have measurable impacts on the quality and safety of care provided across the Trust. Through improved quality and safety risks, as well as addressing variation, the one plan has patient centred quality improvement at its core and is expected to make sustained impact on patient and staff experience.

Reduced crowding and waits, timely assessment, avoided admissions appropriate flow and timely discharge will:

- Improve experiences of care
- Reduce crowding
- Eliminate board
- Reduce risk of hospital acquired infections attributable to crowding
- Reduce variation
- Enhance privacy and dignity
- Support our most vulnerable and their colliding needs

Summary of the Demand and Capacity Impact of One Plan- 75% success rate

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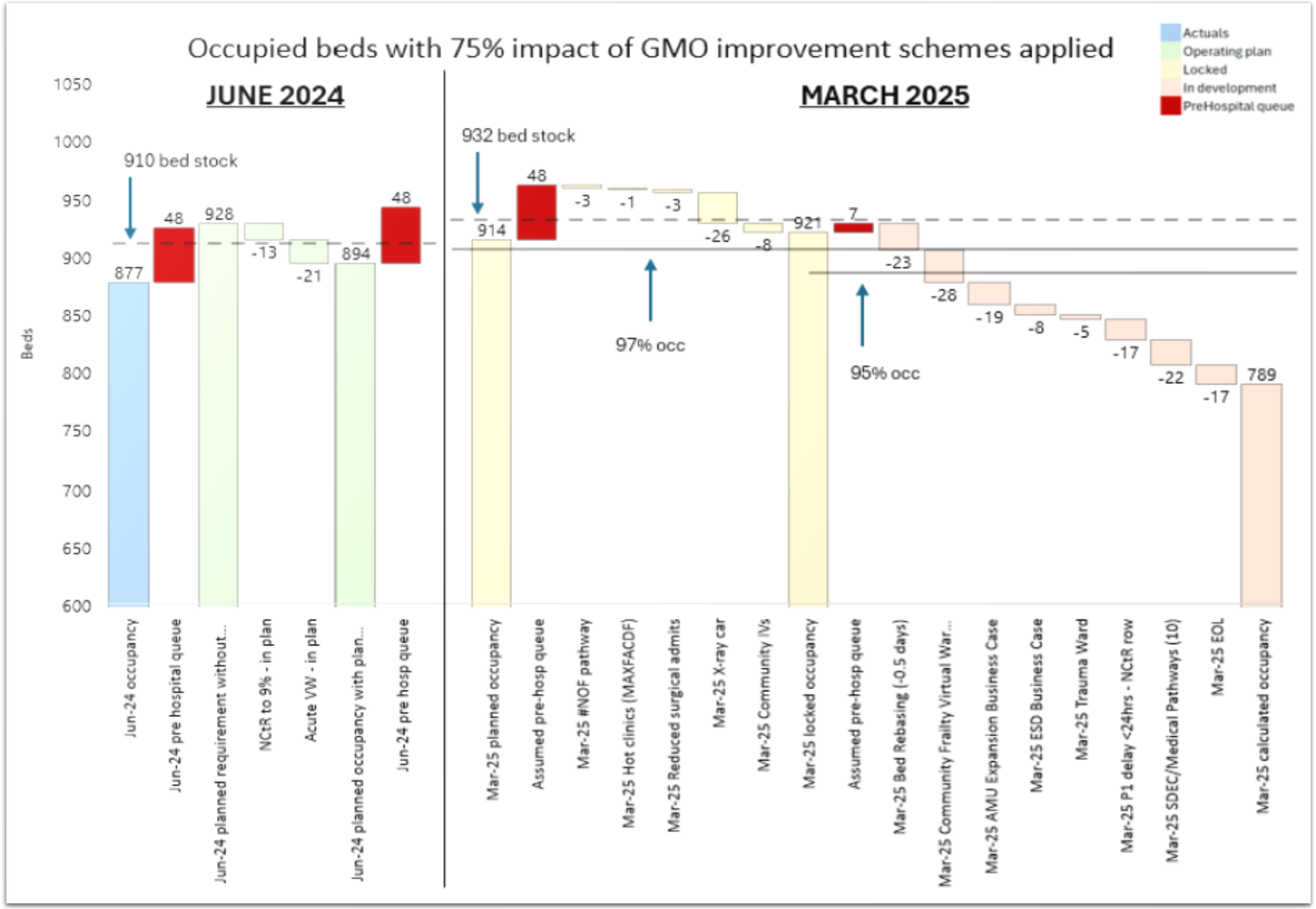

Assumptions

75% success rate of all improvement schemes

Demand doesn't increase

NCtR remains at 9%

Pre hospital queue cleared as priority

Next Steps

We will develop over Qtr2/3 options for this liberated capacity to support current year and future years patient needs

We are also reviewing impact on community beds

Governance

- One plan PMO and PMO room
- PID and weekly highlight report owned by SROs
- Programme Governance in place for all schemes
- Weekly CEO led portfolio board reviewing progress, dealing with escalations and course correction, collaborative working across LSW/UHP with care groups
- Quarterly deep dive report to trust board
- Monthly IPR to trust board
- ICB assurance through locality meeting and SIAG
- Ongoing Engagement to shape design and awareness of new services with care home steering group, LMC, PCNs, coroner, SWAST, care co-ordination, and UHP and LSW operational teams

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Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	22 October 2024
Title of Report:	**End of Life Care**
Lead Member:	Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Gary Walbridge (Strategic Director for Adults, Health and Communities)
Author:	Chris Morley (NHS Devon ICB)
Contact Email:	democraticsupport@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
To provide the Health and Adult Social Care Scrutiny Panel with an update on the delivery and progress against the end of life care recommendations agreed by the committee at their February meeting.

Recommendations and Reasons
1. That the H&ASC Scrutiny Panel considers the improvements made in the provision and performance of End of Life Care in Plymouth.
2. That the H&ASC Scrutiny Panel supports the continued improvement and development approach being undertaken within the city and support partners with its delivery.
3. That the H&ASC Scrutiny Panel help to raise awareness of the death literacy, promotes the importance of talking about death and supports the development of Plymouth as a Compassionate City.

Alternative options considered and rejected
1. Not consider the report: Rejected as the H&ASC Scrutiny Panel has a duty to provide overview and scrutiny of local health services, as provided for by the 2013 regulations.

Relevance to the Corporate Plan and/or the Plymouth Plan
Working with the NHS to provide better access to health, care and dentistry;
Keeping Children, adults and communities safe;
Providing quality public services;
Being a strong voice for Plymouth.

Implications for the Medium Term Financial Plan and Resource Implications:
N/A

Financial Risks

N/A

Carbon Footprint (Environmental) Implications:
N/A

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
N/A

Appendices
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A	End of Life Care: Presentation (NHS Devon ICB & Partners)							

Background papers:

**Add rows as required to box below*

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Sign off:

Fin	**N/A**	Leg	N/A	Mon Off	N/A	HR	N/A	Asset s	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Gary Walbridge (Strategic Director for Adults, Health and Communities)											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 14/10/2024											
Cabinet Member approval: Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care) Date approved: 14/10/2024											

End of Life Care Plymouth

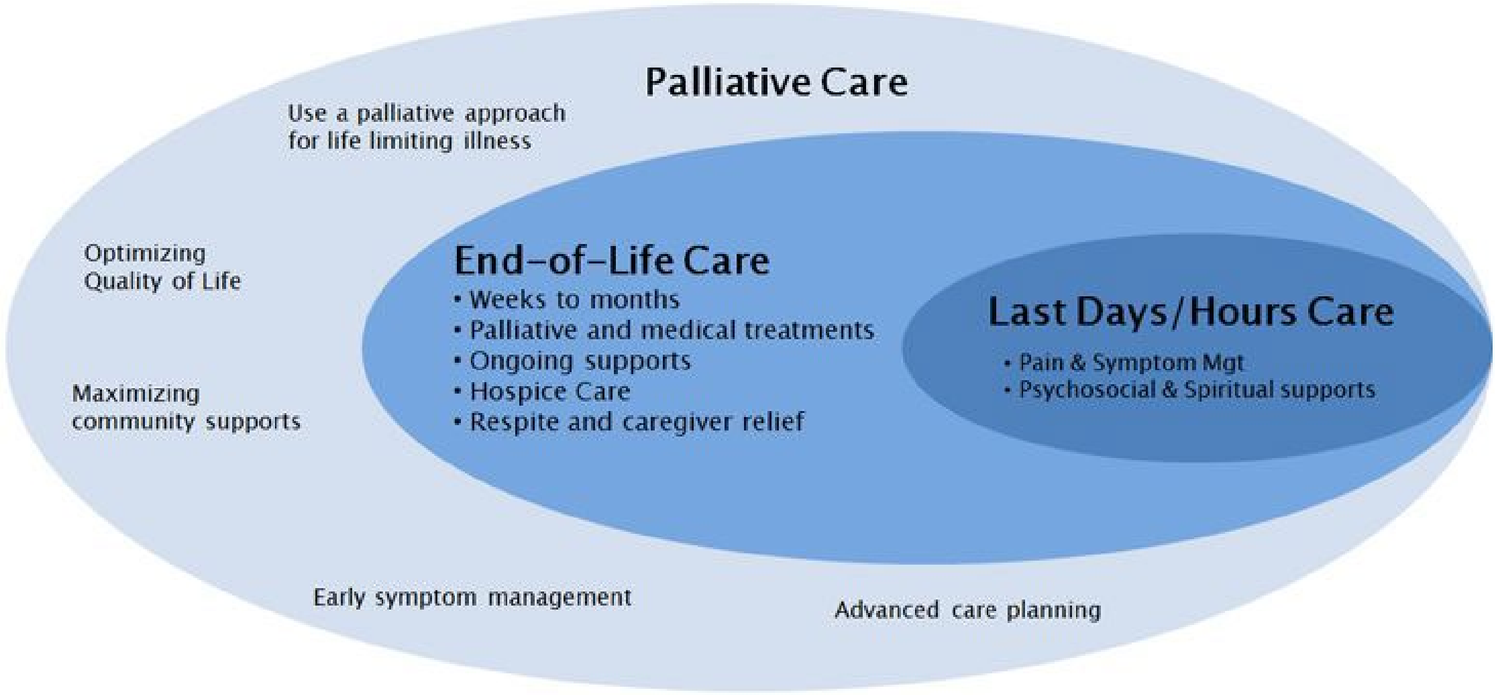
October 2024

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

Recommendations - March 2024

1. **Update on performance against the End of Life Care Improvement Plan**. This is to include delivery of the Palliative Care framework, findings of the Estover Pilot Project, and additional information on the below recommendations.
2. NHS Devon and Partners take into account and record people's preferences for place of death.
3. NHS Devon and partners return at a future time to report on falls prevention measures being undertaken and related performance.
4. Work to **reduce the delay in testing and diagnosis** to enable maximum choice for patients spend their remaining time in the way/location that they wish.
5. Adopt processes to include patients' relatives in the planning and administration of care for their loved ones (where applicable, and consent given). This includes consultation in the development of a Treatment Escalation Plan (TEP).
6. The Council, in partnership with City organisations and individuals, seek to promote and recognise St. Luke's communication of "**Care in the community" and "the hospice coming to you**", rather than the misconception of patients having to be admitted to a hospice.
7. The Cabinet Member for Housing, Cooperative Development and Communities (Cllr Penberthy), ensures that the **Housing Needs Assessment** considers housing standards, and their appropriateness, for individuals with a variety of medical needs (Accessibility and quality).

Refresh



Expected deaths	Population	Expected death rate	Cancer	Organ failure	Frailty	Sudden death
Plymouth CC area only	264,700	2647	662	794	1059	132
			25%	**30%**	**40%**	**5%**

End of Life Locality Plan

Milestone Description	Owner	Milestone Update - 17/9/24	Status	Due date*
Consistent use of a tool to **identify of End of Life phase** and embedding DCCR End of Life register	NHS Devon	Task and finish group started to embed use of tool locally	Off track - recoverable	30 /09/ 24
Ensure the End of Life care service offer is universally understood with a **central information point for individuals** and system partners	St Lukes	First iteration of EOL Care Co-ordination hub for St Lukes patients has started	In Progress / On track	31 /03/ 25
Undertake **demand and capacity analysis** for End of Life care, including assessment of needs and gap analysis	All partners / NHS Devon co-ordination	Information received and being reviewed and added into Devon wide workplan	In Progress / On track	30 /09/ 25
Complete an options appraisal and develop commissioning intentions to meet any identified needs	NHS Devon	Part of NHS Devon EOL review - task and finish group leading work	In Progress / On track	31 /12/ 24
Use the National Audit of Care at the End of Life (https://www.nacel.nhs.uk/) to ensure priorities for individuals are being met and use this audit to evaluate any service improvements	UHP and St Lukes	Audit underway in Autumn 2024	In Progress / On track	31 /12/ 24
Ensure **specialist end of life support** is embedded in the local coordination hub for urgent and emergency care (7 days 8am-8pm)	NHS Devon	Care Co-ordination hub provider moving to Practice Plus Group mid October 2024 NB: please note action above: SLH Coordination hub remains on target and will offer local solution.	On hold	30 /11/ 24
Development and implementation of an **End of Life care communication and training resources** on Hive which includes implementation of a data capture process to monitor End of Life care training uptake	Training partners	Series of webinars being held over 6 month period - joint initiative UHP / LSW - Hive pilot underway to small group of organisations	Off track - recoverable	31 /12/ 24
Developing a strategy for working with communities to expand 'death literacy', building on community assets and the Compassionate City programme	all partners	Plymouth Compassionate City work is being showcased as exemplar of Good Practice at Hospice UK National Conference, Nov 2024: (insert slide of Poster)	In Progress / On track	30 /09/ 24

Estover Project

What we wanted to achieve

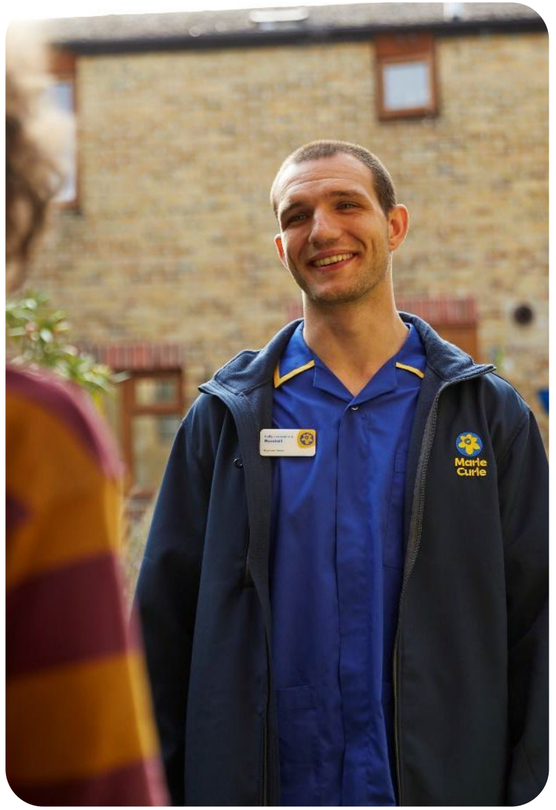
1. Improve the knowledge and culture around dying, death, and bereavement
2. Improve the identification of people nearing the end of their lives
3. Improve the wellbeing of residents and reduce feelings of social isolation
4. Take a proactive approach to Advance Care Planning
5. Aim to work with 200 people over 6 months

What we have found

- **Terminology –** What do we mean by end of life?
- **Recognition –** What is the difference between being frail or having deteriorating health and someone approaching the end of their lives?
- **Conversations –** Whose "job" is it to discuss what matters to people nearing the end of their lives
- **Holistic care -** health and well-being are influenced by a wide range of factors

What we have done

- Community engagement approach
- Senior nurse embedded in GP practice
- Over **70** patients supported and assessed



Estover

Community Engagement - Place Based Project

- Improve knowledge and culture around dying, death and bereavement.
- Improve wellbeing of residents, reduce feelings of social isolation. Recruit volunteers. Introduce Advance Care Plans.
- Improve identification of people nearing end of life.

ESTOVER COMMUNITY

Advanced Care Plans

ONGOING…
- Referral route?
- Delivery?

Stakeholder Communications

- Improving Lives / Mannamead Wellbeing Hub
- Plymouth City Empowerment Manager
- Estover Local Councilor
- ElderTree
- Elm Wellbeing Hub
- Runnymede
- Asda
- Leypark Court
- Estover Library
- Christ Church
- University of Plymouth and Marjon's University - student placements
- Eldertree
- St Lukes
- Pie Club
- Veterans – RBL
- Plymouth Community Homes

**** Socially Isolated, Homebound, Minority Groups**

- Plymouth Community Homes – direct contact between tenants and housing officer.
- Estover library – home visits, read and natter. Dates arranged with Runnymede – new service
- YOUNG MINDS event Local Pub
- Plymouth City Community Digital Volunteers – home visits, new service
- Plymouth Pie Club - befriending
- SART student and refugees together
- Veterans RBL
- Improving Lives Mannamead Hub

Community Events /Static Displays

- Dying Matters – Let's Get Talking
- Pentillie Castle – Celebrating Volunteers and Sponsors
- Elm Community Hub – Relaunch
- Static displays - Marie Curie Information and Support: Asda, Runnymede, Leypark Court, Marjons University, Consort House, Estover Library
- Local Pub – Young Minds TBC

Volunteer Recruitment/Advertising

- Plymouth University and Marjon's University: Negotiations in place to explore recruiting volunteer student nurses.
- Recruitment and Life Café posters displayed: Asda billboard; local businesses socials/website, Marie Curie socials, Plymouth City Empowerment, Elm Wellbeing Hub; Runnymede newsletter, Christ Church newsletter, Pentile Castle, St Lukes retail shop, Consort House… ++

Community Engagement

Elm Wellbeing Hub:
Networking – XL poster FOC displayed on Asda grounds. Dying Matters – in partnership with St Lukes. Marie Curie stall – Hub relaunch.

Christ Church:
Networking -Compassionate Friends training (St Lukes)
Use of room FOC

Asda Superstore: Display table/area offered, FOC.
Staff training rooms, FOC.
Will provide snacks and light refreshments

Estover Survey / Life Café evaluation

Impact and Evaluation in progress.

Inclusivity/Diversity **

SEE **

Life Café Sessions

Runnymede Assisted Care Home

Estover Library + drop by. I&S Display

Leypark Court PCH date tbc

Staff Training: Consort House, Eldertree date tbc, Leypark Court provisional date.

Interim Evaluation results

- There has **been more timely access to appropriate support for people living with a terminal illness**. The work undertaken in the GP surgeries has provided support including assessment of those on the palliative or end of life registers and holistic support for their wellbeing.

- Although we have not had direct feedback from patients, GP surgery staff felt that **the work of the SN addressed patient wellbeing** through talking about their worries and concerns. This can be illustrated through the holistic work enabling a patient to be able to access their outdoor space.

- At least one patient **avoided an ED admission** and the GP surgery staff felt that the demand for appointments would reduce as the SN addressed worries and concerns and reviewed all patients on the palliative and end of life register.

What next?

- Extend to all surgeries in Sound PCN
- Proactive management of EOL / Palliative Care registers
- Convert Senior Nurse post to Advanced Clinical Practitioner
- Seek funding to extend pilot
- Explore joint working with local volunteer delivered services

ED & End of Life Bed Base at Mount Gould (Patient Outcomes)

Achievements and Outcomes

University Hospitals Plymouth NHS Trust

End of Life Education

30 non-medic colleagues trained to complete high quality Treatment Escalation Plans in the Trust

160 colleagues educated in **better recognising and supporting the dying patient**

Redesigned mandatory end of life eLearning package and all staff Trust induction

Supported 150 colleagues across the locality in the roll-out of electronic Treatment Escalation Plans

900+ colleagues have received end of life education I the last year because of Nicki's appointment

End of Life Care at Mount Gould

Flexed position of end of life **4 beds** (2 on Kingfisher and 2 on Skylark)

147 patients transferred to Mount Gould end of life bed

Average length of stay of 9 days

1329 bed days provided away from acute bed base

131 patients **died on site**

16 discharged for **onward care**

Average of **14 patients per month** supported

End of Life Care at UHP (Main Site)

Received **1621 requests for specialist advice** from healthcare colleagues

Supported 698 deaths in the Trust with specialist advice, symptom control and emotional support for patients and carers

Provided 4,434 face to face contacts with patients

Managed a changing caseload, where predominantly those supported are dying from a **non-cancer related illnesses (55%)**

End of Life Care at ED

In 15 months, **440 patents have been supported** by the service

Of this group of people, 86% were supported to die **away from our ED**

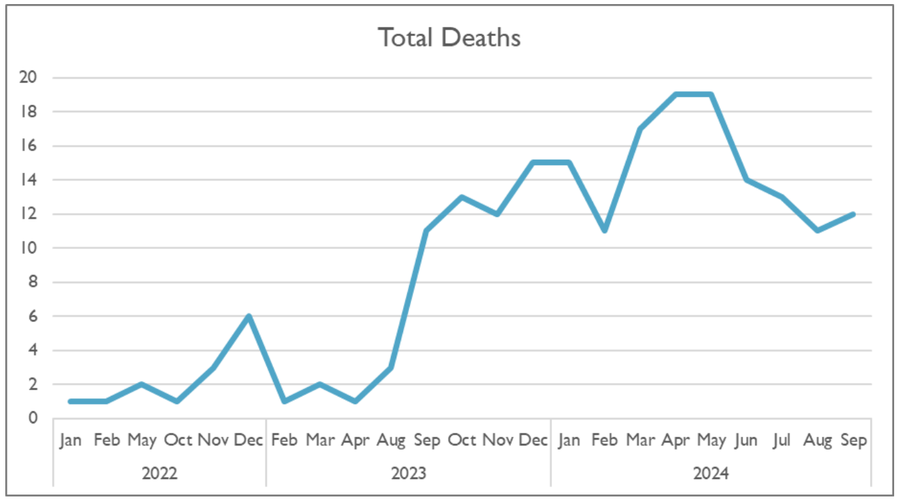
In the last three months, **20% of those patients were transferred to Mount Gould** for End of Life care and/or onward care planning

77% of patients **receive review of the TEP** documentation, supporting appropriate onward care

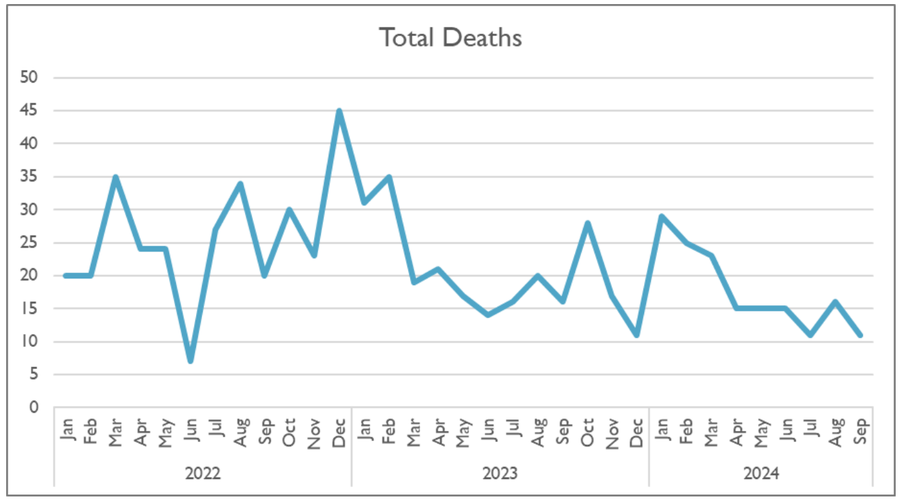
Put people first
Take ownership
Respect others
Be positive
Listen, learn, improve

Brief Update re MG EoL Bedbase

University Hospitals Plymouth NHS Trust



Skylark and Kingfisher deaths



ED Deaths

- A bed base of 4 End of Life beds represents circa 12.5% of all Trust deaths in recent months (average 17 deaths a month in last 6 months)
- These four beds support a death every other day

Put people first
Take ownership
Respect others
Be positive
Listen, learn, improve

High Level Overview – Three Areas of Development

University Hospitals Plymouth NHS Trust

Front Door ED & Hot Floors

A team of four practitioners based in ED

- Supporting better deaths in the department
- Supporting pre-conveyance, with dedicated telephone support, 7 day service, physical outreach where absolutely essential
- Avoiding 260 conveyances pa

Supported by Marie Curie NA in ED – supportive care for those dying in the department, 7 day service

In-Hospital Team Service

- TUPE of St Lukes in-hospital team to UHP management
- Continue to support 1621 (2023/2024) referrals for specialist support and advice (inpatients)
- Providing 4434 face to face interactions and over 5000 contacts (2023/2024)
- 2024/2025 - Further develop support to areas of non-malignancy

Joined by Marie Curie, 7 day service; dedicated patient identification service for those who do not require use of acute bed. To actively identify and expedite discharge for 624 patients pa

Supportive and Palliative Care Beds at Mount Gould

- Co-delivery model with Marie Curie staff working alongside existing UHP Mount Gould nursing team
- Supporting better deaths away from acute bed base, where no other community option suitable/available
- Providing stepped bed availability 4 (6) > 8 (10) > 12 (14)
- Providing 4380 bed days

Specialist in-reach from ED based UHP team and consultant cover from in-hospital team

Put people first
Take ownership
Respect others
Be positive
Listen, learn, improve

St Lukes Hospice “Every Death Matter 2024 -2027

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AIM TWO

Our aim is to provide a strong voice for end-of-life care patients using our expertise to influence health and social care partners and improve services.

INTEGRATED STRATEGY

Act as a driving force in the creation and implementation of a local end-of-life care strategy which reflects national standards and best practice.

COORDINATION

Play a leading role with system partners in reimagining the approach to coordinating end-of-life care services which meets the needs of patients and their loved ones.

FRAILTY

Engage with system partners to shape the role of our end-of-life care services within the context of frailty in a way that meets the needs of our local community.

NATIONAL INFLUENCE

Explore opportunities for influencing the Integrated Care System and national bodies to improve end-of-life care services and secure the future sustainability of hospice services.

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WORKING IN PARTNERSHIP

OUR KEY ACTIVITIES WILL INCLUDE:

- Engaging with other health and social care partners to develop a clear strategy for end-of-life care in Plymouth and the surrounding area.
- Establishing a “coordination hub” providing a single point of contact for both patients and clinicians.
- Exploring what geographically dispersed bed provision might look like and develop a proposal for addressing winter pressures.
- Developing a clear role for St Luke’s in providing and/or supporting frailty services in the future.
- Engaging with other hospices to explore opportunities for working together and potentially sharing medical resources.

OUR SUCCESS WILL BE MEASURED BY:

- Operating within an integrated end-of-life care strategy that is adopted by all health and social care partners in Devon, including GPs and care homes.
- Increasing the number of patients with access to coordination hub support, advice, and response service by 30% in year three.
- Ensuring that 80% of our patients receiving end-of-life care have been identified as such on their primary care health records.
- Implementation of an end-of-life frailty service developed from national best practice models, for example, Dementia UK’s Admiral Nursing service for end-of-life care.
- 5% fewer end-of-life patients being unnecessarily admitted to an acute hospital and increasing urgent care packages by 5%.

Reflecting the voice and needs of our community

“ End of Life Care services should be better coordinated”

Strategy Focus this Year

Co-ordination and Earlier Identification are our key areas for development this year.

System Common Language

GFS Need	Coordination of Care
Blue	Start the conversations - Advanced Care Planning, the Clinical Frailty (Rockwood, Comprehensive Geriatric Assessments / active role within the Living Well MDT
Green	Ensure review and update of the above, Special Rules 1 completed to access benefits. Preferred place of care and death documented.
Yellow	Review all above and ensure is up to date. Review social network / care needs
Red	Urgent Care service to coordinate care

Compassionate City

FROM PLYMOUTH TO IPSWICH TO PRESTON:

COMPASSIONATE COMMUNITIES AWARENESS SESSIONS

ARE THE GIFT THAT KEEPS ON GIVING

BACKGROUND

Compassionate Communities is a public health approach to palliative care acknowledging that death, dying and loss are everybody's business.

St Luke's Hospice Plymouth created Compassionate Friends sessions in 2018, underpinning Compassionate Champions and Buddies schemes and supporting a Compassionate City Charter.

AIM

To optimise the impact and reach of compassionate community education by sharing and collaborating across hospices.

METHOD

St Luke's gifted their initiative to the team at St Elizabeth Hospice (Ipswich) who then developed Compassionate Conversations - online and in-person monthly awareness sessions co-delivered with volunteers.

St Catherine's Hospice (Preston) identified a need to improve death literacy in its community and was gifted awareness sessions and support from the Ipswich and Plymouth teams.

Compassionate Conversations was adapted by St Catherine's and delivered to community groups, nonprofits and volunteers. Sessions are evaluated and qualitative and quantitative data collected.

RESULTS

St Luke's have trained 850 people. Impact includes securing Charter status and the expansion of the Compassionate Buddies scheme into schools.

Since 2021, St Elizabeth Hospice has trained over 1,150 people, supporting a multi-hospice/partner bid for ICB and National Lottery funding to increase activities across Suffolk. Sessions are freely gifted to local partners, with many ripple effects.

Since 2023, St Catherine's have trained over 180 people. Sessions have supported four new community bereavement cafes and one independent bereavement support group.

Our combined efforts have trained almost 2,200 people.

CONCLUSION

With limited resources for developing new education programmes in hospices, partnership and collaboration creates a culture of peer-support and maximises the impact of tried-and-tested effective Compassionate Communities awareness sessions across the UK.

As more hospices adopt this Compassionate Communities approach, they can be gifted this ready-to-use awareness sessions, which ultimately increases the confidence and resilience in communities around death, dying and loss.

To receive your free gift of Compassionate Conversations awareness sessions, please just get in touch and see where this free tried-and-tested awareness sessions will take your communities.

COMPASSIONATE SCHOOLS
FRIENDS, CHAMPIONS AND BUDDIES

99% FEEL MORE CONFIDENT TO TALK ABOUT DEATH AND DYING

LEND (LISTEN, EMPATHY, NOTICE AND DO)

COMPASSIONATE CAFES
COMMUNITY OWNED AND LED

500,000 CONVERSATIONS

100% RECOMMEND THE TRAINING

"I now know how to approach and speak/ empathise with someone who is grieving [and] will speak more openly about dying."

"It has made me less hesitant in talking about death or talking to someone who is recently bereaved, to talk about their loved one."

"There were lots of people participating and it feels good to know there are so many people that are wanting to improve the support for young people."

"I didn't know about Compassionate Cafes before so I now have somewhere I can signpost bereaved people so they can get support in the community."

Authors (alphabetical order): Jenny England, Compassionate Communities Project Lead, St Catherine's Hospice, Preston | Judy Horne, Community Development Worker, St Luke's Hospice, Plymouth | Hugh McElhinney, Community Engagement Manager, St Elizabeth's Hospice, Ipswich
jenny.england@stcatherines.co.uk (St Catherine's Hospice Compassionate Communities Project Lead) | www.stcatherines.co.uk

1 Compassionate communities: end-of-life care as everyone's responsibility | QJM: An International Journal of Medicine | Oxford Academic (oup.com)
Kellehear A. Compassionate communities: end-of-life care as everyone's responsibility. QJM: An International Journal of Medicine. 2013; 106 (12): 1071–1075

2 https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-022-01032-0
Graham-Wisener, L, Toner P, Leonard R and Gerada, J. Psychometric validation of the death literacy index and benchmarking of death literacy level in a representative UK population sample. BMC Palliative Care. 2022; 21: article 145

Housing Needs Assessment

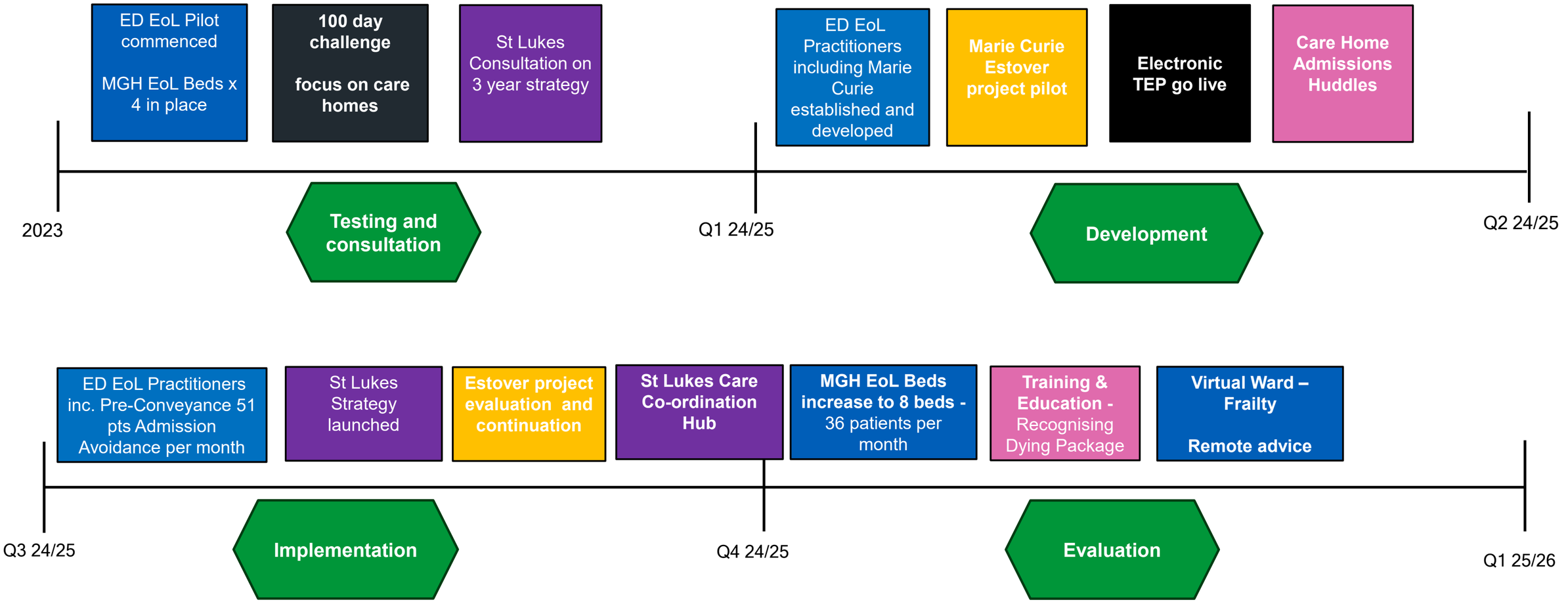
Recommendations

- People with housing experience and responsibility can and should be trained and become proficient in supporting people, their carers and families at the end of life – whether this is, for example, by being appropriately informed of good practice in compassionately carrying out their roles, by signposting to appropriate organisations for support or by escalating housing needs in light of agreed person-centred housing policies.

- Our housing system should become a more integrated part of cross-sector collaboration to improve end of life care and experience in Plymouth.

- A number of organisations have shared their experience and good practice online and these should be reviewed for the continuation of learning and improvement within Plymouth.

Locality End of Life Programme



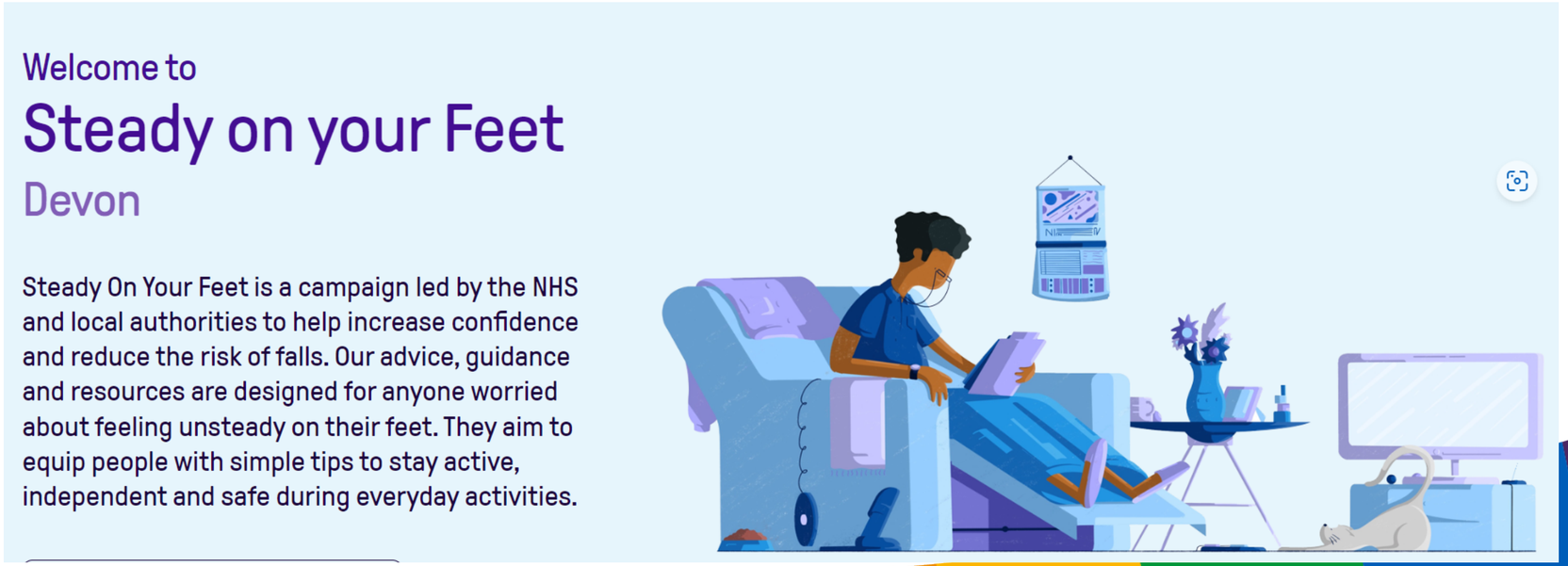
Falls Prevention

Funded for 2 years from Population Health Management programme – at least 320 people per year with a focus on health inequalities

[Falls Team | Livewell Southwest]

Funded until Sept 2025
Website with resources and personal falls risk assessment – details of local support

[Welcome to Steady On Your Feet Devon]



Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	22 October 2024
Title of Report:	**NHS Devon ICS Finance Update**
Lead Member:	Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Gary Walbridge (Strategic Director for Adults, Health and Communities)
Author:	Kirsty Denwood, Deputy Chief Finance Officer, NHS Devon ICB
Contact Email:	democraticsupport@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
The presentation of the Integrated Care System's (ICSs) Finance Report sets out the ICS financial position and risk relating to the ICS financial plan for the year ending 31 March 2025.

The report details the ICS financial position for the period ended 31 July 2024 against the finance plan submitted for the financial year 24/25 on the 12 June 2024.

Recommendations and Reasons
1. That the H&ASC Scrutiny Panel notes the contents of the report

Alternative options considered and rejected
1. Not consider the report: Rejected as the H&ASC Scrutiny Panel has a duty to provide overview and scrutiny of local health services, as provided for by the 2013 regulations.

Relevance to the Corporate Plan and/or the Plymouth Plan
Working with the NHS to provide better access to health, care and dentistry;
Keeping Children, adults and communities safe;
Providing quality public services;
Being a strong voice for Plymouth.

Implications for the Medium Term Financial Plan and Resource Implications:
N/A

Financial Risks

N/A

Carbon Footprint (Environmental) Implications:

N/A

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

N/A

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	NHS Devon ICS: Finance Report							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	**N/A**	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Gary Walbridge (Strategic Director for Adults, Health and Communities)											
Please confirm the Strategic Director(s) has agreed the report? Date agreed: 17/10/2024											
Cabinet Member approval: Councillor Mrs Mary Aspinall (Cabinet Member for Health and Adult Social Care) Date approved: 16/10/2024											

NHS Devon Integrated Care System

Finance Report

Month 4 – 2024/25

1. Financial Performance to date

The presentation of the Devon Integrated Care System's (ICS) Finance Report seeks to provide the necessary assurance to the Board on the financial position of the ICS for the year ending 31 March 2025.

This report details the ICS financial position as at 31 July 2024.

As part of the 24/25 planning round, Devon ICS submitted a final deficit plan of £80m. The ICS forecasting at month 4 is to deliver the plan for the year. The year to date position at month 4 is adverse by £2.8m, reflecting the financial impact of industrial action.

The ICS is reporting £33.4m efficiency achievement in the first quarter of the year. This is £0.2m above plan. The forecast is to achieve the savings plan of £213.3m.

At the planning stage risks of £88m were identified of which £17m were mitigated, resulting in a net risk of £71m. Gross risks by month 4 increased to £105m, driven primarily by risks relating to the efficiencies programme. However, total mitigations also rose to £62m leaving a net risk of £43.5m.

The committee can take **satisfactory assurance** that the plan to date is delivering, subject to the unforeseen impact of industrial action.

2. Financial Position

As at month 4 the Devon ICS is reporting a year to date £54.6m deficit against a planned deficit of £51.8m. The cumulative position at month 4 is adverse by £2.8m, reflecting the financial impact of industrial action. The forecast for the year is currently on plan with a £80m deficit. The year to date and forecast position as at 31 July 2024 is as follows:

Organisation	Year to date			Forecast		
	Plan surplus / (deficit) £000	Actual surplus / (deficit) £000	Variance favourable / (adverse) £000	Plan for the year surplus / (deficit) £000	Forecast surplus / (deficit) £000	Variance favourable / (adverse) £000
Devon ICB	9,475	9,473	(2)	28,419	28,419	0
Devon Partnership NHS Trust	1,398	1,398	0	3,591	3,591	0
Royal Devon University NHS FT	(11,877)	(12,316)	(439)	(9,763)	(9,763)	0
Torbay and South Devon NHS FT	(24,525)	(25,001)	(476)	(47,672)	(47,672)	0
University Hospitals Plymouth NHST	(26,254)	(28,111)	(1,857)	(54,575)	(54,575)	(0)
Total	**(51,783)**	**(54,557)**	**(2,774)**	**(80,000)**	**(80,000)**	**0**

3. Efficiencies

The ICS is reporting £33.4m efficiency achievement in the first quarter of the year. This is £0.2m above plan plan. The forecast is to achieve the plan of £213.3m.

The DPT position YTD is impacted by the phasing of schemes as they have matured. Whereas, the UHP over performance YTD is related to early achievement of non recurrent savings, which is forecast to come back to plan.

The ICS has delivered against the significant step-up in planned delivery in month 4.

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
Devon ICB	2,769	2,805	36	37,228	37,228	(0)
Devon Partnership NHS Trust	4,761	3,894	(867)	15,739	15,759	20
Royal Devon University NHS FT	10,651	10,545	(106)	63,610	63,610	0
Torbay and South Devon NHS FT	5,030	5,036	6	39,900	39,900	0
University Hospitals Plymouth NHS Trust	10,054	11,159	1,105	56,801	56,803	2
Total	**33,265**	**33,439**	**174**	**213,278**	**213,300**	**22**

The plan for the year identifies 30% of savings as non-recurrent. At month 4, there is a shortfall in recurrent savings of £5m, which has been offset by delivery of non-recurrent savings £5.2m ahead of the plan at this point in the year. Providers expect to return to the planned proportions of recurrent and NR savings by the year-end as schemes mature.

None of the efficiencies target remains unidentified at month 4 thus demonstrating scheme maturity progressing. 57% of forecast relates to schemes rated as fully developed, (M03 44%).

Efficiencies	Annual Plan		Year to date				
			Plan CIP delivery		Actual CIP delivery		Variance fav/(adv)
	£000	%	£000	%	£000	%	£000
Recurrent	150,076	70%	25,706	77%	20,661	62%	-5,045
Non-recurrent	63,202	30%	7,559	23%	12,779	38%	5,220
Total	**213,278**		**33,265**		**33,439**		**174**

Risks to the delivery of the system CIP plan are:

- The profile of savings is strongly skewed to the second half of the year, with 71% of the savings plan profiled for delivery in H2.
- Recurrent CIP has not been delivered fully to plan as at Month 4. The shortfall of £5m (15%) is offset by the non-recurrent savings achievement, which has been recognised earlier in the year than planned.
- High risk schemes are at 23% (M3 25%)

Based on the above there is **limited assurance** around delivering the the full efficiency requirement.

Proposed mitigations:.

- The ICB CFO holds monthly Financial Assurance Reviews with all providers where the recurrent vs non-recurrent delivery risk was discussed.
- Trusts have achieved a reduction in unidentified efficiences to zero by the end of Month 4 and this will be followed by reviewing the progress of scheme maturity monthly.
- Trusts have been requested to de-risk efficiency plans so that less than 20% of the efficiency plan is high risk by end of Month 5 and are on target to achieve this.

4. Financial Risks

At the planning stage risks of £88m were identified of which £17m were mitigated, resulting in a net risk of £71m. Gross risks by month 4 increased to £105m, driven primarily by risks relating to the efficiencies programme. However, total mitigations also rose to £62m leaving a net risk of £43.5m.

There is currently therefore only **limited assurance** regarding management of the financial risks identified by the system as they remain significant.

The ICB has a risk on the corporate risk register relating to ‘Delivery of the System Control Total for 2024/25’ with a residual risk score of 16 (4 Likelihood x 4 Impact).

The following controls and assurances are in place to manage this risk:

- Establishment of Programme Management Office (PMO) and review and escalation processes for variance from agreed trajectory.

- Integrated Care System (ICS) monthly finance report for escalation to Finance and Planning Board (FPB), and Senior Leadership Group.
- System Recovery Plan (which is encapsulated in the 2024/25 operational and financial plans) in place. This is a dynamic plan that continually assesses progress against system-wide savings, identification of new schemes and performance against key finance and performance trajectories.
- System Vacancy Control Panel in place to prevent an increase in workforce growth and to support a reduction in running costs.
- Triple Lock Sign-Off Process in place for all revenue investments above £100k, with sign-off required by the organisation, system and NHS England (NHSE) regional team.
- Cost Improvement Programmes (CIPS) in place that contain cost reduction strategies that aim to identify and implement measures to achieve cost savings and efficiency improvements while maintaining or enhancing the quality of healthcare services provided to patients.

5. Workforce, including agency

The ICS is reporting a less than 0.1% (£5.8m) adverse expenditure against plan at month 4, of which £1.8m relates to industrial action pay costs. The forecast indicates a £4.3m adverse expenditure, which is offset by additional funding receipts such as consultant pay award funding.

	Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Class	Plan £000	Actual £000	Variance fav/(adv) £000	Full Year Plan £000	Forecast £000	Variance fav/(adv) £000	Plan wte	Actual wte (per PWR)	Variance fav/(adv)
Substantive	556,569	560,467	-3,898	1,663,036	1,674,178	-11,142	32,045	31,573	472
Bank	28,873	30,487	-1,614	76,062	72,690	3,372	1,257	1,612	-354
Agency	13,808	14,103	-295	37,566	34,064	3,502	469	596	-127
	599,250	605,057	-5,807	1,776,664	1,780,932	-4,268	33,772	33,781	-9

Trusts reported an overspent position YTD of £0.3m against plan on agency costs at month 4 (M03 £0.4m adv). The forecast indicates the favourable position has increased to £3.5m (M03 £1.9m fav).

TSD is 83% (£1.9m) adverse to plan year to date (M03 75%; £1.3m) and expects improvements from implementation of agency price caps and increased workforce controls (panel and roster scrutiny). Forecast is to achieve plan.

Off framework agency staff are low numbers and specific actions are being taken to address each individual. Some instances are due to continuation of contracts to their end to avoid penalties. Situation monitored in detail by Workforce Development Group.

Organisation	Agency expenditure: year to date			Forecast		
	Plan £000	Actual £000	favourable / (adverse) £000	Plan for the year £000	Forecast £000	favourable / (adverse) £000
Devon Partnership NHS Trust	3,411	3,738	(327)	8,506	9,766	(1,260)
Royal Devon University NHS FT	6,350	4,590	1,760	18,530	13,770	4,760
Torbay and South Devon NHS FT	2,322	4,252	(1,930)	5,657	5,657	0
University Hospitals Plymouth NHST	1,725	1,523	202	4,873	4,871	2
Total	**13,808**	**14,103**	**(295)**	**37,566**	**34,064**	**3,502**

NHSE set a system level agency cap of £51.1m (2.9% of total pay) in 2024/25. The system has planned to restrict agency costs to £37.6m (2.1% of pay costs). The forecast position indicates that this target will be achieved.

Further mitigations are in place through the Workforce Delivery Group which is focused on 5 priority areas that will drive down both workforce numbers and costs. The priority areas are:

- Temporary staffing (medical and non-medical) - To improve service and workforce resource planning, such that the requirement for temporary staffing is understood, in advance, and managed. Overall shift from agency to bank to substantive
- Workforce Transformation - To develop a co-ordinated approach to addressing workforce needs for the present and future. To design a standardised approach to planning the workforce resource, to get the best out of a limited resource.
- Rostering - To gain the maximum benefit from planning staff resources through rostering tools.
- Medical Productivity - Aim to create a system wide approach to improving the administration and management of the job-planning process. Focus on "non-standard" job plan expectations, but with the understanding that this will be a long term shift.
- Workforce Controls - Continuation of standard good practice that has evolved in recent years, pushing down on non-standard approaches to recruiting and challenging the need for all new staff.

The committee can take **satisfactory assurance** that the workforce controls and priority areas will deliver the workforce cost and WTE reductions.

6. Capital

System Capital (Including impact of IFRS 16)

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	Allocation Year Ending £'000	Forecast Year Ending £'000
Devon Partnership NHS Trust	947	422	525	10,333	8,480	10,333
Royal Devon And Exeter NHS Foundation Trust	4,427	3,905	522	50,528	35,827	50,528
Torbay And South Devon NHS Foundation Trust	4,410	3,795	615	22,071	17,472	22,071
University Hospitals Plymouth NHS Trust	14,893	5,160	9,733	54,396	43,597	54,396
Total Provider charge against allocation	**24,677**	**13,282**	**11,395**	**137,328**	**105,376**	**137,328**

Year to date providers are £11.4m below plan in relation to capital expenditure, this is in part due to delays whilst plans are reprioritised due to limited capital.

Devon providers have a total allocation of £105.4m which includes the £20m system IFRS16 allocation for the first time. Forecast expenditure currently matches the initial plan, however providers are reassessing their priorities in order to manage within the IFRS16 allocation and late £5m capital allocation reduction that was a requirement of the 12th June final plan submission.

7. Assurance and Recommendations

Based on the discussions held with ICS organisations and review of the financial and workforce reports from each organisation it is recommended that the overall level of assurance that the ICS will achieve the planned forecast outturn for 2024/25 as at Month 4 is as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Limited	No change
Financial risks	Limited	No change
Workforce	Satisfactory	No change