NHS
Devon
Clinical Commissioning Group

NHS Devon Governing Body Meeting
FINAL APPROVED minutes held in PUBLIC

Date: 30 July 2020 Time: 13:30 – 16:10

Location: Via Microsoft Office Teams

Item	Discussion	*Action*	
1	**Welcome and Apologies** PJ, chair welcomed everyone to the meeting, and noted that although no members of the public were observing live, the meeting was being recorded and would be available to the general public through the CCGs website. PJ reminded the members the use of language that can be understood by the public to demonstrate the values we have as a CCG. There were no questions submitted in advance of this meeting. Apologies were noted as detailed below. • ST • SMC • RH		
2	**Register of Interest (ROI)** The members reviewed the ROI there were no changes to the register. As an associate of South West Academic Health Science Network (AHSN) CB declared a conflict of interest around Think 111 national programme. **The Governing Body received and noted the ROI and conflict of interest declared.**		
3	**Minutes of the last meeting** PJ led a page by page review of the minutes of the meeting held on 18 June 2020 and it was agreed these were a true and accurate record of the meeting. **Open action log** **Action 1 – excess deaths compared to other parts of the UK.** VP provided an update and noted for the winter period of 19/20 death rates were lower in Devon and this was partly due to the mild weather and impact of the flu vaccine. We have since undertaken further analysis with support from clinical coders from the Royal Devon and Exeter Hospital (RDE) to look how death rates changed from the beginning of this year to the peak of the virus. The peak in Devon was less than, although higher than expected but death rates compared to the previous 5 years was not too bad and reverted to normal death rates following the peak. PJ referred to data that Public Health had analysed and offered to circulate this to the Governing Body. This action was formally closed.		

	<u>ACTION 1</u> **Excess deaths data analysed by Public Health to be circulated to the Governing Body for information. Post meeting update this was circulated to Governing Body, action closed.**		
4	**Patient experience** CB welcomed Kevin Dixon (KD) from Healthwatch and highlighted that he had been given an opportunity to experience and be involved in the development of the engagement process for the Devon Ethical Framework. KD explained that he was a volunteer, carer and chair of Healthwatch Torbay and gave an account of his involvement in the engagement, co-design and co-delivery of engagement using technology to engage people from across the county and rural locations. He was pleased to say that progress had been made in empowering patients to ensure their voice is heard. Vina Flores (VF), joined to share her experience. Vina is involved with Hikmat Devon a Community Interest Company who enable and support minority ethnic communities in Devon. VF talked through her experience and noted that the consultation was helpful and that it was a privilege for voices to be heard. Often there is a language barrier where people don't always ask for help and there is some learning to take forward to improve the hearing of voices of non-UK nationals that are part of the community. She explained that engagement is important and Hikmat offer online activities and engagement to reduce isolation and build confidence. JH wondered how good the CCG is letting people know what happens following consultation and KD responded that this needs further development, and this could be improved by using social media more. VF noted that Hikmat inform clients what is happening on a regular basis through phone calls and 'what's app'. JWo queried the low response rate from Devon Voices panel for the Ethical Framework consultation which was disappointing. AM replied that it was important to recognise that panel members would be interested in different topics and the engagement went beyond the panel with the support from KD and VF to reach as many other people and he agreed that more work needs to be undertaken with diverse communities to get a wider range of views. SK wondered how he could modernise engagement with patients in his practice and VF felt that word of mouth and signposting them to Hikmat would be a small step towards this. JW wondered if people in the communities had missed meeting people in person during the pandemic and it was acknowledged there is need to get the right balance to meet people's needs. Technology has helped towards different opportunities, but not the solution as face to face engagement can be easier in a larger setting. PJ thanked KD and VF for sharing their experience which has been hugely valuable. *Vina Flores left the meeting.*		
5	**Devon Ethical Framework**		

Jo Turl and John Finn joined the meeting part way through this item.

SL was delighted to present the paper and personally thanked PJ and the CCG for deciding that it was important that the system in Devon had an ethical framework and the courage to do the public engagement work that had been undertaken.

The first task was for the Devon Ethical Group to bring commonality and fill in gaps where there was no national guidance available, so clinician and patients have the guidance expected and need. It was identified early on that a common ethical approach across the system was needed.

SL referred to the ethical framework and guidance for allocation and withdrawal of critical care and mentioned the legal advice received by the CCG last month. She described how Devon Virtual Voice panel were involved in public engagement and three convened separate focus groups with representatives from people who feel the guidance would apply to their situation.

- Black Asian Minority Ethnic (BAME) communities
- People with disabilities
- Older people

SL felt that through this engagement we have received valuable reflections and comments for improvements and we now have a common approach. This has been tested through public scrutiny and the independent representatives sitting on the ethical reference group feel this is cutting edge and that other organisations nationally could benefit from the Devon approach.

JH wondered if there was any reluctance in the system and objections to the framework and SL did not get the sense there was. SL confirmed the ethical guidance is consistent with guidance for local authorities and there was representation from local authority including adult social care on the ethical reference group. PJ acknowledged that alignment had been achieved with such a complex issue and this was positive.

The guidance and framework have been developed to support decision making and includes procedures for escalation if the system becomes overwhelmed and ethical support would need to be available 24/7 at hospital level and at reference group level if required.

SL confirmed that each individual Trust Board will receive and consider the recommendations in the same way as the CCG and then this will become an existing document.

SL felt that as the Devon Ethical Reference Group is an advisory group that it would be more appropriate for individual organisations to monitor the framework through their own ethical committees how this is to be adopted. PH reiterated that every provider does have an individual responsibility for ethical committee and dissemination and ensuring and that it was important that we don't cross over onto their responsibilities.

It was agreed as a commissioner and as part of our responsibilities that we do need to think about how we support primary care to act within the framework. We recognise that primary care are independent providers, but we do know that they want to work collaboratively as a system, and we will discuss how we can support them with the Local Medical Committee (LMC) and Primary Care Committee.

	SL referred to an area of work that regional ethics committee is looking at to address the issues of prioritisation and this work sets out the difficult decisions to be made around allocations of treatment and she offered to share this with the Governing Body when completed. **The Governing Body:** **a) Unanimously approved the Devon Ethical Framework (Appendix A) for use in this organisation.** **b) Unanimously approved the Devon guidance on allocation and withdrawal of treatment (Appendix B) for use in this organisation.** **c) Noted the Public Engagement Report (Appendix C).** **d) Noted the Recommendations adopted by the Devon Ethical Reference Group following Public Engagement (Appendix D) and which have been reflected in the Ethical Framework and Guidance.** **e) Noted that once the Framework and Guidance documents have been approved by all organisations, Devon CCG Communications & Engagement Team will work with provider teams to produce common patient-facing materials working with groups and individuals identified during their Public Engagement.** SL took the opportunity to personally acknowledged and thank Adam Carrick as secretary to the reference group and for his work and contribution in the development of the Ethical Framework. *Kevin Dixon and Nellie Guttman left the meeting*.		
6	**Chair's Report** There was nothing to add to the report, however PJ thanked ST for the way he has led the CCG through Covid and the way he supported his executive team over the challenges we have faced during the past few months. **The Governing Body received and noted the contents of the Chair's report.**		
7	**Accountable Officer's Report** JD presented this report in the absence of ST and summarised the CCGs latest update on our response to Covid, stating that we are stepping down our incident management response in a controlled and phased approach as we move towards business as usual. We are keeping an eye on the environment we are working in and we can stand up our response if required. Nightingale Exeter has been completed and handed over to RDE as the host organisation and is being used in the short term as a diagnostic centre to provide us with capacity around diagnostics but will continue to remain a key part of our surge capacity if needed for that purpose. We are working closely with the team around the return to office-base working in August/ and September and all the necessary safety measures will be put in place to support this. 111 first is an initiative looking at optimal flows for urgent care and directing people to the appropriate setting for care, Philippa Slinger, Devon STP CEO Lead is leading on this on behalf of the system.		

Integrated care partnership work continues to ensure we have a smooth transition for the rest of the year and the winter period, and we are reconsidering integrated care and working with providers for opportunities.

JF, associate director joined the meeting and talked through the Restoration and Transformation planning report as part of phase 2 of the response to the pandemic.

He highlighted the three aims of the report and noted that the CCG was working at pace in planning for phase 3 of the response.

JF referred to the letter received at the end of April from NHS England and the actions required for phase 2 which included 43 objectives focused on several areas including urgent and routine care, women and children and mental health. These objectives were to be completed by a set time frame of the 12 June. JF was pleased to report the delivery of actions was achieved by the timeframe.

To support the delivery of actions teams and groups were used that were operating as business as usual rather than set up new and kept governance as requested.

JF highlighted areas of success learning and impact such as:

- Utilisation of the independent sector and this capacity is still critical to phase 3
- Strengthened capacity of out of hours service include 111
- Discharge services excelled
- Transformation changes how healthcare was delivered including non face to face primary care appointments
- Set up system restoration group across STP, including senior health and social care members – whole system approach
- Devon Referral Support Service (DRSS) 70% back to where classed as normal referrals, low starting point from Mid-April and phase 3 will need to respond to low referral rates
- 52 Weeks quadrupled
- Good robust process put in place to understand waiting lists and providers are operating through categorisation lists
- Urgent care has recovered from pre-Covid levels
- Focusing on mental health services
- Introduced service change process which has now been reversed using Quality Equality Impact Assessment (QEIA) and reported weekly through to the executive team

JF noted that the CCG has not received the Phase 3 letter from NHS England and in the absence of the letter guidance has been received from the regional team around planning principles focused on single winter plan and he assured the Governing Body the processes around winter planning are in an advanced position than this time last year.

SK wondered if there was any insight into the financial impact of phase 3 and the implications of costs such as poorer outcomes for patients not being seen face to face. JF responded that the cost base of services will need quantifying and understanding as to what that means around outpatient work and plans for next year. It was acknowledged that outcomes for patients and access to diagnostics has had an impact and this is a prime focus for the CCG to increase capacity.

	JH highlighted that it was important to recognise the massive amount of work and energy that is already being undertaken by the executives in advance of direction from NHS England and that we need to continue planning and use our own initiative in these processes. On behalf of the Governing Body, PJ thank JF and the team for their work. *John Finn left the meeting.* **The Governing Body received and noted the contents of the Accountable Officer's report and the update on restoration and transformation.**		
8	**Month 3 Financial Report** This report detailed the financial position to end of June 2020 and JD reminded the Governing Body we are currently working within the temporary emergency financial framework that has been put in place by NHSE/I whilst responding to the pandemic. All costs will be covered whilst operating within this framework and this has been formally extended to the end of August. JD referred to page 99 section 3 and the expenditure directly relating to Covid and other services not directly to Covid. It shows at the end of month 3 £18.5m costs directly relate to Covid with £11.6m of that having been reimbursed. We are still working through assurance process NHSE/I around the gap of reimbursed costs. JD noted that the forecast included in the table is for the end July. JD directed the members to page 105 which detailed the Covid related expenditure for the Nightingale Exeter and the faster hospital discharge programme which has been a key system response to Covid. Section 6 detailed the risks and JD declared that uncertainty was the biggest risk around allocation for the population and we are working to understand the forecast expenditure and what this will look like. Once we have confirmation of the allocation this will enable us to make comparison. JD highlighted primary care prescribing which is an area of concern and there is more to be done in this area to understand and we remain in open dialogue with NHS E. JT provided an update on primary care prescribing programmes and the restart of the quality, innovation, productivity and prevention programme (QIPP) on 1 September 2020. We are also reviewing the primary care strategy and how we can further support general practice. GAth pointed out that the paper appeared to show there had been an increase in running costs. JD explained the rate of expenditure which had not increased, and we have seen a reduction in variance. GT wondered about the savings plan and the original budget of £22.6m which has been set aside during Covid. JD confirmed it was the intention to stand up elements QIPP again and we will be reassessing each element of the plan to see what is reasonable and deliverable within context and remainder of the year. NB congratulated JD on the outstanding performance in terms of creditor payments within the 30-day timescale, especially in the current environment and this will have made the difference as to whether business have survived or not.		

	The Governing Body received, reviewed and discuss the month 3 year to date performance and the forecast four-month position including the current risks.		
	Quality and Performance Report DA took the quality element of the report as read but brought the following points to the attention of the Governing Body. • Working to shift quality view to understand impacts on quality • Supporting providers regarding 111 impacts • Open dialogue with Quality Surveillance Group, NHS England and Care Quality Commission (CQC) to better understand the potential of harm • Risk stratification links to forward view • Delay in investigations reviewing the learning • Joint working on good practice to improve care home performance STh referred to the performance report which was for April and May and is underpinned with the restoration and transformation recovery work. She reaffirmed that during our response period we are in a better national position against compliance for diagnostics, Emergency Department (ED) and cancer waiting times. However, 18-week performance has fallen behind the national position. Looking forward we have received new guidance to step back up reporting arrangements. The CCG has not waited for new guidance we have pre-empted and agreed a local approach around health inequalities to make real impact and change going forward. PJ commented that where historically we have been below average in performance, but we have been recognised regionally and nationally for the ability to have used the independent sector and there has been some good work both from commissioners and providers in using opportunities to optimise demand coming through. **The Governing Body received and noted the contents of the quality and performance report for April and May.**		
9	**NHS Devon CCG Constitution and supporting Governance Handbook amendments** GS introduced this paper and reminded the Governing Body that amendments to the constitution were approved at the Governing Body back in January 2020. Following feedback from NHSE/I there are some minor amendments outlined in the paper and GS drew attention to the timescales for the development of the next version of the constitution which will commence in September. List member practices in document appears to be formatting issue make sure corrected before published on our website or sent to GP Practice members. JH referred to the Remuneration and Workforce Committee Terms of Reference (ToR) and proposed changes to the Primary Care Commissioning Committee (PCCC) as result of internal audit report. For the PCCC we can update the ToR as a working arrangement, and we will update the constitution at the next iteration. There was discussion around the agreed membership for the Remuneration and Workforce Committee and this would be clarified outside of the meeting and revisited and reviewed by the members of this committee.		

	GAth queried why the Quality Committee and Finance Committee ToRs were not included in the constitution and this was because the constitution only requires statutory committees to be included, but the ToRs for these committees have been included the governance handbook. **The Governing Body:** • **Approved the amendments requested by NHSE following their review during Q4 2019/20 as outlined in section 2 of this report.** • **Agreed to the circulation of the constitution, once formal approval received from NHSE, to its member practice representatives with a covering letter from the Chair, senior officers of the CCG, and ensure that the formatted constitution and the supporting governance handbook is made publicly available on its website.** • **approved in principal the timeline for the next review of the constitution and inform the CCGs member practice representatives of rationale for this approach** *Suzi Leather left the meeting.*		
10	**Remuneration and Workforce Committee Chair's Report** GT noted there was nothing further to add to this report. He thanked GAth for chairing the committee for the last twelve months and extended thanks to the executive team for their leadership during our response to the pandemic. GT referred to the Devon ICS Lead role and handed over to the chair. PJ set the context of the role and the arrangements that are currently in place. The paper set out the recommendations regarding the nature of the Devon ICS Lead role and next steps in the permanent appointment of this role including the design of the role and the appointment process for it. PJ noted that the benefits for the organisation and system of the combined role, which NHS E have stipulated was articulated in the paper. **The Governing Body:** • **supported and approved the combination roles of ICS Lead with the Accountable Officer of the CCG** • **supported and approved the establishment of a system coordination group to oversee the development of the ICS Chief Executive role (incorporating the CCG AO) job description, person specification and appointment process** • **supported and approved on completion of the development of a robust appointment process, approval will be sought from the Remuneration and Workforce Committee and, thence, Governing Body ahead of advertisement launch and this may be done electronically due to timings, and formally ratified at the next scheduled formal Governing Body** **The Governing Body noted and received the contents of the Remuneration and Workforce Chair's Report**		
11	**Finance Committee Chair's Report** **There was nothing to add to the report. GT informed the members that the finance** committee had been reluctant to close risks and that a couple of risk had been added to the register one of which was around the temporary financial arrangements.		

	The finance committee received a separate report about the interim financial framework and compared to the CCG's original budget set we are receiving more funds than anticipated. Whilst this was good news, monthly we are spending more than the rate of expenditure, and some modelling around potential in year projection savings. **The Governing Body received and noted the contents of the Finance Committee Chairs Report.**		
12	**Audit Committee Chair's Report.** There was nothing further to add to this report. GS referred to the recommendations in the report and drew attention to the Risk Management Framework Policy which is the overarching framework for managing risks which has been updated around strengthening our risk management and be clear on training requirements. **The Governing Body received and noted the contents of the Audit Committee Chair's Report.** **The Governing Body approved the Risk Management Framework Policy.**		
13	**Primary Care Committee** JH highlighted one activity that the primary care team undertook when moving into the transformation approach. An exercise was undertaken to understand the needs of practices and in doing this we used general practice and governing body expertise and JH thanked them for their contribution. And from this piece of work we need to rethink how we support practices needs post Covid. **The Governing Body received and noted the contents of the Primary Care Committee Chair's Report.**		
14	**Quality Assurance Committee** GAth drew attention to the development of a task and finish group and the development of a strategy and workplan. This was not just for the Quality Assurance Committee but also for the quality team. **The Governing Body received and noted the contents of the Quality Assurance Committee Chair's Report.**		
15	**Locality Update Reports** The chair remarked that the locality reports were excellent. <u>Northern Locality</u> The report was taken as read. JWo felt there was change fatigue and desired for certainty around the function, structure and responsibility of and integrated care partnership to allow individuals to manage and deliver change. JW asked about the suicide prevention plan and are the resources in place to support the standing back up of this service. JWo confirmed that he will be meeting with the CEO of Devon Partnership Trust discuss this and how we manage the wider mental health strategy. <u>Eastern Locality</u> The report was taken as read.		

	SK supported the view around strategic direction and the eastern locality is focusing how best to deliver outcomes for patients and the system. A developmental day is being arranged for September to understand the pressures in primary care. <u>Western Locality</u> NB did not propose to go through the report in detail but highlighted the following: 1. Success of connectivity during Covid and weekly systemwide video conferencing 2. Focus on investigating whether we can use fair shares funding and how to use this to substantiate some of the changes during Covid for sustainability 3. Workforce issues – voluntary sector and impact of Covid 4. Resilience of Plymstock GP practices following on from Barton contract which has not been completely resolved 5. Progression of ICP bringing forward to December to ease pressure in system over the winter period – will be challenging <u>Southern Locality</u> DG noted that the report covered recovery and restoration plan and highlighted the way we improve the way we look after chronic conditions. Key priorities going forward include winter planning, diagnostics and elective care. Newton Abbot is part of the population health pilot and we are waiting to see the outcomes. PH explained the concept around the care coordination concept which is a pilot for directing people to community services through a variety of models.		
16	**Any other business** There was none raised. The chair thanked everyone for a good productive day.		
17	The meeting closed at 16:10		

Attendees (attended** / apologies [A])	
Name and initials	*Title and organisation*
Alison Davis (AD) **	Associate Non-Executive Director, Devon CCG
Andrew Millward (AM) **	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Darryn Allcorn (DA) **	Chief Nurse, NHS Devon CCG
David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Gaynor Appleby (GApp) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT) **	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG

James Wooldridge (JW) **		Associate Non-Executive Director, Devon CCG
John Dowell (JD) **		Chief Finance Officer, Devon CCG
John Womersley – Dr (Jwo) **		Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **		Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **		Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF) A (in absence of DG)		Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **		Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **		Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) **Chair** **		Clinical Chair, Devon CCG
Penny Harris – (PH) **		Director, Devon CCG
Philip King (PK) **		Interim Chief Nurse
Ruth Harrell – Dr (RH) A		Director of Public Health, Plymouth City Council
Sarah Thompson (STh) **		Chief Operating Officer, Devon CCG
Simon Kerr – Dr (SK) **		Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc) A		Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST) A		Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **		Interim Director of Commissioning – North, East and South, Devon CCG
Virginia Pearson – Dr (VP) **		Director of Public Health, Devon County Council
In Attendance		
Nikki Coombes (NC) ** **Minute Taker**		Executive Assistant, Devon CCG
Dame Suzi Leather (SL) **Item 4&5**		Independent Chair – Devon STP
Nellie Guttman (NG) **Item 4&5**		Senior Strategic Engagement Manager, Devon CCG
Kevin Dixon (KD) **Item 4&5**		Healthwatch Torbay
Vina Flores **item 4**		Hikmat Devon, Community Interest Company (CiC)
John Finn (JF) **item 7**		Associate Director of Commissioning, Northern and Planned Care and Cancer, Devon CCG
Minutes approved	Date: 27 August 2020	Signed by chair: Nick Ball (in the absence of the Chair)