Public - NHS Devon CCG Governing Body

Governing Body Public

Devon Suite, Exeter Court Hotel, Kennford, Exeter, EX6 7UX

25 July 2019 13:00 - 25 July 2019 17:00

AGENDA

#	Description	Owner	Time
1	Welcome and Apologies Verbal	Chair	13:00
2	Register of Interests (ROI) Paper DOI Governing Body @ 10 July 2019.pdf 7	Chair	13:05
3	Minutes of the last meeting held on 27 June 2019 and action log Paper 2 Master Action Log - Public GB v1 mb.pdf 11 1 Draft minutes held in public 27.06.2019 v1 mb.do... 13	Chair	13:10
4	Patient Experience Story Presentation GB patient story - July 2019 (v2).pptx 23	Lay Member with an interest in patient involvement	13:15
5	Chair's Report Paper Chair's Cover Sheet July 2019.docx 31 Chair's Report July 2019.docx 33	Chair	13:35
6	Interim Accountable Officers Report Paper Interim AO Report Public COVER sheet July 2019.... 35 Interim AO Report Public Devon CCG July 2019.do... 37	Interim Accountable Officer	13:45
7	QUALITY AND PERFORMANCE		
7.1	Finance Committee Chair's Report Paper GB Committee Chair Report - Finance Performanc... 39	Clinical Lead Representative - Southern Locality	14:10

#	Description	Owner	Time
7.2	Month 3 Finance Report Paper FPC_Report_GB_Month 3_FINAL_2019-20 (GB Co... 41 FPC_Report_GB_Month 3_FINAL_2019-20 (GB ve... 45	Director of Finance	13:55
8	RISK AND AUDIT		
8.1	Audit Committee Chairs Report & Risk Management Update Paper Audit Committee Chair Report - July 19 NTB.docx 61 Assurance Framework V3.docx 65 Appendix 2 Corporate Risk Register @ 02 July 201... 85	Chair of Audit Committee	14:25
9	GOVERNANCE AND ASSURANCE		
9.1	Revised Terms of Reference (ToRs) - Remuneration and Workforce Committee Paper Rem Com cover sheet.docx 109 Remuneration Committee terms of reference (sugg... 111	Board Secretary	14:45
9.2	Ipsos Mori 360 Action Plan Paper 9.2 Mori 360 Action Plan cover sheet GB July 2019.... 117 How we are enhancing engagement - Action Plan f... 121	Director of Communications and HR	14:55
10	BREAK		
11	DELIVERY		
11.1	Long Term Plan Verbal Update	Long Term Lead	15:30
12	INFORMATION		

#	Description	Owner	Time
12.1	Quality Assurance Committee Chairs Report Paper QAC July19 Committee Chair Report Final.docx 129	Lay Member with an interest in Quality Assurance	16:20
12.2	Quality and Performance Report Paper 01 Quality and Performance cover sheet.docx 133 Quality and performance report July.docx 135	Director of Commissioning/ Deputy Director of Nursing	16:25
12.3	Locality Updates Paper Northern Locality Report July19 v2.docx 161 Eastern locality GB board report for July 19_.docx 165 FINAL Locality update report- Southern - July 2019.... 169 WL Update Report for July 2019 GB - new formatv3... 173	Clinical Lead Locality Representatives	16:30
12.4	Primary Care Committee Chairs Report Paper Committee Chair Report - PCC July 19.docx 175	Lay Member with an interest in Primary Care	16:55

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Declaration of Interests Register - NHS Devon CCG Governing Body
Report generated by governace team on 10 July 2019

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Atherton	Glynis	Lay Member - Quality	Member Governing Body Member Quality & Assurance Committee (Chair) Member Primary Care Commissioning Committee Member of Remuneration Committee (REMCOM)	Consultancy for FORCE cancer charity – not CCG funded but has a relationship with RD&E hospital Trustee for St. Margaret's Hospice, Somerset Volunteer for Hospiscare, Exeter – helping at events and proof reading applications to charitable trusts Volunteer for University of Exeter – mentoring students Member of the Labour party		14/05/2019		21/05/2019	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Director - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG	Member of Governing Body (Vice Chair) Member of Audit and Assurance Committee (Chair) Member of Finance and Performance Committee Member of Remuneration Committee (REMCOM) Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 ,Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		10/05/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Blackford	Derek	Deputy Chief Finance Officer	Attendee of Audit and Assurance Committee (Deputy for CFO) Member of Finance and Performance Committee Senior Leadership Team (SLT) Member Governing Body (Deputy for CFO)	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Lay Member - Patient and Public Involvement	Member of Governing Body Member of Quality and Assurance Committee Member of Remuneration Committee (REMCOM) Attendee Primary Care Commissioning Committee (PCCC) non voting	I am chair of the Devon Maternity Voices Partnership (MVP) a collective of parents (and parents to be) and organisations who support maternity services (health professionals, charities, Healthwatch, non-health professionals) working together to review and contribute to the development of local maternity care across Devon. Devon CCG provide funding to the MVP		04/04/2019		09/04/2019	General Interest	Direct	Resigned as Chair from the Devon Maternity Voices Partnership. (formally leaves July 2019) Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt	Partner is employed by Livewell Southwest in position of influence	26/09/2017		15/10/2018	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Coles	Anna	Director of Integrated Commissioning Seconded to CCG to Associate Director of Commissioning (Western)	Senior Leadership Team (SLT) Member Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019		12/03/2019				Plymouth City Council
	Collingwood-Burke	Lorna	Chief Nursing Officer and Caldicott Guardian - for NHS Devon CCG Interim Deputy Chief Officer NHS Devon CCG	Member of Governing Body Member of Quality Assurance Committee Member of Audit and Assurance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team QEIA Panel Senior Leadership Team (SLT)	Chief Nursing Officer for both NEW Devon and SD&T CCGs School Governor Ashleigh C 0f E School, Barnstaple and chair of the resources committee Member of and Nurse Lead for the national board for NHS Clinical Commissioners Chair of the Nurse Forum for NHS Clinical Commissioners Director role for DELT	Spouse is: GP Principal Wallingbrook Health Group - primary medical services (PMS) contract holder (ended 30/04/2018). Prescribed Specialised Advisory Group (PSSAG), Department of Health Member of Devon Health and Wellbeing Board GP Locum Devon Performers List from 01/05/2018	1 August 2017 - Joint post with NHS Devon CCG & New Devon CCG		17/04/2019	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015					Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council

	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Senior Leadership Team (SLT) Attendee Audit and Assurance Committee Member of Primary Care Commissioning Committee (PCCC)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	19/06/2018	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	28/03/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration Committee (REMCOM) (Non exec rem)	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	08/11/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Hargadon	Judy	Lay Member - Primary Care and Prevention	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) Chair Member of Remuneration Committee (REMCOM)	Independent Member on Council of University of Exeter NED on Board of Restorative Solutions CIC Ltd	Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	20/05/2019	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Harrell	Ruth	Director of Public Health Plymouth City Council	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)			26/10/2016	26/10/2016	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body (Chair) Member of Remuneration Committee (REMCOM) Transition Sub Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	GP Partner, Cricketfield Surgery Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Clinical Chair NHS Devon CCG 1 March 2017 Church Warden Holy Trinity Church Spouse works in emergency department at RDE and for Exeter Medical School Primary Care Network - Templar Care Network		21/08/2015	04/10/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kennedy	Nick	Secondary Care Doctor	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration Committee (REMCOM) Member of Primary Care Commissioning Committee (PCCC) QEIA Panel Member of Audit Committee	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer Partner, Staplegrove Anaesthetists LLP, Taunton Partner Blackdown Orthopaedic and Spinal Services, Taunton Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of Data safety monitoring committee (DSMC), The GAP study (safety of gabapentin) United Hospitals Bristol Member of national Independent Funding Request Panel NHS England		26/09/2017	06/10/2018	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Member of Integrated Commissioning Executive (ICE) Attendee Remuneration Committee (REMCOM) Attendee of Audit and Assurance Committee Northern and Eastern Preparatory Group	Chair of East Devon GP Members Forum Partner Coleridge Medical Centre Undertakes DDOC shifts 5. Shareholder in Devon Doctors Ltd Shareholder in Devon Health Member of East Devon Health Practice part of the East Devon Federation (March 2018) Chair of East Devon Members forum. Chair Eastern Locality Delivery Group Primary Care Network - Honiton/Ottery/Sid Valley (HOSMS)	Spouse works for Social Services	14/02/2017	13/05/2019	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Lees	Sarah	Representative of Director of Public Health for Plymouth City Council	Member of Governing Body (Deputy) Member of Primary Care Commissioning Committee (PCCC)	School Governor, College Road Primary School, Plymouth	Husband is an employee of Livewell Southwest	10/11/2017		Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

Dr	Manton	Sonja	Director of Strategy Interim Director of Commissioning. Northern, Eastern and South Devon and Torbay	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Joint Staff Partnership Transition Sub Committee Senior Leadership Team (SLT) Member of Quality and Assurance Committee Attendee Audit and Assurance Committee	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit from 1st Nov 2018	03/04/2017	09/10/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Governing Body Clinical Lead – Western Locality Chair of Western Primary Care Partnership	Member of Governing Body Member of Quality Assurance Committee Clinical Cabinet QEIA Panel STP Collaborative Board Remuneration Committee (REMCOM) (Non exec rem) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG)	Elected member, South West Regional Council of BMA Sessional GP (self-employed) at Access Health Ltd Plymouth. GP Appraiser (NHS England)	Partner is Medical Secretary and Board member of Devon LMC Partner is GP Partner, Church View Surgery, Plymstock	26/09/2017	18/12/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Director of Communications and HR functions NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit and Assurance Committee	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University.		19/06/2018	26/02/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Pearson	Nick	Head of Communications	Senior Leadership Team (SLT) Primary Care Operational Group (PCOG) Member Governing Body (Deputy for Director of Communications)	Member of the Labour Party Member of the Exeter City Supporters Trust		13/01/2017	04/04/2018	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Pearson	Virginia	Director of Public Health, Devon County Council Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee	Member, Devon Health and Wellbeing Board Member, Exeter Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Devon Safeguarding Children Board Attends Governing Body of Devon CCG Council Member, Association of Director of Public Health Member, British Medical Association		02/02/2017	02/02/2017	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council
	Polak	Tracey	Public Health Consultant (Devon Council) Honorary Clinical Associate Professor – University of Exeter Medical School	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Northern and Eastern Preparatory Group	Honorary contract with Exeter University	Spouse: Deputy Chief Nursing Officer, Devon CCG	24/10/2017	21/01/2019	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee Audit and Assurance Committee CCG Executive Team Senior Leadership Team Member	No interests declared		22/03/2019	09/04/2019				NHS Devon CCG
	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Senior Leadership Team (SLT) Attendee Audit and Assurance Committee Attendee of Remuneration Committee (REMCOM)	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	07/09/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	STP Director of HR	Attendee of Remuneration Committee (REMCOM) Joint Staff Partnership Senior Leadership Team (SLT) Attendee Governing Body/Member Governing Body (Deputy for Director of Communications)	No interests declared			16/10/2018				NHS Devon CCG

	Turl	Jo	Director of Commissioning - Western	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) Member of Governing Body Attendee Audit and Assurance Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC)	No interests declared		13/08/2015	06/06/2019				NHS Devon CCG
	Webber	Lorraine	Associate Chief Nursing Officer (South & West).	Member of Quality Assurance Committee A & E Delivery Board QEIA Panel Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Member Governing Body (Deputy)	No interests declared		14/03/2017	29/08/2018				NHS Devon CCG
	Wheller	Kevin	Locality Chief Finance Officer (Northern & Eastern)	Attendee of Audit and Assurance Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member Governing Body (Deputy for CFO) Northern and Eastern Preparatory Group		Spouse is employed as a finance manager at Castle Place Surgery in Tiverton. The Surgery is operated by the Royal Devon & Exeter NHS FT	22/10/2015	25/01/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit and Assurance Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration Committee (REMCOM) (Non exec rem) Northern and Eastern Preparatory Group	General Practitioner at Coombe Coastal Practice in Ilfracombe (ended 10/09/2017) Member of Royal College of General Practitioners Director of One Ilfracombe Our Place Programme Chair of One Northern Devon		14/02/2017	31/01/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

NHS Devon Clinical Commissioning Group

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertakenYes/No confirmation if all actions		This will be the lead or person to whom the action was	Confirmation that committee that raised the action is content the action has been	Confirmation if action complete
3	23/05/2019	Governing Body to receive an update on waiting times for Mental Health IAPT/ recovery and access rates.	TBC	Lorna Collingwood-Burke/ Lorraine Webber	27.06.19 - LCB informed a piece of work is being done with Devon Partnership Trust (DPT) and commissioners. There is a perceived gap at the moment, the CCG is gaining assurance that this gap does not exist. Work is underway to look at the ways in which mental health professionals practice and it is on the DPT Quality Committee agenda. The review will be completed to go to the CCGs Quality Committee and will be escalated through the Quality Committee Chairs report to Governing Body in September. This action will remain open until the update is given in September.				**OPEN**
	27/06/2019	Patient Story: Nikki Coombes to pass on Sue Benjamin's details to Mat Fox		Nikki Coombes	18.07.19 - Molly Bishop completed.				**CLOSED**
	27/06/2019	A Non Executive Director is to be appoined to support the AEO in their role around the Emergency Preparedness, Prevention and Response Framework and plans for a no deal EU exit. SM and NB to pick up outside the meting.		Sonja Manton and Nick Ball					**OPEN**
	27/06/2019	Finance and Perfomance Committee Chairs Report: MF highlighted there is an issue with the referral summary as TSDFT seems to be the same level which is different from other Trusts, on page 175. JD to look into this issue in the referral summary.		John Dowell					**OPEN**

	27/06/2019	Locality Updates: ST noted that there was a pilot put in place around Health Navigators last year, ST asked for an update on how effective this has been. ACTION: MF / SM to add this update and evaluation of the Health Navigators pilot to the next report.		Mat Fox and Sonja Manton					**OPEN**

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting held in Public –DRAFT Minutes

Date: 27 June 2019 Time: 13:00

Location: Committee Suites, County Hall, Topsham Road, Exeter EX2 4QD

Item	Discussion	*Action*
1	**Welcome and apologies:** PJ welcomed everyone to the meeting. Apologies received are noted in the table below.	
2	**Patient Experience Story – End of Life Care** CB introduced Sue Benjamin (SB) to the meeting, who is leading the Dying Matters campaign. A video of the campaign was played to the Governing Body. The campaign is to raise awareness about advanced care planning, as national data indicates patient experience is enhanced if advanced care planning is undertaken. SB noted her thanks to the communications team on this campaign as this went out to all GP practices, the media and on social media. There is an on-going campaign throughout the year to prompt discussions. CB commended this campaign and highlighted how this work can be integrated with the voluntary sector and other organisations. JW thanked SB for sharing this story and presenting this campaign. SB informed there will be training sessions for staff to build on this, and to support these conversations to become 'normalised' within families. PJ asked that the dates of training are shared with NC to then prompt locality GPs. NK suggested to incorporate organ donations into this; SB confirmed this is in the prompts. PJ asked if impact will be measured; SB confirmed this will be done through surveys, monitoring discussions and uptake. **ACTION: NC to pass on SB's details to MF.** **The Governing Body welcomed the opportunity to listen to SB and how these experiences can help with our engagement with the public.**	**NC**
3	**Register of Interests** No new conflicts of interests were noted. **The Governing Body received and noted the register of interest.**	
4	**Minutes and action log** The minutes were agreed as an accurate record of the meeting. The actions were updated in the action log.	
5	**Chairs Report** PJ introduced the report and informed he has had useful introductory meetings with partner organisations across Devon, noting particularly his visit to the The Moorings at DPT which offers an out-of-hours mental health support service to anyone aged 16+ in the Devon area.	

	PJ also referred to the CCG's Celebrating You awards. GA congratulated the team for organising this event and the executive team who spoke movingly about their teams and colleagues. PJ passed on his thanks to the communications team and all those involved in organising the event. **The Governing Body received and noted the Chair's Report.**	
6	**Interim Accountable Officers Report** ST informed there are two papers in the appendix of his report that he would like to draw the Governing Body's attention to and discuss. <u>Appendix 1 – Planning Cycle 2020/21</u> ST referred to the planning paper on learning opportunities and proposed planning cycle for next year. ST introduced Lauren Benham (LB) to talk to this paper. LB referred to the concurrent development of this with the Long Term Plan (LTP). Feedback from this years' planning round was around the timeline and ways to improve the alignment between financial planning and activity planning, and to form a coherent plan taking account of all of the workstreams. LB referred to the format of the plans; it is likely the CCG will be required to submit a single system plan with CCG appendix. However, ST confirmed the CCG will still go through the discipline of producing a CCG plan and forming key deliverables. LB informed early planning guidance is expected in the LTP planning framework tomorrow. There is a piece of work being undertaken to align the planning cycle to the local authority and provider plans which will need to feed into and be informed by the system and CCG plan. There is a proposed piece of work across July and August to establish planning assumptions to reflect the CCGs commissioning intentions. Providers will be asked to submit an early draft of activity plans by end of October to allow time for cross-checking and to address any variants collaboratively. There will be a project group to input on this, working across workstreams, meeting fortnightly with LB providing a bridge with the LTP group. PJ noted this feels positive and proactive. PJ also recognised and welcomed the alignment with local authority plans and to fit into a consistent system narrative but to not lose commissioning intentions. ST asked how the Governing Body would like to be involved. PJ suggested this will be discussed when considering commissioning intentions, but it would be useful to have sight of the document at certain points at the Governing Body with an opportunity to comment. PJ asked if the statement in part 5.1.1 of the appendix has had cross-system buy-in. LB confirmed it is an approach that is being used, as it is the same approach in the LTP, which has had cross-system buy-in. AM suggested that the communications have input into the core team. LB noted this request. NB asked if process would be better to update plan with 19/20 actions much earlier that CIP plans are completed, on the basis of numbers that are needed to deliver, rather than later. LB noted this request. **The Governing Body noted and <u>endorsed</u> the paper, subject to the minor requests discussed.** <u>Appendix 2 – Long Term Plan (LTP)</u>	

	ST introduced Penny Harris (PH) to discuss the engagement and process for the LTP. PH provided context; the national LTP was published in January 2019, with a focus on some of the social aspects of health, health inequalities and prevention work. It is a document with a set of deliverables for the NHS to consider. It is transforming of our system and there are significant signals of change. The process for developing the plan is two-fold: firstly, starting to look at the challenges compared to current proposals, and secondly starting a process of engagement. The case for change is being refreshed to consider activity and population change since the last plan. The STP governance process will be used to support this piece of work. The engagement will be at a system level and locality level. The engagement will be in two tiers. The slides give context around local challenges to get feedback to develop the detail of the plan itself. NK asked if any engagement is planned with staff as well as the public. PH confirmed it is both public and staff engagement as the transformation required is significant. CB asked if the engagement includes mixed groups of staff with patients as this can help with discussions. PH noted this. AM highlighted the two tiers of engagement that have been described. AM informed there is a Citizens Panel formed of 1700 people representative of the population of Devon. Local engagement will happen in each of the 4 areas to engage with groups that already exist and other groups. MF asked how executive level GP involvement can come into this. There are primary care representatives being invited. ST noted he would want to involve the Primary Care Network (PCN) Clinical Directors in this as well as locality GPs. SM asked that LCPs are being worked with to provide suggestions on what is engaged on. AM noted need to be mindful that national guidance is expected shortly which may impact this, but this process has been started to ensure ample time for engagement. SM commended AM and PH's teams in working with local authority stakeholders on this for democratic accountability. BM noted his appreciation on how both the Chair and Interim AO reports have developed to provide context for wider decision making. **The Governing Body received and noted the Interim Accountable Officers Report.**	
7	**Quality and Performance** **Quality Committee Report** The report is included for the Governing Body's information. No further comments were made. **The Governing body received and noted the Quality Committee Report.** **Quality and Performance Report** SM talked to the Quality and Performance Report and highlighted the following: <u>Urgent Care</u> SM informed University Hospitals Plymouth (UHP) is not formally reporting against the ED standard as it is in special measures. The CCG has oversight of flow and performance. NB asked whether the overall STP position included UHP, ST confirmed it does not. Other Trusts have seen challenges in demand in urgent care. Torbay and South Devon NHS Foundation Trust (TSDFT) ED performance has deteriorated. There is a significant level of support going into Torbay and South Devon to create a more sustainable urgent care system for the population. Workforce is a predominant issue as well as the increase in demand. There is regulatory oversight in UHP and North Devon Healthcare NHS Foundation Trust (NDHT) in terms of quality, this is softening due to assurance received. In TSDFT, the CCG's quality team has supported reviews of the ED department for patient waiting lists and lengths of time. All 12-hour breaches have been clinically reviewed and regulators are aware of this.	

	Planned Care The 52 week wait position is performing on-track although there are some local variations. TSDFT has been overachieving this trajectory but this is due to preparing for pressures in August. Royal Devon & Exeter NHS Foundation Trust (RD&E) has been challenged in this and is considering proposing to reprofile 52 week waits. The waiting list is also growing in UHP and RD&E which mirrors a significant level of demand. Plans are in place to look to create further capacity, but the current position is heavily reliant on fragile existing capacity. Cancer diagnostics is challenged and in a vulnerable position. It has been asked this is discussed in detail at the next System Performance Group (SPG) in July, in particularly what actions are being taken collectively to improve diagnostic performance as a system. Notably, there will be further resource in cancer services as a system therefore this needs to be used effectively. GA asked about the breast symptomatic performance; ST has also raised this and it will be discussed in the SPG. GA also noted patient experience. This will be covered in the Quality Committee. There are a number of clinical reviews being undertaken which is fed through provider Quality Committees; there is a level of assurance about aspects of harm. Mental health access was raised in terms of the core standards and interface with primary care and community services. This will be covered in more detail in August. The core standards are as reported with some challenges, but there is assurance on improvement for this quarter. LCB added there is a backlog of serious incidents and the CCG is working to clear this. **The Governing Body received and noted the Quality and Performance report.**	
8	**Governance and Assurance** **Governing Body Committee Effectiveness** GS introduced the paper and informed it is a summary of the findings of the committee effectiveness reviews of all committees of the Governing Body. The findings are mainly about the amount of information going to these meetings and cutting this down, as well as reducing duplication. GS outlined the recommendations as follows: 1. Develop a committee and group structure, to be clear on how this works and where decisions are made without creating unnecessary bureaucracy. 2. Develop a process on following-up findings with committees. 3. Review committee objectives and develop standard operating procedures. 4. Ensure the committee is clear of their role, and to review of training offered to committee members. CB asked where the Citizen's Panel fits into this structure and noted there is no replacement for the Engagement Committee after the merger. Once this is developed, PJ, GS and AM will look into this. PJ asked for the diagram to come back to Governing Body. **The Governing Body noted the report and <u>approved</u> the recommendations.** **Revised Emergency Preparedness, Prevention and Response Framework (EPPR)** GS informed that it is one of the CCG's statutory responsibilities to have this framework in place. It is a high-level document for arrangements for managing in emergencies. Work is on-going to develop a joined-up approach with partner organisations, particularly to align resources. The key pieces of work going forward are around refreshing business continuity plans, offering training to support this, and a significant responsibility in terms of assuring provider organsiations' arrangements for EPRR. GS also drew the Governing Body's attention to a statement from Simon Stevens, Chief Executive of NHS England, to plan for no-deal EU	

	Exit. Paragraph 5.3 refers to a Non-Executive Director (NED) being appointed to support the AEO in their role. SM is the AEO, and a NED has not been appointed yet. **ACTION: SM to pick this up with NB outside of the meeting.** AM asked that the communications team is stated in the 'key roles' section. **The Governing Body approved the report subject to the minor amendment noted.**	**SM**
9	**Integrated Care Provider Procurement** AC introduced Mark Procter (MP) and Faye Robinson (FR) to the meeting. The paper describes the work being completed to date around the Integrated Care Provider (ICP) Procurement. This is based on two Lots. Lot 1 includes mental health community services and adult social care. Lot 2 includes the Mayflower Medical Group. AC drew the Governing Body's attention to the sufficient governance arrangements and oversight. There is a programme of governance led by JT and SMc. AC referred to the finance section of the paper which articulates the contractual values. For Lot 1, procurement is on a flat cash arrangement, looking to ensure there is sufficient incentive on the delivery of the outcomes framework. AC informed a significant amount of engagement has been undertaken for both Lots. The purpose of the paper is to seek the Governing Body's approval to launch the procurement of these services in early July 2019. FR informed this has been subject to an NHS England ISAP assurance process in 'light touch'. This is because it did not meet the criteria for the national ISAP process, but NHS England wanted to run a similar process for assurance. This was a comprehensive process in submitting evidence to regulators, who have confirmed they are assured. Part of the submission was this Governing Body paper, along with the specification, outcomes framework, communication plan and financial framework. NB asked how the ISAP process relates to Public Contract Regulations. FR confirmed it does not, ISAP is a specific assurance process, there is criteria to meet to assure on the state of readiness for procurement, which the CCG has met. NB asked what training will be in place for the scoring panel to ensure they have a necessary skillset to undertake the scoring. FR confirmed there is a full suite of training packages which all evaluators will go through. This is an area for contention and legal challenge; the CCG will take clear legal guidance to ensure a robust process. NB asked if the CCG is satisfied that it has the necessary contractual terms to incorporate additional services if needed during the contractual period. FR noted this has been worked through with the legal team. It is an initial 10-year contract with a 5-year extension option. This comes with the caveat to incorporate new services that have been scoped as far as possible and may also be subject to further engagement and consultation. MP confirmed there was a Healthwatch and public representative on the Mayflower Reference Group and regular engagement was held with patients across Mayflower and Mannamead. JW asked the same question for Lot 1; AC informed Living Options were commissioned for independent engagement with the population. They have made use of existing events and undertaken a series of engagement such as surveys, patient groups and sessions. Mental health partnership groups and the voluntary sector have been engaged. PJ asked about the understanding response from the public and if it is supportive. For both Lots, this has been well received. MF asked if Lot 1 also includes the South Hams and if there is a consideration for possible renegotiation of border for services to line up with networks. ST confirmed this is the case.	

	GA asked what weighting is given to quality to assess patient experience. For Lot 1 and Lot 2 there is differential scoring criteria. AC confirmed a Quality and Equality Impact Assessment was undertaken, which provides visibility of un-intended consequences and mitigation. JW asked what the population is for Lot 1 and if it is value for money if extrapolated for Devon. AC confirmed the population is approximately 360,000 people. JD noted the framework is about driving outcomes described in the contract and having an impact on the system locally. This fits within an overall pattern of service for the Western population, but how this compares to overall consumption for North, East and South will be considered outside of the meeting if required. PJ asked what the main risks are and how they will be mitigated. AC confirmed it is a large procurement; there is a risk is timeframe through to mobilisation as potential bidders are unknown until launched. Mitigation is the option to extend mobilisation period. There is a risk from a consultation perspective, but the CCG will continue to engage and be open and transparent. FR noted the risk of any procurement is a risk of documentation subject to legal challenges, and additionally the risk should additional services need to be added and to ensure the contract award allows flexibility. This will form part of the dialogue process. For Lot 2, MP noted there is a risk of no potential bidders although market engagement has been undertaken. The PCN work coincides with this. NK asked about Lot 2 and the proposal to scale down to standard contract within 3 years. MP informed there is a two-year transition period to conclude transformational work and it will go through a dialogue process around how the prospective contract holder would achieve this. PJ asked the voting Governing Body members to confirm whether they approve this paper to go out to procurement for Lot 1 and Lot 2. **The Governing Body noted the paper and all voting members of the Governing Body <u>approved</u> this procurement for Lot 1 and Lot 2.**	
10	**Peninsula Clinical Services Strategy (PCSS)** SM provided an overview of the PCSS work to support acute and specialised services to ensure safe, resilient and affordable services. SM asked for support of the Governing Body as a mandate for this piece of work and seek the views of the Governing Body on how they would like to be sighted on progress. SM informed clinicians have been working on the categorisation of services, it is based on work that has happened nationally. This will come through the relevant governance routes. NB requested that PJ sits on this group, and NK as the secondary care representative. This was agreed. **The Governing Body <u>agreed</u> to support the paper noting the request for representation.** PJ noted there is a statement of commitment within the paper to endorse the initiation paper as a key element of the governance process; PJ took this to a vote. **All voting members of the Governing Body <u>agreed</u> to endorse this initiation paper.**	
11	**PA Consulting Report** ST informed the report has been circulated and ST is in the process of producing an action plan for the system Key Lines of Enquiry (KLOE). In terms of the CCG actions under KLOE 2, ST is in discussions with Philippa Slinger, the new STP CEO, and local authority colleagues in terms of strategic commissioning. As soon as this is completed, ST will bring a report back to the Governing Body to consider. PJ noted there was a meeting of clinicians and NEDs this morning to discuss the report, and it was agreed to give ST time to do this piece of work and consider it at the Governing Body away day.	

12	**Operational Plan 19/20** JD provided an overview of the paper. The CCG was required to submit an Operational Plan to NHS England/Improvement on 23 May. There is no requirement to produce a public facing document, but the headlines are included in this report. JD discussed the context around the STP and achievements and challenges faced. This includes preventable illness rising, particularly diabetes. There are challenges with workforce with around 1 in 8 nurse roles and 1 in 10 social care roles being vacant in Devon. In terms of finances, there is a period of additional growth in allocation in the NHS, but this is not sufficient to meet demand if services continue to be provided in the same way. Within Devon, the population is growing and ageing, and it is expected there will be an increase of about 33,000 over the next 5 years. This is a challenge for demand but an opportunity for workforce. The ageing impact is significant as the number of over 85s will double. JD referred to 2019/20 as a transitional year, to use the growth in allocation to stabalise performance both operational and financial within the provider sector in particular. JD referred to page 159 which sets out the key performance standards that we are seeking to achieve within this years' operational plan. Pages 160/61 of the report was also highlighted, where the financial challenge is set out. Table 1 indicates the previous year-end position with a deficit of £82m in the local system, but after taking the benefit of Sustainability and Transformation Funding (STF), this went to £18m and the CCGs were able to deliver a balanced position. This is contrasted with this years' position which is significantly challenged. JD referred to additional funding of £87m of growth, despite this, given the demand pressure and pressure to improve on underlying performance, in order to deliver an improved deficit position £68m before STF, the system will need to deliver £170m of savings and efficiencies. From a CCG perspective, we will be looking to deliver a deficit position of £27m compared to £25m last year. Without the benefit of STF, the CCG is unable to improve from deficit position of 18/19. NHS England/Improvement have indicated a willingness to work with the CCG on this position. The detailed budgets are set out on final page of the report and JD sought the Governing Body's approval of this financial plan. NB asked if targets can be stretched further, as there are some variants across organisations. JD confirmed work is on-going collaboratively to determine where targets can be stretched. GA asked why community spend is reducing if the intention is to invest more in the community. Last year, there was £41m non-recurrent allocations received. If this is received again it may be targeted to community services again. ST noted winter funding is a good example of this. PJ noted running costs for the CCG are increasing but there is a need for 20% reduction in 2020/21. The CCG is spending below its running cost allocation therefore is already operating at the lower level. The issue is that the rest of the allocation is currently invested in clinical services. **The Governing Body noted the paper and <u>approved</u> the financial plan.**	
13	**Finance and Performance Committee Chairs Report** The report is for information only. BM noted the size of the challenge faced this year in terms of securing support for the changes being discussed. MF highlighted there is an issue with the referral summary as TSDFT seems to be the same level which is different from other Trusts, on page 175.	

	ACTION: JD to look into this issue in the referral summary. **The Governing Body received and noted the Finance and Performance Committee Chairs report.** **Month 2 Finance and Activity Report** **The Governing Body noted and received the Month 2 Finance and Activity report.**	**JD**
14	**Locality Updates** PJ highlighted the reports are for information only. Updates were noted as follows: <u>Southern</u> MF highlighted there are now 45 TSDFT assessors. The Local Care Partnership (LCP) is moving quickly to get understanding of work areas, particularly frailty. MF raised there is a significant challenge in the fragility of some services in Torbay and the infrastructure of TSDFT building. ST noted that there was a pilot put in place around Health Navigators last year, ST asked for an update on how effective this has been. **ACTION: MF / SM to add this update and evaluation of the Health Navigators pilot to the next report.** <u>Eastern</u> JD informed the development of commissioning capability is a focus and services in response to pressure. There has been a rise in referral demand in areas such as cardiology. There are a series of meetings and PJ is attending forums over next couple of weeks. <u>Northern</u> There is a focus on developing PCNs, also reviewing acute services provided by NDHT looking at sustainability, need and form. There is a support agreement in place with the executive function and support by the R&DE; this is coming to an end at the end of June 2020. For many years both Trusts have worked closely together for support, therefore support is already there clinically. There is engagement being undertaken around these messages, NDHT went out to stakeholders last week. The next 4-6 months will involve public engagement, there is also a patient stakeholder network. <u>Western</u> Work has been on-going to finalise the specification for the ICP procurement. NB also referred to the 100-day plan for primary care in Plymouth led by JT. This was a challenge set by the CEO of Plymouth City Council as an innovative plan to attract new GPs in Plymouth area. NB asked for views. It was noted the risk of de-stabalising other areas needs to be considered when promoting schemes in the Plymouth area therefore links need to be made to the system workforce plan. **The Governing Body received and noted the contents of the Locality Reports.**	**MF / SM**
15	**Primary Care Committee Chair's Report** This report is for information only. NK noted there was a discussion on workforce around recruitment to GP posts when trying to recruit consultants. **The Governing Body received and noted the contents of the Primary Care Committee Chair's Report.**	

16	**Close of Meeting** The Chair closed this meeting. The meeting closed at 15:20.	

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*
Andrew Millward (AM)**	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Brian Mackness (BM) **	Non-Executive Director/ Lay Member – Devon CCG
Caroline Dimond – Dr (CD) A	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Dr Matt Fox (MF)**	Clinical Representative, Southern Locality, Devon CCG – *on behalf of Dr David Greenwell*
David Greenwell – Dr (DG) A	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Glynnis Atherton (GA) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Womersley – Dr (JWo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) A	Director of Commissioning - West, Devon CCG
Judith Hargadon (JH) A	Non-Executive Director/ Lay Member – Primary Care
Lorna Collingwood-Burke (LCB) **	Chief Nursing Officer, 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
Simon Kerr – Dr (SK) A	Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc)	Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST) **	Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **	Interim Director of Commissioning – North, East and South, Devon CCG
Virginia Pearson – Dr (VP) A	Director of Public Health, Devon County Council
Anna Coles (AC)**	Interim Director of Integrated Commissioning, Plymouth City Council – *on behalf of Jo Turl*
In Attendance	
Molly Bishop (MB)** **Minute Taker**	Executive Assistant, Devon CCG
James Peskett (JP) **	PA Consulting
Katherine O'Halloran (KOH)**	PA Consulting
Penny Harris (PH)**	Director for Developing the Long Term Plan, Devon CCG
Lauren Benham (LB)**	Planning Manager, Devon CCG
Mark Procter (MP)**	Director of Primary Care, Devon CCG
Faye Robinson (FR)**	Director of Procurement, NHS South, Central and West Commissioning Support Unit
Sue Benjamin (SB)**	Programme Manager – CHC and End of Life, Devon CCG
Minutes approved | Date:	Signed by chair:

NHS
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Mr and Mrs Williams – Experience Story
Improving relationships with the public

Sam Holden – Patient Experience Manager

Background

Mr and Mrs Williams live in Plymouth. Mr Williams made a complaint in April 2018 to NEW Devon CCG. The complaint was on behalf of his wife about their experience of using extended scope physiotherapy (ESP) service provided by Sentinel. Mrs Williams was referred due to hip pain in her left hip, having had her right hip replaced previously, and first needed to be seen by an ESP before being listed for surgery (in line with referral guidance).

Mr and Mrs Williams complained about the poor attitude of the ESP and felt that having to see an ESP first was a waste of time and a tick box exercise given that the GP felt that Mrs Williams would benefit form a hip replacement.

Mr and Mrs Williams also felt that the CCG's referral support service was essentially restricting access to surgery and overruling the GP.

Additional issues

- Investigation response from the provider was poor
- Management of the complaint by the case manager was, at times, unsatisfactory
- The client was challenging in his communication with the CCG
- Client felt that records had been ‘falsified’

All of this led to the client feeling that both the provider and CCG were hiding information or covering for each other and caused a relationship breakdown.

External Review

As a result of the issues raised and the relationship breakdown and following the client meeting with the Chief Nursing Officer we commissioned an external review to be undertaken. The case was passed over to be managed by the Patient Experience Manager who acted as single point of contact for the client and coordinated the external review, this improved the relationship.

The review had 3 elements to it:

The primary care element - undertaken by a GP not connected to the case

The sentinel element – undertaken by an external organisation

The Clinical Commissioning Group element – undertaken by NHS England

External Review

A comprehensive external review was undertaken and highlighted a series of key areas, in particular:

- The referral and process around accessing an ESP for an initial assessment is appropriate and in line with CCG processes nationally, however communication around commissioning and referral pathway could be enhanced

- The notes and record keeping by the provider was poor and led to ambiguity

- The response to the complaint was poor and the management of the complaint could have been improved

Improvements

As a direct result of this review improvements have been made:

- New complaint process for the CCG – enabling the CCG to see provider responses in full and work with them to improve responses where required

- a new peer review and quality checking process has been introduced, peer review, head of department and then Chief Nursing Officer sign off

- More oversight of complaints at quality assurance meeting

- Introduction of client satisfaction surveys

Improvements

- Via the regional patient experience network attended by all providers we will be introducing complaints training by the Ombudsman

- Client has been invited to work with the team on areas of improvement and to see how we quality assure

- Client is also part of our review process for revised complaints policy

Improved relationship

“Our initial experience with Sentinel was poor, we felt so let down. We expected better from the CCG and felt let down again when this didn’t happen.”

“Things vastly improved when our case was managed by Sam. This restored our faith in the CCG and the NHS.”

“Overall we are pleased with the external review and its findings, we are grateful to the CCG in arranging this and recognise their bravery in its exposure of areas which were poor or needed improvement. ”

“I am pleased to be able to provide some contribution to service development with Sam and his team.”

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GOVERNING BODY

Report title: Chair's Report				
Date of committee: 25 July 2019 **Date report produced: 12 July2019**				
Author (s) Name and Title: Dr Paul Johnson, Chair Molly Bishop, Executive Assistant		**Supporting Executive:** Dr Paul Johnson, Chair **Report Approved by:** Name and Title: Dr Paul Johnson, Chair **Date:** 17 July 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				

Executive Summary:

This report contains updates on:

- Devon System Non-Executives Development Day 3 July
- GP Membership Engagement
- Peninsula Clinical Services Strategy
- System Leaders Meeting 17 July
- Governing Body Membership Update

Management of Conflict of interests:

Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.

Committees that have previously discussed/agreed the report and outcomes:

N/A

Key recommendations and actions requested:

This report is for information only and the Governing Body are asked to note the contents

Impact on Strategic Objectives		
None.		
Reference to other documents or accompanying papers:		
https://www.mhm.org.uk/the-moorings-devon		
Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality	Safety: Effectiveness: Experience:	✓
Equality		✓
Resource and Finance		✓
Legal		✓
Engagement and Consultation		✓
Risk		✓

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

NHS
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GOVERNING BODY – CHAIR'S REPORT

1. Introduction

We are now three months into the new CCG and we have seen some real progress. Leadership within localities is starting to take shape with clinical, executive and non-executive presence and engagement with local stakeholders and GP members. We are continuing to embed and develop system working with our partners and have seen particular keenness and enthusiasm from the non-executive leaders within Devon to work together. Our closer working with our local authorities continues and my re-appointment as deputy chair of the Devon Health and Wellbeing Board demonstrates the desire of the local authorities to work closely with NHS organisations. I am starting to sense a growing optimism in much of General Practice now that our 31 Primary Care Networks (PCNs) have been confirmed and the PCN Clinical Directors are starting to explore the opportunities this brings.

2. Devon System Non-Executives Development Day 3 July

As we have come together as a system, Executives (via the STP Programme Delivery Executive Group, PDEG), Clinicians (via Clinical Cabinet) and Chairs (via System Chairs Forum) have been working much more closely together. It had become clear that Non-Executives had not had that opportunity, so with the support of the NHS Confed we held a System Non-Executive Directors (NEDs) Development Day. During the day there was a clear enthusiasm from all organisations NEDs to continue this closer working and get more involved in System working. We heard from the lead NED of Gloucestershire Integrated Care System on how they have embedded non-executives in their system governance and there is much learning we can take from this. A small working group is now meeting to agree how we might apply this learning.

3. GP Membership Engagement

I am continuing to meet with member GPs as below. There has been a generally positive and optimistic welcome of the merged CCG and our values and ambitions. This included a lot of very useful discussion about how we might support the Primary Care Networks to help them to understand their role and opportunity within the wider system. This is balanced by the understandable concern around primary care workload and workforce, and good discussions about what we might do differently to support this as delegated commissioners of primary care.

The presence of the triumvirate leadership of Clinical Representative, Non-Executive and Executive Lead was very much appreciated by the members.

- 5 July Exeter GP Forum
- 16 July East Devon GP Forum
- 19 July Mid Devon GP Forum

- 23 July Western Primary Care Partnership

4. Peninsula Clinical Services Strategy (PCSS)

As requested by Governing Body last month I am now a member of the PCSS Leadership Team along with Nick Kennedy and Sonja Manton. The PCSS is currently progressing in line with the briefing papers that have been presented to Governing Body and we will continue to bring regular updates.

5. System Leaders Meeting on 17 July

System leaders met with Simon Stevens (Chief Executive NHS England) and Dido Harding (Chair NHS Improvement) on 17 July. Simon Stevens, whilst acknowledging the significant challenges faced by the NHS throughout the country, was very clear that financial balance and performance targets remained a clear priority and expectation of NHS England of each STP to achieve. A particular focus was placed on urgent and emergency care given the recent increase in demand and drop in performance in order to ensure each area has the plans and resources to meet the winter challenges of 19/20. Dido Harding presented on the Interim Workforce Plan with a welcome focus on workplace conditions, staff support and wellbeing as key enablers to staff recruitment and retention.

6. Governing Body Membership Update

Following our Governing Body decision last month, we have not had any concerns raised by our member GP Practices regarding the proposed changes to our Governing Body membership. I will therefore be taking proposals to Remuneration Committee this month and subject to their approval we will start the recruitment process for two further full Governing Body members and two associate members.

The proposals are:

- Allied Health Professional
- Lay Member (Finance)
- Associate Lay Members (x2)

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GOVERNING BODY

Report title: Interim Accountable Officer's Report				
Date of committee: 25 July 2019 **Date report produced: 12 July 2019**				
Author (s) Name and Title: Simon Tapley, Interim Accountable Officer Jo Turl, Director of Commissioning – Western Molly Bishop, Executive Assistant to Interim Accountable Officer		**Supporting Executive:** Simon Tapley, Interim Accountable Officer **Report Approved by:** Name and Title: Simon Tapley, Interim Accountable Officer **Date:** 12 July 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				
Executive Summary: This report contains updates on: ▪ Plymouth Integrated Care Partnership ▪ CCG IAF Patient and Community Engagement Indicator 2018/19 Assessment Final Score ▪ Key meetings and visits ▪ The King's Fund Leadership and Management Summit ▪ Integrated Commissioning Executive meeting				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				
This report is for information only.				
Impact on Strategic Objectives				

Commission Safe and Effective Services *Develop Strategic commissioning plans which improve the physical and mental health of the population* *Work in partnership with the wider health and care system to commission integrated and personalied care* *Make best use of resources*
Reference to other documents or accompanying papers:
N/A

Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality	Safety: Effectiveness: Experience:	✓
Equality		✓
Resource and Finance		✓
Legal		✓
Engagement and Consultation		✓
Risk		✓

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

NHS
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Clinical Commissioning Group

Interim Accountable Officer's Report

1. Plymouth Integrated Care Partnership

Following the decision at the last Governing Body meeting in June 2019, the procurement of the Integrated Care Partnership (ICP) has begun in Plymouth and Western to deliver Integrated Community Health and Care services, and the provision of primary medical services for the Mayflower Medical Group and Mannamead Surgery. It is focused on bringing together services to improve patient experience, accessibility and quality of care, and it will be instrumental in promoting health through integration, empowering communities to take active roles in their health and wellbeing, providing locality-based care model design and implementation, shifting resources closer to home, or in people's own homes and extending health and social care integration.

2. CCG IAF Patient and Community Engagement Indicator 2018/19 Assessment Final Score

On 5 July 2019, NHS England released its *2018-19 CCG IAF Patient and Community Engagement Indicator,* an annual rating of the quality of engagement by all CCGs.

It rated both our former CCGs as '**Green Star**' (the highest awarded), recognising the huge effort of our engagement work during the past year.

We were rated as 'Outstanding' for 8 out of the 10 domains for our engagement work.

This is the first time we will have received this rating, as formerly both CCGs were 'Amber' rated.

3. Key meetings and visits

Key meetings and visits this month have included:

- A meeting with system Chief Executives and the regional NHS England/Improvement team relating performance, finance and quality across the system.
- A visit from Roger Davidson, NHS Director of System Partnerships to Devon Partnership NHS Trust which myself, Andrew Millward and Philippa Slinger, the Lead Chief Executive for the Devon Sustainability and Transformation Partnership (STP) attended.
- A System Leaders meeting with Simon Stevens, Chief Executive of NHS England and NHS Improvement, including other Chief Executives in the South West.
- An Exec to Exec meeting with NHS Kernow Clinical Commissioning Group (CCG) to discuss future collaborative working.

4. NHS Devon CCG Celebrating You Award Winners attended The King's Fund Leadership and Management Summit

A cohort of staff from the CCG, drawn from winners and those highly commended in the recent CCG Celebrating You Awards, attended The King's Fund leadership and management summit on compassionate and inclusive leadership in action on 10 July. The summit explored the importance of leadership and culture in addressing workforce challenges, delivering better patient care and driving improvements to population health. Those who attended will be presenting back to the CCG's Senior Leadership Team in September to share their learning and feedback.

5. Integrated Commissioning Executive meeting

The Integrated Commissioning Executive (ICE) meeting is a meeting of CCG and Local Authority partners. It provides a mechanism for joint planning and shared decision making by the relevant responsible senior officers, who have the authority to act in accordance with the decision-making framework of each partner organisation.

Key areas of discussion recently have been:

- Strategic commissioning
- Local Care Partnerships
- The children's services strategy for Devon, including reducing the waiting times for children and young people within the autism diagnostic pathway and support pre and post diagnosis

NHS
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GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee
Date of Governing Body: Thursday 25th July 2019 **Dates of Committees covered in this report:** 18th July 2019 **(Minutes of these committee meetings to be available as an addendum)**
Chair's Name and Title: David Greenwell, Southern Locality Clinical Lead **Contact Details:** david.greenwell@nhs.net
Reports discussed and assurances received
• **Risk Register report** • **Devon CCG Monthly Finance report** • **GB Quality & Performance report** • **STP Monthly Finance report** • **Commissioning Service Risks and Issues**
Reports received and noted
• **Risk Register report** • **Devon CCG Monthly Finance report** • **GB Quality & Performance report** • **STP Monthly Finance report** • **Commissioning Service Risks and Issues**
Risk Register Review (changes and areas of concern)
• **One risk recommended for closure – Risk No. 19**
Committee Decisions
•
Recommendations for Governing Body
• **Closure of Risk No. 19**

Recommendations for other Committees
•
Terms of Reference or other committee effectiveness issues
•

Management of Conflict of interests:

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GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT					
Date of committee: 25th July 2019 **Date report produced:** 18th July 2019					
Author (s) Name and Title: **Finance, Business Intelligence and Contracting Directorate** **Contact Details:** Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting)			**Supporting Executive:** John Dowell **Name and Title:** Director of Finance **Contact Details:** **Report Approved by:** **Name and Title:** John Dowell, Director of Finance **Date** 18th July 2019		
Public or Private (Governing Body only):			**Public**	✓	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**		**Information** ✓
Does this report place individuals at the centre?			**Yes**	✓	**No**

Executive Summary:

The report details the financial position to the 30th June 2019 and provides and assessment of the CCG's risk to delivering its planned deficit of £27m.

The planning round for 2019/20 has been challenging for the Devon System. The balance between performance, growth in activity and finance has proven difficult to square. The Devon System has submitted a combined plan that maintains current performance standards within an environment where activity is increasing. The resulting financial impact led to a projected a deficit of £115m against a deficit control total of £43m for the Devon System.

Since the initial assessment The Devon System has been through an intensive programme, supported by NHSE&I colleagues, to reach an acceptable position in relation to financial performance against control total. This has seen a rapid improvement in the gross system deficit from £115m to £70m (a distance of £27m from control total) based on significantly increasing the level of ambition in our plan and accelerating the pace of change in the transformation programmes the System is undertaking. This revised plan remains draft while we await NHSE&I's approval.

Within the system plan the CCG submitted a Financial Plan for 2019/20 which sets out a forecast deficit to 31st March 2020 of £27m. Within this the CCG has a savings target of £81m which includes the £45m anticipated improvement through accelerating transformation programmes as described above. All parties in the system recognise the challenge this represents and are committed to developing a detailed risk share between NHS partners to enable all parties to recognise individual contributions to the shared risk of delivery.

Consequently the delivery of the required savings plan is the main financial risk and challenge to the CCG. These will require continued focus, priority and joint working across the local community and wider System to mitigate or reduce the potential impact as a result.

This report sets out the financial performance of the CCG to the end of June 2019 (month 3 management accounts).

Management of Conflict of interests:
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Committees that have previously discussed/agreed the report and outcomes:

None

Key recommendations and actions requested:

The Governing Body is asked to note the month 3 position as at 30th June 2019 and the level of risk to delivery of the CCG's control total.

Reference to other documents or accompanying papers:

n/a

Have the legal implications been considered?				
n/a				
Equality Impact Assessment:				
Who does the proposed piece of work affect?	**Patients**	✓	**Carers**	✓
	Staff	✓	**Public**	✓

	Yes	**No**
1. Will the proposal increase discrimination for people in protected groups?		✓
2. Will the proposal reduce discrimination for people in protected groups?		✓
4. Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		✓
5. Will there be a positive benefit to the patients or workforce as a result of the		✓
6. Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?		✓

If the answer to any of the above questions is yes (other than questions 2 and 4) or you are unsure of your answers to any of the above, you should provide further information using **Quality and Equality Impact Assessment**. If a quality and equality impact assessment is not thought to be required briefly explain why and provide evidence for the decision.

***Please add N/A if any of the sections are not relevant*

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NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 3 – 2019/20

Contents

Appendices

1. Executive Summary

The presentation of the Clinical Commissioning Group's (CCGs) financial position in this report seeks to provide the necessary assurance to the Governing Body.

The report details the financial position to the 30th June 2019 and provides and assessment of the CCG's risk to delivering its planned deficit of £27m.

The planning round for 2019/20 has been challenging for the Devon System. The balance between performance, growth in activity and finance has proven difficult to square. The Devon System has submitted a combined plan that maintains current performance standards within an environment where activity is increasing. The resulting financial impact led to a projected deficit of £115m against a deficit control total of £43m for the Devon System.

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Consequently, the delivery of the required savings plan is the main financial risk and challenge to the CCG. These will require continued focus, priority and joint working across the local community and wider System to mitigate or reduce the potential impact as a result.

Financial Position

This report sets out the financial performance of the CCG to the end of June 2019 (month 3 management accounts).

The CCG's 2019/20 forecast deficit is £27.0m.

	Planned Deficit £'000	Actual Deficit £'000	Variance to plan £'000
Year to date position	6,750	6,750	0
Year end forecast	27,000	27,000	0

Although the overall year to date (YTD) position balances to the planned deficit of £6.75m, there are several variances to report at Month 3. These are discussed and set out in later sections.

Savings Plan

As set out in section 4, the CCG has a savings plan of £80.9m. The initial assessment of deliverability suggests a saving of £38.9m could be delivered leaving a risk of £42m under delivery.

Risk

Section 5 provides further detail but after allowing for a modest level of mitigation identified through the planning round the overall risk to delivery of the CCG's plan is assessed at £39.5m.

STP Plan

The CCG's plans sit within an overall plan for the STP which has a deficit of £68.7m (excluding anticipated Transformation Funding) with a savings plan of £170.6m. The plan is based on an agreed set of block contracts but with a large proportion of the savings predicated on joint working to reduce cost within those contracts through an accelerated transformation programme.

Should the system deliver its planned deficit position providers are expecting to receive £56.4m of Transformation funding resulting in an overall STP deficit position of £12.3m.

2. Financial Assurance Dashboard

The NHS England CCG Improvement and Assessment Framework cover 4 domains and a number of clinical priorities. The sustainability domain looks at how the CCG is remaining in financial balance and is securing good value for money for patients and the public from the money it spends.

In terms of financial sustainability, the framework assesses the following two areas

- Financial plan
- In Year Financial performance

The detailed areas of assessment that feed into these top-level indicators are shown in tables below

NO.	INDICATOR	Devon CCG
Financial Plan Ratings detail		RAG
1	Minimum cumulative 1% planned surplus	RED

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	6.8	6.8	0.0%	RED
3	Forecast Outturn in year deficit	27.0	27.0	0.0%	RED
4	QIPP - Year To Date Delivery (% achieved)	-10.5	-4.8	45.7%	RED
5	QIPP - Forecast Outturn Delivery	-80.9	-80.4	99.4%	GREEN
6	Running Costs	25.4	22.5	88.7%	GREEN
7	Risk adjustment to deficit (% of allocation)	0.0	39.5	2.1%	AMBER/GREEN
8	Cash Position (% drawn down)	25.0%	25.0%	100.0%	GREEN
9	BPPC (% paid - value)	95%	99.3%	104.5%	GREEN

NO.	INDICATOR	Devon CCG
CCG Additional Indicator		
10	Delivery of plan YTD	GREEN
11	Delivery of plan FOT	GREEN

3. Detailed Financial Performance

The financial position to the 30th June 2019 by main service heading is as follows:

Month 03 June	DEVON CLINICAL COMMISSIONING GROUP					
	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES						
Acute Services	233,301	233,305	4	933,203	933,172	-31
Mental Health Services	50,148	50,474	326	200,592	200,593	1
Community Health Services	61,255	61,255	-83	245,018	245,019	1
Placements	29,166	30,041	875	116,659	116,659	-1
All Other Healthcare	5,180	3,979	-1,119	9,382	9,413	31
Primary Care Services						
Prescribing	48,497	48,497	-0	193,990	193,990	0
Other Primary Care	50,152	50,148	-4	203,127	203,127	-0
Primary Care Subtotal	98,649	98,645	-4	397,117	397,117	-0
Subtotal	477,699	477,699	0	1,901,972	1,901,972	0
CORPORATE						
Running Costs	5,631	5,631	0	22,527	22,526	-0
TOTAL COMMISSIONED SERVICES	483,330	483,330	0	1,924,499	1,924,499	-0
Allocation excl b/fwd position	476,580	483,330	6,750	1,897,499	1,924,499	27,000
2018/19 Surplus/Deficit	6,750	-	6,750	27,000	-	27,000

There are a number of YTD variances to report at Month 3 including an overspend in mental health individual patient placements (IPPs) of £0.326m and £0.875m in continuing healthcare. This overspend has mainly been offset using reserves, resulting in the planned YTD deficit of £6.75m. This is discussed and set out in later sections.

When set against our available in year revenue resources of £1,897m for Devon CCG the forecast outturn (FOT) expenditure plan results in an overspend of £27m.

The detailed expenditure, contract monitoring information and an analysis of potential risks and mitigations is set out in the remainder of this report and will evolve during the course of the financial year as further improved information and reporting becomes available.

3.1 Acute Services

The CCG 2019/20 activity planning with providers has been submitted to NHSE. The four providers in Devon are forecasting variable growth in activity for 2019/20.

The highest area of growth is for elective activity, which is designed to maintain sustainable RTT waiting list sizes and to significantly reduce the number of patients waiting over 40 weeks, minimising the risk of 52-week breaches.

The system recognises that current growth levels are above national levels, our intention is to bring activity below these forecasts with effective transformation and demand management.

The tables below show each providers performance against the operational activity plans submitted to NHSE. We are closely working with each provider, monitoring delivery against the plans and ensuring we understand any activity variances.

RDE Activity Summary - Month 2

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Total Consultant Led Outpatient Attendances	**47,963**	**46,941**	**-1,022**	-2%	**4,925**	**4,783**	**-142**	-3%
Consultant Led First Outpatient Attendances	18,428	18,754	326	2%	2,657	2,637	-20	-1%
Consultant Led Follow-Up Outpatient Attendances	29,535	28,187	-1,348	-5%	2,268	2,146	-122	-5%
Total Outpatient Appointments with Procedures	13,739	13,067	-672	-5%	1,931	1,895	-36	-2%
Total Elective Admissions	**9,390**	**8,406**	**-984**	-10%	**10,931**	**9,945**	**-986**	-9%
Total Elective Admissions - Day Case	7,766	6,964	-802	-10%	5,937	5,358	-579	-10%
Total Elective Admissions - Ordinary	1,624	1,442	-182	-11%	4,994	4,586	-407	-8%
Total Non-Elective Admissions	**6,462**	**6,482**	**20**	0%	**13,950**	**13,822**	**-128**	-1%
Total A&E Attendances excluding Planned Follow Ups	**14,785**	**14,879**	**94**	1%	**2,015**	**2,130**	**115**	6%
Type 1 A&E Attendances excluding Planned Follow Ups	14,785	14,879	94	1%	2,015	2,130	115	6%

For Month 2 RDE activity is showing under performance across all Elective services; Outpatient first and follow up attendances are below plan by 2% (1,022), Daycases are -10% (802) and Elective Inpatients -11% (182)

Non Elective admissions are marginally above plan by 20 and A&E attendances are exceeding plan by 1% (94)

NDHT Activity Summary - Month 2

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Total Consultant Led Outpatient Attendances	**19,457**	**18,826**	**-631**	-3%	**2,055**	**2,009**	**-46**	-2%
Consultant Led First Outpatient Attendances	6,109	6,377	267	4%	1,029	1,045	15	1%
Consultant Led Follow-Up Outpatient Attendances	13,347	12,449	-898	-7%	1,026	964	-62	-6%
Total Outpatient Appointments with Procedures	4,842	5,222	380	8%	646	673	27	4%
Total Elective Admissions	**3,621**	**3,897**	**276**	8%	**3,082**	**3,040**	**-41**	-1%
Total Elective Admissions - Day Case	3,102	3,360	258	8%	1,625	1,662	37	2%
Total Elective Admissions - Ordinary	519	537	18	4%	1,457	1,379	-78	-5%
Total Non-Elective Admissions	**3,355**	**3,437**	**82**	2%	**6,049**	**7,204**	**1,155**	19%
Total A&E Attendances excluding Planned Follow Ups	**7,301**	**7,761**	**460**	6%	**946**	**979**	**33**	4%

Uncoded activity remains an issue for NDHT, 28% of Daycase, 63% Elective Inpatients, 27% A&E and 75% Non-Elective activity has been uncoded for Month 2, an average tariff has been applied,
First Outpatient activity is 4% (267) above plan, T&O and Clinical Physiology have the highest variance against plan, although referrals to these specialities remain level.
Follow up attendances are -7% (898) from plan

Outpatient Procedures are 8% (380) above plan, ENT has the largest variance to plan (175)

Daycase activity is 8% (258) above plan, main areas of over performance are Colorectal Surgery and Gastroenterology which links in with increased 2ww referrals.

Elective Inpatients are 4% variance from plan (18), Non-Electives and A&E are both exceeding plan at Month 2.

UHP Activity Summary - Month 2

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Total Consultant Led Outpatient Attendances	**36,392**	**36,205**	**-187**	-1%	**3,685**	**3,697**	**12**	0%
Consultant Led First Outpatient Attendances	11,865	11,960	95	1%	1,768	1,771	3	0%
Consultant Led Follow-Up Outpatient Attendances	24,527	24,245	-282	-1%	1,916	1,926	10	0%
Total Outpatient Appointments with Procedures	11,448	12,974	1,526	13%	1,790	1,933	143	8%
Total Elective Admissions	**6,333**	**6,757**	**424**	7%	**7,351**	**6,615**	**-737**	-10%
Total Elective Admissions - Day Case	5,209	5,716	507	10%	3,799	3,744	-54	-1%
Total Elective Admissions - Ordinary	1,124	1,041	-83	-7%	3,552	2,870	-682	-19%
Total Non-Elective Admissions	**6,431**	**6,042**	**-389**	-6%	**12,690**	**11,657**	**-1,033**	-8%
Total A&E Attendances excluding Planned Follow Ups	**21,890**	**21,471**	**-419**	-2%	**2,819**	**2,725**	**-94**	-3%
Type 1 A&E Attendances excluding Planned Follow Ups	14,348	14,217	-131	-1%	2,259	2,186	-73	-3%
Other A&E Attendances excluding Planned Follow Ups	7,542	7,254	-288	-4%	560	539	-21	-4%

For month 2 UHP are showing outpatients are 1% above plan for new attendances but -1% for follow up attendances, there is also a large variance for outpatient procedures showing 13% (1,526) ahead of planned activity.

Daycase admissions are exceeding plan by 10% (507) although are 1% below financial costs but for elective inpatients -7% (63)

Non Elective Admissions and A&E attendances are below plan

TSDFT Activity Summary - Month 2

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Total Consultant Led Outpatient Attendances	**53,700**	**51,085**	**-2,615**	-5%	**5,964**	**5,526**	**-438**	-7%
Consultant Led First Outpatient Attendances	16,261	15,100	-1,161	-7%	2,497	2,341	-156	-6%
Consultant Led Follow-Up Outpatient Attendances	37,439	35,985	-1,454	-4%	3,467	3,185	-282	-8%
Total Elective Admissions	**6,102**	**6,680**	**578**	9%	**5,866**	**5,753**	**-113**	-7%
Total Elective Admissions - Day Case	5,515	6,140	625	11%	3,586	3,888	302	8%
Total Elective Admissions - Ordinary	587	540	-47	-8%	2,280	1,865	-415	-18%
Total Non-Elective Admissions	**6,378**	**5,869**	**-509**	-8%	**11,800**	**10,974**	**-826**	-7%

Due to reporting issues at TSDFT, the reported position above is an indicative view of the provider therefore includes activity which is not commissioned by NHS Devon CCG. We are working with the Trust to ensure we have measures in place for next month.

TSDFT as a provider are -7% (-1.161) below plan for outpatients first attendances and -4% (-1,454) follow up attendances.

Daycases are exceeding plan by 11% (625) and Elective Inpatients are -8% (-47)

Non Elective admissions are -8% (509) below plan.

CCG Referrals Summary

Below is a summary of the CCG YTD referrals for Month 2 showing a 1.1% growth including RD&E ASI adjustment

	YTD Position	2WW	Routine	Working Days Adjusted	Rolling 12 Months
NHS Devon CCG Position	1.9%	7.7%	0.6%	1.9%	2.3%
by Provider					
RD&E	5.5%	2.8%	6.1%	5.5%	3.4%
UHP	5.4%	28.7%	-0.8%	5.4%	4.3%
TSDFT	2.5%	1.6%	2.6%	2.5%	0.1%
NDHT	-3.4%	5.4%	-5.3%	-3.4%	1.5%
Others	-12.8%	0.0%	-12.8%	-12.8%	-6.7%

The NHS Devon CCG YTD position shows 1.9% growth with a 7.7% growth in 2 weeks wait referrals.

The RD&E have 5.5% growth including an ASI adjustment based on DRSS deferred referrals YTD which are not yet included within the RD&E referral data as booked, UHP have 5.4% growth, TSDFT have a 2.5% growth, NDHT have a -3.4% reduction. Referrals to Other providers, including the IS, have also seen a fall at -12.8%.

3.2 Mental Health Services

The 2019/20 Mental Health budget provides services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and Livewell Southwest with the CAMH's service for Northern, Eastern and Southern localities being provided by Children and Families Health Devon through a contract with Torbay and Southern Devon NHS Foundation Trust.

In 2019/20 the CCG has invested £15m (6.1% increase) in Mental Health Services and will be audited on its overall spending in this area at the end of the year.

At month 3 there is a YTD overspend of £0.326m for IPPs due to an unexpected high cost client and complicated Transforming Care Partnership (TCP) client discharges. The position is forecast to break-even as we await confirmation of Funding Transfer Agreement (FTA) monies from NHSE to support the TCP discharges.

3.3 Community Health Services

Community Healthcare Services include contracts with our main providers for community hospital beds and community services as well as children's services, minor injury services and the CCG's investment in the better care fund with our three local authorities.

3.4 Placements

Continuing healthcare is overspent by £0.875m at month 3 due to client number reductions being less than anticipated but plans to mitigate this over the coming months are underway.

There is underlying risk that will require robust financial management over the coming months. The key risks relate to the CHC QIPP savings target of £5m that is embedded within the budget where further detailed plans are required to meet the full challenge and there is inherent risk around the assumption that the number of eligible clients will drop again this year.

In addition, it is likely that some investment will be required to address capacity to deliver timely assessments and reviews for CHC clients. This investment need relates to concerns around assuring care quality for individuals and meeting national expectations.

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

3.5 Primary Care Services

Delegated Primary Care Commissioning

On 1st April 2019 Devon CCG took on the formal responsibility for primary care commissioning from NHS England. This means that the CCG is now responsible for a budget of £166m to commission GP services in Devon.

As at month 3 we are forecasting a breakeven position across delegated primary medical care. However, early signs of pressure (mainly premises based) are emerging that will challenge this position and more detailed reporting of these will be provided in future periods.

Primary Care Prescribing

It is too early in the year to accurately forecast expenditure, and the position has been reported at breakeven for both accrued year to date and forecast outturn. Work is currently under way to finalise the QIPP plans, with financial amounts allocated against each scheme. We are planning to start reporting against this plan for M04 to provide the assurance needed. The Data group is assisting with this to insure we are now consistently reporting across all areas and one source is used as appropriate.

It remains too early to understand the impact of price concessions, and subsequent tariff changes are having on the position, and it is assumed these are within planning assumptions, helping to inform a breakeven position. There does appear to be some risk around this as they have already started to rise.

Other Primary Care Services

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

3.6 All Other Healthcare

All Other Healthcare includes contracts for Integrated Urgent Care, hospices, patient transport and other intermediate care services. It also includes reserves and any unallocated savings targets.

3.7 Running Costs

CCGs are required to manage the running costs (administration costs) of the organisation within an allowance which amounts to £25.4m for the CCG. Running costs are deemed to be those which are not for or related to the purchase of healthcare services (programme costs).

The forecast outturn at month 3 is estimated at £22.5m which would be an underspend of £2.9m when compared to the £25.4m allocation received.

3.8 Resource Allocation

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

	NEW Devon CCG	SD & Torbay CCG	Devon CCG
Planned revenue resources	£'000	£'000	£'000
Final allocation after place based pace of change	1,257,424	433,048	1,690,472
Other funding pace of change	2,191	475	2,666
Total recurrent revenue resources	**1,259,615**	**433,523**	**1,693,138**
Recurrent adjustments			2,336
Non recurrent adjustments			14,815
Primary care commissioning			161,805
Running costs allocation			25,405
Total revenue resources			**1,897,499**
Total forecast expenditure			1,924,499
Total revised planned overspend 2019/20			(27,000)

4. QIPP/Systems Savings Plan

In order to support the priorities and contractual commitments within the CCGs financial plans for 2019/20, it requires delivery of a series of efficiency improvements and service changes in relation to its existing expenditure.

This can be extended to the ability of the healthcare system in the whole of Devon to live within the resources available to it, with the plan developed for this financial year targeting £166.3m across the Devon system. This is being managed and delivered jointly with the CCG's local system partners as part of the STP foot print.

Work streams to identify efficiency opportunities and put in place plans to deliver the attendant savings are in place. The overall programme is managed through its continual focus at the system Programme Delivery Executive Group (PDEG) meetings as well as the respective organisations finance committees and Board/Governing Body.

The management of the system savings programme includes regular assessment of likely delivery, with the shortfall against the plan (unmitigated risk) a continued key focus for the respective organisations to identify further opportunities and apply robust financial management processes to close this gap.

This means that for the CCG, although the total 2019/20 QIPP savings required is £80.9m, the transformational savings plans (i.e. not contractualised) within this amount to £35.0m. All parties in the system recognise the £35.0m challenge and are

committed to developing a detailed risk share between NHS partners to enable all parties to recognise individual contributions to the shared risk of delivery.

A summary of the CCG's total QIPP plans and high-level initial risk assessment is as follows:

QIPP Delivery	Plan	Upside Forecast	Upside Risk	Downside Forecast	Downside Risk
Description	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Demand/activity management and transformation programmes	37,500	27,500	10,000	10,500	27,000
Reduction in spend on individual patient placements	2,000	1,500	500	1,000	1,000
Joint commissioning	7,000	4,000	3,000	2000	5,000
Continuing healthcare	5,000	5,000	0	1,000	4,000
Primary care prescribing	8,000	8,000	0	4,000	4,000
Allocations/income	10,000	10,000	0	5,000	5,000
Further benchmarking opportunities	3,896	2,500	1,396	0	3,896
Non-rec opportunities	6,000	6,000	0	6,000	0
Procurement/Non-healthcare contract/Admin	1,500	1,500	0	1,500	0
Total QIPP	**80,896**	**66,000**	**14,896**	**31,000**	**49,896**

Future reports will provide more detail of the savings made to date as well as the estimated forecast savings for the CCG.

5. Risks

The assessment of financial risk at month 3 is estimated at £39.5m as follows.

Devon CCG		Month 2	Month 3
Risk	**Description**	**£'000**	**£'000**
Acute Services	Latest assessment of the level of risk attached to the activity and transformation programmes being developed with system partners for delivery in 19/20. Monitoring arrangements and an appropriate risk share mechanism are being refined and implemented	24,500	24,500
Mental Health Services	Potential risk of not delivering in full the target set for the reduction in cost of out of area placements.. There is a process for monitoring and managing this area and the arrangements in place	500	1,000
Community Healthcare Services	Reassessment of opportunities which were explored and delivered against in 19/20 but at present don't exist for this financial year.	7,000	4,000
Continuing Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arrangements are in place through the Control Centre and this will be proactively managed during the year	1,000	3,500
Primary Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arrangements are in place to monitor delivery but the latest assessment doesn't meet the required target.	2,000	2,000
Primary Care Delegated Commissioning	Initial assessment in advance for full financial due diligence of the potential risks which may materialise in the next two years. This is currently being discussed and developed further with NHS England	1,500	1,500
Other Programme Services	Continuing assessment of opportunities for mitigating against some of the risk which exists in the CCG plan, including non-recurrent solutions and limiting existing exposure to cost pressures	7,000	7,000
Total Risk		**43,500**	**43,500**
Mitigations	**Description**	**£'000**	**£'000**
Acute Services	Potential sources of funding to mitigate opening plan risk being agreed with system partners	-2,000	-2,000
Other Programme Services	Initial reassessment of opening plan risks and potential mitigating solutions	-2,000	-2,000
Total Mitigations		**-4,000**	**-4,000**
Total unmitigated risk		**39,500**	**39,500**

Changes to the risk profile for mental health placements, continuing healthcare and community services reflect an updated assessment following review of the month 3 position in these areas.

The scale of the unmitigated risk represents a significant challenge to the CCG delivering its plan for 19/20. Further work on mitigations either through acceleration of transformation programmes or other risk sharing mechanism are being considered by all partners in the Devon STP with a view to reducing the risk exposure to the CCG.

In addition, a detailed action plan is being prepared to provide assurance to the CCG Governing Body that all opportunities are being explored to address the challenge.

6. Other Financial Information

6.1 Statement of Financial Position

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

The CCG's position at 30th June 2019 is shown in appendix 1.

6.2 Capital

As part of financial planning the CCG had requested £168k of capital for business as usual projects, to include IT infrastructure. However, NHS England have informed the CCG that the bid for the resource was not approved and hence the CCG will need to deal with this accordingly.

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non NHS Creditors - % of bills paid within target	94.32%	98.90%
NHS Creditors - % of bills paid within target	93.29%	99.43%

The target of 95% has not been met for the number of invoices paid within 30 days. This looks to be due to the merger of the two CCGs. Legacy organisations invoices had to be re-scanned, coded and paid via Devon CCGs ledger which resulted in a delay in the process. The CCG has moved closer to the 95% benchmark this month and looks to be on target to match the benchmark in month 4 and going forwards.

6.4 Cash

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

7 Recommendations

The Governing Body is requested to:

Note and review the month 3 year to date performance and the forecast year end position including the current risks around delivery of the CCG's control total.

Appendices

Appendix 1: Statement of Financial Position

AS AT 30 JUNE 2019	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	2,876
Intangible Assets	10
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	2,886
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	4,272
Trade & Other Receivables - Non NHS	27,069
Other Current Assets	-
Cash & Cash Equivalents	913
Non-current Assets held for Sale	-
Total Current Assets	32,654
Total Assets	35,539
CURRENT LIABILITIES	
Trade & Other Payables - NHS	- 49,395
Trade & Other Payables - Non NHS	- 92,937
Other Liabilities	- 950
Borrowings / Cash in Transit	- 8,856
Provisions	- 255
Total Current Liabilities	- 152,392
Total Assets less Current Liabilities	- 116,853
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 95
Total Non Current Liaibilities	-
Total Assets Employed	- 116,948
FINANCED BY TAXPAYERS EQUITY	
General Fund	116,948
Total Taxpayers' Equity	116,948

Appendix 2: Cash

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

Measure	Month 3
CCGs must operate within their Maximum Cash Drawdown (MCD) *The MCD is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,920.096m for Devon CCG the year.*	25.% of the MCD has been utilised as at month 3 (25% is expected based on a straight-line trajectory at month 3).
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £7,425 for June.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: 25th July 2019

Dates of Committees covered in this report: 10th July 2019

(Minutes of this meeting are not yet available)

Chair's Name and Title: Nick Ball, Non-Exec Director

Contact Details: nick.ball1@nhs.net

Reports discussed and assurances received

Risk Management Update Report (attached as appendix to this document)

- Received and discussed in detail the New Style Assurance Framework. This represents a considerable improvement in the link between the CCGs Strategic Aims and its Control Assurance process. The Committee made some recommendations for further improvements.
- Noted progress with the recommendations made by the Internal Audit Corporate Governance (Risk Management) Audit including development of the new Risk Management Framework and Assurance Framework. Also noted that the Risk Management Training programme will be commencing in September. A review of Corporate Risk Register is underway to improve quality and completeness.

- Noted that work is underway to develop mechanisms for the management of system risk. As these mechanisms develop links to the CCG risk register will be clarified and the role of Non-Executive Directors in system-working will be strengthened.

Health and Safety Update

- Noted that the Health and Safety Policy was approved by the Governing Body in May 2019. The CCG has an assigned independent Competent Advisor as required by the Health and Safety Act.
- Since April 2019 there have been five incidents none of which resulted in time off work or categorised as RIDDOR

Reports received and noted

Update on Information Governance – noted that this is reviewed at the quarterly Data Security and Protection Steering Group

Losses and Special Payments - Noted that Clinical Commissioning Groups' (CCG) are required to report any potential losses or special payments to the Audit & Assurance Committee. There were no new items on the registers reported to the Committee in the first quarter of 2019/20.

External Audit Update Report and Sector Report – noted. This report included the An nual Auditors Letter to the CCG, confirming the Unqualified Audit Opinions for the two predecessor CCGs for 2018/19. I would like to record my thanks to John Dowell and everyone in the Finance teams for this outstanding achievement.

2018/19 Annual Audit letters for South Devon and Torbay CCG and NEW Devon CCG - Noted

Internal Audit Update Report - noted
Report summarises the work of ASW Assurance since the previous Audit Committee meeting in May 2019 – for the Audit Committee's information and assurance. This update included

- CCG Merger – Project Management lessons learnt
- Clinical Governance Risk Areas
- Delivery of Financial Plans

2018/19 Internal Audit Annual Report – noted
Report summarises the work delivered by ASW Assurance to NEW Devon CCG and South Devon and Torbay CCG in 2018/19 and service performance measure – for the Audit Committee's information and assurance.

Counter Fraud Interim Report - noted

Risk Register Review (changes and areas of concern)

Approved closure of Risk 39
There is a risk that the CCG will fail to meet its requirements to have its assurance status restored due to non-delivery of one or more of the NHS England components, which will impact on the CCG's reputation and public confidence. Components include:
Domain 1 – Better Health
Domain 2 – Better Care
Domain 3 – Sustainability
Domain 4 - Leadership

Noted that 5 new risks have been added to the Risk Register

105 – Delays in out of hours GP response

106 – Delivery of medium/long term financial sustainability plan

107 – Reduction in visibility to stakeholders

108 – Capacity in Primary Care

109 – Performance on Constitutional Standards

Committee Decisions

Agreed that the CCG needed a more robust process for identifying and disseminating good practice (clinical and non-clinical) – Board Secretary asked to take this action

Agreed Internal Audit and Assurance Plan for 2019/20

Following the Audit Committee an Auditor Panel was held to review the provision of Internal and External Audit to the CCG. The panel:

- Agreed to the two-year contract extension proposed by Grant Thornton.
- Accepted the contract documents proposed by the consortium and ASW Assurance on a rolling three year basis

Recommendations for Governing Body
The Governing Body is asked to approve the Assurance Framework and to note that the following work is underway: • The first page of the Assurance Framework will list the risks on the Corporate Risk Register which link to each strategic objective. The detail of these risks and how they are being mitigated will be held on the CRR • Each of the Principle Risks on the Assurance Framework will also appear as a risk on the CRR to ensure active management. • Sources of Assurance will be added to the Assurance section for each of the Principle Risks on the Assurance Framework • The Assurance Framework will be presented to each Audit Committee to advise of any updates/changes • The Corporate Risk Register will be presented to the Audit Committee twice a year. • A rolling programme of Exec Directors attending the Audit Committee will be established to give an update on the risks in their Directorate.
Recommendations for other Committees
NA
Terms of Reference or other committee effectiveness issues
NA

Management of Conflict of interests:

Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.

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

Devon CCG – GB Assurance Framework

Corporate Objective	AF Ref	Corporate Risk Register mapping	Principle Risks ***There is a risk that…….***
We will continue to commission safe, effective and accessible services by: • Being in the top 10% of CCGs by improving performance against core NHS standards • Meeting all statutory requirements • Improving our populations health, their experience of care and the cost-effectiveness • Increasing the use of technology	1	2, 3, 11, 59, 70, 74, 80, 89, 106, 109	We do not have sufficient, credible plans to deliver improved performance within agreed timescales
	2	49, 102, 104, 30, 110	The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress.
	3	19	The pace of change for roll out of ICM is too slow and therefore does not achieve planned outcomes
	4	42, 44, 72, 73	We do not commission mental health services which meet local need or national expectation
	5		We do not develop commissioning plans which incorporate best practice in the use of technology
We will work as a strategic partner in Devon by: • Working as one system to support the delivery of all objectives • Working more closely with local communities to plan local services • Developing evidence-based services	6	8, 90, 95	We do not have full commitment from all system partners to deliver operational system plan so change is not delivered.
	7	100	The system does not have robust mechanisms for identifying and responding to emerging risks
	8	107	Our plans do not reflect the views of patients and the public as there has not been sufficient engagement.
	9	15,17, 20, 24, 45, 82	We do not develop evidence-based commissioning plans due to lack of capacity and capability within the CCG

• Empowering, motivating and developing our staff	10		We have not addressed the issues raised in the 2018 staff survey so staff leave or do not perform to their full potential
We will improve the physical and mental health of our population by: • Integrating and personalising care • Addressing issues that cause ill health • Reducing health inequalities	11		We have not evolved our integrated strategic commissioning arrangements sufficiently to develop plans to deliver improvements in population outcomes
	12	77, 92	We have not invested sufficiently in prevention so we do not achieve improvements in population health
	13	75, 79	We are not targetting our resources at the areas that most need them so health inequalities are exacerbated.
We will make best use of resources by: • Using population health management approaches to target resources where they are needed most • Improving efficiency, productivity and sustainability • Achieving financial balance across the whole health and care system in Devon • Increasing investment in services to meet identified need	13	See previous	We are not targetting our resources at the areas that most need them so health inequalities are exacerbated.
	2	See previous	The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress
	6	See previous	We do not have full commitment from all system partners to deliver operational system plan so change is not delivered.
	14	83, 97, 105, 108	There is insufficient workforce capacity and capability in Primary Care (GPs, nurses and pharmacists) to meet demand

<table>
<tr><td colspan="2">Objective: We will commission safe, effective and accessible services.</td><td>Director Lead:

Sonja Manton and Jo Turl</td></tr>
<tr><td colspan="2">Risk: AF 1 – We do not have sufficient, credible plans to deliver improved performance within agreed timescales</td><td>Date Last Reviewed:</td></tr>
<tr><td>Risk Rating
Initial:
Current:
Appetite:</td><td>Impact x likelihood

5x4
5x2</td><td>Reason for current score:

Plans based on potential opportunities but impact is only hypothetical and cannot be tested without delivery

Rationale for risk appetite:

Robust plans can be produced to ensure delivery</td></tr>
<tr><td colspan="2">Controls: (What are we currently doing about this?)

System Operating Plan has been produced and signed off by all partner organisations. Detailed workplans have been agreed and leads have been identified/appointed

Mitigating Actions: (What should we do?)
Further Development of LCPs to deliver at locality level

Specific pieces of work will be implemented and will demonstrate future deliverability

Ongoing review of delivery will result in changes to plans</td><td>Assurances:

PDEG and committees have governance arrangements in place for system working and monitoring performance

A&E Delivery Boards, Planned Care Forums and ICM Groups in place in each locality

Assurance Score:

Gaps in Assurance: (What additional assurances should we seek?)

Line of reporting to CCG needs to be strengthened to focus on CCG deliverables which contribute to system plan</td></tr>
</table>

Objective: We will commission safe, effective and accessible services. **We will make the best use of resources**		**Director Lead:** **Simon Tapley**
Risk: AF2 – The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* **5X4** **5X3**	**Reason for current score:** Insufficient capacity for programme management in CCG due to demands of system working **Rationale for risk appetite:** CCG needs to ensure robust programme management.
Controls: *(What are we currently doing about this?)* *Agreed recruitment to increase PMO capacity – Business Case agreed by Exec Team 18/6/19.* **Mitigating Actions:** *(What should we do?)* *Need to establish reporting mechanisms/ formats/content and clear expectations of role of PMO and others in supporting new arrangements* *A dashboard will be developed to clearly set out progress against agreed metrics.*		**Assurances:** Quality and Performance reports to GB and Committees largely focus on provider performance **Assurance Score:** **Gaps in Assurance:** *(What additional assurances should we seek?)* *Robust reporting to GB and Committees on:* *Delivery of Operational Plan* *Progress with delivery of Corporate Objectives*

<table>
<tr><td colspan="2">Objective: We will commission safe, effective and accessible services.</td><td>Director Lead:

Sonja Manton and Jo Turl</td></tr>
<tr><td colspan="2">Risk: AF3 – The pace of change for roll out of ICM is too slow and therefore does not achieve planned objectives</td><td>Date Last Reviewed:</td></tr>
<tr><td>Risk Rating
Initial:
Current:
Appetite:</td><td>Impact x likelihood

5X4

5x3</td><td>Reason for current score:

Progress with implementation of ICM blueprint has stalled

Rationale for risk appetite:

Blueprint has been developed and mechanisms in place for implementation. Systemwide commitment to delivery</td></tr>
<tr><td colspan="2">Controls: (What are we currently doing about this?)

Blueprint developed and agreed by the system
Revised arrangements for ownership, accountability and governance
Systemwide approach led by joint SROs in NHS and LA
Systemwide resource agreed for implementation
Priorities and programmes of work agreed

Mitigating Actions: (What should we do?)
Development of Locality Care Partnerships to support implementation

Further data analysis required to understand actual vs hypothesised impact and whether this can be better than flat levels of growth. This will be supported by the further development of the One Devon dataset.

Development work required to increase local system maturity and reduce variation between systems</td><td>Assurances:

Reporting to PDEG by programme workstream

Assurance Score:

Gaps in Assurance: (What additional assurances should we seek?)

LCPs to develop workplan and establish regular reporting to PDEG on delivery</td></tr>
</table>

<table>
<tr><td colspan="2">Objective: We will commission safe, effective and accessible services.</td><td>Director Lead:

Jo Turl</td></tr>
<tr><td colspan="2">Risk: AF4 – We do not commission mental health and learning disability services which meet local need or national expectation</td><td>Date Last Reviewed:</td></tr>
<tr><td>Risk Rating
Initial:
Current:
Appetite:</td><td>Impact x likelihood

5x4
5x3</td><td>Reason for current score:

Current services to not meet national specification

Rationale for risk appetite:

Delivery programme agreed to support system working</td></tr>
<tr><td colspan="2">Controls: (What are we currently doing about this?)

Mental Health Care Partnership with agreement

Work programme (including Out of Area Placements and First response)

2 day mental health conference held

Transforming Community Services Group for LD

Mitigating Actions: (What should we do?)
System workshop planned for September

Review of Learning Disability Beds

Work being undertaken to understand and develop the market</td><td>Assurances:

Exec to Exec meetings with providers

Report to NHSE

ICE

Regular contract meetings with Providers

Assurance Score:

Gaps in Assurance: (What additional assurances should we seek?)</td></tr>
</table>

	Support required from PMO in CCG to improve regular and adhoc reporting arrangements

Objective: We will commission safe, effective and accessible services.		**Director Lead:** **John Dowell**
Risk: AF5 – We do not develop commissioning plans which incorporate best practice in the use of technology		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* *4x4* *4x3*	**Reason for current score:** There are insufficient links between the digital workstream and the development of commissioning plans
		Rationale for risk appetite: Arrangements can be developed that will ensure closer working
Controls: *(What are we currently doing about this?)* *Digital workstream in place and workplan agreed – Reporting into PDEG.* *System Director – Nick Hopkinson and SRO Suzanne Tracey* *CCG represented by Jim Goodwin* *John McCormick – Clinical Digital Lead – Linked to national programme* **Mitigating Actions:** *(What should we do?)* *Increased representation from CCG staff on workstream programme steering group* *Improve links between digital workstream group and delivery*		**Assurances:** PDEG AEDB, Planned Care Boards, ICM
		Assurance Score:
		Gaps in Assurance: *(What additional assurances should we seek?)*

groups such as AEDB, Planned Care Boards and ICM Groups *Ensure Digital rep on each LCP to champion use of technology* *Each commissioning group to identify good practice from outside Devon*	*Commissioning plans need to incorporate delivery of required technological changes*

<table>
<tr><td colspan="2">Objective: We will work as a strategic partner in Devon

We will improve the mental and physical health of the population</td><td>Director Lead:

Simon Tapley</td></tr>
<tr><td colspan="2">Risk: AF6 – We do not have full commitment from all system partners to deliver operational system plan so change is not delivered</td><td>Date Last Reviewed:</td></tr>
<tr><td>Risk Rating
Initial:
Current:
Appetite:</td><td>Impact x likelihood

5X4
5X3</td><td>Reason for current score:

Development work required to support system working arrangements

Rationale for risk appetite:

System is required to reach ICS status by April 2021.</td></tr>
<tr><td colspan="2">Controls: (What are we currently doing about this?)

System workplan agreed and being managed through system PMO
Regular reports from all workstreams and projects to PDEG.
STP SRO and Chair appointed
Collaborative Board providing oversight of system working and supporting development of relationships.

Mitigating Actions: (What should we do?)
Self assessment against ICS maturity matrix underway
ICS Development Plan to be produced and implemented.
Development of new Governance Framework in line with national guidance.
Implementation of recommendations of PA Consulting review of</td><td>Assurances:

Progress monitored through Programme Delivery Executive Group(PDEG) and feedback to CCG through AO and other Execs

Updates on operational plan to GB

Non-Exec Directors aligned to Locality Care Partnerships

Assurance Score:</td></tr>
</table>

system working Develop and implement Risk Share agreement	**Gaps in Assurance:** *(What additional assurances should we seek?)* Need to have PDEG performance reports to CCG Finance and Performance Committee Need to develop Non-Executive oversight of system working

Objective: We will work as a strategic partner in Devon		**Director Lead:** **Simon Tapley**
Risk: AF7 – The system does not have robust mechanisms for identifying and responding to emerging risks		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* *5x4* *5x3*	**Reason for current score:** *No system-wide process for identifying and managing risk* **Rationale for risk appetite:** *All statutory organisations have risk management processes in place*
Controls: *(What are we currently doing about this?)* *Most workstreams and programmes of work have risks identified and are managing risk log* *Programme managers meeting reviews risks to individual programmes* **Mitigating Actions:** *(What should we do?)* *System-wide risk and opportunity log being developed for Collaborative Board. This will include risks to system delivery identified by working groups. Links to specific organisational risks will be highlighted.*		**Assurances:** *Finance working group monitors financial risks* *SPDG monitors performance and delivery risks* *Clinical cabinet monitors clinical risks* *AEDB, Planned Care and ICM Groups also maintain overview of relevant risks* **Assurance Score:** **Gaps in Assurance:** *(What additional assurances should we seek?)*

	? Prevention Board *Need PDEG report to Finance and Performance Committee* *Need to clarify reporting and management mechanisms for risks identified at local QSGs.*

Objective: We will work as a strategic partner in Devon		**Director Lead:** **Andrew Milward**
Risk: AF8 – Our plans do not reflect the views of patients and the public as there has not been sufficient engagements		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* **4x2** **4x2**	**Reason for current score:** *Robust mechanisms in place but wide range of issues and large population size mean that it is difficult to have comprehensive approach*
		Rationale for risk appetite: *Risk level will fluctuate with time (e.g. when large or contentious consultation underway) so plan is to maintain risk at current level by actions outlined.*
Controls: *(What are we currently doing about this?)* *Significant Resource in Comms Team (3 dedicated staff) undertake countywide/large scale work and provide support to local teams on smaller issues.* *Engagement Strategy/Plan agreed* *Engagement Panel meeting on monthly basis.*		**Assurances:** *NHSE Annual Assurance on engagement* *NED for Patient and Public Engagement*
		Assurance Score:

Mitigating Actions: *(What should we do?)* *Implement engagement process for LTP* *Continue to develop all staff within the CCG to increase capacity supporting engagement* *Establishing citizens panel (17k people representative of Devon population)* *Continue to support and develop PPGs to deliver their practice role and to increase their involvement in wider engagement initiatives*	**Gaps in Assurance:** *(What additional assurances should we seek?)* *Need to agree new arrangements for Engagement Panel reporting/accountability.*

Objective: We will work as a strategic partner in Devon		**Director Lead: Sonja Manton and Jo Turl**
Risk: AF9 – We do not develop evidence-based proposals due to lack of capacity and capability within the CCG		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* *4x4* *4x2*	**Reason for current score:** We do not have sufficient level of expertise in some areas (e.g. digital)
		Rationale for risk appetite: CCG has identified the need to develop this expertise or identify support from elsewhere
Controls: *(What are we currently doing about this?)* Some individuals with high levels of knowledge and skills including those linking to national roles **Mitigating Actions:** *(What should we do?)* *Need to review current levels of skills and experience in commissioning team* *Develop stronger links with AHSN and establish potential level of support*		**Assurances:** *Proposals developed and reviewed by delivery groups and LCPs* *QEIA process*
		Assurance Score:

Need horizon scanning mechanisms to translate national examples for applicability in Devon *Talent Management Programme and ongoing staff development and PDAR.*	**Gaps in Assurance:** *(What additional assurances should we seek?)*

Objective: We will work as a strategic partner in Devon		**Director Lead:** **Andrew Milward**
Risk: AF10 – We have not addressed the issues raised in the 2018 staff survey so staff leave or do not perform to their full potential		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* *4x3* 4x1	**Reason for current score:** *A lot of work has been undertaken to address staff survey concerns but impact of these changes is unknown*
		Rationale for risk appetite: *It is within the CCGs powers to address many of the issues raised in the staff survey and it is important to maintain key staff*
Controls: *(What are we currently doing about this?)* *Each Directorate has reviewed staff survey and agreed actions* *Redesigned appraisal process* *Increased staff engagement and listening events* *Development and implementation of organisational Vision and Values* *Celebrate You initiative and successful first event* **Mitigating Actions:** *(What should we do?)* *Staff Partnership Forum is focused on addressing the results of*		**Assurances:** *Remuneration and Workforce Committee* *HR Dashboard to SLT, Execs and Governing Body* *Quarterly joint meeting of Staff Partnership Forum and Execs*
		Assurance Score:

the survey and is developing an action plan *Implementing quarterly survey to obtain ongoing feedback* *Develop and implement Talent Management Programme*	**Gaps in Assurance:** *(What additional assurances should we seek?)* *None*

Objective: We will improve the mental and physical health of the population		**Director Lead:** **Sonja Manton and Jo Turl**
Risk: AF11 – We have not evolved our integrated strategic commissioning arrangements sufficiently to develop plans to deliver improvements in population outcomes		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* *4x4* *4x2*	**Reason for current score:** *Integrated strategic commissioning is developing and there are examples of good practice but comprehensive framework is not in place*
		Rationale for risk appetite: *Arrangements are developing and good relationships in place*
Controls: *(What are we currently doing about this?)* *ICE ToR agreed and has met 3 times* *ICE Workplan agreed* *Some limited commissioning for outcomes (e.g. ICP procurement)* *BCF plans in place* *Some Section 75s in place* *Several Joint roles appointed and working well* *Good working relationships between individuals*		**Assurances:** *ICE monitors progress and reports into CCG through AO and other Execs.* *Papers from ICE shared with Governing Body.*

Mitigating Actions: *(What should we do?)* *Further development and delivery of ICE workplan* *Developmental time for ICE* *Need to refresh and embed Outcomes framework*	**Assurance Score:** **Gaps in Assurance:** *(What additional assurances should we seek?)* *Need to develop Non-Exec oversight for Integrated Strategic commissioning*

Objective: We will improve the mental and physical health of the population		**Director Lead:** **Sonja Manton and Jo Turl**
Risk: AF12 – We have not invested sufficiently in prevention so we do not achieve improvements in our population health		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* *5x4* **5x2**	**Reason for current score:** *Low levels of investment in prevention mean that limited progress is being made. Low level of system commitment is making it difficult to address this.*
		Rationale for risk appetite: *Prevention is key to ensuring long term and sustainable change in population health*
Controls: *(What are we currently doing about this?)* *£2m investment in prevention* *40 bids received for this money* *Prevention workstream co-ordinating wider prevention agenda with projects embedded in other workstreams* *System SRO appointed*		**Assurances:** *PDEG reporting to the CCG through the Accountable Officer and other Executives*
		Assurance Score:

Dedicated PMO resource for programme management *Significant progress with some projects e.g. Active Devon* ***Mitigating Actions:*** *(What should we do?)* *Programme needs to be expanded to incorporate all requirements of LTP* *Need to increase system commitment to prevention to ensure input from all organisations* *Need to clarify investment for future years to support projects requiring recurrent funding.* *Ensure that Prevention is regularly on PDEG agendas and sufficient time available for discussion*	**Gaps in Assurance:** *(What additional assurances should we seek?)* *GB needs improved oversight of prevention programme.*

Objective: We will improve the mental and physical health of the population **We will make the best use of resources**		**Director Lead:** **Sonja Manton and Jo Turl**
Risk: AF13 – We are not targeting our resources at the areas that most need them so health inequalities are exacerbated		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* *4x4* *4x2*	**Reason for current score:** *No agreement in place on the allocation of resources based on population need*
		Rationale for risk appetite: *Evidence available to support decision making*
Controls: *(What are we currently doing about this?)* *Framework in place for development of Locality Care Partnerships LCPs have developed workplans based on local population health need*		**Assurances:** **Finance and Performance Committee review financial spend and delivery**
Mitigating Actions: *(What should we do?)* *Need to agree process for moving to resource allocation based on health need* *Need Governing Body decision to accelerate shift of resource to primary and community care.* *Need to develop CCG and System approach to Population Health Management including access to shared information datasets and developing skills of commissioning staff.*		**Assurance Score:** **Gaps in Assurance:** *(What additional assurances should we seek?)* *Mechanisms and information required to monitor spend at locality level not yet developed.*

Objective: We will make the best use of resources		**Director Lead: Jo Turl**
Risk: AF14 – There is insufficient workforce capacity and capability in Primary Care (GPs, nurses and pharmacists) to meet demand		**Date Last Reviewed:**
Risk Rating Initial: Current: Appetite:	*Impact x likelihood* **5x4** **5x3**	**Reason for current score:** *Recognised lack of capacity in several areas impacting on ability to deliver*
		Rationale for risk appetite: *Primary Care Networks offer opportunity to develop new ways of working.*
Controls: *(What are we currently doing about this?)* *GP Strategy agreed* *Workforce strategy agreed* *Locality Workforce Groups* *GP Provider Collaborative Groups* *GP Framework associated with long term plan reviewed to identify Primary Care Networks agreed* *GP International Recruitment Scheme.* *Three candidates offered positions on the GPIRS following interviews and educational needs assessments* *Practice resilience toolkit developed* *Heat map devised to identify vulnerable GP practices* *Regular resilience meetings with Devon LMC* **Mitigating Actions:** *(What should we do?)* *Encouraging collaborative working on a locality basis to establish increased resilience.* *Work with the Provider Organisations to establish broader based models of care.* *Developing role of Primary Care Networks*		**Assurances:** *Primary Care Commissioning Committee* *Primary Care Operational Group* *STP and Workforce Groups* *Regional Workforce Board*
		Assurance Score:
		Gaps in Assurance: *(What additional assurances should we seek?)*

NHS DEVON CCG
Integrated Risk Report

Date produced: 02-07-2019 - 12:38

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners	Assurance Score
108	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand and capacity) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system could be affected. This risk replaces risk 09 (SDT) and 68 (NEW Devon) (HISTORIC ID: Na)	Primary Care Commissioning Committee Primary Care Operational Group GP Strategy STP Workforce Group & Strategy Locality Workforce Groups GP Provider Collaborative Groups Regional Workforce Board [Control Gaps] Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support In part a lack of evidenced change to new models	20 (L=5 x I=4)	Risk Opened: 29/05/2019 Reviewed: 11/06/2019	[29/05/2019] Feb 19 - The GP framework associated with the long term plan, having been released, is being reviewed for opportunities to further mitigate this risk Apr 19 - Work continues to support practices in working closer together and with wider parts of the system and also building on the skill mix development as outlined in the contract reform GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments ,	Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. practice resilience toolkit Heat map devised to identify vulnerable GP practices Regular resilience meetings with Devon LMC Developing role of Primary Care Networks [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Paul Baker	
97	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	There is a risk that the Mayflower procurement will not be successful within the global sum. The impact of this is that there could (a) be no provider, (b) continue with emergency framework or (c) have to top up the contract value. (HISTORIC ID: Na)	Currently going through engagement and development phase of new procurement, which is being linked into the wider Western system services procurement [Control Gaps] None	16 (L=4 x I=4)	Risk Opened: 27/11/2018 Reviewed: 11/06/2019	[11/06/2019] 18 Dec 18 - market engagement sessions held with providers. Ability to identify opportunity and issues to inform procurement process. 29 Jan 19 - Work is being undertaken to look at the ability to align this with the Integrated Care Provider procurement with the aim to mitigate the risk. Apr 19 - work on procurement continues May 2019 – following contract handback from Mannamead surgery, decision to integrate into the Mayflower group and procure as part of a wider contract. Patient engagement includes letter to all patients over 16 and engagement events at the practice. Letters also sent to all registered patients of Mayflower. Interim provider – Access Health Care Ltd - to commence service delivery on 1 July 2019. New Contract due to commence 1 April 2020. ,	Joint Operational Group between CCG and NHS England Oversight Group involving Plymouth City Council, CCG and NHS England Governance structure - linking into Integrated Care Provider [Assurance Gaps] None	Executive Lead: Jo Turl Owner: Kirsty Lewis	11

100	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk that the population of Devon will not receive timely access to 999 emergency ambulance care when needed. The impact of this is upon public and professional confidence in the system; patient experience and safety and CCG reputation. (Previously linked to mirrored risk 101 which is now closed) (HISTORIC ID: Na)	July 2019 - CCG awaiting single item QSG on 8 July - Mark Elster now attending (SZ) June 2019 - The call stacking risk has been reduced by SWASFT to 20. It is now accepted that the system wide* collaboration and application of mitigating actions has decreased the likelihood of call stacking. This will continue to be assessed on a daily basis by SWASFT with regular review by the SWASFT Executive. NB: *System wide = SWASFT footprint. An NHSE/I Quality Surveillance Group meeting has been planned for July where the risk will be discussed further. SZ unable to attend the July QSG as on leave but SPo will attend for this item. An action from the Quality Assurance Committee was for this risk to be reviewed including the scoring. Score reduced to 16 as we know the call stack exists, that is does impact upon response times and could cause significant harm but there is no recent evidence of this (SZ) June 2019 - The call stack risk was discussed in some detail at the May SWASFT QAG. SWASFT are reviewing their trigger points currently, liaising with other ambulance services to see how they manage (and score) the risk - they want to benchmark themselves, but there is a reluctance to share information. The CCG were made aware of a further three deaths that may be attributable to call stacking across the SWASFT footprint (none in Devon). A further system QSG is being planned via NHSE/I. It was agreed that although SWASFT continue to rate this at 25 for the time being, that individual CCGs can rate differently according to their own evaluation of the risk in their area. SZ is satisfied that SWASFT are taking actions to bring this risk down, and are under considerable pressure to do so. In terms of lower level harm arising from call stacking, SZ spoke with Deputy DoN & Chair of the Dorset SWASFT QAG who advises that Dorset are not doing anything in particular around looking at lower level risks. SWASFT produce a regular report on long waits, and we received the most recent reports yesterday. They randomly choose long waits to review according to agreed thresholds. These reports are not indicating harm. However it was recognised that they are only reviewing the patient to the point that they are closed by SWASFT and so this does not account for any harm that might be detected at a later point. We have therefore agreed that some full end to end reviews are needed. The CSU will be planning a programme of end to ends on different themes, this one included. We along with Kernow will be doing end to end on Health Care Practitioner calls (SZ) [Control Gaps] System ownership of risk	16 (L=4 x I=4)	Risk Opened: 21/01/2019 Reviewed: 01/07/2019	[21/01/2019] CCG review of SIRIs/Complaints and Yellow Cards pertaining to the risk June 2019 - the review has take place and action can now be closed (SZ), [21/01/2019] CCG leading on aspects of Joint Commissioner Action Plan June 2019 - this is ongoing and continues (SZ),	May 2019 - the CCG is working closely with this provider in relation to patient safety issues around gaps in service and the different models of care including changes to workforce such as nurse practitioners (SW) April 2019 – Two out of the four EDs have undertaken a deep dive end to end review of handover delays (60 mins+) and the remaining two have been prompted that this is an outstanding action: findings will be reported back to the Devon A&E Delivery Board in May 2019 (SZ) [Assurance Gaps] System ownership of risk	Executive Lead: Lorna Collingwood-Burke Owner: Sarah Zanoni	11
2	To make continued improvements in performance against core standards to deliver measurable results	There is a risk that the 95% of people seen 4hour wait standard in A&E is not met at Torbay and South Devon NHS Trust which may impact on achievement of national standards and patient experience (and risk of handover delays from the ambulance to A&E department - Ambulance Handover issue see Risk 110). (HISTORIC ID: 91)	Revised trajectory agreed. Following CQC letter, revised action plan in place. Monitored through fortnightly urgent care improvement and assurance meetings - CCG attends. Weekly performance metrics produced by trust to show progress against time to initial assessment, time to treatment and frequency of observation. SRG agreed trajectory for improvement on 4 hour wait with trust (combined ED and MIU). STF trajectory agreed. Improvements monitored through TSD flow board and AE delivery board. Weekly performance metrics produced by trust to show progress against time to initial assessment, time to treatment and frequency of observation. Daily monitoring of performance against STF trajectory on daily escalation briefing. Jun 18 - Improvement plan drafted Learning has been gathered from local system hard resets. [Control Gaps] No gaps identified	16 (L=4 x I=4)	Risk Opened: 11/02/2014 Reviewed: 02/05/2019	[02/05/2019] April 2019 - Revised processes in Trust to deliver improvement. System leads appointed and three groups (emergency floor, wards and home first) convened to drive change, incorporating recommendations from ECIST diagnostic (Jan 19) and GIRFT (Aug 18). 0.5 WTE performance role funded by CCG in Trust to drive change. , [09/10/2018] Jun 18 - Improvement plan has been drafted with aim of improving performance within the 4 hour wait for ED.Learning has been gathered from local system hard resets. Oct 18 - work continues on this , [04/06/2018] Apr 18 - OPEL 4 declared on 4 occasions (10 days in total) in March 18. Performance was below target at 73% (95% was the national target for March). May 2018 - The Trust held an extra-ordinary meeting of the patient flow board to discuss priorities to "re-set" the local urgent care system., [25/04/2018] Apr 18 - OPEL 4 declared on 4 occasions (10 days in total) in March 18. Performance was below target at 73% (95% was the national target for March).,	Monthly reporting to Commissioning and Finance Committee, Senior Leadership Team and Governing Body in place. Daily reporting to CCG On Call Director and others as part of daily escalation processes. Weekly SIT reps to NHS England Board to board meetings. August 2016 onwards urgent care board becomes A&E delivery board, chaired by Liz Davenport System Lead for UEC. Patient flow Board meeting monthly to discuss issues. [Assurance Gaps] No gaps identified	Executive Lead: Sonja Manton Owner: Christine Branson	8

102	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk that the number of DPTs overdue RCA Serious Incident (SI) reports might affect the embedding of learning and improvement. The impact of this to the CCG is a lack of assurance that patient safety improvements from incident learning are identified and actioned in a timely way (Previously linked to mirrored risk 103 which is now closed) (HISTORIC ID: Na)	July 2019 - A Deep Dive is planned on DPT Serious Incidents and the ToR are currently being written for the visit. Report from the Deep Dive to go to Quality Assurance Committee (QAC). If NHSI are unable to meet the timescales and attend with Devon CCG the report to be shared with them separately. Devon CCG working on dates with DPT /NHSI and SP to provide a verbal update at the July QAC (SD) June 2019 - Devon CCG & DPT met on 30/05/19 to discuss the current position in relation to the outstanding SI's. DPT have considered not just the immediate ways to address the backlog but also in how to support the team long term, in the standard and detail of completing the reports. This should reduce the amount of time for further information being requested. DPT are looking at delivering training for the RCA team with regard to this and the CCG have offered to support with the training. In addition, the opportunity for real time feedback has been offered by the CCG if DPT have any questions regarding individual reviews. Work has been done to streamline the SI process particularly around S42 investigations so not to duplicate work and to free up time for action implementation. Further work has also involved clinical teams taking responsibility for developing the action plans as a result of investigations rather than the RCA Lead. This means that there is increased ownership by the clinicians, greater opportunity to embed learning and drive to complete the actions. Several actions have been agreed with the CQC to help support the reduction of DPT's overdue SI status to no more than 10 (IL) April 2019 - written report from DPT received that includes the trajectory and added to the agenda for the Quality Assurance Committee (formally QCiC). In addition SP meeting with the DDoN on a monthly basis to track improvements (SP) March 2019 - report received from DPT DoN to outline the trusts action/improvement plan. The CCG Quality Committees in Common are reviewing this at the March 19th meeting. The CCG continue to report this as a risk in our monthly quality assurance framework and flash report for this provider (LW/VC) DPT report and update the risk through the Quality & Safety committee. The provider and Safety Systems monitor and report on the status of overdue incidents. Concerns escalated through flash report that goes to CCG QCiC. DPT attended QCiC & provided a verbal report on the management of overdue SI's and the written report was to be submitted [Control Gaps] Assurance still lacking at QCiC due to the written report on the management of SI's not being submitted – CCG chasing	15 (L=5 x I=3)	Risk Opened: 25/01/2019 Reviewed: 02/07/2019	[03/06/2019] The CCG will have received the revised S42 reports (currently 17) by Friday 14th June 2019 with the agreed new summary report action plan. , [03/06/2019] CCG to have received all 30 SI's requiring FIR information by Friday 7th June 2019 and for these to be sent onto the original reviewers, [03/06/2019] DPT to send by the 3rd June 2019, the CCG an updated spreadsheet with information on SIs where they have a difference of opinion on ie: DPT report they have been closed, [25/01/2019] Written report around the implementation of improvements including the SI process to be provided to QCIC in February 2019 Rationale for closure: Written report received from DPT that includes the SI process and trajectory and added to the agenda for the next Quality Assurance Meeting (previously QCiC). In addition SP meeting with the DDoN on a monthly basis to track improvements, [25/01/2019] Request to provider to provide a trajectory for reducing overdue numbers. Assurance requested about the quality of 72hr reporting. Provider and CCGs to monitor these. Rationale for closure: Written report from DPT including the trajectory received and on the agenda for the next Quality Assurance Meeting as required by this risk. In addition SP meeting with the DDoN on a monthly basis to track improvement ,	June 2019 - Devon CCG & DPT met on 30/05/19 to discuss the current position in relation to the outstanding SI's. DPT have considered not just the immediate ways to address the backlog but also in how to support the team long term, in the standard and detail in completing the reports. This should reduce the amount of time for further information being requested. DPT are looking at delivering training for the RCA team with regard to this and the CCG have offered to support with the training. In addition, the opportunity for real time feedback has been offered by the CCG if DPT have any questions regarding individual reviews. Work has been done to streamline the SI process particularly around S42 investigations so not to duplicate work and to free up time for action implementation. Further work has also involved clinical teams taking responsibility for developing the action plans as a result of investigations rather than the RCA Lead. This means that there is increased ownership by the clinicians, greater opportunity to embed learning and drive to complete the actions. Several actions have been agreed with the CQC to help support the reduction of DPT's overdue SI status to no more than 10 (IL) May 2019 - CCG sort further assurance through actions including close liaison with the safety systems team, weekly meetings and monitoring of SI delays (SW) [Assurance Gaps] Action planning for overdue incidents is not visible whilst overdue. The quality of 'immediate' 72hr reporting is important in assuring that identified safety issues have been implemented.	Executive Lead: Lorna Collingwood-Burke Owner: Simon Polak	10

104	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk that the CCG does not have the required resource to effectively administer Datix which is used to deliver a number of functions including statutory requirements. In addition, it has been identified that there is no governance infrastructure. The impact of this is the likelihood of user error and inconsistency with the use of application due to lack of training. There will also be a financial cost to increase the modules within Datix and source the appropriate level of resource to effectively manage the system. (HISTORIC ID: Na)	July 2019 - SPo to put a paper together to go through the exec SLT for a business case consideration (LCB) July 2019 - Devon CCG met with DELT at the beginning of April where the Datix gaps and challenges were discussed. Following the meeting it was identified that the CCG would benefit from having a data privacy impact assessment and DELT concluded with options available. A further meeting has been held to discuss the above and it was agreed for a business case to be completed (linking with Corporate/IG) to highlight the concerns with Datix which includes; lack of resource to support the system, lack of processes/infrastructure with regard to IG and system changes, lack of modules bought to support the needs of what the CCG require Datix to be used for (risk, Safeguarding, CHC, etc.,) (LD) June 2019 - Risk discussed at Quality Assurance Committee and action for LCB to discuss the content of the risk with LD & SPo (SD) May 2019 - Results of the meeting with Delt received along with an Information Asset Register spreadsheet and Data Protection Impact Assessment that helps demonstrate the sensitivity and risk presented in the services delivered. CCG to review options given (SD) April 2019 - A meeting has taken place with the Head of Solution Delivery Delt Shared Services Ltd. to scope a business plan which will highlight the full requirements of a system and its resource required for the CCG to manage and coordinate the functions identified. Delt to produce a business plan to ensure all identified users are provided with a Datix account and introduced to the system (LD) [Control Gaps] April 2019 - The impact of having only two identified staff members (not amounting to a WTE post) supporting the DATIX information system is that there is no resilience in place across the CCG to maintain or develop the framework required to properly support a significant number of critical information, in line with current business continuity arrangements. Identified functioned required on Datix which have yet to begin including: • Corporate Risk Register • CCG Internal Incidents • Continuing Healthcare (CHC) • Significant Event Audits (Primary Care) • QEIA • Safeguarding: o Operations o Suspensions o Allegation Management o Care Intelligence o Deprivation of Liberty o Looked After Children • Claims (to be developed or deleted?) Identified gaps are reviewed regularly to ensure the business need for the functions required on Datix have not changed and to prioritise them in order of requirement once resource is available.	12 (L=4 x I=3)	Risk Opened: 09/04/2019 Reviewed: 01/07/2019	[07/06/2019] June 2019 -The CCG to complete a business plan to support the use of Datix within the CCG, to include the areas highlighted as a current risk and identified gaps identified within our meetings with Delt. July 2019 - Following a meeting with DELT it has been agreed for a business plan to be completed (linking with Corporate/IG) to highlight the concerns with Datix which includes; the lack of resource to support the system, the lack of processes/infrastructure with regard to IG and system changes, the lack of modules bought to support the needs of what the CCG require Datix to be used for (risk, safeguarding, CHC, etc.,) (LD) July 2019 - SPo to put a paper together to go through exec SLT for a business case consideration (LCB), [09/04/2019] To ensure all identified users are provided with a Datix account and introduced to the system, [09/04/2019] To ensure all identified users are provided with a Datix account and introduced to the system June 2019 - Completed, [09/04/2019] To complete a baseline assessment May 2019 - Baseline assessment outcome report due 10 May 2019 June 2019 - Delt provided a baseline assessment - Complete, [09/04/2019] DELT to produce a business plan,	May 2019 - A baseline assessment to identify the key information and flows through Datix has been completed and the outcome report will be submitted to the CCG by the 10 May 2019 (LD) April 2019 - The system continues to function, providing key information for the following statutory duties: • Serious Incidents • Patient experience o Complaints o Patient advice and concerns o Friends and Family Test data (for the purpose of reporting) o Care opinion feedback data (for the purpose of reporting) o Yellow Cards • Safeguarding o Adults o Children • Quality and Equality Impact Assessment (QEIA) Baseline assessment to be completed (LD) [Assurance Gaps] April 2019 - A baseline assessment is required of the key information that flows through Datix to help understand what governance requirements are required (LD)	Executive Lead: Lorna Collingwood-Burke Owner: Emma Greenslade	10

105	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk that patient safety will be compromised and / or harm may occur due to delays in out of hours GP response times. Delays occur due to Devon Doctors being unable to fill rota slots. The impact of this is upon public and professional confidence in the system; patient experience and safety and CCG reputation. (This risk supersedes risk 25). (HISTORIC ID: Na)	July 2019 - DDOC have reduced their level of risk associated with the call stack to 12. There is evidence of increased level of complaints relating to the call stack and DDOC have been asked to provide more detail on this (SZ) June 2019 - SZ and EF met with DDoc Medical Director and Director of Ops on 22nd May to review staffing and call stack position. This is detailed on the provider risk register. DDoc have an improvement plan in place and this includes workforce: 12 ANPs have been recruited and are expected to be in post by end September 2019, this will release GP time back to triage which will enable improved management of the stack. Additionally a rota review has been undertaken and trialled with positive effect - this is to be rolled out in September 2019. Pending sustained improvement DDoc are ensuring information is available to the system to support system working - participating in escalation calls as required (SZ) May 2019 - CCG attendance at IUCS Quality & Governance meeting (monthly); CCG attendance at Devon A&E Delivery Board (monthly); CCG meeting with Devon Doctors Medical Director planned and Devon Doctors taking short term actions to fill rota (SZ) [Control Gaps] None identified	12 (L=3 x I=4)	Risk Opened: 01/05/2019 Reviewed: 01/07/2019	[01/05/2019] May 2019 - CCG to meet with Devon Doctors Medical Director on 09/05/19 to explore the call stack challenges and ascertain the long-term action plan to mitigate. Outcome to be added to the risk (SZ) June 2019 - Update on action: SZ and EF met with DDoc Medical Director and Director of Ops on 22nd May to review staffing and call stack position. This is detailed on the provider risk register. DDoc have an improvement plan in place and this includes workforce: 12 ANPs have been recruited and are expected to be in post by end September 2019, this will release GP time back to triage which will enable improved management of the stack. Additionally a rota review has been undertaken and trialled with positive effect - this is to be rolled out in September 2019. Pending sustained improvement DDoc are ensuring information is available to the system to support system working - participating in escalation calls as required (SZ),	June 2019 - SZ and EF met with DDoc Medical Director and Director of Ops on 22nd May to review staffing and call stack position. This is detailed on the provider risk register. DDoc have an improvement plan in place and this includes workforce: 12 ANPs have been recruited and are expected to be in post by end September 2019, this will release GP time back to triage which will enable improved management of the stack. Additionally a rota review has been undertaken and trialled with positive effect - this is to be rolled out in September 2019. Pending sustained improvement DDoc are ensuring information is available to the system to support system working - participating in escalation calls as required (SZ) May 2019 - CCG requested that this risk be added to the provider risk register and will be clarified at the meeting on the 09/05/19 with the Med Director. Outcome of that meeting to be added to the CCG risk and the provider risk to be managed by DDoc internal processes (SZ) [Assurance Gaps] May 2019 - Long term action plan to remedy situation (SZ)	Executive Lead: Lorna Collingwood-Burke Owner: Sarah Zanoni	
106	To ensure that the organisation contributes to system financial balance and maintains improvements in efficiency, productivity and sustainability for the wider benefit of the NHS	There is a risk to the CCG delivering a medium to longer term financially sustainable plan which achieves breakeven within the Financial Recovery Plan timeframe. For NEW Devon CCG this was 2020-21 and for South Devon & Torbay CCG it was 2019-20 The medium-term Financial Plan will be developed in the Autumn as a response to the NHS long-term plan. The high-level view submitted to NHS England as part of the Operational Plan for 2019-20 highlights that the CCG would maintain the pre-CSF outturn recorded for 2018-19 and then be back to its original FRP trajectory in 2020-21; return to financial balance in 2022-23 and then to the delivery of surplus in 2023-24; The impact of this is that the plan would be unsupported by NHS England for the CCG and in the context of the wider system financial plan and that it either pushes the CCG to deliver an improvement plan through escalation or issues further direction and/or intervention as a result. (HISTORIC ID: Na)	1) Plans developed through CCG Financial Planning Lead / Senior Finance Team, through the Finance & Performance Committee and system-wide approach through financial principles 2) Joint Chief Executive (PDEG) and Finance Working Group agreed on level of system plan following detailed work, which will continue into 2019-20 3) MOU signed by all parties within Devon to support returning CCG to financial balance/sustainable financial position 4) Detailed system peer review and due diligence process undertaken across each individual organisations plan, carried out by System review team and NHS Regulators 5) CCG supported in External NHS England planning meeting to maintain system plan view [Control Gaps] 1) CCG 2019/20 finance plan does not at present meet NHS England issued control total of break-even; 2) Development of medium-term Financial Plan which supports the return of the system to financial balance and the strategy/transformation required to deliver it. 3) NHS England and NHS Improvement response to both CCG financial plan and system control total;	12 (L=4 x I=3)	Risk Opened: 08/05/2019 Reviewed: 08/05/2019		1) The CCG has met the 2018/19 financial plan - £25m deficit for combined CCG, prior to access and application of Commissioner Sustainability Funding 2) Robust CCG 2019/20 operational financial plan aligned to the System Plan, the technical accuracy of the plan is robust. The gap to formal control total is due to the systems ability to deliver level of savings originally required within the required Financial Recovery Plan timeframe. [Assurance Gaps] None identified	Executive Lead: John Dowell Owner: Derek Blackford	11

42	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is currently insufficient capacity and a lack of flow in local acute mental health bed stock, with a number of people resulting in people needing to be placed out of area for their acute care and/or for people to be waiting for transfer in the community, in police cells or waiting longer than 4 hours in A and E. There is a financial risk if the use of out of area beds is not reduced to a level that has been allowed for within the Financial Plan. There is also clinical risk related to people waiting in the community for an inpatient bed to be identified before they are admitted. There is a reputational risk to the CCG where transfers from police cells are not able to be made in a timely manner. (HISTORIC ID: 126)	DPT have completed bed capacity modelling which was discussed in a meeting between CCG's DCC, TCC and DPT in April 2017. A joint approach was agreed in which commissioners and DCC would join the DPT Urgent Care Board from the end of April 2017. The primary action is to agree a joint acute care pathway improvement plan which seeks to enable access by managing occupancy levels, avoiding admissions and reducing delayed discharges. This plan needs to be supported by a financial plan and agreed KPI's and delivery timeline and be delivered at pace. A series of meetings have occurred between DPT, NEW Devon CCG and RDE re A&E trolley breaches to agree a plan and it was agreed that the block of out of area beds would be increased by 3. A further meeting took place in early May 2017. A&E Breaches to be discussed through the A&E Delivery Board DPT have scoped the gap in CRHT capacity and will share the business case with the CCG but will be included in the improvement plan. DPT have been offer additional CCG commissioning capacity for DTOC and Acute Care Pathway Redesign but have not yet made use of this. 12 ED trolley breech escalation protocol, DPT Bed Management Protocol & DPT daily bed management meetings are in place. CCG has made investment for ACP available through 17/18 DPT contract. June 17 ACP Board will agree how investment will be deployed. 04/07/17There has been 1 week slippage on agreeing improvement plan [Control Gaps] DPT Acute Care Pathway Business Case and plan has not be formally approved by the CCG. CCG's now attending DPT ACP Board and investment to be approved at that board. No plan for adult DTOC has yet been received by N&E A&E Delivery Board. DTOC is a workstream within the ACP Programme.	12 (L=3 x I=4)	Risk Opened: 13/04/2014 Reviewed: 25/06/2019	[25/06/2019] The risk will be reviewed again on the 2nd July and further updates will be included in the next update in July. Derek O'Toole 25 June 2019, [01/02/2019] 22.11.18 The Senior commissioning team reviewed the current corporate risk register at their meeting on 22.11.18. Agreed to remove risk from corporate risk register, to be included on mental health program risk register for oversight by mental health care partnership board., [09/11/2018] 09.11.18 High usage of out of area beds peaked in October but further actions have since been implemented by DPT in order to reduce the flow of people out of area. DPT have procured a number of block beds with Cygnet Healthcare, in two locations, Taunton and Weston Super mare which will be able to offer additional capacity for South Devon and Torbay CCG geographical area and allow DPT to better manage their acute stock by Locality. The DPT Acute Care Pathway Action continues to be implemented. DPT have also strengthened the operational leadership of the urgent mental health pathway by designating a Deputy Director of Operations to this role.,	DPT report the use of out of area beds through the monthly performance databook Mental Health Commissioning Coordinating Centre is aiming to coordinate commissioning activity across NEW Devon and SD&T CCG from May 2017 Commissioners have been invited to attend the DPT Urgent Care Board alongside DCC Jointly agreed ACP Improvement Plan and KPI's are not yet in place Urgent Mental Health care pathway is an agenda item at N&E A&E Delivery Board DPT DTOC plan for older people is in place and receives high level oversight at the A&E Delivery Board. Acute Care Pathway forms part of the new STP Crisis and Urgent Care Workstream. [Assurance Gaps] DPT Integrated Provider Assurance Board has been stood down and there is no formally agreed trajectory for the reduction in the use of out of area beds DPT ACP Board has developed a suite of metrics, the summary sheet will be made available to CCG. KPI's and reduction trajectory still require further development	Executive Lead: Jo Turl Owner: Derek OToole	10
89	To make continued improvements in performance against core standards to deliver measurable results	The risk is that the NHS Constitution target will not be achieved. The impact is that not achieving the NHS continuation target will have a reputational impact on the overall system. (HISTORIC ID: 97)	1. New A&E improvement plan from NHS England 2. Local A&E Board - comprising executive representation across system, who receive monthly updates on the progression of the whole system action 3. Western System Improvement Board established for oversight of the whole system 4. Peer review of ED completed, and an action plan has been developed. 5. A&E Delivery Board received and agreed winter escalation plan. 6. Gold command hard reset to focus on ED (Updated 22/11/2018) [Control Gaps] 1. A&E activity levels influenced by many external factors 2. Acute assessment unit not at full capacity(see phase 2 plan) (Reviewed no change 22/11/18)	12 (L=4 x I=3)	Risk Opened: 10/09/2015 Reviewed: 04/12/2018	[06/11/2018] 1. System wide flow programme incorporates HIC and safer quality initiatives 2. System wide winter plan developed 3. Escalation 4. Second phase of delivery plan for AAU drafted and to be agreed 5. Hard Reset still continues but some actions are now business as usual. 6. Specific work plan developed to improve ED performance 7. Hard reset week planned for w/c 8.10 and then on into gold command process with bi-weekly calls intended. All teams in UHP first week of New Year. 8. Hard Reset of ED w/c 29/10/18 - ongoing 9. Additional SI support from Commissioning Manager (Updated 22/11/2018) , [05/07/2018] 1. System wide flow programme incorporates HIC and safer quality initiatives 2. System wide winter plan developed 3. Escalation 4. Second phase of delivery plan for AAU drafted and to be agreed 5. Hard Reset still continues but some actions are now business as usual. 6. Specific work plan developed to improve ED performance 7. Hard reset week planned for w/c 8.10 and then on into gold command process with bi-weekly calls intended. All teams in UHP first week of New Year. (Updated 26/09/2018) ,	1. Robust performance metrics agreed for hard reset. Monitoring and managed through Gold Command. Updates and actions cascaded to system. 2. Daily reporting through emails 3. PAG reports 4. PSQ monitored complaints, compliments, SIRIs 5. Reported to Locality Board monthly 6. Performance monitored through A&E Board and PAG, including ECIST and tactical control centre 7. Daily operational call to discuss system flow and escalation of any issues 8. Recommendations of reviews incorporated into relevant Action Plans and progress monitored. 9. Internal replacement for ALAMAC being developed 10. Performance metrics improving. 11. Quality monthly walk throughs commencing,. (Reviewed no change 22/11/18) [Assurance Gaps] 1. Workforce and clinical leadership availability 2. System wide review of the impact and benefit of various actions to be undertaken and timescale agreed. (Reviewed no change 22/11/18)	Executive Lead: Simon Tapley Owner: Elaine Fitzsimmons	11

90	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	The CCG is not assured that NDHT is able to fully demonstrate safe and effective service. Northern Devon Healthcare NHS Trust (NDHT) cannot appropriately demonstrate that quality & safety of patient care is being met by the for key services including Maternity, end of life and outpatient services due to system, leadership & workforce issues that are currently impacting on the provider's ability to maintain these service and as highlighted in the CQC report (Feb 2018). The impact of this is that the delivery of patient care may be negatively impacted upon with a potential for patient harm, poor patient experience and wider health economy reputational damage. (HISTORIC ID: Na)	July 2019 - The CCG will attend the Trust System Oversight Meeting on the 17th July and feedback afterwards (SPo) June 2019 - NDHCT have continued to make good progress with regard to governance processes and addressing quality and operational management. There remain a range of concerns that are being addressed and we will continue to monitor the arrangements to ensure that improvements are sustained (SP) April 2019 - NDHCT continues to make progress in developing governance processes, however this has exposed further issues which includes the backlog to clinical coding and mortality data. Scrutiny continues with the Trust including through the System Oversight Meeting / Integrated Delivery Meeting and liaison with regulators (SP). March 2019 - Scrutiny continues by the CCG, NHSE & NHSI through the System Oversight Meeting (SOM). Positive clinical engagement and support for the new governance arrangements have been observed through CCG attendance at a range of provider assurance and governance meetings. Specific issues in respect to quality and patient safety still require further review and assurances from the provider. Until the further embedding of change is evidences, the assurance position remains (SW) [Control Gaps] January 2019 - There is a delay in completing the governance reform and improvements will need to be sustained for further risk reduction (SP)	12 (L=4 x I=3)	Risk Opened: 26/06/2018 Reviewed: 01/07/2019		May 2019 - Significant progress in relation to improving governance processes within the organisation, these include the SI process however full implementation and embeddedness is required and until this assurance is provided the risk cannot be rescored. The CCG understand that this improvement will require time and the organisation continue to be closely monitored by the regulators and CQC (SW) April 2019 - There is no change to the risk score. NDHCT continues to make progress in developing governance processes, however this has exposed further issues which includes the backlog to clinical coding and mortality data. Scrutiny continues with the Trust including through the System Oversight Meeting / Integrated Delivery Meeting and liaison with regulators (SP). March 2019 - Scrutiny continues by the CCG, NHSE & NHSI through the System Oversight Meeting (SOM). Positive clinical engagement and support for the new governance arrangements have been observed through CCG attendance at a range of provider assurance and governance meetings. Specific issues in respect to quality and patient safety still require further review and assurances from the provider. Until the further embedding of change is evidences, the assurance position remains (SW) [Assurance Gaps] April 2019 - NDHCT continues to make progress in developing governance processes, however this has exposed further issues which includes the backlog to clinical coding and mortality data (SP).	Executive Lead: Lorna Collingwood-Burke Owner: Simon Polak	11

95	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	No Third Party Delegation Process in use within some localities. There is a risk that NHS providers who do not utilise and support a third party delegation framework or process for level 3 patient/client interventions are unable to support patient choice or the personalisation/Integrated Personalised Commissioning (IPC) agenda. This leads to Registered Nurse packages of care being required to enable the patient/client to remain at home. The impact of this is: • Financial impact to the CCG as care package costs are significantly higher as only care providers with Registered Nursing are used to meet the patient/client needs. • Health and care services are unable to support patient choice or the wider personalisation agenda. • Inhibits the delivery of integrated care models eg 'care closer to home' • Continuity of care compromised for the patient/client as may have multiple agencies commissioned in delivering care. A third party delegation framework enables nursing care interventions to be safely and effectively delegated to another provider. It ensures carers can be given education and training to deliver specific interventions to a named patient/client. (HISTORIC ID: Na)	June 2019 - The guidelines are now finalised and a distribution plan is to be agreed. They are due to be circulated in early July 18 (SBe) April 2019 - The draft guidance has been updated following comments received. This updated guidance has been circulated to the task and finish group. Feedback due back in April 2019. A final draft will be produced for sign off by Associate CNO (LW). Final distribution May 2019 (SBe) [Control Gaps] November 2018 - LW is awaiting task & finish group attendees to be identified and meeting arranged (LW)	12 (L=4 x I=3)	Risk Opened: 22/08/2018 Reviewed: 20/06/2019	[22/08/2018] CHC team to consider a review of those cases where care interventions could be delivered within a third party delegation process and estimate financial implications (potential cost savings) of these June 2019 - SBe highlighted it would be difficult to estimate financial savings as the CCG don't know how many third party delegations will be put in place or are in place. Request to close action because of this, [22/08/2018] Discussion at NHSE DoNs meeting - briefing paper to be provided - this will also prompt and enable local commissioner/ provider discussions to occur April 2019 - A paper was written but it was decided it was not appropriate to take to DoNs meetings so item can be closed (SBe) April 2019 - A briefing paper was prepared to support any future discussions with the SW Director of Nursing Network group but it was thought that discussions at a local level, to introduce and raise awareness of the third party delegation framework, were our preferred starting point. This has been undertaken through the provider working group and will continue in the planned workshops (LW), [22/08/2018] Guidance Policy in development - first draft to be reviewed/consulted A draft document has been circulated - it was agreed to re-circulate this for further comment during Jan 19 with a view to being finalised in Feb 2019 The draft guidance has been updated following comments received. This updated guidance has been circulated to the task and finish group. Feedback due back in April 2019. A final draft will be produced for sign off by Associate CNO (LW). Final distribution May 2019 (SBe) Providers have been involved in working groups to develop a draft guidance document (LW) , [22/08/2018] A series of workshops are being planned that will enable staff working in frontline operational teams to gain knowledge and confidence in third party delegation April 2019 - These will happen once the guidelines have been finalised June 2019 - The CCG have discussed a workshop however have not yet taken this forward. Given the current work pressures this is likely not to happen until the Autumn. To remain open,	June 2019 - The guidelines are now finalised and a distribution plan is to be agreed. They are due to be circulated in early July 18 (SBe) May 2019 - Guidelines reviewed by LW and comments added to be followed up by SBe (LW) May 2019 - Following re-circulation of the updated Third Party Delegation guidelines there has been no further comments. There is outstanding work to undertake with regard to the DCC guidelines, follow up on the Third Party delegation for EOL medication, LW and SBe have met to go through guidelines and the current arrangements, LW to feedback to SBe by mid-May if the document is satisfactory it is to be formally circulated through the DoN routes and the risk has been reviewed and agreed a risk status of 12 (SBe) [Assurance Gaps] None identified	Executive Lead: Lorna Collingwood-Burke Owner: Carol Green	10

3	To make continued improvements in performance against core standards to deliver measurable results	There is a risk that crews may be delayed responding to 999 calls on days when there are delays in handing over patients to Emergency Department. This also means that the ambulance handover performance standard may not be met and the immediate handover Standard Operating Procedure (SOP) may be implemented. (Cross reference with Risk 91) (HISTORIC ID: 110)	Daily reporting regarding ambulance handover and ED performance activity. Monthly dashboard discussed at A&E Delivery Board monthly meeting. On call provider to provider discussion as required. Performance against trajectory reviewed monthly. Acute handover plan in place, will be updated. Handover monitor discussed at SWASFT IQPMG. [Control Gaps] No gaps identified	12 (L=3 x I=4)	Risk Opened: 16/07/2014 Reviewed: 02/05/2019	[02/05/2019] April 2019 - trajectories and action plans in place, two exec level meetings held to identify additional actions for improvement. ECIST recommendations for changes made, incorporated into ED recovery plan., [18/01/2019] The Senior commissioning team reviewed the current corporate risk register at their meeting on 22.11.18. Agreed to remain on register, however this will form part of the urgent care risk, see risk NEWD 89., [09/10/2018] May 2018 - Continued improvement in hours lost, NHSE led initiative to improve handover with Derriford - workshop to follow. 21 Jun 18 - continued improvement in hours lost. NHSE workshop planned for Jun. 7 Aug 18 - NHSE workshop took place and well attended by Devon CCGs and Acutes. Key points to be adopted by all Acutes. Oct 18 - work on this continues , [25/04/2018] Apr 18 - New handover system fully embedded, resulting in an improved position of 130 hours lost in March with 13 handovers above 60 minutes.,	Ambulance handover position regularly discussed at A&E Delivery Board. Handover delays discussed at monthly SWASFT IPQMG (Integrated Performance and Quality Management Group) meeting including review of performance against trajectory. Fortnightly operational meetings to improve handover processes, with CCG in attendance including clinical lead. [Assurance Gaps] No gaps identified	Executive Lead: Sonja Manton Owner: Christine Branson	11

8	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	There is a risk that Providers will not meet their response times for requests for contributions to Education Health Care Plans, from Devon County Council and Torbay Council. The impact of this is that Children Young People and families don't get their plans within the statutory timeframe, or that plans are sent out incomplete to meet timeframes and have to be redrafted once health information has been submitted, causing duplication in the system that children's needs are not addressed in a timely way. The CCG/ health will be assessed as one element of any local area inspection for SEND. (HISTORIC ID: 230)	Nov 2017 - action plan agreed and updated via JTWG. Feb 18 - Devon Special Educational Needs and Disability (SEND) IB has own risk register. DCC has a SEND Improvement Board which CCG commissioners sit on. DCC has an Operational Delivery Group, which SDTs Designated Medical Officer attends. TC has strategic and Operational delivery groups which commissioners/ providers attend. DCC has a quality assurance audit planned in early 2018. Commissioners have established a health provider group, to focus on addressing health needs. Clarity has been gained on legal position of CCGs. DMOs are in place across the STP Multi agency training has been offered to health providers -supported by DMOs. In addition the DMO has attended specific professional group meetings to look at improving the health contribution of plans. CCGs have agreed to share Education Health and Care Plans (EHCP) SAF data on a shared portal DCC use a panel process which commissioners have been involved in to look at individual EHCPs. Oct 18 - DCC have implemented new weekly moderation process for s selection of plans TC have implemented monthly deep dive audit t consider the content on plans. SDIP agreed with VCL for South Devon, currently going through contracting. Action Plan agreed with TSDFT. Both for 2018/19. [Control Gaps] Provider resources are limited to support the SEND agenda and staff involved are also key to the reprocurement of children's community health services. Requests often come though in spikes and additional clinics can not be provided at short notice. DMO time is limited and what is commissioned isn't enough to meet the draws on this time. Panels are weekly which is a capacity issue for commissioners, attendance will be delegated to providers in 2018. Providers submissions need to be improved to lessen the chance of EHCPs being taken to tribunal.	12 (L=3 x I=4)	Risk Opened: 25/07/2017 Reviewed: 16/05/2019	[11/06/2019] Risk Score reduced It is proposed for stepdown from the Corporate Risk Register to now be included in the Women's and Children's Team Risk Register as the scoring sits below 16, current risk score 12. This risk will be reviewed and updated at monthly W&C Team meetings. Performance against timeliness and quality has been included in NHS provider contracts and will be monitored through the CQRM mechanisms. The CCG and DCC have submitted the Written Statement of Action, the strategic oversight of this plan is being monitored by the SEND Strategic Action Group and the Devon SEND improvement Board. The is clear governance and monitoring between the CCG, NHS providers and the Local Authorities at the SEND Improvement Boards and Strategic Group. It is proposed that the Quality Assurance Committee have regular updates to assure progress and monitoring of the risk by the Women's and Children's Team, led by Sharon Matson. , [09/10/2018] ICO have been asked for a more detailed action plan Nov 17 - Action plan has been agreed with the ICO ICO have reported that Speech and Language Therapy (SALT) responses are now being returned during the agreed timeframe. ICO have reported that by mid October all Children and Young People (CYP) awaiting a paediatric appointment will have been offered a slot and future bookings will have moved to within required time scales. Feb 18 - Both DCC and TC have engaged directly with providers. Commissioners have developed an action plan with TSDFT, this is being monitored through JTWG. Commissioners are developing an STP wide proposal for the Designated Medical/ Clinical Officer roles which would support the improvement to the content of plans. SDT CCG to meet with DfE and NHSE in February to discuss issues/ solutions for Torbay. A similar meeting will be replicated for Devon later in 2018. CCGs have agreed to take part in a joint project with the Council for Disabled Children, to review what data we should collect from providers to gain an accurate picture of our local SEND services. This work is being led by PCC. May 18 - Service Development Improvement Plans to be agreed with Virgin Care Ltd and TSDFT - other providers in Devon will need similar agreements. Functions of DMO/ DCO to be reconsidered across the STP footprint. October 2018 - SDIP agreed with Virgin Care L for South Devon, currently going through contracting. Action Plan agreed with TSDFT. Both for 2018/19. Options paper to reconsider DMO options across the STP to be drafted, in light of increased concerns around the response of health services to tribunal and mediation requests for EHCPs (Education Health Care Plans).,	Nov 17 -TSDFT have provided assurance that 6 week deadlines are being met. Meeting scheduled between Torbay Council and TSDFT in November. Both DCC and TC have engaged directly with providers. Commissioners have developed an action plan with TSDFT, this is being monitored through JTWG. Commissioners are developing an STP wide proposal for the Designated Medical/ Clinical Officer roles which would support the improvement to the content of plans. SDT CCG to meet with DfE and NHSE in February to discuss issues/ solutions for Torbay. A similar meeting will be replicated for Devon later in 2018. CCGs have agreed to take part in a joint project with the Council for Disabled Children, to review what data we should collect from providers to gain an accurate picture of our local SEND services. this work is being led by PCC. TSDFT have appointed an EHCP co-ordinator to improve the response from health services. DCC has appointed a health and social are co-ordinator to support the co-ordination of health information in drafting EHCPs. [Assurance Gaps] CHIS Team provide a single point of contact at the ICO, from April 2018 the CHIS will no longer be provided by TSDFT, so an alternative SPoC will need to b provided. Nov. 17 - Torbay Council report 6 week deadlines are not being met consistently and report a 0% return rate for 6 weeks for Speech and Language Therapy (SALT). Commissioners regularly quality assure EHCP plans for DCC - there are a number of issues with the content of health provided submissions.	Executive Lead: Sonja Manton Owner: Jo Hooper	8

11	To make continued improvements in performance against core standards to deliver measurable results	There is a risk that the Trust may not be able to fully implement the four clinical standards for seven day services in urgent and emergency care by 2020. The impact of this is that the Trust would not be complying with national guidance to enable it to continue to provide a safe and sustainable urgent and emergency care pathway. (HISTORIC ID: 217)	The Trust has appointed Dr Ian Currie, Deputy Medical Director, as the clinical lead for 7DS locally; he is supported by Liz Davenport, Chief Operating Officer. A Trust working group has been established, and the CCG invited to join (Christine Branson to attend). The standards are clear and nationally mandated and audited bi-annually. Trust participate in national audits as required. [Control Gaps] No gaps identified	12 (L=3 x I=4)	Risk Opened: 27/04/2017 Reviewed: 02/05/2019	[02/05/2019] April 19 - 7DS subject to process of self-assessment by Trusts to NHSI. 7DS incorporated into Trust "ward based processes" improvement meetings. Key issues remain timeliness to consultant assessment and review over weekends., [09/10/2018] Oct 2018 - position remains the same, [26/04/2018] 14 Mar 18 - Current key risks identified by the recent audit relate to lack of progress on reaching the target of admitted emergency patients being seen and assessed within 14 hours by a consultant. There continues to be limited or emergency on call services at weekends, particularly linked to complex discharge arrangements, therefore maximising patient flow at weekends remains a challenge. Apr 18 - no update,	Progress with seven day services is reported monthly to the SDT A&E delivery board. The ability to comply with 7DS standards across the Urgent and Emergency Care (UEC) pathway was a key consideration in the UEC arm of the Devon STP acute service review and is a “gateway” for the service configuration proposals. NHSE in contact with the Trust and CCG on progress inc telecons. NHSE/I completed stocktake of TSD in May, action plan produced as a result. [Assurance Gaps] No gaps identified	Executive Lead: Sonja Manton Owner: Christine Branson	9
70	To make continued improvements in performance against core standards to deliver measurable results	There is a risk that harm could be increased if there is a delay in a patient accessing diagnostics. The impact is that the RTT/future treatment pathway will be compromised. CT risk is reducing however MRI and Echo risk has increased dramatically (HISTORIC ID: 84)	1. MRI breaches decreased from 404 to 260 in Oct-18. Large number of breaches due to increase in inpatient demand. 2. CT breaches decreased from 195 to 60 3. Alternative capacity for ultrasound is continuing to be explored and referral mechanism being reviewed to allow equitable waits between acute and AQP providers 4. CCG attendance at weekly diagnostic meetings (updated 03/12/2018) Updated - 16/04/2019 - the number of MRI breaches has reduced significantly – from 629 in April 2018 to 94 in Feb ’19; CT breaches also reduced – from 310 in April ’18 to 8 in Feb ’19. Endoscopy breaches are the main modality of concern – this is being addressed through insourcing in the short term and longer term the STP report on endoscopy is anticipated will help to resolve the situation. [Control Gaps] 1. Activity plan largely dependent on sub-contracts and recruitment of appropriate trained staff. (reviewed – no change 03/12/2018)	12 (L=3 x I=4)	Risk Opened: 10/09/2015 Reviewed: 16/04/2019	[06/11/2018] 1. UHP Planned Care Forum meetings to seek assurance (reviewed – no change 03/12/2018) , [05/07/2018] 1. MRI action plan & Trajectory produced by UHP with CCG and NHSE. Sickness and absence plus internal pressure creating additional pressure 2. RTT Meetings to seek assurance. ,	1. Monthly RTT meeting signposting queries to relevant board. 2. CQC Improvement notice issued in relation to waiting times and subsequent action plan developed 3. Weekly diagnostic meeting focussing on CQC improvement action plan (reviewed – no change 03/12/2018) [Assurance Gaps] 1. Unsighted on demand/capacity analysis for 2017/19. 2. Western team seeking additional evidence. 3. No sight of waiting list size. Requested access through BI and PHNT BI team. (reviewed – no change 03/12/2018)	Executive Lead: Simon Tapley Owner: Fiona Phelps	9
72	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk that there are long internal waits for tier 3 and 4 psychological therapies. The impact of long waits for therapy is likely to increase the length of treatment required and reduce recovery rates further impacting on demand and capacity in the system 212 people waiting over 18 weeks (October 2018) (reviewed updated 22/11/18) (HISTORIC ID: 119)	1. People who require secondary M/H services will be seen by Community Mental Health teams (CMHT) whilst waiting. 2. CMHTs have psychologists within the team who will be able to provide some support and guidance to staff working with individuals or 1:1 support. 3. If individuals are discharged from community teams pending therapy they will have fast track access back into services (reviewed 22/11/18)No Change [Control Gaps] Referral patterns have now re-stabilised following wider system changes. Service capacity should be able meet demand however backlogs have still to be addressed The service continues to experience staffing difficulties to remove the backlog. Speed of backlog reduction does not indicate it will be addressed in the financial year Overall numbers waiting have decreased May (369) October (290). Numbers waiting over 18 May (244) –Oct (212) and 52 weeks May (115) Oct (89) have decreased. (reviewed updated 22/11/18)	12 (L=4 x I=3)	Risk Opened: 14/02/2014 Reviewed: 25/06/2019	[25/06/2019] The risk will be reviewed again on the 2nd July and further updates will be included in the next update in July. Derek O'Toole 25 June 2019, [01/11/2018] 1. Review staffing plan to deliver backlog clearance (reviewed 22/11/18) No change, [07/09/2018] 1. Funding has been agreed to remove the backlog over 18 weeks and staff are in place. 2. Baseline data was developed for the historic referral patterns, however increases in numbers of people referred means that revised data is required to understand service requirements - to be produced by July 2018 (reviewed 25/09/18) , [05/07/2018] 1. Funding has been agreed to remove the backlog over 18 weeks and staff are in place. 2. Baseline data was developed for the historic referral patterns, however increases in numbers of people referred means that revised data is required to understand service requirements - to be produced by July 2018 ,	1. Funding and staff are in place to remove the backlog. 2. Numbers waiting are decreasing 3. Waiting times are reviewed by Livewell performance committee attended by commissioner 4. (reviewed updated 22/11/18) [Assurance Gaps] There remain gaps in some specific therapeutic skills and staff absences (reviewed 22/11/18)No Change	Executive Lead: Jo Turl Owner: Derek OToole	9

73	To make continued improvements in performance against core standards to deliver measurable results	There is a risk that the national target for recovery rates for IAPT services will not be achieved. The impact of this is increased scrutiny by NHSE. In Q2 the recovery rate was achieved and target was exceeded in Aug and Sept. (HISTORIC ID: 338)	1. Livewell Southwest has an improvement plan in place to deliver the 50% recovery target. 2. Livewell have implemented a process of evaluating the impact of the range of delivery models and options they have implemented to ensure that the options delivered are the most effective 3. The recovery plan is monitored via their performance committee attended by commissioners (reviewed 31/10/18) [Control Gaps] 1. The actions completed need to be embedded to achieve sustained delivery. 2. Recruitment of staff to remove the step 3 waiting lists remains challenging 3. The recovery rate for Q1 was 39.6%. Recovery rate in Q2 was 51.8% but continues to fluctuate (reviewed 31/10/18)	12 (L=4 x I=3)	Risk Opened: 03/11/2016 Reviewed: 25/06/2019	[25/06/2019] The risk will be reviewed again on the 2nd July and further updates will be included in the next update in July. Derek O'Toole 25 June 2019, [01/02/2019] The Senior commissioning team reviewed the current corporate risk register at their meeting on 22.11.18. Agreed to remove risk from corporate risk register, to be included on mental health program risk register for oversight by mental health care partnership board., [05/07/2018] 1. Additional funding has been agreed to remove step 3 waits. (reviewed 31/10/18) ,	1. Performance and delivery of the action plan in monitored via the Livewell performance committee (reviewed 31/10/18) [Assurance Gaps] No gaps in assurance currently identified. (reviewed 31/10/18	Executive Lead: Jo Turl Owner: Derek OToole	8
74	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk that RTT for children's Speech and Language service continues to breach national standards The impact of this is children and young people are at risk of a delayed intervention and/or support being received at the right time. (HISTORIC ID: 342)	The service and transformational plans of CFHD offer assurances and controls to improve this waiting times for SLT in 2019/20. The STP wide communication project aims to improve the integration and system offer across health, education and care using evidence based tools, best practice innovation from the leading expert in SLT. Livewell South West is the incumbent provider and has systems already in place. Concerns regarding data raised at team huddle. [Control Gaps] 1. CFHD data is incomplete, currently reportable for Devon only 2. Integration of CFHD teams still in process of being embedded. 3. Consistency of CFHD systems still being developed.	12 (L=3 x I=4)	Risk Opened: 25/11/2016 Reviewed: 31/05/2019	[05/07/2018] 1. LSW are fully engaged with Phase 1 of the integration of Community Health, Wellbeing and Special Educational Needs & Disability (SEND) Support Services. 2. Single Point of Access went live in August 18 and early indications are that system working well. no change 26.11.18 ,	1. Data book, RTT data 2. Phase 1 integration work through Access 3. Livewell South West cSALT action plan 4. Voice of children, young people and their families through regular engagement 5. Risk monitor/owner to attend contract management meetings 6. Livewell South West data: CYPSLT mean wait 12.1 CYPSLT longest wait 4.3 CYPSLT >52 week waits 0 CYPSLT total waiting 272 CYPSLT >18 week waits 64 [Assurance Gaps] CFHD monthly dashboard does not indicate metrices at sufficient granular level: unable to ascertain specific SLT data	Executive Lead: Simon Tapley Owner: Sharon Matson	8
75	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	There is a risk that the wait for completion of assessment following initial consultant/ referral for Plymouth School Age Autistic Spectrum Disorder Assessment continues to breach national standards. The impact of this is children and young people are at risk of a delayed intervention and/or support being received at the right time. (Current wait for assessment is 9 months as of June 2018) (HISTORIC ID: 343)	1. UHP continue to make progress with the ASD pathway – both the number of children waiting and the length of wait. Figures below: Improving picture - as at November 2018 there are 87 (from 102) children waiting for assessment with the longest wait without an appointment booked being 26 weeks from 37 weeks. If staffing levels remain stable it is anticipated the wait for an assessment to commence will have fallen to below 6 months by the new year. Updated 26.11.18 [Control Gaps] Preferred provider for integrated children's service now confirmed as LSW. Await contract award following GB in common 29 November 2018. Updated 26.11.18	12 (L=4 x I=3)	Risk Opened: 25/11/2016 Reviewed: 06/03/2019	[05/07/2018] 11. UHP are fully engaged with Phase 1 of the integration of Community Health, Wellbeing and Special Educational Needs & Disability (SEND) Support Services. Plans to create single ASC pathway with LSW underway. No change 26.11.18 ,	1. Data book RTT data 2. Phase 1 Integration work through 'Access' 3. UHP ASC Action Plan – quarterly reporting 3. Voice of Children, Young People and their families through regular engagement - CDC are communicating with those waiting and no complaints about the wait have been received to date. No change 26.11.18 [Assurance Gaps] 1. Possible staffing/ recruitment issues. No change 26.11.18	Executive Lead: Simon Tapley Owner: Sharon Matson	8

77	To improve collaborative working arrangements with communities promoting self-care, prevention and make continuous improvements in health and wellbeing for the population of Devon	There is a risk that Devon continues to have a high avoidable amputation rate. The impact of this can have a considerable personal impact on the patient as well as a financial impact on the health and care system. (HISTORIC ID: 376)	1. Action plans have been developed as part of the Diabetic Transformation programme. These are wide ranging and comprehensive and are available on request covering all 3 elements of the pathway: prevention & self-help; achievement of treatment targets and NICE NG28 and compliance with NICE NG19 for MDFT. Programme of work using an integrated team across organisations. Reviewed 14/03/19 [Control Gaps] 1. 1. Internal reporting via Diabetes Delivery Board which reports into the Long-Term Condition Board 2. Additional ad hoc reporting to COTM, OLG and QC 3. External reporting to NHSE via six weekly returns which is next due on 22 March 4. Sustainability post-NHSE diabetes transformation funding period. Risk to reputation. Reviewed 14/03/19	12 (L=4 x I=3)	Risk Opened: 19/09/2017 Reviewed: 30/05/2019	[15/11/2018] 1. Community based specialists working with primary care to improve diabetes care 2. Foot care teams offering education for primary care 3. System-wide audit of major diabetes related amputations in place 4. Offer of funded diabetes education programmes for all practices in place. Updated 14/03/19 , [05/07/2018] 1. Investment is time limited and there needs to be a system wide agreement to transfer resources into the correct services to ensure continue.,	1. 1. Close scrutiny of data and finances to demonstrate changes in care and pathways are occurring 2. Investments in staff are enacted and activity monitored 3. NHSE attend internal Delivery meeting for assurance and scrutinize quarterly reports 4. MDFT Peer Review at Derriford on 07/02/19 – awaiting report. Issues highlighted: a) DRSS process required to action urgent MDFT referrals via DRSS and not straight to foot clinic; b) urgent hot-slots not yet set up in foot clinic. Progress will be reviewed via Diabetes Board meetings. Updated 14/03/19 [Assurance Gaps] 1. Long delays in getting national data returns back (NDA was extracted in May, results due Oct) making change hard to monitor 2. Some internal audits depend on self-assurances which may not be the same as external ones Reviewed 14/03/19	Executive Lead: Simon Tapley Owner: Pru Fong	9
44	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	Adults: Autism Bill makes it a statutory requirement to provide diagnosis. However there are no resources for provision of treatment. Autism is not always recognised as a disability by systems and diagnosis is important. Access to diagnostic pathways is limited as there is insufficient capacity. Waiting times are high and there are complaints from users. Following diagnosis there are limited support options for individuals. The total care pathway is inadequate Children: There is a risk that Children and Young People are experiencing significantly longer waiting times for Autistic Spectrum Condition (ASC) Diagnosis. (HISTORIC ID: 111)	Adults: Dave McAuley leading on a piece of work that seeks to address: Access to mainstream services Access to a specialist diagnosis Post diagnostic support The aim is to provide a consistent, high quality offer across the STP footprint. I am aiming to have recommendations in May and am engaging with users and stakeholders in April to present our findings and co-produce a solution. the CCG PSQ Team have requested VCL provide assurance, in order to mitigate against the risk of harm to a young person experiencing a long wait for this service,. The following assurance has been provided: Implementation of ICS Access policy (January 18): a process where teams can check harm has not occurred. Policy includes: senior clinical lead reviewing every referral, scores against RAG system to triage/ prioritise, on-going review of long waiters, letters to contain SPA telephone number and actions to take if require earlier assistance/ have concerns, report each long wait over 18 weeks as an incident. Additional work planned with SPA team to ensure clinical escalation when calls come in. Audit plan in place (by Clinical Effectiveness Lead), to ensure changes/ Access Policy embedded. CYP champions plans include their involvement in addressing experience during long waits, improving signposting etc. Children: Waiting times are regularly reviewed through CRM. Regular meetings with commissioners to review work plans. Business case for additional resource to address the backlog of patients waiting has been considered by senior managers. Waiting times were identified as an issue in the re-procurement of Children's Community Health Services. CYP waiting for a significant amount of time have been highlighted as a cost pressure to the CCGs for 2019/2020. Action plan: Waits for ASD will be focused on as part of the mobilisation of the new contract, although it is noted that VCL have been asked to discontinue trajectory forecasts as the end of the current contract approaches. ASD is a more general theme for Devon County Council and the NPSI, led by VCL have taken a multi agency approach to developing this. [Control Gaps] Control Gaps Commissioners require additional information and evaluation of the current challenges. ASD Children - understand the impact of changing and increasing demands and referral patterns and how waiting times target will be achieved and sustained. Adults: There are long waiting times for access to the diagnostic service, and resources in Devon are limited compared to demand	10 (L=5 x I=2)	Risk Opened: 01/04/2013 Reviewed: 05/03/2019		Trajectories show a gap between new referrals and capacity to undertake these is slowly closing. New contract for Children's Community Health services from April 2019 will bring together neurodevelopmental conditions into a single diagnostic service, bidders have been asked to consider what this might look like as part of their submissions at tender and the preferred bidder will be identified as a system leader in addressing ASD more widely. NPSI multi agency group reports to the SEND Improvement Board led by DCC. VCL and CCG Patient Experience Team report less patient complaints/concerns, as families are better informed. The following assurance has been provided: - Implementation of ICS Access policy (January 18): a process where teams can check harm has not occurred. Policy includes: senior clinical lead reviewing every referral, scores against RAG system to triage/ prioritise, on-going review of long waiters, letters to contain SPA telephone number and actions to take if require earlier assistance/ have concerns, report each long wait over 18 weeks as an incident. - Additional work planned with SPA team to ensure clinical escalation when calls come in. - Audit plan in place (by Clinical Effectiveness Lead), to ensure changes/ Access Policy embedded. [Assurance Gaps] ASD diagnostic and post-diagnostic pathways across health ,education and social care that are consistent with standards and is sustainable. IPAMs are not monitoring autism regularly, there are no agreed KPIs and autism pathway is not on the IPAM dashboard	Executive Lead: Simon Tapley Owner: Sharon Matson	10

107	To improve collaborative working arrangements with communities promoting self-care, prevention and make continuous improvements in health and wellbeing for the population of Devon	There is a risk that becoming a larger CCG could lead to a reduction in the visibility of teams/individuals to members, staff and stakeholders. The impact of this is that they may receive less effective engagement/contact with key people from the CCG. (HISTORIC ID: Na)	Executive, Lay and Clinical Lead aligned to each locality Ongoing development of Senior Leadership Team to increase visibility Ongoing OD for newly merged organisation STP and ICE support working with Local Authorities. [Control Gaps] Arrangements for locality commissioning not yet clarified.	9 (L=3 x I=3)	Risk Opened: 21/05/2019 Reviewed: 21/05/2019	[21/05/2019] Chair undertaking review of membership engagement Review of constitution to ensure appropriate GB membership and engagement. GS Board Secretary,	Feedback from members and level of engagement Mori Stakeholder Survey Health and Wellbeing Board [Assurance Gaps] no gaps identified	Executive Lead: Andrew Millward Owner: Andrew Millward	
109	To make continued improvements in performance against core standards to deliver measurable results	There is a risk to the CCGs' reputation for underperformance against some key constitutional standards: 52 week waits Diagnostics 62 day cancer standard A and E 4 hour waits The impact of this would be that the CCGs' credibility with regulators and public would be affected, leading to increased levels of scrutiny and assurance of how we are enabling the system to meet these standards, potentially diverting more resources from delivery and attracting external intervention. (HISTORIC ID: Na)	For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. [Control Gaps] none identified	9 (L=3 x I=3)	Risk Opened: 06/06/2019 Reviewed: 05/06/2019		Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. [Assurance Gaps] none identified	Executive Lead: Sonja Manton Owner: John Finn	
79	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	If Stroke patients do not spend 90% of their stay on an acute stroke unit, then there is a risk of delayed clinical outcomes/ harm to patients who have had a stroke. (HISTORIC ID: 98)	1. Stroke Clinical Pathway Group (CPG) re-established. 2. Remedial action plan from CPN, now part of the Stroke CPG 3. Acute Stroke Review now reviewing whole pathway. (Reviewed no change 22/11/18) [Control Gaps] 1, Relationships between providers (Reviewed no change 22/11/18)	9 (L=3 x I=3)	Risk Opened: 10/09/2015 Reviewed: 04/12/2018	[15/11/2018] 1. Remedial action plan from CPN is now part of the Stroke CPG and continues to be monitored through the CRM. Ongoing 2. DTA 3 beds commissioned for Stroke patients. Complete 3. HASU/ASU Stroke STP review 4. Hard Reset reviewing the Stroke pathway and processes ongoing (Updated 22/11/18) ,	1. Hard reset for stroke pathway – review of all delays in order to maintain flow (Updated 22/11/18) [Assurance Gaps] 1. Workforce & clinical leadership (Updated 22/11/18)	Executive Lead: Simon Tapley Owner: Elaine Fitzsimmons	10

80	To make continued improvements in performance against core standards to deliver measurable results	There is a risk that the dementia diagnosis rate will not be achieved The impact of this is A combination of the following: • social factors – early diagnosis gives the patient more opportunity to plan for the future and to improve their own and their carer's wellbeing • reputational to the CCG if target is not achieved (reviewed 25/09/18) (HISTORIC ID: 121)	1. NHSE new assurance framework now includes annual GP reviews as a measure of performance. 2. Plan is monitored bimonthly (reviewed 31/10/18) [Control Gaps] 1. Consistent permanent psychiatrists have not been recruited. 2. Date for additional clinic space has yet to be confirmed 3. Plan has not delivered improvement (reviewed 31/10/18)	9 (L=3 x I=3)	Risk Opened: 10/09/2015 Reviewed: 25/06/2019	[25/06/2019] The risk will be reviewed again on the 2nd July and further updates will be included in the next update in July. Derek O'Toole 25 June 2019, [01/02/2019] The Senior commissioning team reviewed the current corporate risk register at their meeting on 22.11.18. It was agreed that the risk remain on the corporate risk register as dementia diagnosis is a direct national commissioning target. ACTION: JT to review risk narrative and scoring and reflect risk across both CCGs., [04/12/2018] Consultant Psychiatrists recruitment is challenging with substantial vacancies across the UK. Plan to be revisited to improve levels of assurance (reviewed 22/11/18)No Change , [14/11/2018] It is being clarified as to whether this risk is a duplication of risk 59 and it has been suggested that it should be a whole Devon risk. This is being reviewed. , [05/07/2018] 1. An action plan is in place to improve the diagnosis rate required number of diagnosis have been made in individual months however consistency has not been reached. 2. NHSE have agreed a further 12 months for NEW Devon to achieve target of 67% diagnosis rate. This will allow completion of revised pathway 3. The new post-diagnosis support service will be has been procured and is in mobilisation phase operational May 2018 (reviewed 31/10/18) No Change ,	1. Quarterly performance data is being supplied by Livewell South West. 2. Plan is monitored bimonthly (reviewed 31/10/18) [Assurance Gaps] Consultant Psychiatrists recruitment is challenging with substantial vacancies across the UK. Plan to be revisited to improve levels of assurance (reviewed 31/10/18)	Executive Lead: Jo Turl Owner: Derek OToole	10

15	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	There is a risk of long waits for children's neurological assessments. The impact is that currently children without a diagnosis are not able to access all appropriate levels of support for example in education settings or from other community/ diagnostic services. (HISTORIC ID: 32)	Joint working with Devon on community based pathways and service specification supported by clinical leads and health care professional. Close scrutiny by BPP. Raised through Joint Technical Working Group. Dec 2015 - Service review meeting scheduled for end of January 2016 to consider pathway and trajectories. Finalisation of service specification to take place end January 2016 (JH) Jan 2016 - Finalisation of service specification to now take place end March 2016 (JH) Autism assessment services are included in the reprocurement proposals for childrens services. July 2017 - action plan updated by TSDFT and shared with commissioners. Commissioner requested meeting with Virgin Care Ltd planned for September to update on position. In the longer term Autism Spectrum Disorder assessment will form part of the children's services reprocurement from April 2019, as part of that commissioners have engaged with incumbent providers across Devon, Torbay and Plymouth and parent groups looking at existing good practice and aspirations for the future. Further engagement is planned during the school summer holidays with young people. Oct 17 - Service specifications to be shared with potential providers/ public in October providing opportunity for discussion. May 18 - Business case with Children's team to manage waiting lists to an acceptable level, to be agreed for the STP footprint. Oct 18 -business case was not deemed appropriate at this time, potentially there are implications to the reprocurement if additional funds are offered to the preferred bidder within a defined time period. Providers were notified of the outcome of the business case. Torbay have made further improvements to their waiting times. future planning had ben put on hold with providers as ASD assessment was part of the reprocurement of children's community health services. Planning will resume as part of mobilisation to consider . Meetings also scheduled with both Torbay and South Devon Providers in October to consider position by April 2019. [Control Gaps] none identified	9 (L=3 x I=3)	Risk Opened: 15/06/2012 Reviewed: 05/03/2019	[09/10/2018] October 2018 - Business case with Children's Team to consider waiting lists in preparation for any new service provider. Business case was not progress as CSU advised any aware of additional resources could impact on the reprocurement of childrens community health services. , [01/05/2018] May 18 - Business case with Childrens Team to consider waiting lists in preparation for any new service provider.,	April 2016 - End of year statement produced detailed trajectories to reduced waiting times by Torbay. Lead has been nominated in Virgin to support review of South Devon position on Autism Spectrum Disorder (JH) Virgin Care Limited have been asked to provide a 15/16 review of service by 10th June. The ICO will also be asked to update their 15/16 review . VCL have confirmed they will not meet the 18 week target. They have agreed to lead county wide workshops to look at a new condensed pathway which should reduce waiting times in 2017/18. VCL - workshops continue. Aug 17 - VCL - workshops continue moving toward a revised pathway - JADES Model which would reduce the number of appointments for parents and make better use of existing information. In the last quarter joint paediatric appointments have been trialled. SFHFT have maintained a waiting time of 8 months despite carrying staff vacancies. Trust has confirmed they have now appointed to all vacancies and should be running at full capacity by the end of September 2017. Waiting times should being to decrease again from there. The Trust are also working towards better supporting information for families who have been accepted onto the pathway- parents have told the CCG the do not mind waiting longer if they are better supported during the wait. Oct 17 - TSDFT have prioritised clinical psychology hours into the service, allocated a paediatrician lead who is also part of the CDC pathway and a new Clinical ASD Lead came into post in September, all training is now complete. Oct 18- Torbay Council has reported improved return rates. [Assurance Gaps] April 2016 - Torbay needs to appoint new service lead following resignation of the current post holder which could delay trajectories (JH) Virgin Care Ltd have not reached agreed target - 18 week waits by August 2016. VCL have not been able to confirm a date when they will achieve the 18 week wait target. Aug 17 - Neither TSDFT or VCL have confirmed when they will reach an 18 week target. It is anticipated this will be confiremd during September 2017. October 2017 -update meetings with both providers will be scheduled for Q3.	Executive Lead: Simon Tapley Owner: Jo Hooper	11

17	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	There is a risk of ever growing demand on all services supporting patients with Long Term conditions including primary care, urgent care and community services. The impact is that we will continue to have to invest more and more in services to meet an increasingly complex population without any effective interventions in place to reduce the growth of LTCs within our population, or motivate and support our patients with LTCs to avoid co-morbidities and/or live as healthy lives as possible for as long as possible. Updated May 2019 (HISTORIC ID: 87)	STP Prevention Board and work stream. Locality Prevention work streams. Integrated personalised care work stream - including self care. Integrated Care Model work streams. Updated May 2019 [Control Gaps] No gaps identified	9 (L=3 x I=3)	Risk Opened: 09/01/2014 Reviewed: 18/06/2019	[18/06/2019] May 2019 - Prevention and ICM are system priorities and supported by STP wide steering group , [15/03/2018] Jan 2018 - Insight report containing a series of recommended projects / change will be available mid January for sign off by joint exec team. Newly appointed Assistant Director for Organisational Development meeting with enabler leads to discuss alignment of plans. Mar 2018 -Revised governance now live. Enablers now being piloted / deployed across STP programmes. Some issues remain re infrastructure to support some of the key enablers within the prevention model. Behavioural change workstreams progressing well - initial workforce INsight report & accompanying recommendations well received within the local system and resultant workstreams now in initiation or live development.,	March 2017 - rollout of self-care model via 3 delivery work streams (Learning and Dev Programme; Comm Asset Dev; & Info Asset Dev). Info asset and comm asset work streams focussed on delivering requirements of Health and Wellbeing teams + focus in primary care for emerging health navigators roles. Further detail & assurances required from Learning & Dev work stream. July 2017 – local engagement event in July will establish the work programme for behavioural change partner, along with assisting us in profiling benefits / savings for each work stream. Local implementation group proposing increased governance of delivery through Care Model Delivery Group to ensure local buy in from services to delivery. Sept 2017 Joint Execs sign off of proposed plan for Insight gathering and addressing a number of quick win opportunities (21/09/17). Implementation work under way across a number of areas, including support to UEC; Torquay and Newton Abbot Health and Wellbeing Teams; Shared Decision Making (whole Devon approach showing portability / scalability of the model that has been developed). Proposed model road testing well in implementation areas. Nov 2017 - prevention, wellbeing and self-care enablers now described and either in place or in development. Revised governance processes for local prevention programme (agreed Nov 2017) will give increased focus to implementation via existing groups such as CMDG and A&E Delivery Board. A number of STP workstreams are also in play to embed elements of the model at a whole-Devon level. Mar 2018 -Revised governance now live. Enablers now being piloted / deployed across STP programmes. May 2018 - Some issues remain re infrastructure to support some of the key enablers within the prevention model. Behavioural change workstreams progressing well - initial workforce INsight report & accompanying recommendations well received within the local system and resultant workstreams now in initiation or live development. May 2019 - STP Prevention work stream in place and funding allocated for year. Locality structures to deliver locally. Social Prescribing framework in place across STP. [Assurance Gaps] Sept 2017: Further work needed to establish system wide narrative into which the behavioural change work will be fed. Following Joint Exec meeting it is proposed that "chapter 2 of the care model" is the overarching narrative. Further work required with comms teams to embed the requirements of the prevention & self-care work in the development and delivery of this message. Nov 2017 - investment will be required in elements of infrastructure (for example: online information; platform for electronic patient activation measure). Programme still operating in the absence of an evaluation framework. Mar 2018 - assurance gaps remain largely the same from the last update - investment will be required in elements of infrastructure (for example: online information; platform for electronic patient activation measure). Programme still operating in the absence of an evaluation framework. May 2019 - None	Executive Lead: Sonja Manton Owner: Jenny Turner	8

20	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	There is a risk that tier 2 patients who have shown no significance of healing following 4 weeks of treatment with compression therapy, will not receive a consistent standard of care across the South Devon and Torbay footprint. All GP practices in South Devon and Torbay are contracted to deliver the tier 2 service under the PPO LES from October 2018 but are not mobilising effectively. The impact of this is inconsistent patient care and pressures in the service. (linked to risk 94) Updated June 2019 (HISTORIC ID: 162)	Significant work undertaken to determine the right long-term pathway of care for patients and the interface between the LLTS, primary care and other services to be in place by April 2020. Updated June 2019 [Control Gaps] Practices are not developing a consistent response and service and so patients will receive differing levels of care from general practice. This work is clogging up the waiting list for the LLTS tier one service and is an unsustainable long-term solution. Updated June 2019	9 (L=3 x I=3)	Risk Opened: 10/12/2015 Reviewed: 18/06/2019	[18/06/2019] May 2019 - supporting delivery through PPO LES. , [08/08/2018] Aug 18 - A proposal for service redesign has been shared with the Business Meeting 03/08/18. , [25/04/2018] March 2018: A clinical audit of activity in primary is being undertaken by an MDT of LLTS, podiatry, vascular and lymphoedema services. This will support the development of accurate clinic capacity modelling to inform the business case. April 2018: Clinical audit in process which is due to complete 15 May 18,	The CCG is working with practices to make sure that they understand and deliver on their contractual obligations. Close liaison between CCG and Lower Limb Therapy service to manage increasing back log. CCG working to ensure practice nurses have access to appropriate training. Updated June 2019 [Assurance Gaps] No gaps identified	Executive Lead: Sonja Manton Owner: Jenny Turner	9
82	To deliver integrated care closer to home	A number of individuals are at risk of having to be referred out of area for treatment due to a lack of local specialist autism services, particularly in regard to people with behaviours that challenge. The lack of services could also potentially be challenged legally. The impact is likely to be reputational damage as well as financial. (21/09/18) (HISTORIC ID: 116)	1x1= 1 1. A comprehensive action and local delivery plan for service improvement has been developed and signed off by senior management. 2. Work is being carried out to improve data recording processes on diagnosis. 3. Data collection processes have been put into place by Livewell South West. 4. In Plymouth diagnosis for individuals with no Learning Disability is undertaken by the Community Mental Health Teams (CMHTs). (reviewed - no change 01/11/2018) [Control Gaps] 1. The strategy and action plan requires robust data to base service planning on across the STP footprint. 2. Further work needs to be completed to obtain data across the STP Footprint. 3. JSNA for Plymouth is being developed 4. Investigation on options to improve post diagnostic support pathways. 5. The current diagnostic service does not meet NICE guidance. (reviewed - no change 01/11/2018)	8 (L=4 x I=2)	Risk Opened: 02/12/2013 Reviewed: 01/02/2019	[01/02/2019] The Senior commissioning team reviewed the current corporate risk register at their meeting on 22.11.18. Agreed to remove risk from corporate risk register, to be included on mental health program risk register for oversight by mental health care partnership board., [01/10/2018] 1. Development of comprehensive autism action plan requires senior management sign off – Completed June 2017 2. Improve the autism data collection process for Autism across the STP Footprint. Reviewed March 2018 3. One central location on the Plymouth Online Directory (POD) for Autism information. Ongoing and will be completed by March 2018 4. Autism Case for Change to obtain sign off through the STP Governance route from March18 onwards. Supported by CCG and LA's. To be presented at PDEG in October 2018. (reviewed and updated 21/09/18) , [03/08/2018] 1. Development of comprehensive autism action plan requires senior management sign off – Completed June 2017 2. Improve the autism data collection process for Autism across the STP Footprint. Reviewed March 2018 3. One central location on the Plymouth Online Directory (POD) for Autism information. Ongoing and will be completed by March 2018 4. Autism Business Case to obtain sign off through the STP Governance route from March18 onwards. Supported by CCG and LA's. To be presented at PDEG in November 2018 (reviewed and updated 01/11/2018) , [03/08/2018] 1. Scrutiny- monthly at PHNT Quality sub-group (of the board). 2. Projects are monitored at Planned Care Control Centre. 3. Long waits monitored by the service lines (weekly) 4. UHP managed discharge process (targeting over 40 week waits (Ongoing) 5. UHP – NHSI IST reviewing backlog (on-going) 6. UHP service line FUP backlog meetings (on-going) Updated Action List added.,	1. Plans are reviewed and monitored by the Autism Partnership Board and the STP LD and Autism Leadership Meeting. 2. Benchmarking is available against the Autism Self -Assessment framework. 3. Plans are being developed at STP level to address gaps in autism provision. Case for change developed and will be presented at PDEG in November (reviewed and updated 01/11/18) [Assurance Gaps] 1. There are no agreed KPIs and autism pathway is not on the performance dashboard. (reviewed - no change 01/11/2018)	Executive Lead: Simon Tapley Owner: Shona Charlton	8

83	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	There is a risk that variable and limited capacity in general practice and networks in the Western patch could affect the ability to transform, improve sustainability and enable system wide developments The impact is that general practice and networks may experience difficulty responding in a timely way to national timelines. (HISTORIC ID: 345)	4-weekly meetings of the Western System Primary Care Partnership. Wide representation from commissioners and providers including groups of practices. This group holds the Primary Care Improvement Plan. The Primary Care Improvement plan is reported to the Western System Improvement Board. Action Plan: Working with practices to identify resource requirements for priority improvements (ongoing through GP forums and other engagement) Ensure sufficient resource is invested into primary care (GPFV, NHSE, CCG) and through STP Investment to be provided to the four groups of practices with funding and human resource to drive improvements as part of the system's primary care plan (complete for 17/18) [Control Gaps] No known gaps.	8 (L=4 x I=2)	Risk Opened: 25/11/2016 Reviewed: 11/06/2019	[11/06/2019] Feb 19 - working with practice to support and develop the formation of networks held 16th Jan 19. Follow up expected Mar 2019. Primary Care Development teams supporting with practice plans. CCG development leads completing Train the Trainer Primary care home training to support progression through primary care home development stages. Investment in ongoing management of Investment funding. Monitoring of Improved Access utilisation and improving uptake. Mar 19 - CCG met with practices providing care to the most deprived areas of Plymouth; we are supporting the formation of a 'Deep End' practice group covering said deprived localities Apr 19 - Working with practices to implement contract reform. Supporting Primary Care Network development June 2019 – 9 Primary Care Networks confirmed in Western area. One practice not wishing to join a network; work to secure access to services for patients ongoing. , [25/06/2018] 1. Working with practices to identify resource requirements for priority improvements (ongoing through GP forums and other engagement) 2. Ensure sufficient resource is invested into primary care (GPFV, NHSE, HEE, CCG) and through STP 3. General Practice Forward View Transformation Funding – Plans in development with support from CCG. 4. Improved Access – Two Lead Providers for Western agreed at PCC. Proposals in development for Oct implementation 5. Primary Care Transformation Plans are aligned with Health and Wellbeing Hubs plans. Joint working with Plymouth City Council 6. Expression of Interest submitted for First Contact Practitioner Physiotherapy Service at four Sound Health practices ,	Reported through the Western Primary Care Partnership and the Western Locality System Improvement Board [Assurance Gaps] Insufficient change capacity at all required levels	Executive Lead: Jo Turl Owner: Paul Baker	10

24	To ensure that the organisation contributes to system financial balance and maintains improvements in efficiency, productivity and sustainability for the wider benefit of the NHS	Following a recent internal review process against the 2014 changes to the definition of Deprivation of Liberty (DoLs) whereby more people in the community may be subject to a DoL, the CCG has identified that some patients have not had a community DOL application, which could have a financial impact on the CCGs, the level of which is currently unknown. (previously linked to mirrored risk 88 which is now closed) (HISTORIC ID: 243)	June 2019 - The Community DoL development plan has been reviewed and presented with a report to the safeguarding steering group. The issue was also presented to the Quality Assurance Meeting for discussion around expectation of community teams. A number of annual renewals have come due across Livewell and DPT. The issues of staff time to complete the renewals is an ongoing issue which may affect the overall risk level and will be monitored (RA) April 2019 - Issues regarding staff time in DPT to complete applications has been escalated to CCG SLT (nursing directorate) (RA). [Control Gaps] July 2018 - The SDT CCG Designated Nurse for Safeguarding Adults is awaiting a meeting with the MCA lead for TSDFT to develop a process for informing and updating the CCG regarding patients managed by TSDFT (DG)	6 (L=2 x I=3)	Risk Opened: 26/04/2018 Reviewed: 20/06/2019	[12/12/2018] A development plan will be written up including clear actions to be appended to the report, a copy of this will be provided to the executive lead Rationale for closure: This development plan is complete and has been provided to the risk owner and the safeguarding steering group, [07/11/2018] A detailed report has been submitted to the risk owner and chair of the safeguarding steering group providing a comprehensive update on the risk, controls and assurances Rationale for closure: Any actions arising from this will be added in the December 2018 update, [07/11/2018] In July 2018 the Designated Nurse for Safeguarding Adults met with the Mental Capacity Act (MCA) Lead and Safeguarding Adults Operational Manager on 1st August and agreed a range of actions to support the CCG in: * knowing the number of healthcare funded patients managed through TSDFT * knowing of these who either requires approval from the CoP and how TSDFT has triaged them or has received approval from the CoP * understand how TSDFT as an organisation is management the risk within the zones once the cases have been triaged and passed to the zone The Safeguarding Adults Operational Managers is raising this with the TSDFT Director of Operations (Community) and the Associate Director of Adult Social Care April 2019 - the above bullet points will all be addressed during a meeting with TSDFT the week commencing 15/04/19. Action to remain open (RA) June 2019 - This action was discussed at the meeting in April although feedback from the meeting still awaited. Request from RA for this action to be closed on the RR and be managed via the Community DOL development plan (RA), [17/05/2018] Risk to be added also to the NEWD Risk Register although monitored via SD at SDT CCG (risk 390),	June 2019 - The Community DoL development plan has been reviewed and presented with a report to the safeguarding steering group. The issue was also presented to the Quality Assurance Meeting for discussion around expectation of community teams. A number of annual renewals have come due across Livewell and DPT. The issues of staff time to complete the renewals is an ongoing issue which may affect the overall risk level and will be monitored (RA) May 2019 - The CCG met with TSDFT and agreed line of communication about community deprivation of liberty. Further work is required to identify commissioner for those identified by TSDFT. System to replace DoLs and need for court applications for community DoL has finised passage through parliament and is awaiting royal assent. Community DoL development plan ot be reviewed to consider where best to focus resources to prepare for change of legislation. The risk score has been reviewed against the risk management framework policy and therefore not appropriate to reduce the score at this time. There was a recent ombudsman judgment against a local authority for failing to comply with the law in this area, so the attention on the issue is not reduced due to the upcoming LPA changes (RA) [Assurance Gaps] May 2018 - SGA Lead is due to meet with DPT and discuss a process similar to that with the CHC team in SDT (DG) April 2018 - The demand on care coordinators which impacts on their ability to undertake necessary work is reviewed by the control centre and it will be necessary for communication between the safeguarding steering committee and the quality/CHC team to monitor the risk (RA)	Executive Lead: Lorna Collingwood-Burke Owner: Michelle Thornberry	9
38	To improve collaborative working arrangements with communities promoting self-care, prevention and make continuous improvements in health and wellbeing for the population of Devon	As the CCG increases its level of collaborative working within the STP and as part of the wider Devon sustainability & transformation plan governance arrangements, there is a risk that it may fail to adhere appropriately to one or more of its statutory duties or internal governance requirements, thus potentially failing in one or more of its legal duties. (HISTORIC ID: 319)	The CCG is undertaking work to strengthen its internal governance and risk management mechanisms. The CCG is engaging with system partners to develop appropriate governance structures and mechanisms to support system working. These governance arrangements will ensure each organisation is able to meet its statutory requirements whilst working together to deliver system objectives. [Control Gaps] No agreed governance arrangements for the system. No agreed governance lead to undertake the work	6 (L=2 x I=3)	Risk Opened: 10/10/2016 Reviewed: 21/05/2019	[21/05/2019] 14/05/19 – Review of governance arrangements for STP to be undertaken GS, [27/06/2018] 26/06/18 OD work commenced by Accountable Officer with Directors,	Review by PA consulting under discussion by system partners. All organisations have their own processes for risk management and decision making and these take priority over system arrangements. [Assurance Gaps] Lack of non-executive oversight of system working and decision making. Lines of accountability from the STP to statutory organisation are not clear	Executive Lead: Ginny Snaith Owner: Clare Doble	12
39	To ensure that the organisation contributes to system financial balance and maintains improvements in efficiency, productivity and sustainability for the wider benefit of the NHS	There is a risk that the CCG will fail to meet its requirements to have its assurance status restored due to non-delivery of one or more of the NHS England components, which will impact on the CCG's reputation and public confidence. Components include: Domain 1 – Better Health Domain 2 – Better Care Domain 3 – Sustainability Domain 4 - Leadership (HISTORIC ID: 328)	Action plans are monitored, maintained and updated quarterly (as a minimum) and performance against assurance requirements are presented to Governing Body no less than quarterly. [Control Gaps] no gaps identified	6 (L=2 x I=3)	Risk Opened: 10/10/2016 Reviewed: 21/05/2019		We have regular quarterly meetings in place with NHS England. Assurances are provided to Governing Body through regular reports following NHS England updates. [Assurance Gaps] no gaps indentified	Executive Lead: Ginny Snaith Owner: Clare Doble	13

19	To make continued improvements in performance against core standards to deliver measurable results	There is a risk that intermediate care placements cannot be placed out of area whilst we await new funding agreement for primary care from TSDHFT. The impact of this is that it will increase admissions to hospital and/ or delay discharge from hospital if places are not available. (HISTORIC ID: 161)	ICO and localities are co-designing a proposal for medical cover which will form a key component of the new model of care. The CCGs CFC and SLT meetings are overseeing the implementation of the new model of care. The Care Model Operational Delivery Group and the Finance Committees in common are overseeing the implementation and delivery of the care model. [Control Gaps] No gaps identified	6 (L=2 x I=3)	Risk Opened: 09/12/2015 Reviewed: 18/06/2019	[18/06/2019] May 2019 - propose close risk as contracts with GP practices in place. , [08/08/2018] April 2018: The Collaborative Board is reviewing the revised proposal from the Trust. Aug 2018 - SPCCB and the LMC have worked with TSDFT to define contracts ,	TSDHFT and the LMC are co-designing a proposal for medical cover which will form a key component of the new model of care. IC contracts are in place with practices [Assurance Gaps] No gaps identified	Executive Lead: Sonja Manton Owner: Jenny Turner	9
92	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk that a combination of reduced infection prevention and control (IPC) capacity within the joint CCGs, combined with systemic issues in accessing, analysing and storing the necessary primary care data, will result in a failure to achieve the E coli bloodstream infection audits requested within the national Quality Premium: * Part a - ii. Collection and reporting of a core primary care data set for all E coli BSI in Q2-4 2017/18. This will require completion of requisite data through the existing Public Health England Data Capture Set (PHE DCS) reporting system for E coli BSI and the refined data collection for primary care related aspects. Collection and reporting of a core primary care data set for all E coli BSI will continue during 2018/19. The impact of this is reputational, in that the CCGs will not achieve a nationally set objective; financial, in that the CCGs will not be eligible for this aspect of the Quality Premium payment (~£150,000, with a further ~£300,000 for reduction of E coli bloodstream infections based on this data); patient safety, in that the CCGs will not have the information recommended nationally to address the problem of E coli bloodstream infections. (previously linked to mirrored risk 91 which is now closed) (HISTORIC ID: Na)	2019 June - The Community Infection Management Service (CIMS) has now received funding approval through the prevention work streams of the finance plan for 19/20. We are now progressing at pace to implementation, setting out key activities and milestones. We will be providing a monthly update report on progress (LW) 2019 May - The CCG continue to await confirmation of the approved funding to enable the CIMs to progress to implementation/recruitment. I have been advised that further discussion on the schemes within the prevention finance allocation for 19/20 is taking place the w/c 13/05/19. I understand that we are also awaiting approval through NHSE as part of the CCG overall financial plan (LW) 2019 April - Continued discussions with NHSE at SW IPC meeting. Job description for System IPC lead post drafted and progressing to job evaluation. Awaiting confirmation on agreed funding for additional posts within providers to enable recruitment to commence (LW) 2019 March - Role definitions / JDs and service specification for CIMS are drafted and a task and finish group comprising microbiologists, IPC specialist nurses and DIPCs from across Devon with the CCG Nursing & Quality Directorate is working to progress this (LW) [Control Gaps] 2018 July - * There is no mandated requirement for current acute/community providers to report on or review primary care Ecoli infections and this is defined in the guidance as a CCG reporting requirement from 18/19 (Q2). * Outline business case not yet approved.	6 (L=3 x I=2)	Risk Opened: 06/07/2018 Reviewed: 02/07/2019	[06/08/2018] August 2018 - LW had further discussions with NHSE and other CCG areas as also experiencing challenges in undertaking this aspect of the Quality Premium (QP). Small test of data collection from 26 hospital records to ascertain how much of this data can be extracted easily, however these are patients that have had an admission. Draft QEIA completed to supoort the outline business case for CIMs. Next actions: Review evidence that could be used to support the QP (LW) Rationale to close action: This review info was previously fedback to NHSE and has been discussed since at the SW IPC meeting. It was also reported as part of the IPC report to QCiC back in Nov or Dec 2018 . Action to be closed,	2019 July - Monthly progress reporting against the implementation of the community infection management service is now underway through the STP prevention work stream monitoring group. Risk score reviewed and remains unchanged at present until release of funds to enable recruitment within providers has occurred and the service specification is agreed across CCG and provider contract managers (LW) 2019 February - Further discussion with NHSE and neighbouring CCGs about actions taken to evidence work within the Quality Premium and a SW regional Infection Control Committee has commenced to share challenges and ideas with NHSE. LW attended the SW Infection Control Committee on 29th January. The proposal for a Community Infection Prevention Service for Devon was discussed and supported at Devon Clinical Cabinet on [Assurance Gaps] * Engagement with primary care * Regular formal engagement with acute IPC teams	Executive Lead: Lorna Collingwood-Burke Owner: Lorraine Webber	10

45	To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome	There is a risk to Children and Young People who are waiting longer to start treatment for Speech and Language Therapy (SALT) services (HISTORIC ID: 360)	It was agreed that 92% of children and young people should be on an incomplete pathway of care within 18 weeks of their referral to the service. When a threshold is not achieved the Speech and Language Therapy Service Provider (Virgin Care Integrated Children's Services) is required to provide an exception report to the Commissioners that outlined details of how the potential impact on the CYP is being managed. What has been done: Within the last 12 months additional resources have been committed to ensure that children and young people can access speech and language therapy services within the commissioned timescale. It has been agreed that additional reporting requirements will be in place to ensure that access after the initial appointment continues to comply with clinical appropriate access standards. VCL ICS are actively engaged in the wider STP review of Speech and Language Services/Support (Improving Access to Communication Services/Support Project). This project is currently at the understand phase – mapping out what is on offer from all main providers in relation to Speech, Language and Communication Needs across 3 tiers of provision (universal, targeted and specialist) in relation to: Family support Environment Training Identification Intervention The project will also focus on capacity and sustainability of provision across the all providers (whole system approach). Our most recent reports from Virgin Care Integrated Children's Services indicate: 94.44% of children and young people were seen within the 18-week period. (1.34% increase from previous reporting period). The median length of time between referral and start of treatment was 8.3 weeks Longest wait: 53.7% (increase) 44 Children/Young People waited more than 18 weeks. Overall there continues to be improvement in performance. [Control Gaps] Control Gaps Commissioners require additional information and evaluation of the current challenges: The threshold for access has not been achieved.	6 (L=2 x I=3)	Risk Opened: 07/02/2017 Reviewed: 31/05/2019		Assurances are gained via the Contract Review Meeting for VirginCare Ltd [Assurance Gaps] Local SALT/ language and communication model of care and the pathways for language and communication across universal to specialist provision needs a review and re-modelling. The changes need to support a sustainable improvement in waiting times.	Executive Lead: Simon Tapley Owner: Sharon Matson	11
49	To make continued improvements in performance against core standards to deliver measurable results	There is a risk that there will be inappropriate access to CCG records, due to confidential documents not being stored correctly and desks not being cleared, this will impact on patient, staff and corporate records confidentiality (HISTORIC ID: 296)	28/05/2019- There has been a change to this risk relating to inappropriate access to CCG data as all CCG sites now have smart-card restricted access since moving away from Newcourt House. County Hall has a hot-desking system in place to assist with data security, however this is not universal. Pomona House and Crown Yealm House still have personal desks and desk drawers rather than lockers. Additionally, in County Hall, office space is now shared with Devon County Council. It was noted that all staff have a responsibility for their personal area and that there is a clear desk assessment form within the policy for use by business managers. MS will need to undertake further clear desk assessments following the site changes. KK noted that there has been a recent proposal for access for printers to be via smart-card rather than a PIN system, which would increase printer security. It was agreed that due to significant changes in accommodation and processes, this risk would be closed, and a new risk opened following feedback from clear desk assessments 06/12/2018 - All necessary mitigating actions in place at Newcourt House, the corporate office is locked when unoccupied and manned from 8.00am to 6.00pm. Confidential waste bins are in place and actively used and checked by the IG Manager on a routine basis. Where confidential information is in offices, this is the responsibility of the officer to lock away at the end of the day in line with clear desk policy. The accommodation move is underway for staff to move to County Hall A CCG wide clear desk policy has now been ratified. The document includes assessments which will be completed by the IG Department. 10/10/2018 as part of merger data cleansing and records management will form part of the responsibility of the transition merger group. This therefore forms part of a clear programme of work that will be undertaken during quarter3/4 [Control Gaps] Misuse of the unrestricted drive, including PID.	6 (L=2 x I=3)	Risk Opened: 05/07/2016 Reviewed: 28/05/2019	[13/03/2019] MS to raise at the next meeting of IGSG , [05/06/2018] Staff are aware of their personal responsibility through the mandatory data security & protection training, and the clear desk policy/inspections by business managers. ,	The clear desk policy is now in force and the Information Governance Officer is in liaison with business managers to ensure it has been communicated, actioned, reviewed and reported in their departments. Access to buildings/areas in all but one site (Newcourt) is via secure electronic entry. Newcourt has keypad locks for all external doors and visitors pass through reception for access. [Assurance Gaps] Reviews will also be taking place on CCG Unrestricted shared drive.	Executive Lead: Ginny Snaith Owner: Clare Doble	8

59	To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon	Risks are a combination of Clinical (lack of timely diagnosis leads to poorer outcomes), financial (implications for Better Care Fund and Quality Premium)and reputational (NEW Devon CCG lags behind SW and England average). Likelihood score remains at 5 due to continuing likelihood of failing to achieve the target.Given the issues described below it would seem that achievement of diagnosis rates is unlikely and as a result this score should remain at 5. The impact score remains reduced as the risk to patients is relatively small given the assurance in the template about providing support appropriately to carers, maintaining the overall risk score at 10. There are concerns that over the last 3 years we have spent a lot of time, energy, resources in increasing the dementia prevalence. Over the last year our CCG (and nearly all CCGs in the south west) have found the prevalence rates plateau, despite further work streams. We felt this demonstrates that unless you throw vast resources at it, we are unlikely to improve significantly. We unanimously felt this would be wrong when considering dementia care as a whole. Most importantly, the figures of the predicted rates have been questioned via Public Health and SCN Dementia Implementation Group and this has been fed back to NHSE as it supports our view that the blanket application of a 67% rate may be unachievable. For information 'The idea that there is a specific number to hit for a specific location from an overall national prevalence is not epidemiologically justified and as a study we do not endorse such an approach'. CFASII Author (HISTORIC ID: 122)	Progress to date in raising awareness of increasing diagnosis has been via the following: Liaison with the Alzhiemer's Society, who run the Dementia Adviser Service, to increase collaboration with General Practice. This has been well received and it is anticipated that representatives of the organisation will attend each locality meeting before April 2018. A gap analysis has been sent out to organisations, voluntary sector and statutory to see what services are available across Devon and to identify gaps and areas of good practice which can be expanded. A diagnosis audit will be undertaken at each of the four acute hospitals to increase awareness of diagnostic pathways. Liaison with Patient Groups to support awareness of Dementia Diagnosis, including events run by the voluntary sector and Alzheimer's Society. [Control Gaps] There are difficulties in Patients self-identifying/referring themselves for Cognitive Impairment Assessments (Stigma) GPs understanding the value of a Dementia Diagnosis and therefore not referring or diagnosing as appropriate In some areas there are simply not the numbers of individuals with Dementia as per the prevalence due to the demographics within Devon.	4 (L=4 x I=1)	Risk Opened: 16/06/2014 Reviewed: 25/06/2019	[25/06/2019] The risk will be reviewed again on the 2nd July and further updates will be included in the next update in July. Derek O'Toole 25 June 2019, [14/11/2018] It is being clarified as to whether this risk is a duplication of risk 80 and it has been suggested that it should be a whole Devon risk. This is being reviewed. ,	Latest figures indicate NEW Devon continues to achieve a diagnosis rate of around 60%. David Jenner instigated a recent meeting with the National Clinical Director for Older People's Mental Health (the portfolio includes dementia) at which it was agreed that more work was needed to see if the prevalence assumptions are accurate. We continue to oversee our diagnosis rate action plan through the OPMH Steering Group which focuses on some key areas: • systematise follow up of people identified as part of the Acute Trust CQUIN. • Clear information for GPs about the Memory Assessment process and post diagnosis pathway. • Raise the profile of post diagnosis services • DeAR GP option initiated by GPs in partnership with their local care homes • simple toolkit for GPs to develop dementia friendly GP practices • build on award winning care home support examples to improve identification/outcomes for people with dementia in care homes • Continuing focus on data accuracy [Assurance Gaps] None	Executive Lead: Jo Turl Owner: Derek OToole	10

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Revised Renumeration Committee Terms of Reference				
Date of committee: 25/07/2019 **Date report produced: 18/7/19**				
Author (s) Name and Title: **Ginny Snaith – Board Secretary** **g.snaith@nhs.net**		**Supporting Executive:** **Name and Title:** **Report Approved by:** **Name and Title:**		
Public or Private (Governing Body only):	**Public**	√	**Private**	

Executive Summary:

These revised Terms of Reference for the Renumeration and Workforce Committee reflect an extension of the Committee's remit to include assurance on wider workforce issues and the CCG's role as a partner in system working.

Management of Conflict of interests:
Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.

Committees that have previously discussed/agreed the report and outcomes:

Remuneration Committee – 28th May 2019

Key recommendations and actions requested:

The Governing Body is asked to approve the Terms of Reference.

Impact on Strategic Objectives		
Reference to other documents or accompanying papers:		
Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality	Safety: Effectiveness: Experience:	No No No
Equality	Improved assurance on strategic workforce management and reporting of equality issues	
Resource and Finance		No
Legal		No
Engagement and Consultation		No
Risk		No

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

NHS Devon Clinical Commissioning Group

Remuneration and Workforce Committee
Terms of Reference

1. Constitutional Obligations

1.1. The Remuneration and Workforce Committee of NHS Devon Clinical Commissioning Group is established in accordance with its Constitution, standing financial instructions, standing orders and scheme of delegation.

1.2. These terms of reference set out the Membership, remit, responsibilities and reporting arrangements of the Committee.

1.3. The Remuneration and Workforce Committee of 'the CCG' is a Non-executive Committee of the Governing Body and has no executive powers other than those specifically delegated in this Terms of Reference or through the Constitutional scheme of delegation.

2. Purpose

2.1. The purpose of the Remuneration and Workforce Committee is to provide assurance and oversight of all aspects of strategic people management and organisational development; recommending the appointments, determinations regarding matters of remuneration to the Governing Body, fees and other allowances for employees and for people who provide services to the CCG, and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS Pension Scheme. The Remuneration and Workforce Committee has clear delegations for decision making which are set out in the Scheme of Reservation and Delegation.

3. Responsibilities

3.1 The Remuneration and Workforce Committee will apply best practice in the decision-making processes, for example, when considering individual remuneration, the committee will:

- Comply with current disclosure requirements for remuneration;
- On occasion seek independent advice about remuneration for individuals,
- Ensure that decisions are based on clear and transparent criteria.

- Advise ‘the CCG’ Governing Body of the approval process for recruiting and appointing Governing Body and other Executive Team Members, including any interim or off- payroll arrangements.
- Ensure all arrangements are in line with NHS England/DH/SoS/HMRC directions e.g. 02.06.15 Financial Controls Letter, CCG Remuneration Gateway Publication 03656 etc.
- Make recommendations to Governing Body on any proposed remuneration and terms of service for clinical and non-clinical Governing Body Members, taking into account any national or local guidance as necessary, so as to ensure that the individual is fairly rewarded for their individual contribution to the CCG, whilst having proper regard to ’the CCG’ circumstances and performance. This shall include all aspects of salary (including any performance related elements or bonuses), provisions for other benefits and any other contractual terms.
- Advise ‘the CCG’ Governing Body on pay policy and any annual award for all employees of ‘the CCG’ including, pensions, remuneration, fees, travelling or other allowances payable to employees and to other persons providing services to ‘the CCG’. This includes overseeing the implementation of appropriate contractual arrangements for staff and clinicians, including the proper calculation and scrutiny of termination payments, excluding ill health and normal retirement, taking into account such national guidance as is appropriate.
- Monitor and advise on succession planning for the Executives residing on Governing Body and VSM senior team Members, to ensure there is a process for identifying and developing internal staff and clinicians with the potential to fill key leadership positions in ‘the CCG’ in accordance with NHSE Guidance, ‘the CCG’ Constitution, standing orders and any associated documentation, whilst taking into account the challenges and opportunities facing ‘the CCG’, and what skills and expertise are therefore needed in the future.
- Ensure that all provisions regarding disclosure of remuneration, including pensions, are fulfilled.
- Consider any payments, in addition to salary, for very senior managers (VSM) and where appropriate ensure that any approvals are sought such as seeking HM Treasury approval as appropriate and bringing these to the attention of the governing body for approval.
- Provide assurance to the Governing Body on the CCG’s arrangements for strategic people management and Organisational Development including the management of risks relating to these areas.
- Ensure that the CCG is meetings its obligations in relation to reporting on workforce issues including (but not limited to) senior pay and equality and diversity (including gender equality).
- At the request of the accountable officer, to advise on exceptional payments to staff outside of the Governing Body.

- Ensure that the CCG has the appropriate governance arrangements for the recruitment, employment and remuneration of "hosted" staff on behalf of other organisations.
- Authority to establish Sub-Committees.
- The Committee has full authority to commission any reports or surveys it deems necessary to help it fulfil the remit outlined above.
- Performance management of the Accountable Officer.
- The committee will not discuss Non-Executive Lay Member remuneration or succession planning of these positions. This will be discussed at a meeting convened by the NHS Devon CCG Chair and most appropriate senior officer(s), guided by the national framework and with support from HR and Governance. The Business Manager for REMCO will formally note the minutes and any actions in accordance with section 11 of these terms of reference.

4. Membership

The core Membership of the Remuneration and Workforce Committee shall be:

- Four Non-Executive Lay Members*
- Secondary Care Doctor
- CCG Chair (Non-voting)

*The Chair of Remuneration and Workforce Committee cannot be either the CCG Chair or the Audit Chair.

Agenda and minutes will be shared with all Non-Executive Lay Members to enable them to offer comment and consideration, ahead of the committee meeting, to support the Chair and the core Members of the Committee in their decision making.

Senior representation from Human Resources or from Governance will be in attendance in an advisory role to support the Remuneration and Workforce Committee in its work but do not form part of the Membership. The attendance of such staff Members will be subject to invitation from the Chair of the Remuneration and Workforce Committee.

Additionally, the following individuals may be invited to attend for all or part of the meeting, providing their own remuneration or terms of service are not being discussed:

- Accountable/Chief Officer
- Chief Operating Officer
- Chief Finance Officer

In addition, external advisors can be called upon as required by the Chair of the Committee.
The Chair may request any external advisors clinical or senior officer to attend should their presence be required to assist the Members of the Committee. Any such invited attendees will be asked to verbally declare any interests to ensure no conflict of interest exists upon their attendance.

5. Quorum

5.1. A minimum of three Non-Executive Lay Members will constitute a quorum.

5.2. A decision put to a vote at the meeting shall be determined by a majority of the votes of Members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

5.3. People invited to attend the Committee do not have the right to vote.

5.4. If the Chair is absent then the Members of the Committee will select a chair for that meeting from the Non –Executive Lay Members present, this cannot be the CCGs Audit Chair or CCG Chair – this will be overseen by governance to ensure that no conflicts arise, and that the Committee remains quorate

6. Register of Interests

6.1 Members and attendees will be asked by the Chair of the Remuneration and Workforce Committee to declare any interests at the beginning of each meeting. If a Member or attendee feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

7. Frequency of Meetings

7.1 The Remuneration and Workforce Committee will meet at least four times a year to discharge its duties with extraordinary meetings held as required and in line with the corporate calendar.

7.2 The Remuneration and Workforce Committee has agreed that in the interest of expediency or when there are few items to be discussed that business of the committee can be conducted by e-mail and the actions/decision will be recorded by the Administrator for purposes of transparency and recording. Where a discussion is required, all Members

must respond, and the administrator will oversee this to ensure that all Members are accounted for.

8. Reporting Arrangements

8.1 The Remuneration and Workforce Committee Chair shall report formally to the Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the confidential meeting of 'the Governing Body. The Remuneration and Workforce Committee shall make recommendations to the Governing Body on any area within its remit where action or improvement is needed.

8.2 Minutes and reports of the meetings will be confidential. The committee minutes may be shared with voting Members of the Governing Body, the senior officer of governance and the Associate Director of HR & OD, for NHS Devon CCG.

8.3 Extracts from minutes will be made public as appropriate.

9. Risk Reporting

9.1 Where timeliness is of the essence in managing a significant risk or issue, the Chair of the Remuneration and Workforce Committee will be informed of an issue by the quickest possible means (e.g. verbally) and this will be acted upon in accordance with the CCGs risk management framework.

10. Statutory Functions, Committee Oversight and KPIs (Internal Monitoring)

10.1 The Remuneration and Workforce Committee shall act in accordance with the scheme of reservation and delegation to ensure Constitutional compliance. Any deviation from this must be brought to the attention of the most senior officer of Governance.

11. Administration

11.1 The Committee will be formally minuted by a designated administrator. Agendas and papers will be available three working days before the meeting is scheduled to take place. A formal attendance and action and decisions log will be held and reported to each meeting.

12. Review

12.1 An annual effectiveness review will be undertaken by the Head of Governance as good governance practice and to ensure compliance with the Annual Governance Statement of internal control.

12.2 These Terms of Reference will be reviewed on an annual basis or sooner if required through the Head of Governance with recommendations made to the Governing Body for approval by the Chair of the Remuneration and Workforce Committee.

END

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: How the CCG is planning to enhance engagement with key stakeholders – an action plan following the IPSOS MORI 360 report					
Date of committee: 25 July 2019 **Date report produced:** 13 July 2019					
Author (s) Name and Title: Andrew Millward, Director of Communications and HR Contact details: andrew.millward@nhs.net		**Supporting Executive: N/A** **Name and Title: N/A** **Contact Details: N/A** **Report Approved by:** Andrew Millward **Name and Title:** Director of Communications and HR **Contact Details:** andrew.millward@nhs.net **Date:** 13 July 2019			
Public or Private (Governing Body only):			**Public**	☞	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**		**Information** ☞
Does this report place individuals at the centre?			**Yes**	☞	**No**

Executive Summary

Over the past year our CCG has changed its approach to engaging with key groups – from member GPs to MPs, and from patient groups to local communities. As part of this we have implemented new ways of engaging with local people, such as digitally with mothers on 'Better Births' and a more positive approach to talking and meeting with communities, such as in Okehampton, Sidmouth and Holsworthy.

Our efforts and our new approach have been positively recognised externally:

1. NHS England has just released its annual ratings – called the *2018-19 CCG IAF Patient and Community Engagement Indicator* – and rated both our former CCGs as **'Green Star'** for the past year. In the five domains that contribute to the overall rating – we were rated as 'outstanding' for 8 out of the 10 domains for our engagement work.

2. Ipsos MORI's 360 survey of all CCGs earlier this year showed that Devon CCG had vastly improved its relationships with key stakeholders across the county. These results were regarded as very positive in the NHS England Annual Assurance Meeting, as they were in sharp contrast to the very mixed picture of both our former CCGs when they were assessed in 2017/2018. The results showed that:
    - 84% of stakeholders said they had a very/fairly good working relationship with the CCG.
    - 67% said the CCG was an effective local system leader.

Despite the improvements over the past year, this paper outlines in summary our Action Plan for the year ahead. Building on our new approach to stakeholder engagement, our Action Plan focuses on how we intend to enhance engagement with a range of defined stakeholders.

The key stakeholders we are focused on for 2019/20 are as follows:

1 GPs and Member Practices.
2 OSCs and Health and Well Being Boards.
3 MPs.
4 Other local politicians at county, district and town level.
5 Healthwatch.
6 Patient groups, PPGs and voluntary sector organisations.
7 Local communities.
8 System partner organisations.

This paper covers the actions we intend to take with these stakeholders in the year ahead.

Management of Conflict of interests:
Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.

Committees that have previously discussed/agreed the report and outcomes:

N/A

Key recommendations and actions requested:

This report is for information only.

Reference to other documents or accompanying papers:

N/A

Have the legal implications been considered?

N/A

Equality Impact Assessment:

Who does the proposed piece of work affect?	**Patients**	✓	**Carers**	✓
	Staff	✓	**Public**	✓

	Yes	No
1. Will the proposal increase discrimination for people in protected groups?		✓
2. Will the proposal reduce discrimination for people in protected groups?		✓
3. Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		✓
4. Will there be a positive benefit to the patients or workforce as a result of the proposed work?		✓
5. Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?		✓

If the answer to any of the above questions is yes (other than questions 2 and 4) or you are unsure of your answers to any of the above, you should provide further information using **Quality and Equality Impact Assessment**. If a quality and equality impact assessment is not thought to be required briefly explain why and provide evidence for the decision.

***Please add N/A if any of the sections are not relevant*

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

How the CCG is planning to enhance engagement with key stakeholders – an action plan following the IPSOS MORI 360 report

Introduction

Over the past year our CCG has changed its approach to engaging with key groups – from member GPs to MPs, and from patient groups to local communities. As part of this we have implemented new ways of engaging with local people, such as digitally with mothers on 'Better Births' and a more positive approach to talking and meeting with communities, such as in Okehampton, Sidmouth and Holsworthy.

Our efforts and our new approach have been positively recognised in NHS England's recent engagement ratings and the MORI survey undertaken earlier this year.

NHS England annual engagement rating

NHS England released its annual ratings earlier this month (5 July 2019) – called the *2018-19 CCG IAF Patient and Community Engagement Indicator* – and rated both our former CCGs as '**Green Star**' for the past year.

In the five domains that contribute to the overall rating – we were rated as 'outstanding' for 8 out of the 10 domains for our engagement work.

This is the first time we will have received this rating, as formerly both CCGs were 'Amber' rated.

NHS England annual 360 degree survey of stakeholders, undertaken by Ipsos MORI

As you are aware, each year Ipsos MORI conducts a 360 survey of CCGs across the country to measure how effectively they manage relationships with key stakeholders – from GP Member Practices to leads of Health and Well Being Boards, and from Healthwatch to patient and voluntary groups.

The MORI 360 results for 2018/19 (where we were rated as Devon CCG as a whole) were released on 3 April 2019 and show that:

- **84%** of stakeholders said they had a **very/fairly good working relationship with the CCG.**
- **67%** said the CCG was an **effective local system leader.**
- **74%** said that the CCG **considers the benefits of the whole health and care system when making a decision**.
- **73%** said that the **CCG works collaboratively with system partners** to improve the health of the population.
- **85% of Member Practices said that they had an effective working relationship with the CCG.**

These results were regarded as very positive in the NHS England annual Assurance Meeting, as they were in sharp contrast to the very mixed picture of both our former CCGs when they were assessed in 2017/2018.

The assessment in 2017/18 highlighted major differences between the views of stakeholders of both CCGs. This is illustrated in two examples:

- **57%** said they had a very/fairy good "working relationship" with NEW Devon CCG, compared to **89%** in South Devon and Torbay CCG.
- **52%** of stakeholders said that NEW Devon CCG was very/fairy effective in its role as an "effective system leader", compared to **78%** in South Devon and Torbay.

The results for 2018/19 are very promising as it shows we have moved all our scores up towards the levels achieved by the former South Devon and Torbay CCG. That means our engagement for the whole of Devon almost matches that undertaken previously on a much smaller scale.

Despite the improvements over the past year, this paper outlines in summary our Action Plan for the year ahead.

Our Action Plan for 2019/20

Building on our new approach to stakeholder engagement, our Action Plan focuses on how we intend to enhance engagement with a range of defined stakeholders.

The key stakeholders we are focused on for 2019/20 are as follows:

1. **GPs and Member Practices.**
2. **OSCs and Health and Well Being Boards.**
3. **MPs.**
4. **Other local politicians at county, district and town level.**
5. **Healthwatch.**
6. **Patient groups, PPGs and voluntary sector organisations.**
7. **Local communities.**
8. **System partner organisations**.

This paper covers the actions we intend to take with these stakeholders in the year ahead, and more detail is covered overleaf.

1. GPs and Member Practices

Earlier this year, we met with a range of GPs, practice managers and other staff to discuss how we could enhance engagement with primary care. A paper was produced and shared with our locality GP leads. The paper contained 18 recommendations for improvement.

Some of these have already been actioned this year, for example:

- The communications team works closely with the primary care team to advise on and help develop agile communications channels within – and across – the new primary care networks.
- The communications team works to further strengthen links with the LMC, keeping channels open with LMC comms.
- An intensive schedule of engagement is pursued to make the new chair known and accessible to general practice across the localities.
- The two separate CCG bulletins are merged into a single, weekly GP update, absorbing the need-to-know content that would currently be in the NHS England weekly commissioner bulletin.
- The Chair and Governing Body members do more to engage through Twitter, demonstrating that they are engaging with the health and care community and are open and accessible.

Future actions for the year ahead include the following:

- The communications team have a designated lead on communications and engagement with primary care, who works at a strategic as well as transactional level and forms close working relationships with the primary care team and with general practice/LMC. This is in hand.
- The communications team support the wider CCG in developing and publicising a leadership development programme for those in the primary care networks and federations, and in actively seeking out networking opportunities/peer support events for the new organisations.
- The communications team builds relationships with practice managers by attending their forums where practicable. This would be a role for a designated primary care communications specialist, when appointed.
- Each of the GP locality leads visit one or more of the other localities' GP forum meetings or Collaborative Boards once a year
- A number of GP practices are visited by Governing Body members in the first year of the merged CCG.
- To reduce the email burden on general practice, the CCG encourage partner organisations and internal CCG teams to send their bulletins/news/requests to the communications team, for distribution as links in the weekly update.
- Emails from GPs be acknowledged within 24 hours and replied to in full within three days, unless extra time is needed to gather information.

2. OSCs and Health and Well Being Boards

During the past year, we have put a lot of focus into managing relationships with Overview and Scrutiny Committees (OSCs) and Health and Well Being Boards, briefing them in advance and seeking their views on direction of travel. We have:

- Coordinated face-to-face briefings through the creation of a central contact point for public affairs.
- Focused one of our team on fostering better relationships with members and council executive teams, including having regular officer-to-officer telephone calls and meetings.
- Created a monthly corporate briefing document that is shared with stakeholders including Overview and Scrutiny committees and Health and Wellbeing Boards about CCG business.
- Developed a “heads up” approach to information sharing so that members are not surprised by NHS announcements.

Future actions for the year ahead include the following:

- Developing a digital dashboard which will detail OSC/HWB reports, emerging local issues, and further engagement opportunities. To be available to all CCG directors via Office 365.
- Creating a shared engagement post with Devon County Council to increase collaboration and links.
- Introducing preparatory briefings and formal meetings with Overview and Scrutiny and Health and Wellbeing Board members on important issues.
- Developing an advanced schedule of meetings so that we have a planned approach to taking issues to formal OSC and Health and well Being Board meetings.
- Establishing Chair/Chief Officer meetings with OSC/HWBB Chairs twice a year to provide strategic overview and suggest areas that members may find useful as part of a spotlight reviews.
- Revisiting pairing of CCG Directors with Overview and Scrutiny Committees and Health and Wellbeing Boards Chairs to aid information flow and develop closer working relationships.

3. MPs

During the past year, we have put a lot of focus into managing relationships with MPs, briefing them in advance and seeking their views on direction of travel. We have:

- Introduced more face-to-face meetings between MPs and the CCG Chair and Chief Officer.
- Made it standard practice that only senior managers brief MPs.
- Coordinated face-to-face briefings with MPs through the creation of a central contact point for public affairs.

- Created a monthly Corporate Briefing document that is shared with stakeholders including MPs and their offices.
- Developed a “heads up” approach to information sharing so that MPs are prepared for NHS announcements.

Future actions for the year ahead include the following:

- Joining “all MP” parliamentary briefings in London to bring elected members up to speed on significant issues. We will do this in association with Devon County Council in the first instance, and then broaden out the approach.
- Developing a digital dashboard which will detail MP correspondence and interactions plus emerging local issues, and further engagement opportunities. To be available to all CCG directors via Office 365.
- Monitoring MP activity on social media and respond positively where able
- Work with local groups (Holsworthy/Teignmouth etc) containing key influencers on MPs, recognising the importance of the impact that such groups have on elected representatives.
- Revisit possible pairing of CCG Directors with MPs to aid information flow and develop rapport.

4. <u>Other local politicians at county, district and town level</u>

There has been little focus on these specific groups in recent years. However, last year we started to really engage with local politicians at county, district and town level. Our approached has been recognised nationally by NHS England, who asked that we share our approach at a national conference in London.

Recent actions include:

- Involving local politicians in planning for the Long Term Plan process.
- Inviting local councillors to the launch event of the CCG and the CCG awards ceremony.
- Meeting and responding to key councillors on specific issues at their request.
- Writing to newly elected councillors to congratulate them and build relations.

Future actions for the year ahead include the following:

- Moving from a reactive to a proactive approach to councillors
- Encouraging councillors (as key influencers) to join and lead local groups (Holsworthy/Teignmouth etc) with the aim of educating and informing the wider community.
- Promoting councillors in media statements/releases that support the overall direction of travel of the NHS.
- Mapping county, district and town councils to update contact details.

5. Healthwatch

The three Healthwatch groups have been a big priority of our communications efforts in recent years. Recent actions include:

- Instigating regular monthly meetings with Healthwatch Chairs and Chief Officers from across the county to provide strategic updates.
- Inviting Healthwatch officers to contribute to NHS heads of communications meetings and engagement planning.
- Commissioning Healthwatch to independently analyse survey results.
- Inviting Healthwatch to attend other CCG meetings so as to use their expertise in engagement.
- Facilitating closer working between patient participation groups (PPG) and Healthwatch by reinvigorating the Devon PPG network.
- Creating a monthly corporate briefing document that is shared with stakeholders Healthwatch about CCG business.
- Part-funding Healthwatch Torbay's digital project across the county to support people to be digitally enabled.
- Developing a "heads up" approach to information sharing with Healthwatch.
- Coordinating media releases, providing Healthwatch with CCG quotes and spokespeople.
- Contributing CCG content to 2018/19 Healthwatch annual reports, recognising their input in to NHS business across Devon over the last year.

Future actions for the year ahead include the following:

- Introducing key people from the system to join our monthly Healthwatch meetings – for example Dame Suzi Leather now joins on an active basis.
- Commissioning Healthwatch expertise and independent analysis, where appropriate to do so
- Supporting Healthwatch to develop PPGs across Devon with the creation of a PPG toolkit.
- Involving Healthwatch in CCG-wide internal events.
- Increasing the availability of shareable communications content to make it easier for Healthwatch to use in their own channels.

6. Patient groups, PPGs and voluntary sector organisations

These groups represent the grassroots of our local communities and their involvement and experience is vital in the planning and delivery of local health and care services. As such, work has been underway for a number of years to develop and nurture relationships. Recent actions include:

- Creating a new post that will help us join up activity between the voluntary, community and social enterprise sector and the NHS.

- Better supporting the Devon PPG Network. The CCG is now actively involved in supporting the work and aims of this important Network.
- Supporting the launch of the very first annual PPG conference in Devon.
- Creating a monthly corporate briefing document that is shared with the Devon PPG Network about CCG business.
- Regular meetings with campaign groups – such as Save Our Hospital Services (SOHS) to build stronger relations.

Future actions for the year ahead include the following:

- The new VCSE lead will help us strengthen key relationships between the CCG, wider NHS and the voluntary, community and social enterprise sector.
- Introducing a bi-monthly PPG Bulletin, administered by the CCG, with written content provided by PPGs, for sharing best practice, ideas and events across all PPGs.
- Developing an up-to-date PPG Chair contact list to enable us to strengthen communications.
- Looking at how PPGs – who struggle with membership – can be strengthened by aligning them with our new Primary Care Networks.

7. Local communities

As with patient groups and the voluntary sector, the experience and involvement of local communities underpins the planning and delivery of local health and care services. Recent actions include:

- Introducing a new strategy for Devon-wide engagement which focusses on developing local plans with communities. This builds on the success of existing groups (such as Holsworthy, Sidmouth and Okehampton) and working with their members as advocates for their local communities.
- It aims to develop local communities to take action, mobilise and focus on health and care.
- Working with these groups can help to inform local NHS commissioning intentions.
- This has led to the approach being showcased nationally by NHSE and helped to improve local relationships an overall reputation.

Future actions for the year ahead include the following:

- Establishing four new community involvement groups in towns across Devon following the blueprint established in Holsworthy. This approach will shortly be rolled out in other towns in Devon.
- Ensuring we engage with people using methods and platforms that suits them, including social media and other digital methods
- Establishing a virtual voices panel of 1,700 members of the public online to enable us to better test and listen to people's views on key issues.

8. System partner organisations

System partners were particularly mixed in their attitudes towards the CCG in the most recent MORI survey.

This naturally reflected some of the big leadership changes that happened late last year, and so is likely to improve as we move forward.

The approach being taken by the Chair, Chief Officer and Directors is already strengthening current relationships and this will continue moving forward. Other actions will include:

- Utilising the plethora of face-to-face and other channels to build relations with system partners. These include PDEG and Collaborative board at senior level, but also Finance Working Group, the Heads of Communications Group and others at mixed levels.
- Holding more Exec to Exec type meetings with organisations.
- More regular meetings between the CCG Chair and system Chairs, and likewise at CEO, Executive and clinical levels.

NHS England's future plans

We are aware that NHS England has decided to cease the annual Ipsos MORI survey for CCGs.

However, we are committed to continuing to seek stakeholder views, therefore we will be putting in place plans for this feedback process to continue.

NHS
Devon
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GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee Public

Date of Governing Body: 25 July 2019

Dates of Committees covered in this report 11 July 2019

(Approved minutes of the 11 July 2019 Quality Assurance Committee meeting available as an addendum)

Chair's Name and Title: Glynis Atherton, Lay Member (Chair)

Contact Details: glynis.atherton@nhs.net

Reports discussed, and assurances received

- **Quality Risk & Assurance Report including Risk Register:** Please see below with regards to Risk Register Review (changes and pertinent areas).

- **Quality Assessment Framework (QAF) – including Flash Reports:** Northern Devon Healthcare NHS Trust (NDHT); Devon Partnership NHS Trust (DPT); Torbay and South Devon NHS Foundation Trust (TSDFT); Children and Family Health Devon; University Hospitals Plymouth NHS Trust (UPHNT); South Western Ambulance Services NHS Foundation Trust (SWASFT); Urgent Care (system)**; Devon Doctors (DDOC).**
- QAC remain not assured about the backlog of serious incidents (SIs) at DPT which has been escalated to a very senior level. DPT has provided a letter of assurance and progress will be monitored closely by QAC over the coming months.
- QAC are partially assured through the work of the CCG and Torbay and South Devon Foundation Trust quality teams that harm has not occurred however are not assured about the resilience, and sustainability of this position, should the Trust remain in a challenged environment.
- QAC noted other areas where there was partial assurance was noted and which will be kept under review by the Committee.

- **Theatres Efficiency Report**
  Theatre efficiency work is being undertaken in order to improve quality of planned care for patients across Devon. Further system wide actions are being considered. The CCG is currently assured by the system approach to improving quality of care for patients and that impact is being assessed by providers as they consider and plan next steps.

- **Yellow Card Development / Peer Improvement Tips for Care and Health (PITCH) Report:** QAC received a presentation providing an update on Yellow Card (in place since 2014) and the re-branding to PITCH (Peer Improvement Tips for Care and Health). The planned roll out will include Cornwall. The aim is to implement in the South West Peninsula a free and easy to use single electronic system to enable health and social care colleagues and volunteers to raise concerns and challenges within the system, highlight contributory factors and put forward solutions for improvement as well as to identify and share common themes and trends. Under delegated commissioning, PITCH also provides a route for general practice colleagues to raise Significant Events and formal serious incidents to the CCGs.

- **QEIA Annual Report:** QAC received a report that has been approved in principle by the QEIA Panel Chair and Deputy Chief Nursing Officer, to be formally ratified by QEIA Panel 11 July (pm). The report provided an overview of the QEIA progress within NHS Devon CCG during the financial year 2018/19. The report covered:
    - QEIA Activity 2018-19
    - QEIA Panel Developments 2018-19
    - Lookback Reviews
    - Equality Impact Assessment (EIA)
    - QEIA Promotion
    - Future Challenges and Next Steps.

- **Positive assurance: QAC asked that the Executive should be sighted on the following two items as exemplar pieces of work linking to the transformation and What Matters to Me agendas:**

- **Third Party Delegation:** QAC received a briefing report to describe the guidance document developed for Third Party Delegation of health care related tasks / interventions. Third Party delegation of tasks are for professional registered staff to delegate a health care task to a non-registered worker / carer or informal carer. QAC noted that Third Party Delegation is an identified risk on the CCG's risk register as it impacts on consistency of care across Devon, an individual's choice and personalised care options.

- **Verification of Expected Death:** QAC received a report outlining the guidelines for Verification of Expected Death (VOED) which sets out the expectations for VOED and who other than a doctor can undertake this with appropriate training. The guidance is for NHS Devon providers to adopt / adapt as their own policy. QAC recognised the amount of work that had gone into this guidance, the learning that this guidance has been based on, and the engagement with LMC, Coroners and providers across the system and endorsed the guidance for implementation.

Reports received and noted

In addition to the reports received and discussed above:

- None.

Risk Register Review (changes and areas of concern)

- QAC received a report that effective risk management processes are in place to identify, assess, manage and mitigate risk and inform of any changes since the last meeting of the QAC 13 June 2019. QAC noted that the risk data had been extracted on 25 June 2019.
- Of the 23 risks aligned to QAC, 19 of the 23 risks have been reviewed as at 10 July, with 4 risks remaining to be reviewed (all are high risks and were last reviewed on 02 December, 01 February, 01 May). This position was discussed at the Executive Senior Leadership Team Meeting and the relevant Executive Lead is ensuring that a review of these risks is underway.
- QAC noted that no new risks had been recommended to be added.
- QAC noted that there were no risks recommended for closure.
- QAC noted that risk 100 has been reviewed

Committee Decisions

- None.

Recommendations for Governing Body
• To note the reports received and positions of assurance by Quality Assurance Committee.
Recommendations for other Committees
• None.
Terms of Reference or other committee effectiveness issues
• None.

Management of Conflict of interests:

Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.

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

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GOVERNING BODY

Report title: Quality and Performance report				
Date of committee: **Date report produced:11/07/2019**				
Author (s) Name and Title: **Lorraine Webber – Associate Chief Nursing Officer (South & West) South** **Kelvin Grabham: Associate Director of Business Intelligence** **Karen Helliwell: Senior Information Specialist** **Contact Details: karen.helliwell@nhs.net**		**Supporting Executive:** **Name and Title:** **Kelvin Grabham – Associate Director of Business Intelligence** **Lorna Collingwood-Burke– Interim Deputy Chief Officer** **Contact Details:**		
		Report Approved by: **Name and Title:** **Date11/07/2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
For information and assurance				
Executive Summary: This report provides the latest information on key quality and performance indicators including those contained in the NHS Constitution. The report includes as an appendix the Improvement and Assessment Framework (IAF) indicators for the latest quarter.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				

None
Key recommendations and actions requested:
For information and assurance
Impact on Strategic Objectives
Reference to other documents or accompanying papers:
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality	Safety: Effectiveness: Experience:	
Equality		
Resource and Finance		
Legal		
Engagement and Consultation		
Risk		

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

Governing Body – Quality & Performance Report

July 2019

Summary

This report is based on validated nationally reported performance with the latest available data (at the point of this report being collated) being March 2019 for the majority of the indicators. However, it is important that the Governing Body are appraised of current performance across the STP and so where later un-validated data is available this is referenced in the performance commentaries.

Performance against the main constitutional standards is summarised below:

- A&E 4hr wait: performance remains challenging with June showing a decrease from 87.9% to 85.4% and TSD seeing performance fall from 84% to 80%. However, early July data suggests an improving position at around 88%.
- The STP level RTT position improved in May from 80.1% to 81.3% as all providers saw performance rise. Over 52 week waits continued to fall moving from 179 to 153 at STP level. TSD (59) and NDHT (8) both saw reductions in breaches with RD&E (71) flat and UHP seeing breaches increase from 49 to 57.
- All providers except for TSD saw increased diagnostics breaches in May with the STP position moving from 12.0% to 15.2%. NDHT (19.3%) and RD&E (19.9%) continue to have the highest levels of breaches, which across Devon are primarily related to endoscopy and imaging.
- The acute delayed transfers of care (DTOC) position moved very slightly above the 3.5% target in May at 3.51%. NDHT and TSD continued to meet the target and there was further improvement at RD&E from 4.5% to 4.1%, but UHP delays rose from 3.3% to 4.0%.
- Cancer: May saw a continued improvement in performance at STP level against the 62-day target from 75.4% to 77.7%, the fourth consecutive monthly rise. However, TSD were the only provider to achieve the 85% target and the backlog of over 62 day waits increased. STP level performance improved against both two-week wait measures but remained under the 93% targets, with the main 2ww standard at 85.9% and breast symptomatic at 64.3%.

The Patient Safety and Quality assessment against the main constitutional standards is summarised below.

The Patient Safety & Quality team (PSQ) uses the quality assurance framework as a surveillance tool under the key domains of effectiveness of care, people's experience of care and the safety of care provided. A range of quantitative and qualitative sources is used to support the assurance process and an 'enhanced quality surveillance tool' which formalises actions where quality risk levels trigger as high, has been implemented.

Development of Local Quality Surveillance Groups

Quality Surveillance Groups (QSGs) are one element of a wider framework to ensure that quality is the organising principle of our health and care system. They bring together different parts of the health and care system, to share intelligence and work in a collaborative way to improve quality locally or across the whole system. Since the national guidance was reviewed in July 2017 there is now an emphasis on evolving these groups further to include providers and Local Authorities.

The first Local Quality Surveillance Group commenced in the South locality on 1st July 2019. The CCG is also liaising with NHSE/I and across organisations in other localities as part of a plan to implement local QSG's across Devon.

Primary Care Quality Assurance Development

A workshop was held on 6 June 2019 with the aim of identifying core quality surveillance and assurance requirements. Key stakeholders attended including CCG Clinical Leads and the CQC Inspector for local Primary Care. Open discussion was facilitated, and a range of current quality data options was considered as these are readily available within publicly available information. For future quality assurance reporting to the Governing Body, through the CCG Quality Assurance Committee, additional primary care information through the Business Intelligence team will be required. In addition, surveillance information will include:

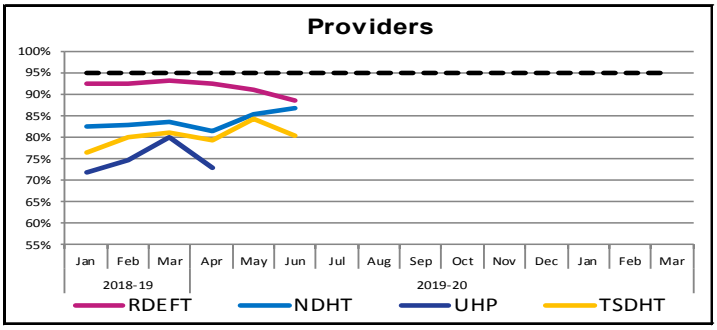
- CQC reports and ratings – Retrospective reviews of all existing inspection reports will not be possible however these are available on the CQC public website if required. All newly published reports will be reviewed to identify any key themes or areas of good practice or learning required. It will also be important to look across practices at any recurring themes that may require system wide consideration.
- Primary Care Quality Reporting (incident reporting) - The CCG now administers and reviews all Serious Incidents (SI) and Significant Events requiring Analysis (SEA) for General Practice. There is also intelligence from yellow cards received from across Devon. This range of information provides assurance around quality and safety systems and processes in practices and also gives intelligence around staff and patient experience.
- Quality Outcomes Framework (QOF) - current targets provide minimal information to support broad quality reporting and were discussed as a more transactional element of contracting. But there was agreement that the EOL and prescribing new indicators would be worth focusing on.
- Safeguarding Adults and Children- The team are already developing an electronic survey with training and compliance, safeguarding leads etc. This will provide the CCG baseline. This is also the same information that CQC review and it includes a self-declaration from each practice – section 11.

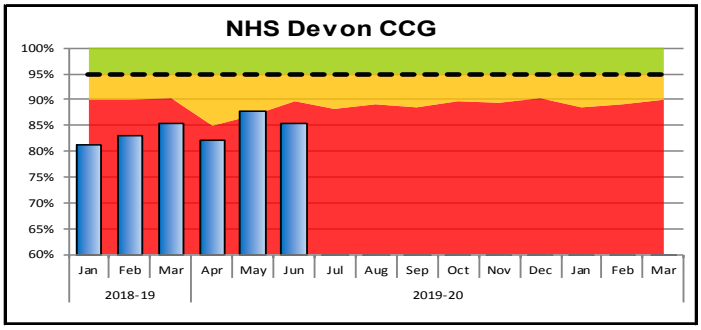
Initial reporting requirements were agreed and will commence with a monthly flash report to the CCG Quality Assurance Committee on key areas for exception and a full report each quarter. The report(s) will also be presented to the Primary Care Committee for information. Additional reviews or deep dives on any key issues that arise can will also be reported on. The CQC inspectors offered to attend the CCG Quality Assurance Committee and report in directly if the CCG required.

A&E Performance - Percentage of patients waiting less than 4 hours.

Trust	Trajectory	June	2019/20
RDEFT	94%	88.3%	90.6%
NDHT	84%	86.8%	84.4%
UHP	81%	N/A	N/A
TSDFT	78%	80.3%	81.2%

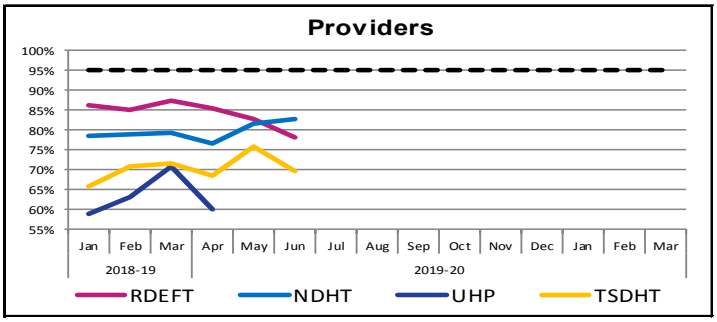
CCG	Trajectory	June	2019/20
NHS Devon	85%	85.4%	84.8%
ENGLAND		87.7%	87.0%

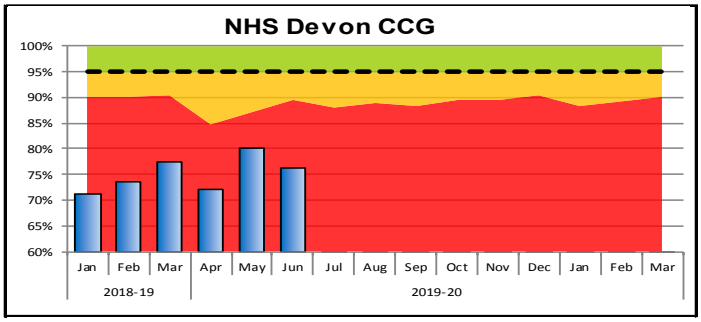




Trust	Trajectory	June	2019/20
RDEFT	94%	78.2%	82.2%
NDHT	84%	83.0%	80.5%
UHP	81%	N/A	N/A
TSDFT	78%	69.9%	71.5%

CCG	Trajectory	June	2019/20
NHS Devon	85%	76.3%	75.7%
ENGLAND		81.2%	80.0%





Performance Commentary

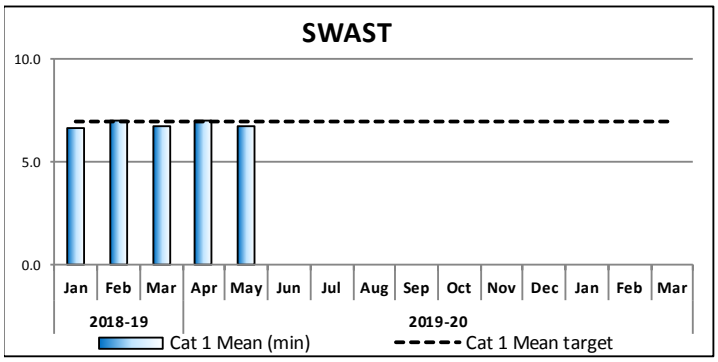
In June the STP position was 85.4%, down from 87.9% in May, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. RD&E performance fell slightly from 91.1% to 88.3%, NDHT improved from 85.2% to 86.8% but TSD fell from 84.2% to 80.3%.

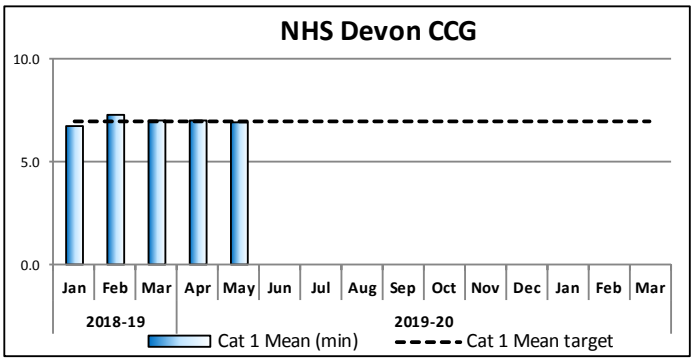
Quality Commentary and Improvement Actions

The Devon system has continued to experience increased demand impacts within the urgent and emergency care pathways and this has had significant impact in the South and West localities which have regulatory oversight. The CCG is therefore continuing with additional quality reviews including a rolling programme of observational audits which will be undertaken across all localities.
Information around patient experience, safety and effectiveness of care from this additional surveillance is shared with the providers and informs the local system escalation calls that are in place in these localities. It is clear from the additional quality review findings that patient experience and privacy and dignity are often adversely impacted during periods of escalation. It is also increasingly evident that a number of patients attending emergency departments could have been seen in an alternative location or service. Demand management plans and urgent care improvement work aims to maximise the use of alternatives for patients requiring minor injury support or non-emergency urgent care.

SWAST Cat 1 Mean response time

Trust	Target	May	2019/20
NHS Devon	7.00	6.80	7.0
SWAST	8.00	6.80	6.9





Performance Commentary

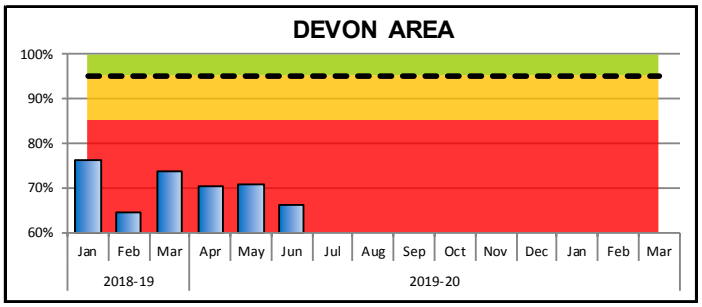
At STP level the 7 minute response time target was met in May.

Quality Commentary and Improvement Actions

SWASFT have now reduced the level of risk associated with call stacking from 25 to 20. This is based on the positive impact mitigating actions have had, reducing (but not eliminating) the level of the call stack. This risk is monitored regularly by the SWASFT executive and is reported through the SWASFT Quality Assurance Group chaired by Dorset CCG as coordinating commissioner where it is considered as part of a package of quality indicators. SWASFT continue to monitor for harm caused by delays in getting to patients, and currently report no evidence of serious harm.

NHS 111 answering calls within 60 Seconds

Trust	Target	June	2019/20
DEVON	95%	66.0%	69.1%
ENGLAND	95%	86.0%	86.7%



Performance Commentary

The proportion of calls answered within 60 seconds fell in June to 66% from 71% in May. Performance remains well below the target of 95%.

Quality Commentary and Improvement Actions

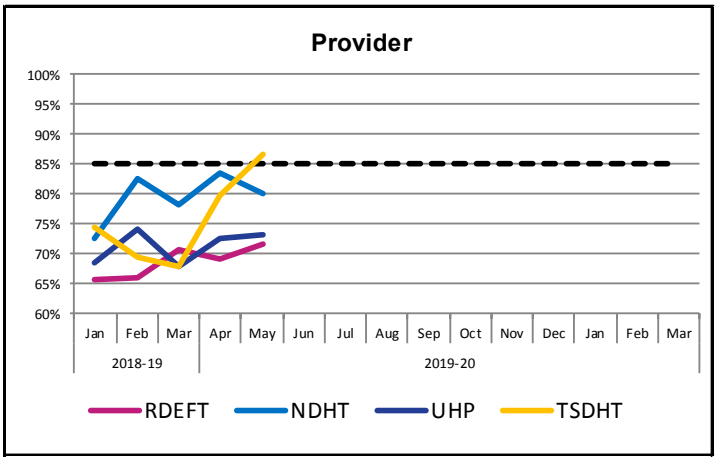
A number of calls are abandoned by patients before answering: it is not clear if this is due to length of wait to be answered or another reason. Collating information and experiences from these patients is challenging as it is not clear if these patients then access alternative services such as ED or primary care. Incident reviews and end to end reviews enable us to look at contacts with health services that some of these patients may have made, however this will only provide information for a small number of patients. The CCG quality assurance process continues to check quality intelligence sources for any adverse impact on patient care or experience as a result of delays in call answering. It is noted that a number of call handling staff have recently left employment and whilst a number of new staff have been recruited there will be a gap in call handling capacity pending training and recruiting to establishment.

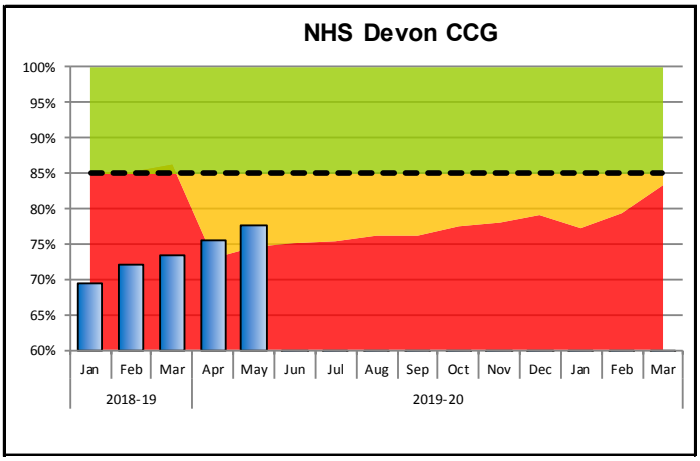
Devon Doctors Ltd continue to report challenges with staffing and the impact on waiting times and experience for patients as well as on the health and wellbeing of staff. They continue to participate in local escalation calls and system planning to mitigate risk of harm to patients.

Cancer 62 day Urgent Referral

Trust	Trajectory	May	2019/20
RDEFT	74%	71.6%	72.9%
NDHT	85%	80.2%	78.1%
UHP	70%	73.2%	73.8%
TSDFT	80%	86.5%	79.0%

CCG	Trajectory	May	2019/20
NHS Devon	75%	77.7%	76.5%
ENGLAND	85%	77.5%	77.5%





Performance Commentary

Performance improved at STP level in May, rising from 75.4% to 77.7%. TSD saw an improvement from 79.9% to 86.5%, RD&E increased from 69.3% to 71.6%, whilst the UHP position also improved from 72.6% to 73.2%. NDHT, though, saw a decrease from 83.6% to 80.2%.

The May over 62-day backlog position increased at all providers except for UHP, with over 104 week waits also rising.

Quality Commentary and Improvement Actions

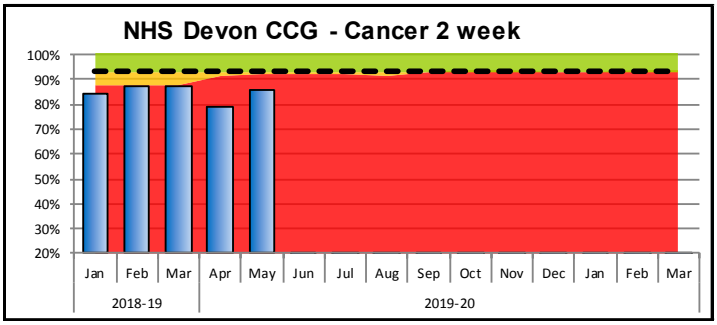
The CCG has a strategic plan in place that clearly sets out key areas of work that aim to provide sustainable achievement of the 62 day standard. Each provider's improvement plan is overseen by the CCG and it is envisaged that these plans will not only ensure patients are seen safely within the given time frames, but also have a positive experience of services at this potentially difficult time.

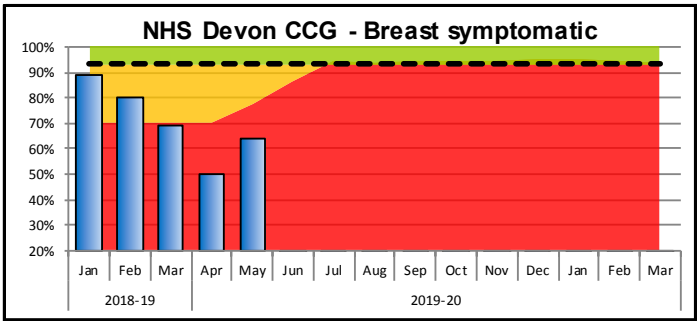
Providers have given assurance on the mechanisms by which they maintain patient safety through clinical triage processes, ensuring long waiting patients on cancer pathways are regularly reviewed and remain safe.

A significant improvement in quality has been achieved by the Devon Referral Support Services (DRSS) who are leading an initiative to offer greater patient choice of treatment with other providers.

Cancer Targets (May-2019)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	85.9%	82.2%	94.1%	94.3%	77.5%
93%	2 week breast	64.3%	91.8%	96.3%	8.5%	97.7%
90%	62 day screening	89.2%	100.0%	N/A	85.7%	90.9%
85%	62 day consultant	81.1%	83.9%	73.2%	75.5%	85.7%
96%	31 day first	95.7%	92.4%	95.6%	95.1%	99.5%
94%	31 day surgery	92.0%	86.5%	94.4%	93.8%	97.1%
98%	31 day drugs	99.4%	99.3%	100.0%	99.2%	100.0%
94%	31 day radiotherapy	90.2%	97.7%	100.0%	67.8%	96.9%





Performance Commentary

Across the wider range of cancer targets TSD & NDHT performed relatively well but there was more mixed performance at other providers with RD&E achieving three of the eight measures and UHP only meeting two.

Breast symptomatic performance improved significantly in May as both TSD and RD&E performance increased. The STP position moved from 50% to 64% as TSD rose from 50.7% to 97.7% and RD&E increased from 72.5% to 91.8%, just under the 93% target. NDHT also improved, meeting the target at 96.3%. However, UHP performance remained very low at 8.5%.
Performance against the main 2ww standard remained above target at NDHT whilst UHP also achieved the target, improving from 92.0% to 94.3%. RD&E moved from 80.4% to 82.2% and TSD rose from 53.4% to 77.5%, although still under the 93% target. The overall STP position was 85.9%, up from 78.8% in April.

Quality Commentary and Improvement Actions

The CCG continues to seek quality assurance from providers in relation to their actions taken to improve communication with patients and timeliness of patient appointments.

There are also cancer specific recovery plans in place for each provider. The aim of these is to set out clear actions to move the Trusts to sustainable achievement of the cancer standards, improving experience for patients requiring cancer care across Devon. These plans now form part of a robust monitoring process supported by NHSI colleagues.

Several cancer targets remain challenged and long waits potentially impact on patient experience, including anxiety; all providers acknowledge this impact within their harm reviews.
There remains evidence of appropriate referrals for many cancer pathways, with some showing increased conversion rates from referrals. However, some specialties do not evidence these conversion rates and it is therefore unknown if the referral was appropriate for the patient at that time. Providers are therefore working together as a system to address specific pathways where conversion rates are not monitored and are also collaborating to drive improvement within the Cancer Network Alliance.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

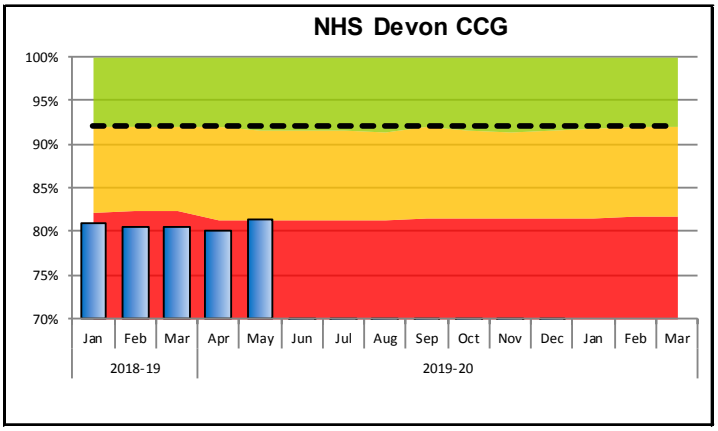
Trust	Trajectory	May	2019/20
RDEFT	82.6%	82.4%	81.8%
NDHT	79.1%	79.9%	79.6%
UHP	77.7%	77.3%	76.9%
TSDFT	81.0%	81.9%	81.3%

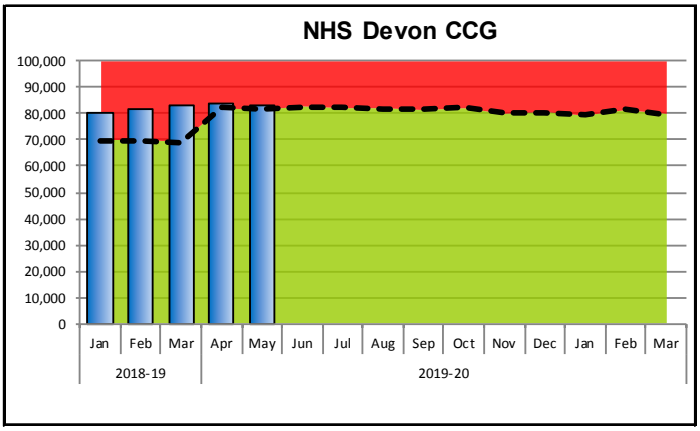
CCG	Trajectory	May	2019/20
NHS Devon	81.2%	81.3%	80.7%
ENGLAND	92.0%	86.9%	86.7%

RTT incomplete waits volume

Trust	Trajectory	May
RDEFT	33,783	35,690
NDHT	11,665	11,403
UHP	28,476	28,611
TSDFT	18,548	19,534

CCG	Trajectory	May
NHS Devon	81,536	83,041





Performance Commentary

The STP level RTT position improved in May from 80.1% to 81.3% as all providers saw performance rise. RD&E increased from 81.1% to 82.4%, UHP improved from 76.4% to 77.3%, TSD rose from 80.7% to 81.9% and NDHT also increased from 79.3% to 79.9%. Both TSD and NDHT are above trajectory with UHP and RD&E slightly under.

The incomplete waiting list fell by 500 at STP level with RD&E seeing a reduction of over a thousand patients, NDHT relatively flat but increases at UHP and TSD. NDHT and RD&E are both below their respective waiting list trajectories.

Quality Commentary and Improvement Actions

It is acknowledged that improved performance in some pathways across the STP has led to positive patient experience, however some specialities continue to be challenged. This includes urology and cardiology. Actions are in place to monitor for patient harm, as well as ensuring a continued positive experience. In addition, providers are working together to reduce exceptionally long waits, utilising staff across providers, as well as sharing resource/infrastructure. There is work to further support primary care which includes developing advice and guidance and other options for providing appropriate first steps for GPs and reducing variation in referrals. This will support an improved patient experience as expectations will be realistic.

UHP has identified a number of patients that have chosen to delay their treatments significantly and those patients are now being contacted each week to further discuss whether they wish to remain on the waiting list – this is being undertaken with NHSI and CCG oversight.

TSDFT continue to be challenged as a result of their ongoing reduced theatre capacity and a monthly patient impact report is overseen through their Quality Improvement Group. Patients for many specialities continue to be offered alternative locations for treatment during this period. Planned reopening of full theatres is expected in August 2019

RTT Incomplete Pathways long waiters

40-52 week waits

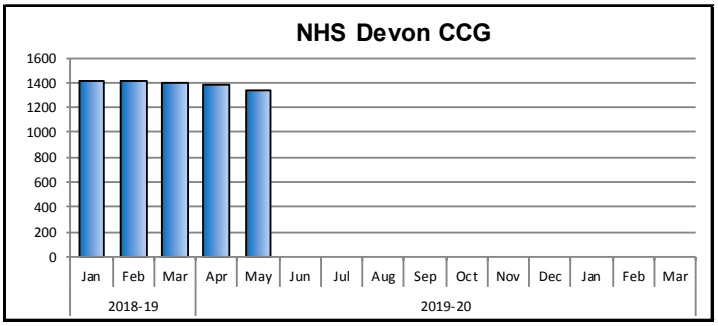
Trust	May	2019/20
RDEFT	571	1117
NDHT	111	227
UHP	674	1312
TSDFT	314	622

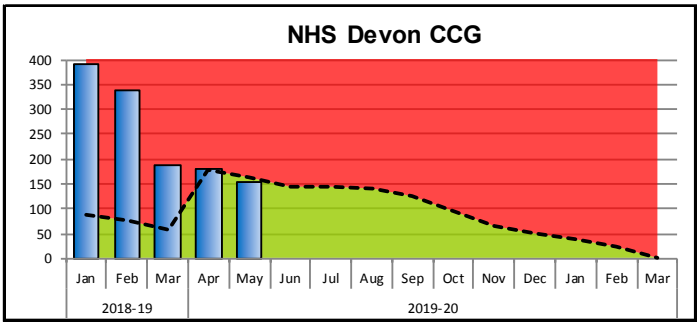
CCG	May	2019/20
NHS Devon	1339	2720

Over 52 week waits

Trust	Trajectory	May	2019/20
RDEFT	25	71	137
NDHT	8	8	25
UHP	49	57	106
TSDFT	103	59	130

CCG	Trajectory	May	2019/20
NHS Devon	163	153	332





Performance Commentary

Over 52 week waits continued to fall in May moving from 179 to 153 at STP level. TSD (59) and NDHT (8) both saw reductions in breaches with RD&E (71) flat and UHP seeing breaches increase from 49 to 57.

Quality Commentary and Improvement Actions

Across the STP providers have given assurance on how they check for harm, as well as ensuring as positive an experience as possible for patients, through clinical reviews and communicating with patients. Elements of planned care work continue to be outsourced to the independent sector, with the aim of improving choice and experience and reducing potential risk from a long wait. The CCG's continue to seek assurance that provider Trusts are undertaking surveillance to ensure quality is maintained when outsourcing service provision.

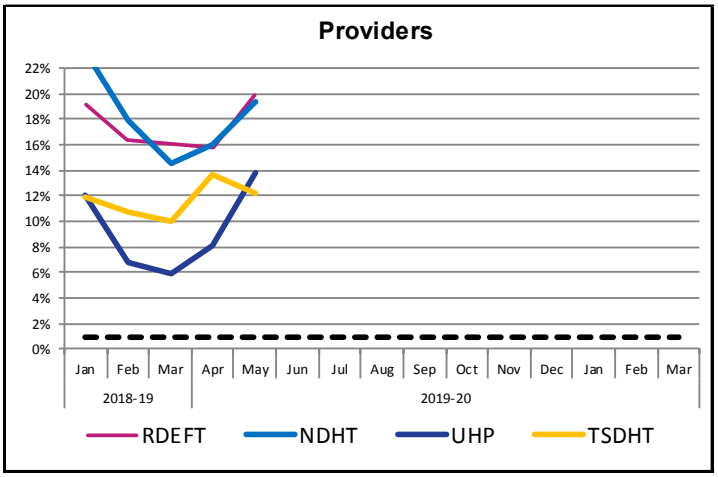
Quality and equality impact assessments have been undertaken by providers when planning their activity improvement trajectories. These are reviewed by the CCG Quality, Equality Impact Assessment (QEIA) Panel. These assessments enable consideration of the potential positive or negative impacts to patient safety, effectiveness, experience and the wider system

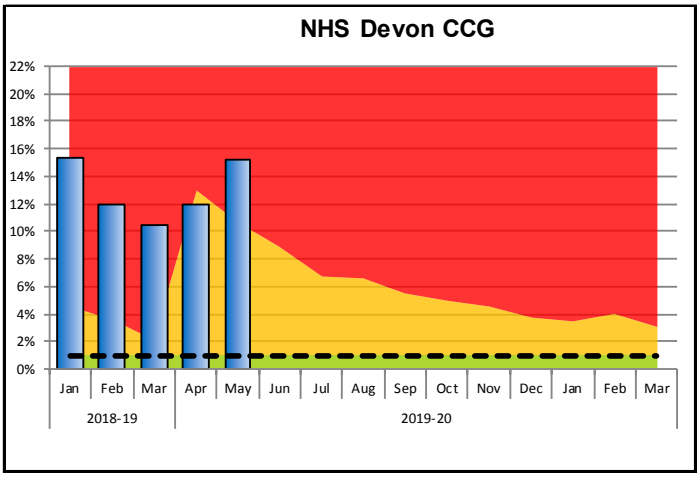
Patient choice impacts on this standard and can provide a challenge as impacting on long waits, including 52 week waits. All providers evidence actions to reduce the number of patients waiting for lengthy time periods and they communicate effectively with patients, but they also acknowledge that patients have this option. It is essential to acknowledge the choices that patients make and ensure the patient voice is heard alongside the performance metrics.

Diagnostic 6 week wait

Trust	Trajectory	May	2019/20
RDEFT	11.0%	19.9%	19.9%
NDHT	15.5%	19.3%	19.3%
UHP	6.7%	13.8%	13.8%
TSDFT	12.7%	12.1%	12.1%

CCG	Trajectory	May	2019/20
NHS Devon	10.6%	15.2%	13.6%
ENGLAND	1.0%	4.1%	3.8%





Performance Commentary

All providers except for TSD saw increased breaches in May as the STP position rose again from 12.0% to 15.2%. UHP increased from 8.1% to 13.8%, NDHT rose from 15.9% to 19.3% and RD&E performance worsened from 15.7% to 19.9%, all significantly under improvement trajectories. TSD improved from 13.7% to 12.1%, achieving May's trajectory of 12.7%. The majority of breaches continue to be for imaging and endoscopy.

Quality Commentary and Improvement Actions

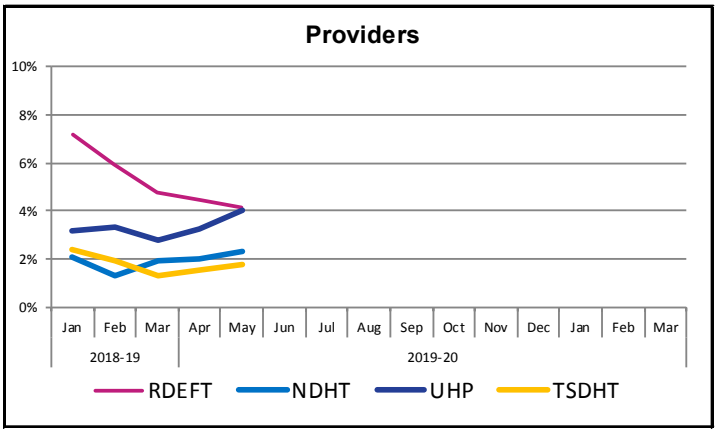
Through the System Performance Group, chaired by the CCG, the providers have reported initial collaborative steps with the aim of improving diagnostic wait times for patients. Improving experience is central to their work and they hope to achieve this through a wide range of actions. Sharing teams and other resources, such as is already in place between NDHT and RDEFT supports wider system collaboration. All providers continue to rely heavily on external sourcing for diagnostics but have evidenced their governance processes around this. The CCG support this quality assurance through close working with NHS providers and seeking additional assurance from non-NHS providers if required.

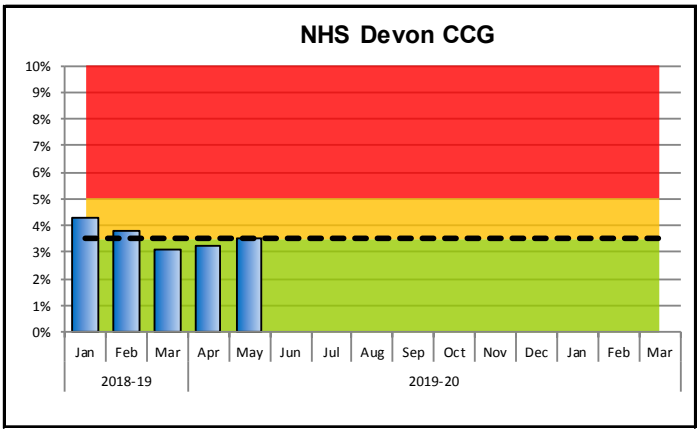
There are some improvements in certain pathways across the STP, but patients continue to experience long delays in others, so continued assurance is sought to ensure no harm occurs, recognising patient experience may be affected.

Acute Delayed Transfers of care

Trust	Target	May	2019/20
RDEFT	3.50%	4.1%	4.3%
NDHT	3.50%	2.3%	2.2%
UHP	3.50%	4.0%	3.6%
TSDFT	3.50%	1.8%	1.6%

CCG	Target	May	2019/20
NHS Devon	3.50%	3.5%	3.4%





Performance Commentary

The acute delayed transfers of care (DTOC) May position was slightly below target at 3.51% NDHT and TSD remain under 3.5% and there was continued improvement at RD&E from 4.5% to 4.1% in May However, UHP delays increased from 3.3% to 4.0%.

Quality Commentary and Improvement Actions

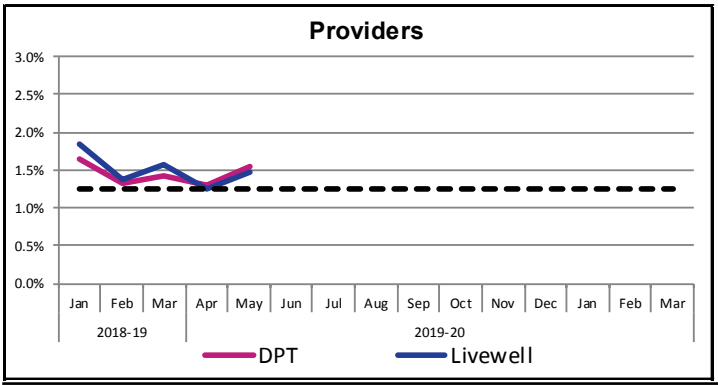
Progress against performance and quality actions continues to be reviewed through the locality A&E Delivery Boards, with reporting and oversight through the Devon A&E Delivery Board. Impact of delayed transfers of care can be seen across the urgent care pathways and the CCG has sight of the position through receipt of the daily situation reports from providers. The patient and system impact of delayed transfers is also a key element of escalation discussions.

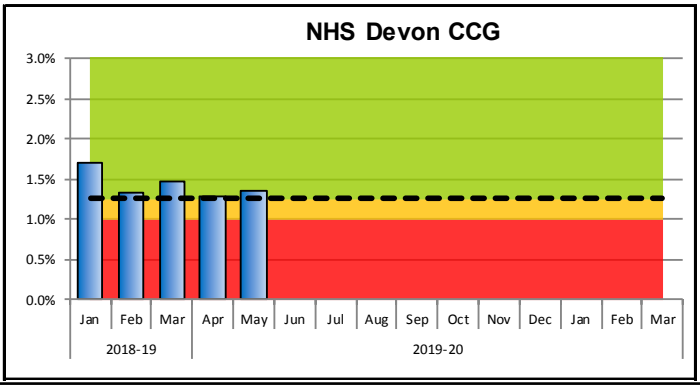
Each locality monitors and manages delayed transfers of care for individual patients and they consider their local system capacity to ensure patients are transferred in a timely way, including processes for ensuring weekend discharges. In the last few weeks some key areas impacting on patient transfer delays that have been identified are now incorporated into the provider improvement plans and are reviewed by the CCG. These include issues with discharge medicines not being ready, access to social care support, challenge in accessing appropriate patient transport and the timely repatriation of patients back to county of origin. End-to-end reviews from two providers (with the potential implementation of this review process in the remaining two providers) have provided recommendations that will lead to actions to improve flow. This includes improvements in the discharge process.

IAPT Monthly Access rate

Trust	Target	May	2019/20
DPT	1.25%	1.5%	2.8%
LIVEWELL	1.25%	1.46%	2.70%

CCG	Target	May	2019/20
NHS Devon	1.25%	1.3%	2.6%





Performance Commentary

Performance for the IAPT access rate indicator was above target at STP level for May with both providers meeting the target

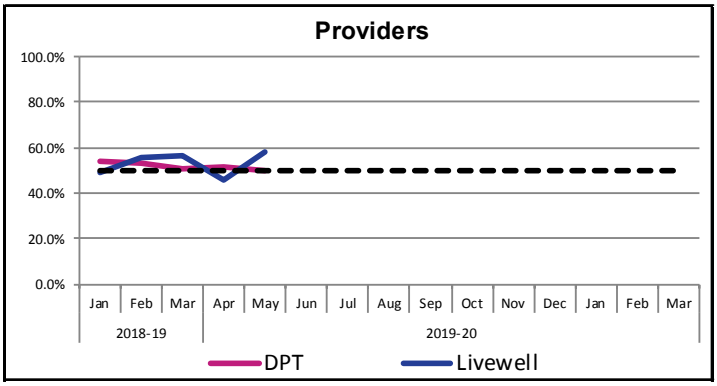
Quality Commentary and Improvement Actions

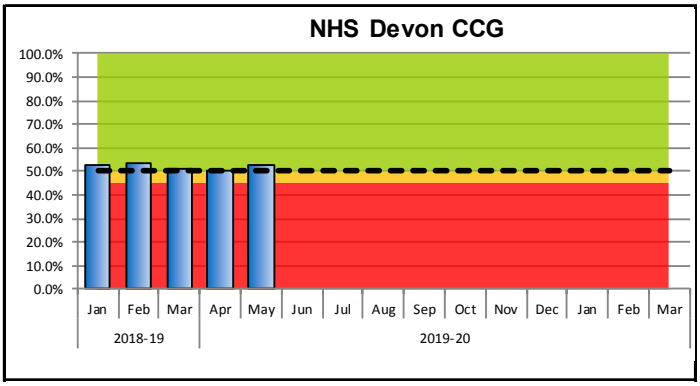
Quality assurance continues through a range of sources and the CCG also receives feedback via the yellow card system from professionals working within the system and these are shared with the providers for review and response. This enables any concerns around crisis response timeliness to be identified. Challenges remain in relation to patient experience, whilst many patients are assessed and receive treatment in a timely manner, others may wait for long periods of time and there is evidence of inconsistency and variance in patient pathways across Devon. Quality is monitored through routine CCG assurance routes, but the CCG will now be increasing attendance at other provider quality meetings to seek further assurance.

IAPT Recovery rate

Trust	Target	May	2019/20
DPT	50%	49.9%	50.7%
LIVEWELL	50%	57.7%	51.7%

CCG	Target	May	2019/20
NHS Devon	50%	52.4%	51.5%





Performance Commentary

The STP was above the target for IAPT recovery in May, with Livewell performance recovering above the 50% target at 57.7% and DPT very marginally under at 49.9%.

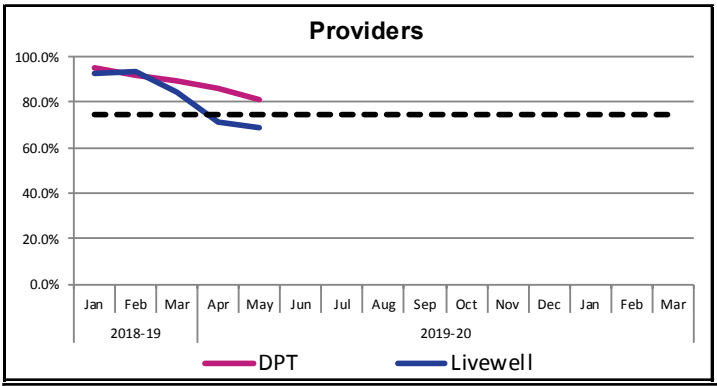
Quality Commentary and Improvement Actions

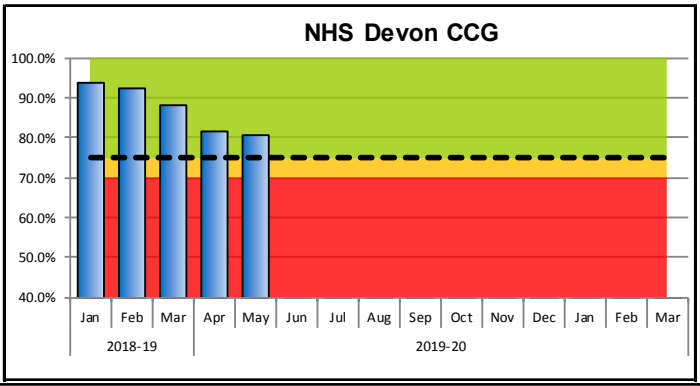
The CCG continues to review all information from provider meetings and other sources to inform the range of indicators within the quality assurance process.

IAPT waiting 6 weeks

Trust	Target	May	2019/20
DPT	75%	81.5%	83.6%
LIVEWELL	75%	68.6%	69.7%

CCG	Target	May	2019/20
NHS Devon	75%	80.5%	81.2%





Performance Commentary

DPT achieved the target in May but Livewell fell below at 68.6%

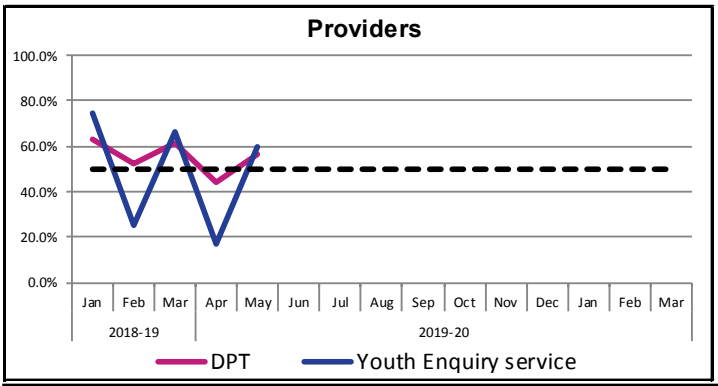
Quality Commentary and Improvement Actions

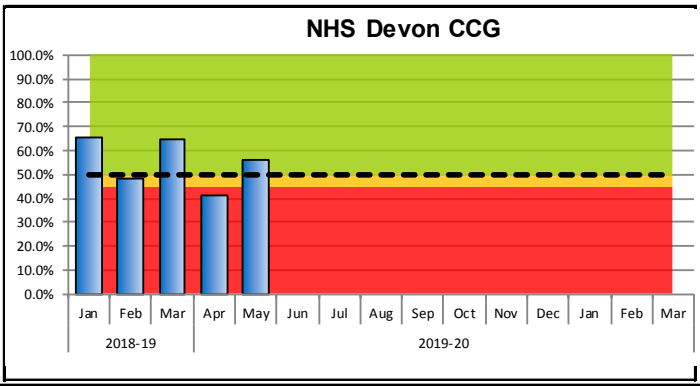
Quality assurance continues through the quality assurance framework process and the CCG is currently reviewing challenges raised by Primary Care for those patients who may not be eligible for Community Mental Health Services but present as too complex for depression and anxiety services. Findings from this review will be presented to the August Quality Assurance Committee.

Mental Health Early Intervention

Trust	Target	May	2019/20
DPT	50%	56.3%	50.0%
THE ZONE	50%	60.0%	43.8%

CCG	Target	May	2019/20
NHS Devon	50%	56.0%	48.9%
ENGLAND	50%	76.7%	75.1%





Performance Commentary

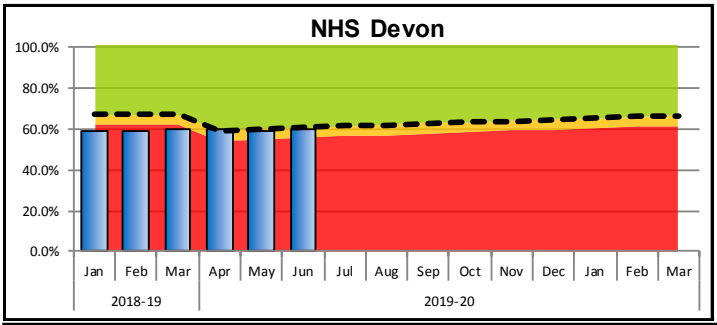
This is a two-part indicator for patients with suspected first episode psychosis or at risk mental state on a completed pathway receiving NICE-recommended care package and allocated to and engaged with an EIP care co-ordinator. Performance improved in May to 56%, with both DPT and The Zone achieving the national target.

Quality Commentary and Improvement Actions

The CCG quality assurance process has continued to demonstrate the positive impact of early intervention services however as detailed above, there are challenges in achieving timely access to services for some patients. The CCG receives minimal information from patients through complaints, feedback and incidents however, will now be strengthening the range of intelligence received through regular attendance at a number of provider governance and quality meetings. This will support assurance by enabling a view of providers internal information, themes, learning and improvement actions being taken.

Dementia Diagnosis Rate

CCG	Trajectory	June	2019/20
NHS Devon	60.7%	60.0%	59.6%
ENGLAND	67.0%	68.5%	68.4%



Performance Commentary

STP level performance remained static and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (41.7), Mid Devon (53.6) and Plymouth (56.3). Conversely Exeter is at 71.4%, Torbay 66.7% and East Devon at 64.7%.

Quality Commentary and Improvement Actions

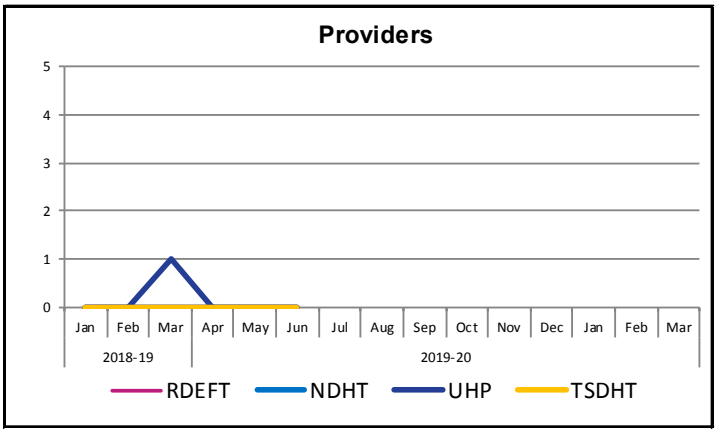
The dementia diagnosis dashboard is in place and gives information on diagnosis rates by locality and individual GP practice. Correct coding of patients diagnosed with dementia within primary care remains a key piece of improvement work. Following analysis with DPT and LWSW, letters to GP practices to support in correctly coding those patients who have a confirmed diagnosis are planned. The CCG are also seeking input from clinical colleagues to develop a proposal for improving the early identification and diagnosis of dementia in care home residents.

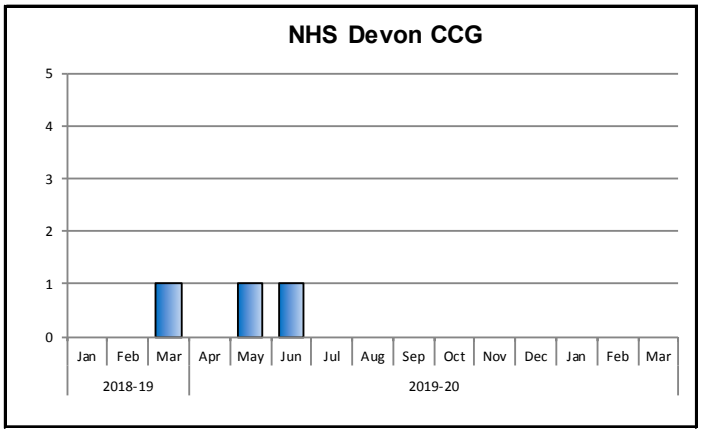
Early identification and diagnosis of dementia can positively impact on both patients and their family and carer's as treatments, education and support options can be offered.

MRSA breaches

Trust	Target	June	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	0	0
TSDFT	0	0	0

CCG	Target	June	2019/20
NHS Devon	0	1	2





Performance Commentary

There was one reported MRSA case in June which was out of area.

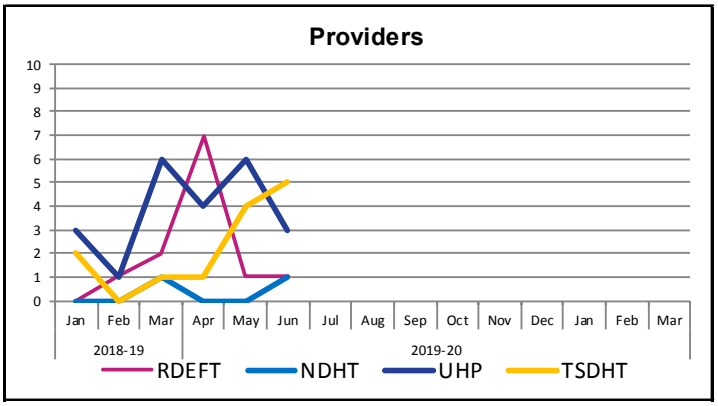
Quality Commentary and Improvement Actions

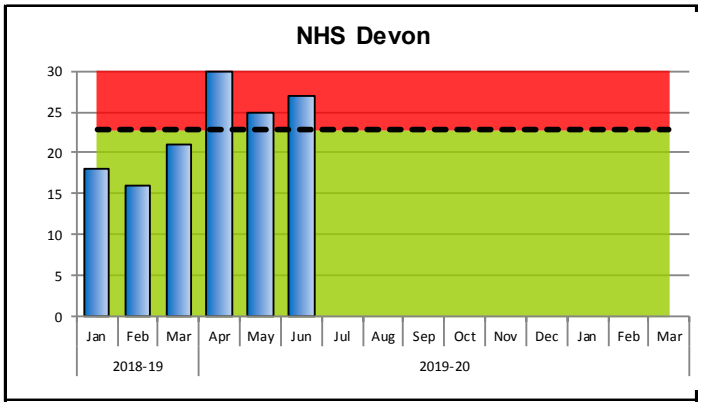
Local reviews of any MRSA case that occurs continues.

C-Diff breaches

Trust	Target	June	2019/20
RDEFT	<31	1	9
NDHT	<9	1	1
UHP	<63	3	13
TSDFT	<36	5	10

CCG	Target	June	2019/20
DEVON STP	<274	27	82





Performance Commentary

There were 10 C-Diff cases acquired within the acute providers and 27 across the STP in June.

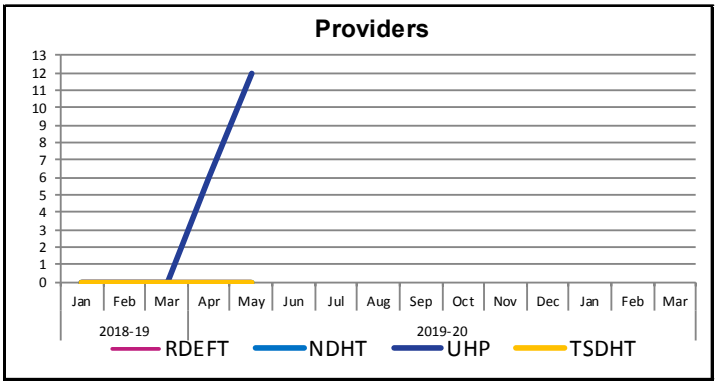
Quality Commentary and Improvement Actions

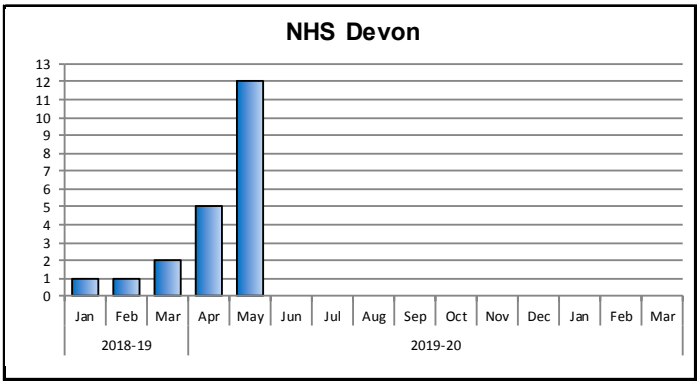
There has been a Period of Increased Incidence (PII) of C difficile at RDEFT in April, involving ten cases. These have been fully reviewed and ribotyped, and there is no evidence of an outbreak. There has been a PII of C difficile at TSDFT in May/June in the community hospital setting, involving three cases. Ribotyping has shown links between cases confirming this as an outbreak. Actions including investigation are continuing and the CCG will be updated on progress against this.

Mixed Sex accommodation breaches

Trust	Target	May	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	12	6
TSDFT	0	0	0

CCG	Target	May	2019/20
NHS Devon	0	12	17





Performance Commentary

UHP have seen 12 breaches in May, all of which are attributed to NHS Devon.

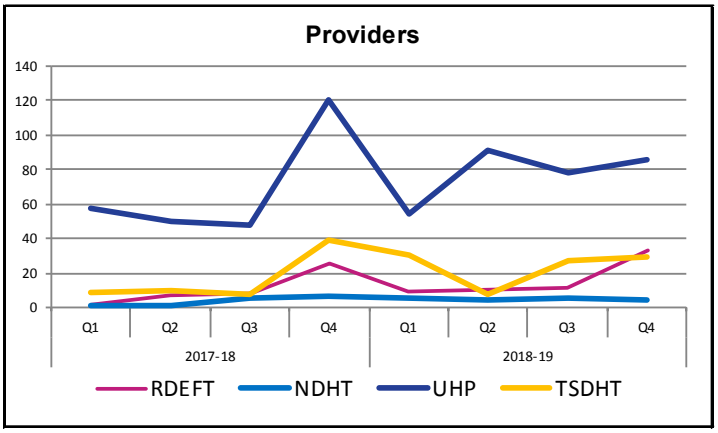
Quality Commentary and Improvement Actions

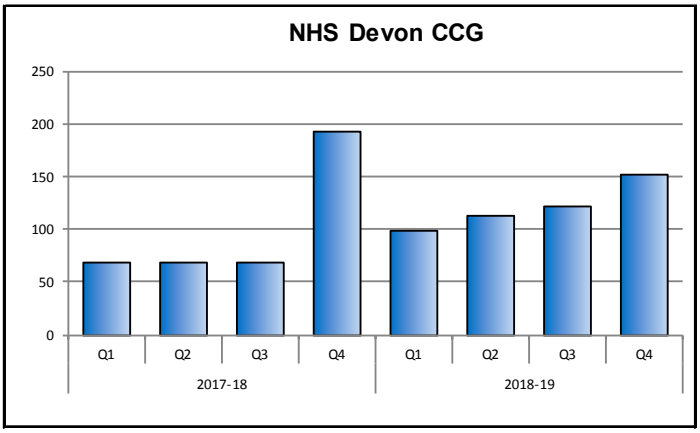
Mixed Sex Accommodation (MSA) data continues to be provided on a monthly basis. The CCG will continue to seek assurance from the provider organisations that any MSA breaches reported are clinically justifiable. Where it has been indicated that the breach was unnecessary, further assurance from the provider is sought including confirmation of any actions taken to address or lessons learnt as a result.

Cancelled operations not treated with 28 days of cancellation

Trust	Target	Q4	2018/19
RDEFT	0	33	63
NDHT	0	4	18
UHP	0	86	309
TSDFT	0	29	94

CCG	Target	Q4	2018/19
NHS Devon	0	152	484





Performance Commentary

There is a zero breach tolerance for last minute cancelled operations not treated within 28 days of cancellation. Quarter four showed an increase from quarter three due to a rise in breaches at RD&E and UHP. Breaches remain highest overall at UHP and comparatively low at NDHT.

Quality Commentary and Improvement Actions

Regular updates on cancelled operations are now received from providers. Information in relation to quality, including experience, is now more robust and there is more information around communication, options and patient choice. Various complexities are acknowledged for specific complex surgical operations, therefore additional assurance continues to be sought through the planned care forum.

NHS Northern Eastern Western Devon

Summary

	Area	Indicator	Period	England value	Target		99P: NHS Northern, Eastern and Western Devon CCG Rate	Rank	Change
Better Health	Annual assessment	999a: Annual assessment	2017-18				GD		
	Child obesity	102a: Percentage of children aged 10-11 classified as overweight or obese	2014-15 to 2016-17	33.9%			29.5%		↓
	Diabetes	103a: Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, c..	2017-18	38.7%			36.1%	(158/195)	↓
		103b: People with diabetes diagnosed less than a year who attend a structured education course	2017-18 (2016 cohort)	8.54%			7.44%	(104/195)	↑
	Falls	104a: Injuries from falls in people aged 65 and over	18-19 Q3	2051			1690		↓
	Personalisation and choice	105b: Personal health budgets	18-19 Q3	60			385		↑
	Health inequalities	106a: Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensiti..	18-19 Q2	2109			2162	(92/195)	↓
	Antimicrobial resistance	107a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	2018 12	0.977	0.965	●	0.971	(82/195)	↓
		107b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	2018 12	8.71%	10%	●	9.53%	(131/195)	↑
	Carers	108a: The proportion of carers with a long term condition who feel supported to manage their condition	2018	0.59		●	0.60	(90/195)	
Better Care	Provision of high quality care	121a: Provision of high quality care: hospital	18-19 Q3				63		
		121b: Provision of high quality care: primary medical services	18-19 Q3				70		
		121c: Provision of high quality care: adult social care	18-19 Q3				65		
	Cancer	122a: Cancers diagnosed at early stage	2017		53.52%	●		(1/0)	
		122b: People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	18-19 Q3	79.5%	85%	●	76.5%	(144/195)	↑
		122c: One-year survival from all cancers	2016	72.8%		●	74.2%		↑
		122d: Cancer patient experience	2017				8.9		↑
	Mental health	123a: Improving Access to Psychological Therapies – recovery	18-19 Q3	51.8%	50%	●	50.6%	(119/195)	↓
		123b: Improving Access to Psychological Therapies – access	18-19 Q3	4.48%			3.87%	(148/195)	↓
		123c: People with first episode of psychosis starting treatment with a NICE-recommended package of car..	2019 02	75.9%		●	69.8%	(147/195)	↓
		123e: Mental health crisis team provision	2017-18				0.00%	(114/180)	
		123f: Mental health out of area placements	18-19 Q3	123			415	(184/195)	↓
		123i: Delivery of the mental health investment standard	18-19 Q3				Green		+
		123j: Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI)	18-19 Q2	Null			0.93		
	Learning disability	124a: Reliance on specialist inpatient care for people with a learning disability and/or autism	18-19 Q3				40		+
		124b: Proportion of people with a learning disability on the GP register receiving an annual health check	2017-18	51.4%			53.8%	(81/195)	↑
		124c: Completeness of the GP learning disability register	2017-18	0.49%			0.54%	(65/195)	↑
	Maternity	125a: Neonatal mortality and stillbirths	2016	Null			3.92	(69/154)	↑
		125b: Women's experience of maternity services	2018	82.7			84.2	(67/195)	↑
		125c: Choices in maternity services	2018	60.4			60.1	(105/195)	↓
		125d: Maternal smoking at delivery	18-19 Q3	10.5%		●	10.9%	(92/195)	↓
	Dementia	126a: Estimated diagnosis rate for people with dementia	2019 02	67.9%		●	59.2%	(162/195)	↓
		126b: Dementia care planning and post-diagnostic support	2017-18	77.5%			77.2%	(123/194)	↓
	Urgent and emergency care	127b: Emergency admissions for urgent care sensitive conditions	18-19 Q2	2409			2185	(68/195)	↓
		127c: Percentage of patients admitted, transferred or discharged from A&E within 4 hours	2019 03	86.6%	95%	●	85.7%	(84/195)	↑
		127e: Delayed transfers of care per 100,000 population	2019 02	10.3			13.2	(156/195)	↓
		127f: Population use of hospital beds following emergency admission	18-19 Q2	499			427		↑
	End of life care	105c: Percentage of deaths with three or more emergency admissions in last three months of life	2017	5.37%			4.15%		↑
	Primary care	128b: Patient experience of GP services	2018	83.8%			89.0%		
		128c: Primary care access – proportion of population benefitting from extended access services	2019 02				100.0%		+
		128d: Primary care workforce	2018 09	1.05			1.21		↑
		128e: Count of the total investment in primary care transformation made by CCGs compared with the £3 h..	18-19 Q3				Green		↑
	Elective access	129a: Patients waiting 18 weeks or less from referral to hospital treatment	2019 02	87.0%	92%	●	80.5%	(185/195)	↓
	7 day services	130a: Achievement of clinical standards in the delivery of 7 day services	2016-17				2	(56/195)	
	NHS Continuing Healthcare	131a: Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	18-19 Q3	9.23%		●	0.00%		+
	Patient safety	132a: Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by th..	2017				Amber		
	Diagnostics	133a: Percentage of patients waiting 6 weeks or more for a diagnostic test	2019 02	2.30%		●	12.0%	(194/195)	↓
Sustai..	Financial sustainability	141b: In-year financial performance	18-19 Q3				Amber		+
	Paper-free at the point of care	144a: Utilisation of the NHS e-referral service to enable choice at first routine elective referral	2018 12	99.6%		●	99.3%	(157/191)	
	Demand management	145a: Expenditure in areas with identified scope for improvement	18-19 Q3				Red		+
Leadership	Probity and corporate governance	162a: Probity and corporate governance	18-19 Q3						
	Workforce engagement	163a: Staff engagement index	2017	3.78			3.83		↑
		163b: Progress against the Workforce Race Equality Standard	2017	0.13			0.14	(140/189)	↑
	Quality of leadership	165a: Quality of CCG leadership	18-19 Q3				Amber		+
	Patient and community engagem..	166a: Compliance with statutory guidance on patient and public participation in commissioning health and..	2017				Amber		
	CCGs local relationships	164a: Effectiveness of working relationships in the local system	2017-18				55.8	(180/189)	↑

Direction of change arrows
- ↑ Increase
- ↓ Decrease
- \+ Equal
- X No data

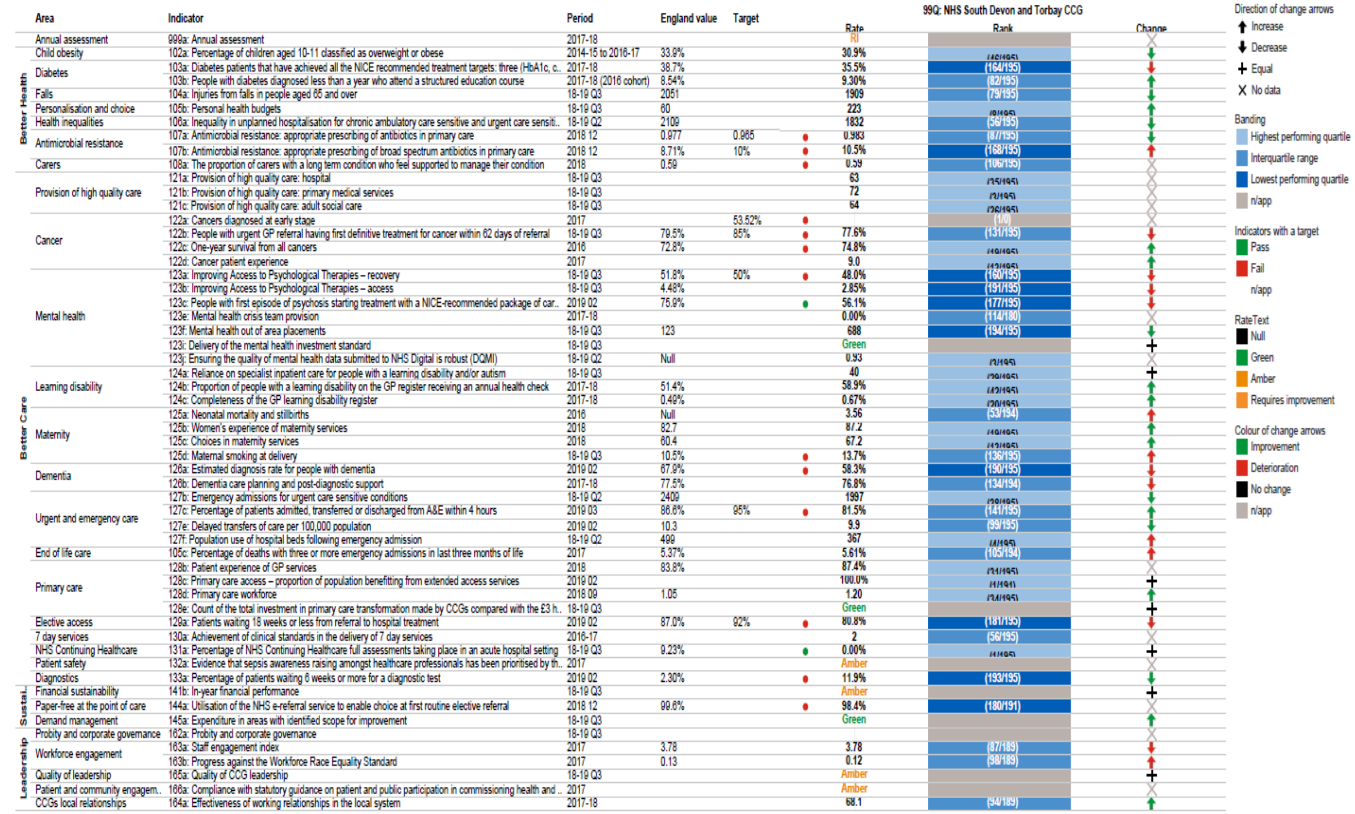
Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile
- n/app

Indicators with a target
- Pass
- Fail
- n/app

RateText
- Null
- Green
- Amber
- Red
- Good

Colour of change arrows
- Improvement
- Deterioration
- No change
- n/app

Summary



	Area	Indicator	Period	England value	Target		Rate	99Q: NHS South Devon and Torbay CCG Rank	Change
	Annual assessment	999a: Annual assessment	2017-18				RI		
Better Health	Child obesity	102a: Percentage of children aged 10-11 classified as overweight or obese	2014-15 to 2016-17	33.0%			30.9%	[illegible]	↓
	Diabetes	103a: Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, c..	2017-18	38.7%			35.5%	(164/195)	↓
		103b: People with diabetes diagnosed less than a year who attend a structured education course	2017-18 (2016 cohort)	8.54%			9.30%	(82/195)	↑
	Falls	104a: Injuries from falls in people aged 65 and over	2018-19 Q3	2051			1909	(79/195)	↓
	Personalisation and choice	105b: Personal health budgets	18-19 Q3	60			223	[illegible]	↑
	Health inequalities	106a: Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensiti..	18-19 Q2	2109			1832	(56/195)	↓
	Antimicrobial resistance	107a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	2018 12	0.977	0.965	●	0.983	(87/195)	↓
		107b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	2018 12	8.71%	10%	●	10.5%	(168/195)	↑
	Carers	108a: The proportion of carers with a long term condition who feel supported to manage their condition	2018	0.59		●	0.59	(106/150)	
	Provision of high quality care	121a: Provision of high quality care: hospital	18-19 Q3				63	[illegible]	
		121b: Provision of high quality care: primary medical services	18-19 Q3				72	[illegible]	
		121c: Provision of high quality care: adult social care	18-19 Q3				64	[illegible]	
	Cancer	122a: Cancers diagnosed at early stage	2017		53.52%	●		(1/0)	
		122b: People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	18-19 Q3	79.5%	85%	●	77.6%	(131/195)	↓
		122c: One-year survival from all cancers	2016	72.8%		●	74.8%	[illegible]	↑
		122d: Cancer patient experience	2017				9.0	[illegible]	↑
	Mental health	123a: Improving Access to Psychological Therapies – recovery	18-19 Q3	51.8%	50%	●	48.0%	(160/195)	↓
		123b: Improving Access to Psychological Therapies – access	18-19 Q3	4.48%			2.85%	(191/195)	↓
		123c: People with first episode of psychosis starting treatment with a NICE-recommended package of car..	2018 Q2	75.8%		●	56.1%	(177/195)	↓
		123e: Mental health crisis team provision	2017-18				0.00%	(114/180)	
		123f: Mental health out of area placements	18-19 Q3	123			688	(194/195)	↓
		123i: Delivery of the mental health investment standard	18-19 Q3				Green		+
		123j: Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI)	18-19 Q2	Null			0.93	[illegible]	
Better Care	Learning disability	124a: Reliance on specialist inpatient care for people with a learning disability and/or autism	18-19 Q3				40	[illegible]	+
		124b: Proportion of people with a learning disability on the GP register receiving an annual health check	2017-18	51.4%			58.9%	[illegible]	↑
		124c: Completeness of the GP learning disability register	2017-18	0.49%			0.67%	[illegible]	↑
	Maternity	125a: Neonatal mortality and stillbirths	2016	Null			3.56	(53/134)	↑
		125b: Women's experience of maternity services	2018	82.7			87.2	[illegible]	↑
		125c: Choices in maternity services	2018	60.4			67.2	[illegible]	↑
		125d: Maternal smoking at delivery	18-19 Q3	10.5%		●	13.7%	(136/155)	↑
	Dementia	126a: Estimated diagnosis rate for people with dementia	2018 02	67.9%		●	58.3%	(190/195)	↓
		126b: Dementia care planning and post-diagnostic support	2017-18	77.5%			76.8%	(134/194)	↓
	Urgent and emergency care	127b: Emergency admissions for urgent care sensitive conditions	18-19 Q2	2409			1997	[illegible]	↓
		127c: Percentage of patients admitted, transferred or discharged from A&E within 4 hours	2018 03	86.6%	95%	●	81.5%	(141/155)	↑
		127e: Delayed transfers of care per 100,000 population	2018 02	10.3			9.9	(99/195)	↓
		127f: Population use of hospital beds following emergency admission	18-19 Q2	499			367	[illegible]	↑
	End of life care	105c: Percentage of deaths with three or more emergency admissions in last three months of life	2017	5.37%			5.61%	(105/134)	↑
	Primary care	128b: Patient experience of GP services	2018	83.8%			87.4%	[illegible]	
		128c: Primary care access – proportion of population benefiting from extended access services	2018 02				100.0%	[illegible]	+
		128d: Primary care workforce	2018 09	1.05			1.20	[illegible]	↑
		128e: Count of the total investment in primary care transformation made by CCGs compared with the £3 h..	18-19 Q3				Green		+
	Elective access	129a: Patients waiting 18 weeks or less from referral to hospital treatment	2018 02	87.0%	92%	●	80.8%	(181/195)	↓
	7 day services	130a: Achievement of clinical standards in the delivery of 7 day services	2016-17				2	(56/195)	
	NHS Continuing Healthcare	131a: Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	18-19 Q3	9.23%		●	0.00%	[illegible]	+
	Patient safety	132a: Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by th..	2017				Amber		
	Diagnostics	133a: Percentage of patients waiting 6 weeks or more for a diagnostic test	2018 Q2	2.30%		●	11.9%	(193/195)	↓
Sustai..	Financial sustainability	141b: In-year financial performance	18-19 Q3				Amber		+
	Paper-free at the point of care	144a: Utilisation of the NHS e-referral service to enable choice at first routine elective referral	2018 12	99.6%		●	98.4%	(180/191)	
	Demand management	145a: Expenditure in areas with identified scope for improvement	18-19 Q3				Green		↑
Leadership	Probity and corporate governance	162a: Probity and corporate governance	18-19 Q3						
	Workforce engagement	163a: Staff engagement index	2017	3.78			3.78	(87/189)	↓
		163b: Progress against the Workforce Race Equality Standard	2017	0.13			0.12	(98/189)	↑
	Quality of leadership	165a: Quality of CCG leadership	18-19 Q3				Amber		+
	Patient and community engagem..	166a: Compliance with statutory guidance on patient and public participation in commissioning health and ..	2017				Amber		
	CCGs local relationships	164a: Effectiveness of working relationships in the local system	2017-18				68.1	(94/189)	↑

Direction of change arrows
- ↑ Increase
- ↓ Decrease
- \+ Equal
- X No data

Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile
- n/app

Indicators with a target
- Pass
- Fail
- n/app

RateText
- Null
- Green
- Amber
- Requires improvement

Colour of change arrows
- Improvement
- Deterioration
- No change
- n/app

FIGURES FOR NHS DEVON CCG																				
PERFORMANCE MEASURES																				
INDICATOR	**TARGET**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**2019/20 YTD**
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	>=92%	80.9%	80.6%	80.5%	80.1%	81.3%											80.7%				80.7%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	391	339	188	179	153											332				332
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	<=1%	15.3%	11.9%	10.5%	12.0%	15.2%											13.6%				13.6%
Cancer - percentage seen within 2 weeks - urgent referral to first seen	>=93%	84.4%	87.6%	87.1%	78.8%	85.9%											82%				82.3%
Breast symptomatic- percentage seen within 2 weeks	>=93%	89.1%	80.0%	69.0%	50.2%	64.3%											57%				56.8%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	>=85%	69.3%	72.1%	73.5%	75.4%	77.7%											77%				76.5%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.7%	92.1%	86.7%	95.6%	89.2%											93%				92.7%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	87.0%	82.6%	85.5%	76.5%	81.1%											79%				79.2%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	94.5%	93.1%	93.2%	92.8%	95.7%											94%				94.3%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	88.5%	87.9%	88.4%	93.0%	92.0%											92%				92.4%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.7%	99.7%	99.7%	99.3%	99.4%											99%				99.3%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	92.9%	93.7%	91.2%	92.8%	90.2%											92%				91.5%
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	71.3%	73.7%	77.4%	72.0%	80.3%											76%				75.7%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	>=95%	81.3%	82.9%	85.4%	82.1%	87.9%											85%				84.8%
Ambulance Category 1 Mean response Duration (min)	7	6.8	7.3	7.0	7.0	6.9											7.0				7.0
Ambulance Category 1 90th response Duration (min)	15	12.0	13.1	12.3	13.1	12.5											12.8				12.8
Ambulance Category 2 Mean response Duration (min)	18	28.5	28.3	27.3	26.0	26.1											26.1				26.1
Ambulance Category 2 90th response Duration (min)	40	58.7	59.5	56.0	53.7	54.3											54.0				54.0
Ambulance Category 3 90th response Duration (min)	120	169.7	161.3	156.5	162.4	155.1											158.8				158.8
Ambulance Category 4 90th response Duration (min)	180	220.2	214.4	200.1	196.4	186.4											191.4				191.4
Cancelled Operations - Number of patients not treated within 28 days of cancellation	0			152																	
IAPT Percentage of people entering treatment against the level of need in the general population (Monthly Access rate)	1.25%	2%	1%	1%	1.3%	1.3%											2.6%				2.6%
IAPT recovery rate - percentage of people who are moving to recovery	50%	53.0%	53.7%	51.4%	50.7%	52.4%											51.5%				51.5%
IAPT - started treatment with 6 weeks of referral	75%	94.0%	92.3%	88.0%	81.8%	80.5%											81.2%				81.2%
Mental Health - Percentage of people on CPA who were followed up with in 7 days of discharge	95%	97.7%	87.0%	97.9%	91.1%	94.7%											93.1%				93.1%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	93.7%	93.4%	93.5%	91.4%	91.4%											91.4%				91.4%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	65.2%	48.1%	64.7%	40.9%	56.0%											48.9%				48.9%
Dementia diagnosis rate	62%	59.1%	58.9%	59.6%	59.5%	59.3%											59.6%				59.6%
QUALITY MEASURES																				
INDICATOR	**TARGET**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**2019/20YTD**
MRSA bacteraemia - number of hospital infections	0	0	0	1	0	1	1										2				2
Clostridium difficile - number of hospital infections	316	18	16	21	30	25	27										82				82
Mixed sex accommodation (MSA) - number of hospital breaches	0	1	1	2	5	12											17				17
Delayed transfers of care - patient delays as a percentage of occupied beds (Acute only)	3.5%	4.3%	3.8%	3.1%	3.3%	3.5%											3.4%				3.4%
Delayed transfers of care (all) - Percentage of delays per Occupied bed	3.5%	5.3%	4.9%	3.9%	4.2%	4.6%											4.4%				4.4%

Appendix D: Sustainability Transformation Plan (STP) Summary

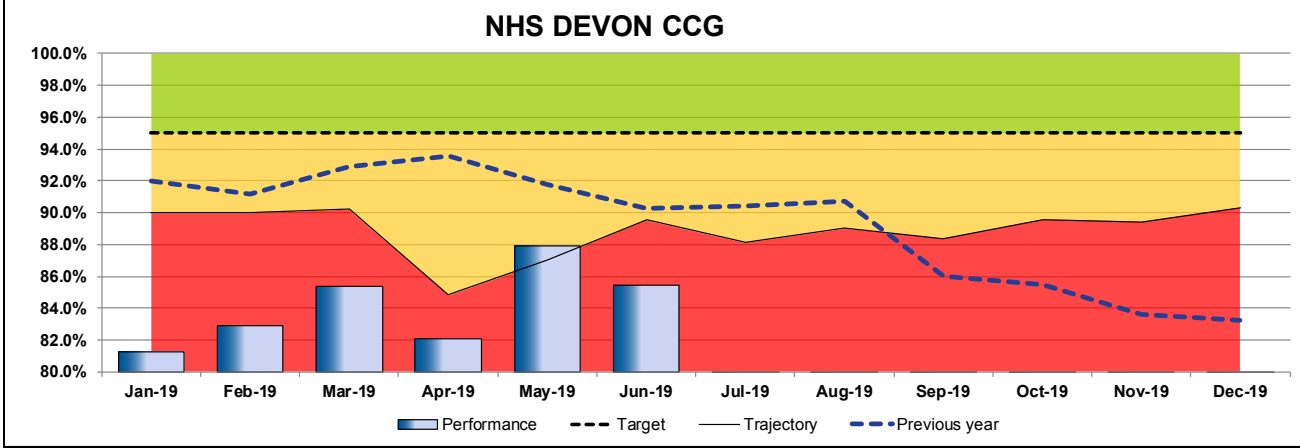
STP KPI Summary

INDICATOR	TARGET	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	ENGLAND April position	STP April Position	Q1	Q 2	Q 3	Q 4	2019/20 YTD
Referrl to treatment - Incomplete waits	78364	80,089	81,661	82,913	83,546	83,041											N/A	N/A	83,041				83,041
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	STP Trajectory	80.9%	80.6%	80.5%	80.1%	81.3%											86.9%	41 / 44	80.7%				80.7%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	391	339	188	179	153											N/A	N/A	332				332
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	STP Trajectory	15.3%	11.9%	10.5%	12.0%	15.2%											4.1%	44 / 44	13.6%				13.6%
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	71.3%	73.7%	77.4%	72.0%	80.3%	76.3%										81.2%	17 / 44	75.7%				75.7%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	STP Trajectory	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%										87.7%	21 / 44	84.8%				84.8%
Accident and Emergency over 12 hour trolley waits	0	26	7	8	14	12	7										1 Average	0 / 44	33				33
Cancer - percentage seen within 2 weeks - urgent referral to first seen	STP Trajectory	84.4%	87.6%	87.1%	78.8%	85.9%											90.8%	43 / 44	82.3%				82.3%
Breast Symptomatic - percentage seen within 2 weeks	>=93%	89.1%	80.0%	69.0%	50.2%	64.3%											78.9%	40 / 44	56.8%				56.8%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	STP Trajectory	69.3%	72.1%	73.5%	75.4%	77.7%											77.5%	38 / 44	76.5%				76.5%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.7%	92.1%	86.7%	95.6%	89.2%											87.4%	10 / 44	92.7%				92.7%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	87.0%	82.6%	85.5%	76.5%	81.1%											83.0%	36 / 44	79.2%				79.2%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	94.5%	93.1%	93.2%	92.8%	95.7%											96.0%	42 / 44	94.3%				94.3%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	88.5%	87.9%	88.4%	93.0%	92.0%											92.2%	19 / 44	92.4%				92.4%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.7%	99.7%	99.7%	99.3%	99.4%											99.3%	26 / 44	99.3%				99.3%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	92.9%	93.7%	91.2%	92.8%	90.2%											96.3%	40 / 44	91.5%				91.5%
Cancelled Operations - Number of patients not treated within 28 days of cancellation (Acute only)	0			152													N/A	N/A					
Cancelled Operations - Urgent Operations cancelled for a 2nd or more time	0	1	2	0	1	2											N/A	N/A	3				3
Delayed transfers of care - days delays as a percentage of occupied beds (Acute only)	3.5%	4.3%	3.8%	3.1%	3.3%	3.5%											N/A	N/A	3.5%				3.4%
Delayed transfers of care - days delays as a percentage of occupied beds (Acute &community)	3.5%	5.3%	4.9%	3.9%	4.2%	4.6%											N/A	N/A	4.4%				4.4%
Delayed transfers of care - days delays as a percentage of occupied beds (MH only)	7.5%	4.5%	4.6%	5.4%	5.1%	5.6%											N/A	N/A	5.3%				5.3%
Category 1 Mean response Duration (min)	7	6.8	7.3	7.0	7.0	6.9											18	N/A	7.0				7.0
Category 1 90th response Duration (min)	15	12.0	13.1	12.3	13.1	12.5											31	N/A	12.8				12.8
Category 2 Mean response Duration (min)	18	28.5	28.3	27.3	26.0	26.1											22	N/A	26.1				26.1
Category 2 90th response Duration (min)	40	58.7	59.5	56.0	53.7	54.3											45	N/A	54.0				54.0
Category 3 90th response Duration (min)	120	169.7	161.3	156.5	162.4	155.1											148.50	N/A	158.8				158.8
Category 4 90th response Duration (min)	180	220.2	214.4	200.1	196.4	186.4											197.13	N/A	191.4				191.4
Hear & Treat	11%	12.5%	12.4%	11.4%	11.1%	12.5%											N/A	N/A	12%				12%
Ambulance Incidents Resolved Without Conveyance to an Emergency Department	54.6%	52.1%	52.9%	52.0%	52.2%	52.3%											N/A	N/A	52%				52%
Ambulance Handovers Taking Between 30 and 60 minutes	0	444	324	648	260	179											N/A	N/A	439				439
Ambulance Handovers Taking over 60 Min	0	32	19	17	21	16											N/A	N/A	37				37
Care Programme Approach (CPA) proportion of people under adult MH specialties on CPA followed up within 7 days of discharge from psychiatric in-patient care	95%	97.7%	87.0%	97.9%	91.1%	94.7%											N/A	N/A	93.1%				93.1%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	93.7%	93.4%	93.5%	91.4%	91.4%											N/A	N/A	91.4%				91.4%
IAPT Percentage of people entering treatment against the level of need in the general population (Monthly Access rate)	1.25%	1.7%	1.3%	1.5%	1.3%	1.3%											N/A	N/A	2.6%				2.6%
IAPT recovery rate - percentage of people who are moving to recovery	50%	53.0%	53.7%	51.4%	50.7%	52.4%											N/A	N/A	51.5%				51.5%
IAPT - started treatment with 6 weeks of referral	75%	94.0%	92.3%	88.0%	81.8%	80.5%											N/A	N/A	81.2%				81.2%
Dementia diagnosis rate	67%	59.1%	58.9%	59.6%	59.5%	59.3%	60.0%										68.5%	0 / 44	59.6%				59.6%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	65.2%	48.1%	64.7%	40.9%	56.0%											76.7%	26 / 44	48.9%				48.9%
MRSA bacteraemia - number of hospital & community infections	0	0	0	1	0	1	1										N/A	N/A	2				2
Clostridium difficile - number of hospital & community infections	<=316	18	16	21	30	25	27										N/A	N/A	82				82
Mixed sex accommodation (MSA) - number of hospital breaches	0	1	1	2	5	12											N/A	N/A	17				17

4 hour waits A&E &MIU

NHS Devon CCG

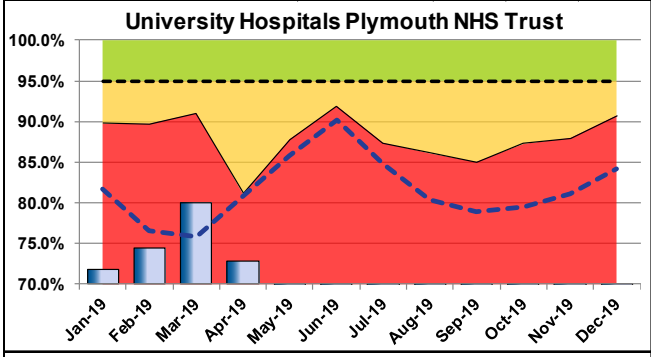
STP footprint	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>95%	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%						
Trajectory		90.0%	90.0%	90.2%	84.8%	87.0%	89.5%	88.1%	89.0%	88.4%	89.6%	89.4%	90.3%
NHS England		84.4%	84.2%	86.6%	85.1%	88.0%	87.7%						

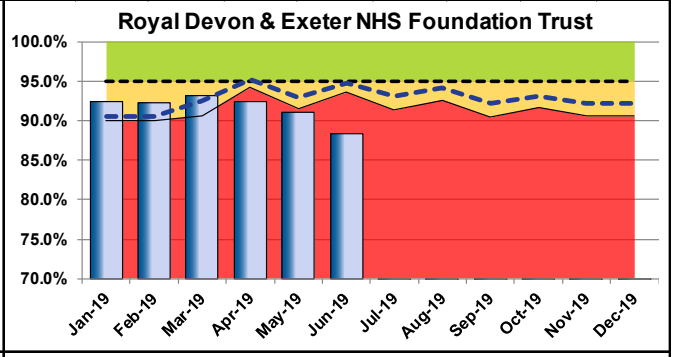


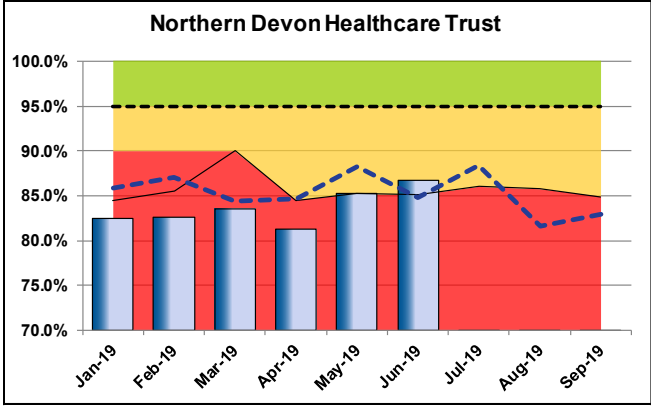
Comment:
In June the STP position was 85.4%, down from 87.9% in May, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. RD&E performance fell slightly from 91.1% to 88.3%, NDHT improved from 85.2% to 86.8% but TSD fell from 84.2% to 80.3%.
Early unvalidated July performance shows the STP position rising slightly to 88% with NDHT at 85%, RD&E improving to 90% and TSD increasing to 84%.

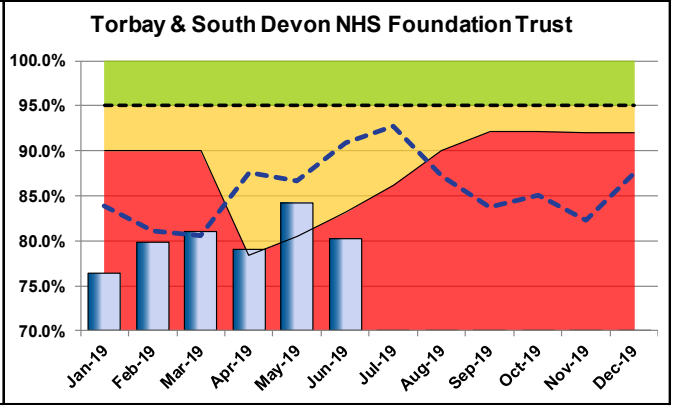
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	71.8%	74.5%	79.9%	72.8%								
	Trajectory	89.8%	89.7%	91.0%	81.1%	87.8%	91.9%	87.4%	86.1%	85.0%	87.3%	88.0%	90.7%
RDEFT	Actual	92.5%	92.2%	93.2%	92.4%	91.1%	88.3%						
	Trajectory	90.0%	90.0%	90.7%	94.2%	91.5%	93.6%	91.3%	92.6%	90.4%	91.7%	90.6%	90.6%
NDHT	Actual	82.5%	82.7%	83.5%	81.3%	85.2%	86.8%						
	Trajectory	84.5%	85.5%	90.1%	84.5%	85.2%	85.1%	86.0%	85.8%	84.9%	84.6%	84.4%	84.2%
TSDFT	Actual	76.4%	79.8%	81.0%	79.1%	84.2%	80.3%						
	Trajectory	90.0%	90.0%	90.0%	78.4%	80.5%	83.1%	86.2%	90.1%	92.1%	92.2%	92.0%	92.0%





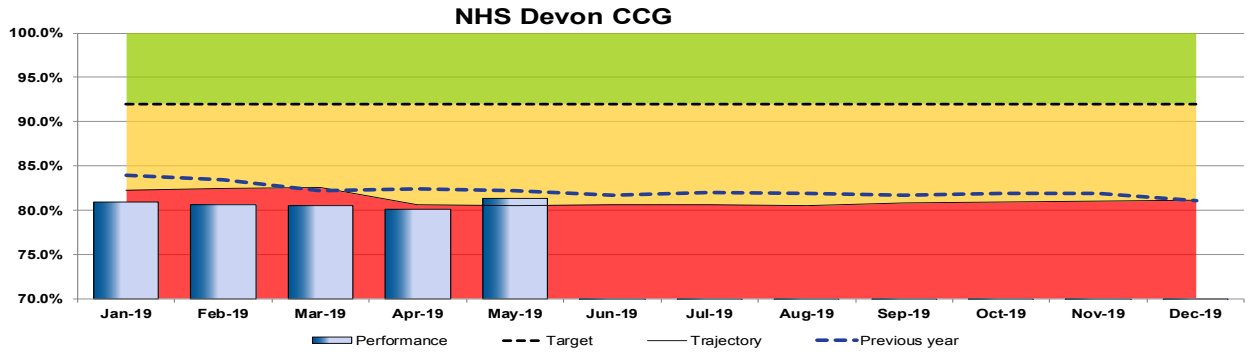




18-week RTT (incomplete pathway)

NHS Devon CCG

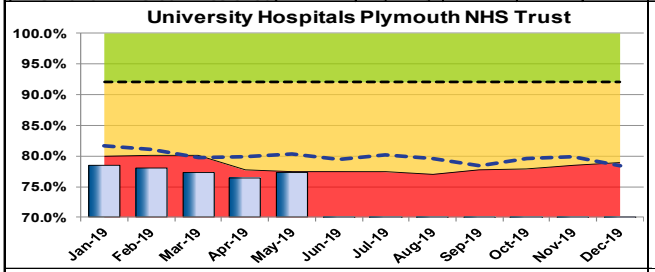
NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>92%	80.9%	80.6%	80.5%	80.1%	81.3%							
Trajectory		82.3%	82.4%	82.5%	80.6%	80.5%	80.6%	80.7%	80.5%	80.8%	80.9%	81.0%	81.1%
NHS England		86.7%	87.0%	86.7%	86.5%								
RTT total waiting list	78,364	80,089	81,661	82,913	83,546	83,041							
Trajectory		75,616	75,353	74,733	77,422	76,681	77,445	76,874	76,318	76,098	76,817	75,251	75,669

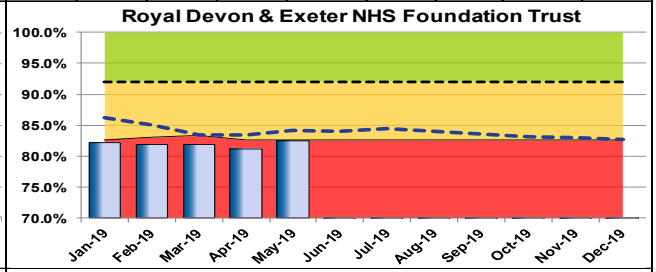


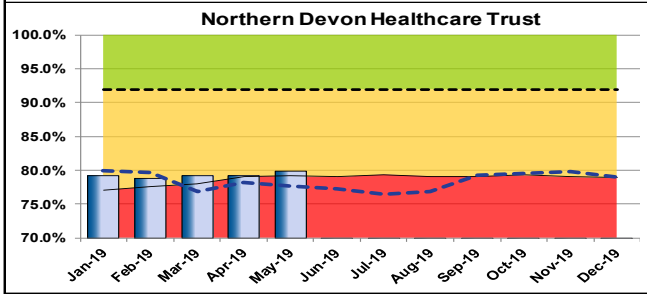
The STP level RTT position improved in May from 80.1% to 81.3% as all providers saw performance rise. RD&E increased from 81.1% to 82.4%, UHP improved from 76.4% to 77.3%, TSD rose from 80.7% to 81.9% and NDHT also increased from 79.3% to 79.9%. Both TSD and NDHT are above trajectory with UHP and RD&E slightly under.
The incomplete waiting list fell by 500 at STP level with RD&E seeing a reduction of over a thousand patients, NDHT relatively flat but increases at UHP and TSD. NDHT and RD&E are both below their respective waiting list trajectories.
Over 52 week waits continued to fall in May moving from 179 to 153 at STP level. TSD (59) and NDHT (8) both saw reductions in breaches with RD&E (71) flat and UHP seeing breaches increase from 49 to 57.

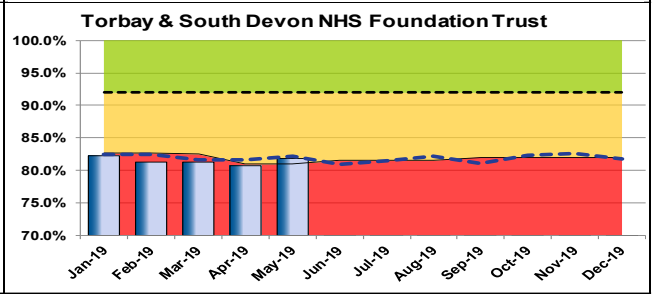
Provider level

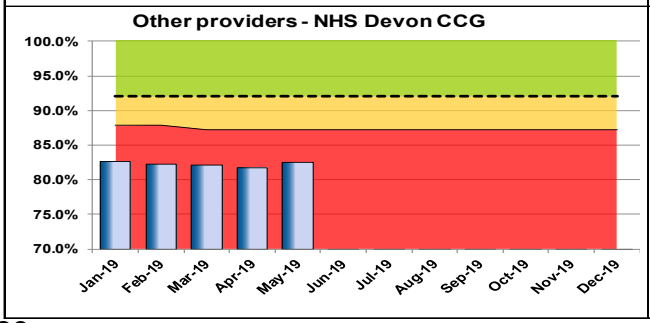
Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	78.4%	78.0%	77.3%	76.4%	77.3%							
	Trajectory	80.0%	80.0%	80.1%	77.7%	77.5%	77.5%	77.4%	77.0%	77.8%	77.9%	78.5%	78.9%
	Waiting list	27,356	27,872	27,922	28,195	28,611							
	Trajectory	25,772	25,725	26,347	28,351	28,476	28,496	28,533	28,730	28,354	28,277	27,927	27,703
RDEFT	Actual	82.2%	82.0%	81.9%	81.1%	82.4%							
	Trajectory	82.7%	83.0%	83.3%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%
	Waiting list	33,386	33,770	34,262	33,619	35,690							
	Trajectory	30,783	30,496	30,178	34,555	33,783	34,857	34,374	33,707	33,992	35,016	33,628	34,374
NDHT	Actual	79.2%	78.9%	79.2%	79.3%	79.9%							
	Trajectory	77.1%	77.6%	78.0%	79.1%	79.2%	79.1%	79.4%	79.1%	79.1%	79.3%	79.1%	78.9%
	Waiting list	11,790	11,633	11,520	11,385	11,403							
	Trajectory	13,439	13,299	13,101	11,797	11,665	11,564	11,396	11,313	11,194	11,044	10,960	10,863
TSDFT	Actual	82.2%	81.3%	81.3%	80.7%	81.9%							
	Trajectory	82.7%	82.6%	82.5%	81.0%	81.0%	81.5%	81.5%	81.5%	82.0%	82.0%	82.0%	82.0%
	Waiting list	18,430	18,564	19,425	19,016	19,534							
	Trajectory	18,282	18,332	18,332	18,567	18,548	18,416	18,398	18,379	18,249	18,231	18,213	18,194
Other providers (NHS Devon CCG commissioned)	Actual	82.7%	82.2%	82.1%	81.7%	82.5%							
	Trajectory	87.8%	87.9%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%







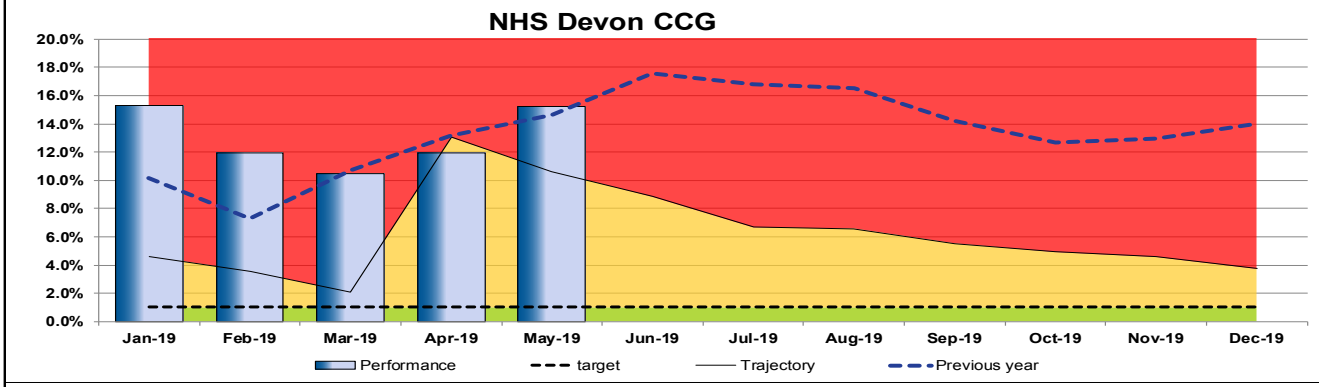




6 Week Diagnostics

NHS Devon CCG

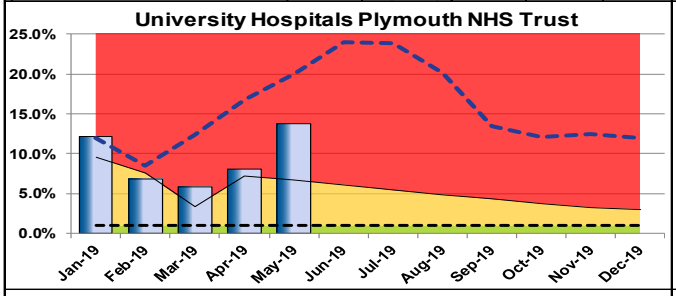
NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>1%	15.3%	11.9%	10.5%	12.0%	15.2%							
Trajectory		4.6%	3.6%	2.1%	13.0%	10.6%	8.9%	6.7%	6.6%	5.5%	4.9%	4.6%	3.7%
NHS England		3.6%	2.3%	2.5%	3.6%								

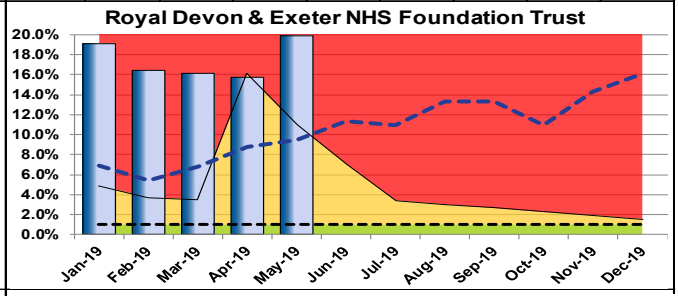


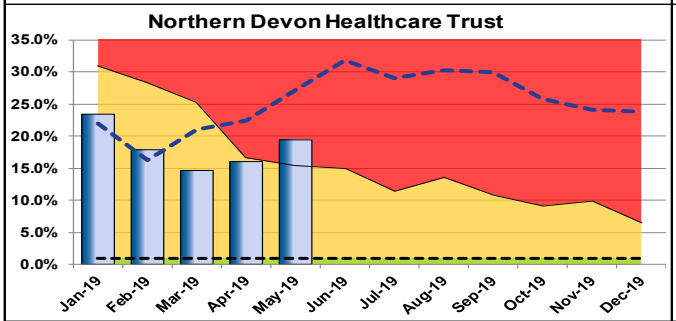
All providers except for TSD saw increased breaches in May as the STP position rose again from 12.0% to 15.2%. UHP increased from 8.1% to 13.8%, NDHT rose from 15.9% to 19.3% and RD&E performance worsened from 15.7% to 19.9%, all significantly under improvement trajectories. TSD improved from 13.7% to 12.1%, achieving May's trajectory of 12.7%. The majority of breaches continue to be for imaging and endoscopy.

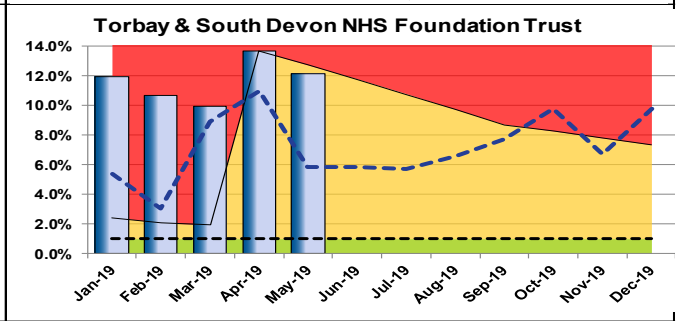
Provider level

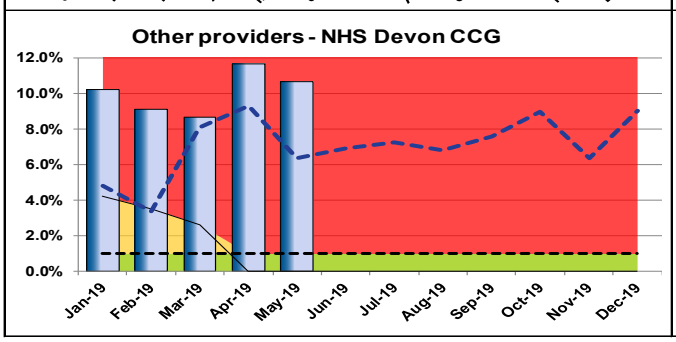
Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	12.1%	6.8%	5.9%	8.1%	13.8%							
	Trajectory	9.6%	7.5%	3.4%	7.2%	6.7%	6.1%	5.4%	4.9%	4.4%	3.8%	3.3%	3.0%
RDEFT	Actual	19.1%	16.4%	16.1%	15.7%	19.9%							
	Trajectory	4.9%	3.7%	3.5%	16.1%	11.0%	7.1%	3.4%	3.0%	2.7%	2.3%	1.9%	1.6%
NDHT	Actual	23.3%	17.9%	14.6%	15.9%	19.3%							
	Trajectory	30.9%	28.3%	25.3%	16.6%	15.5%	15.0%	11.4%	13.5%	10.8%	9.1%	9.9%	6.4%
TSDFT	Actual	12.0%	10.7%	10.0%	13.7%	12.1%							
	Trajectory	2.4%	2.1%	1.9%	13.7%	12.7%	11.8%	10.8%	9.7%	8.7%	8.3%	7.8%	7.3%
Other providers (NHS Devon CCG commissioned)	Actual	10.2%	9.1%	8.7%	11.7%	10.7%							
	Trajectory	4.2%	3.5%	2.6%									







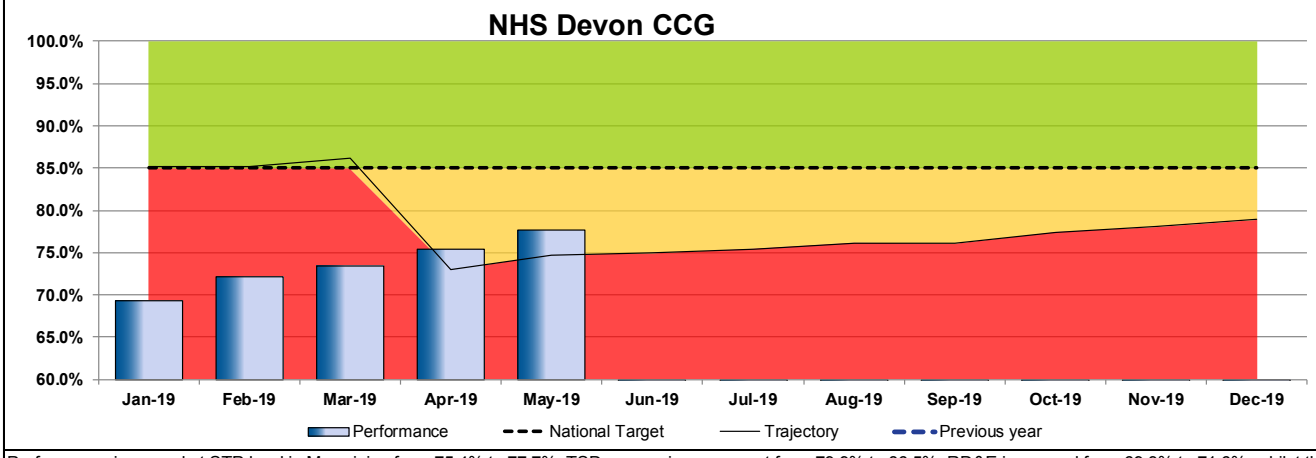




62 day standard Cancer waits

NHS Devon CCG

NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>85%	69.3%	72.1%	73.5%	75.4%	77.7%							
Trajectory		85.2%	85.2%	86.1%	73.0%	74.7%	74.9%	75.4%	76.1%	76.1%	77.4%	78.1%	78.9%
NHS England		76.2%	76.1%	79.7%	79.4%								

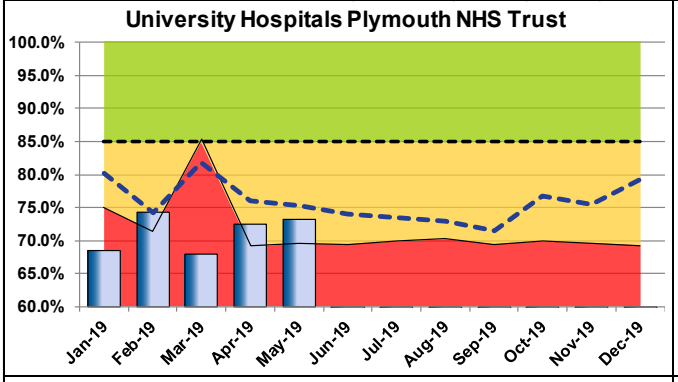


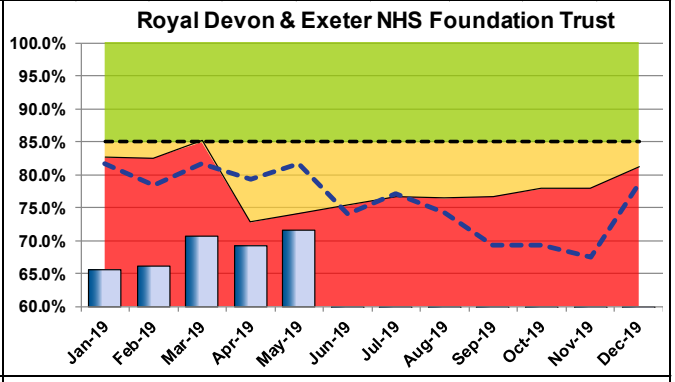
Performance improved at STP level in May, rising from 75.4% to 77.7%. TSD saw an improvement from 79.9% to 86.5%, RD&E increased from 69.3% to 71.6%, whilst the UHP position also improved from 72.6% to 73.2%. NDHT, though, saw a decrease from 83.6% to 80.2%.

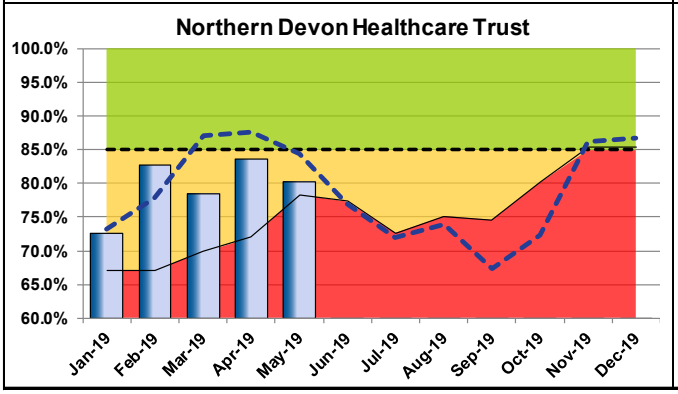
The May over 62-day backlog position increased at all providers except for UHP, with over 104 week waits also rising.

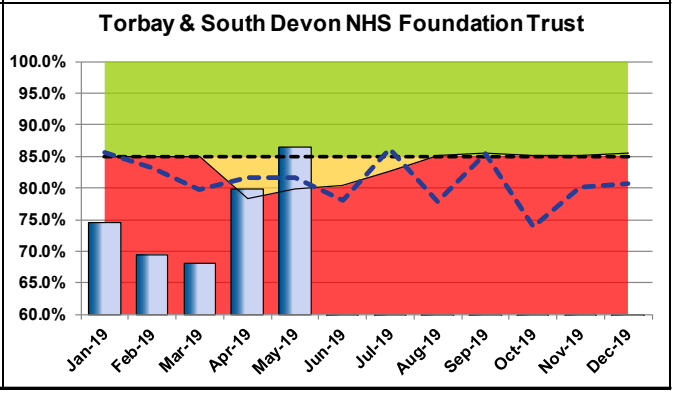
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	68.5%	74.3%	68.0%	72.6%	73.2%							
	Trajectory	75.0%	71.4%	85.4%	69.2%	69.6%	69.4%	69.9%	70.2%	69.5%	70.0%	69.7%	69.2%
RDEFT	Actual	65.7%	66.1%	70.8%	69.3%	71.6%							
	Trajectory	82.7%	82.6%	85.2%	72.8%	74.2%	75.4%	76.8%	76.5%	76.7%	77.9%	78.0%	81.2%
NDHT	Actual	72.6%	82.7%	78.4%	83.6%	80.2%							
	Trajectory	67.0%	67.1%	69.9%	72.0%	78.3%	77.3%	72.6%	75.1%	74.6%	80.2%	85.4%	85.3%
TSDFT	Actual	74.5%	69.4%	68.0%	79.9%	86.5%							
	Trajectory	85.0%	85.0%	85.0%	78.3%	79.8%	80.4%	82.8%	85.1%	85.5%	85.1%	85.1%	85.5%









NHS
Devon
Clinical Commissioning Group

Locality update report

Locality:	Northern
Period covered by update:	June 19
Locality clinical representative:	John Womersley
Locality executive lead:	Andrew Millward
Locality non-executive representative:	Charlotte Burrows

Key achievements/progress

- The STP **social prescribing** programme launched funded social prescribing in Ilfracombe, Barnstaple, Torrington and Braunton using IBCF funding. The programme has developed strong links with Active Devon and will be partnering with the national campaign 'Undefeatable' focused on increasing physical activity levels of people with LTCs and encouraging behaviour change. Our **One Northern Devon** Communities Group has oversight of the differing initiatives and is working with Primary Care Networks to establish community mappers, builders and connectors

- Strong sustained engagement continues with the **Holsworthy Community Involvement Group** and we are developing cross border collaborative opportunities with Kernow. The group's achievements to date include: -

  Spearheading the opening of beds at Deer Park Care Home for people at the end of life and those with intensive rehabilitation needs.
  Mapping more than 100 community groups, such as local voluntary, charity and statutory services.
  Analysing local needs using Devon County Council's Joint Strategic Needs Assessment of the area.
  Meeting more than 100 people face-to-face to listen to their views in a series of focus groups to understand needs.
  Delivering information leaflets about the project to 16,000 people in the area
  Establishing a list of local priorities to be addressed.

The project recently won the 'collaboration of the year' category in the Celebrating You awards

- The **Red Bag Scheme**, part of the Enhanced Health in Care Homes designed to support transfers of care is being piloted with scope for roll-out across North Devon. The Medicines Optimisation in Care Homes Pharmacist is working with the North Devon care homes team, QAIT and primary care to provide thorough medication reviews to care homes in the North. These developments form part of the **Enhanced Health in Care Home** Framework, a Northern plan for the roll-out of the Framework is in development with partners from across the system including the AHSN and the market.

- The **Planned Care** Programme in the North continues working to align with the priorities in the Long-term plan and priorities identified within the Peninsula Clinical Service Strategy (PCSS). We now have clarity on the key deliverables within the Planned Care programme for 19/20 and these will include Demand Management, PCSS related projects and delivery of the national performance standards.

- The Northern sub-group of the STP Diabetes Transformation Steering Group has reviewed NDHT sustainability business case with clinical and operational leads at the Trust to ensure alignment and delivery of the **Diabetes Strategy** outcomes and to ensure sustainability of the initiative.

- **The Moorings** mental health crisis café has had a very positive reception since opening in April 2019.

Key priorities for the next three months

- NDHT are undertaking a review of a selection of the key hospital services needed by the population of Northern Devon, and for each service asking two questions: -
  What are the clinical arrangements which best meet the healthcare needs of the population of Northern Devon?
  What is the organisational form which best delivers these arrangements?
  Following this process will allow NDHT to start discussions in the right place by firstly understanding any challenges facing their services and how the trust best meets people's needs, and then determining the organisational form that best delivers that.

- Co-working with NDHT on the "sustainable-model" of acute care.

- We are developing deflection/alternate solutions to Care Home acute admission particularly Ambulatory Care sensitive conditions. The focus is on closer working between ICM and UEC to understand gaps and over-laps weaknesses and opportunities. The Northern system needs to work together to seek ways to mitigate the small surges in A&E that have such a disproportionate impact.

- Re-instate Clinician-to-Clinician Groups by specialty to promote/deliver service change and support the local delivery of the long-term plan.

- Great emphasis on co-produced data-sets that allow shared emphasis on the correct variances to manage. This has particular relevance in the Urgent Care arena.

- Engage with emerging PCNs and Clinical Directors on diabetes transformation plan.

- NHS Devon CCG now has responsibility for commissioning sexual violence therapeutic services for residents of Devon and Torbay. North Devon Healthcare Trust has been commissioned in-line with NHSE guidance to provide Sexual Violence and Therapeutic Services. To increase capacity, sustainability and viability of a range of providers a procurement exercise will be undertaken to identify a suitable organisation to take forward delivery against the additional funds.

Issues of concern or risk

- NDHT's sensitivity to small changes in demand destabilising ED performance and flow through the hospital continues to be a challenge.

- The requirement for a Community Urgent Care Strategy to resolve Locality configuration is increasingly important to avoid delaying a robust good quality local solution locally to national guidance.

- As in the Eastern locality our 'Out of Area acute mental health bed usage remains a concern, but this has been lessened through the procurement by DPT of 16 male beds at Cygnet, Taunton. Place of safety Out-of-Hours Provision is challenging when it occurs, but numbers are low.

- Ophthalmology capacity remains a concern. The backlog is receiving attention and we have requested a more robust provider action plan to support implementation of improvement.

- Clinical coding pressures remain within the mortality and morbidity review process. The immediate concern of the coding backlog has been resolved, but assurance has not yet been received regarding long term sustainability of the coding system.

- There have been several overdue Serious Incident analysis reports from DDoc and DPT which could affect the embedding of learning. The Safety and Quality Team is actively promoting more timely reporting.

- There remain significant workforce challenges in mental health inpatient care. The two acute mental health wards at NDHT have been combined into one 26 bedded ward due to insufficiency in the number of mental health nurses. QEIA being reviewed by Patient, Safety and Quality.

- Referral pathway delays in Children and Family Health Devon. There are delays in treatment for some pathways, including autism, leading to potential PSQ issues for children, young people and their families. The PSQ Team will maintain a level of awareness and seek assurance from the provider in relation to harm reviews through the CRM/JWTG assurance meetings. A QEIA is being developed

Support required from CCG/system or barriers to progress

- Early resolution to Community Urgent Care Strategy outcome.

- Some reports are compiled to cover the Northern and Eastern Localities combined. This makes local analysis, learning and planning more difficult. With the planned move to Local Care Partnerships we would request the localisation of reports whenever possible.

- Continued support required from CCG to support recruitment of locality clinicians to support delivery of the operating plan for 19/20 and the long-term plan.

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Locality update report

Locality:	Eastern
Period covered by update:	June/July 19
Locality clinical representative:	Dr Simon J Kerr
Locality executive lead:	John Dowell
Locality non-executive representative:	Glynis Atherton

Key achievements/progress

Eastern GP practices have established 11 primary care networks (PCN) & identified 12 Clinical Directors (CD). These GP's now meet regularly together at the eastern GP collaborative board. The board is chaired by Dr Jennie Button and is actively engaging with many eastern locality stakeholders.

PCN CD's attended a refreshed version of the Eastern locality delivery group on July 3rd and the meeting explored both the opportunities for PCN's to contribute to the Devon response to the 10 year NHS plan and the thinking regarding how primary care provision should be incorporated into an Eastern locality care partnership. Much was learnt from the meeting particularly with regard to needing to facilitate both population health intelligence, building relationships with community service managers, district and housing colleagues & a directory of who's who was thought to be likely to be helpful to new colleagues going forwards. Ideas were shared with regard to how PCN CD's could be engaged with the eastern planned care and A+E delivery board meetings and it's hoped to develop a local care partnership executive group likely engaging the chair of the collaborative board to represent primary care provision.

3 member forum engagement meetings are underway in July & are further exploring urgent care provision, ambulance services and the potential for commissioning an additional alternative patient transport service. There are presentations from care of the elderly consultants, social prescribing and Dr Paul Johnson is being able to meet the representative GP's from each practice.

The eastern system is already planning for winter 19/20. The eastern winter pressures monies have been identified and bids sought for ideas and projects to support admission avoidance where clinically appropriate and earlier facilitation of

hospital discharge. Bids are being actively sought from primary care from their PCN's clinical directors through the collaborative board and a broad spectrum of additional & innovative services to manage predicted demand is anticipated.

The locality has now just 4 GP clinical sessions per week currently engaged and is working with HR to recruit a further 3 x 2 sessions with one "strategic clinical adviser" from each it's three districts. It's hoped new clinical commissioners will both support the GP forums within the three districts and enhance the clinical contribution particularly to the commissioning of mental health, urgent care and preventative services.
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Key priorities for the next three months

Recruitment of 3 locality strategic clinical advisers, one from each of the three district forum footprints.
It's hoped these individuals might be ready to begin on an interim basis perhaps early in September.

Further establish a locality care partnership structure empowering PCN CD's to engage both with commissioners, acute and mental health secondary care, social care and voluntary sector providers to optimise clinical pathways in both planned and unplanned care. Focus these clinicians on both the requirements of the PCN's and preparation of delivery of service specifications under the contract proposed for 20/21 but also the financial imperative and 5+2 system priorities to manage demand detailed in the operating plan

Prepare for a joint GP members forum on Sept 18th to explore the opportunities digital technology can bring to health provision in east with engagement of primary, secondary clinical and managerial colleagues to attend.

Begin preparation for Governing body (GB) development and "showcase" for November in E. locality.

Agreeing joined-up plans re: winter pressures monies

Agreeing shared ICM priorities with providers and partners and implementation plans

Agreeing shared plans across the partnership for the roll-out of the Enhanced Health in Care Homes Framework

Reducing demand for and increasing supply of personal care e.g. guaranteed hours contract, Proud to Care campaign

Issues of concern or risk

Lack of engaged and focussed clinical commissioning time in the locality.

On-going concerns re cardiology and community based secondary mental health services.

Delay to the roll-out of comprehensive assessment, due to IG issues and software development time

Insufficient medical input into the Urgent Community Response Teams

Challenges developing joined up plans re: winter pressures monies within the time-frames

There are currently 108 people waiting for a package of care, requiring 1293 hours (about 8% of total demand) with the capacity of care agencies the main problem

Residential - DPT have raised concern regarding the impact of not being able to source adequate nursing home placements for people with an advanced dementia and challenging behaviour is having on Franklyn Hospital. They currently have 8 patients out of area as far as Northampton and South Wales which is having a significant impact on families and budget

Support required from CCG/system or barriers to progress

On-going HR support to engage 3 strategic clinical advisors

Primary care commissioning support for greater clarity re working with new PCN's

Support from comms services to ensure PCN CD's are fully connected with both STP plans , public engagement plans and eastern wider locality stakeholders

Further engagement of commissioning managerial leads with respect to helping to populate this GB report on a monthly basis.

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Locality update report

Locality:	Southern
Period covered by update:	July 19
Locality clinical representative:	Dr David Greenwell Dr Matthew Fox
Locality executive lead:	Dr Sonja Manton
Locality non-executive representative:	Judy Hargadon

Key achievements/progress

Integrated Care Model (ICM)

- Project Board established, key workstreams and priorities agreed, project leads for both operations and commissioning identified, ICM plan shared with local system leaders.
- Two new Commissioning Managers started this month, filling vacancies left by recent leavers
- Enhanced Health in Care Homes framework gap analysis completed

Long Term Conditions (LTCs)

- **Diabetes:** Agreed distribution of NHS E transformation funding across localities focusing on multi-disciplinary foot clinics and GP Champions.
- **Respiratory:** first multi-agency steering group held and vision for integrated service developed.
- **Cardiovascular disease** (CVD): Atrial Fibrillation project received allocation of resources from prevention funds. Impact on prescribing spend on novel oral anticoagulants (NOACs) is being analysed prior to roll-out.

Primary Care Networks (PCNs)

- Several PCN leads joined local partnership delivery group for focused session on PCN development and engagement. Agreed to continue using that forum for ongoing support and sharing of best practice.
- Social prescribers in place in some PCNs, others out to advert

Quality

- Development of local Quality Surveillance Group (QSG) – a workshop with key stakeholders and regulators took place on 28th May followed by an inaugural local QSG on 1st July.

TSDFT performance

- Weekly improvement and assurance meetings with TSDFT and NHSEI have commenced, replacing the gold calls
- The System Improvement Board meeting in early July included focused discussion on key performance concerns with a view to implementing sustainable improvement plans and continues to meet monthly.
- Ambulance handovers times are improving, but weekend discharges and the average time to record vital signs need to improve and are now the focus of the weekly meetings
- The ECIST and GIRFT teams are supporting the Trust with several urgent and emergency care improvement workstreams, and we will be supporting them with the key workstreams.

Key priorities for the next three months

ICM

- Allocation of social prescribing resources from prevention fund to be agreed.
- Roll out of falls prevention strength and balance project
- Systematic embedding of Making every Contact Count training across locality.
- Management of high intensity users of ambulance service.
- Teignmouth reconfiguration – Teignbridge District Council to decide on bid for Brunswick Street. Local engagement plan to be implemented and assurance process undertaken with NHSE.

Integrated Urgent Care Services

- Devon Doctors complete their staff engagement on IUCS, including opening hours, in mid-July. We will need to work with them to understand their proposals and any implications for the Newton Abbot service, although there is no proposal to close any treatment centres.
- We continue to develop the South model for community urgent care services, including on-going development of Newton Abbot MIU as a designated urgent treatment centre.

Local Care Partnership (LCP) development

- Continue to involve and support Local Care Partnership arrangements

Long term plan

- Engagement on Long Term Plan commences July, coordinated by STP strategy team and led locally by comms leads and TSDFT Interim Director of Transformation and Partnerships. Healthwatch also involved.

Staffing

- We will confirm local clinical commissioning expertise to support key pieces of work

- Senior Commissioning Manager starts with the CCG in August, filling the remaining vacancy in the team, and will provide greater resilience to urgent care support specifically.
- New Director of Transformation and Partnerships starts at TSDFT in late July

Issues of concern or risk

- TSDFT Performance and financial position – the Trust has been identified as one of seven in the South West which require intensive support in respect of ambulance handover delays. Other safety metrics (1st & 2nd vital signs) within the Emergency Department continue to be below target. Additional quality reviews have been undertaken by the CCG and we are assured quality of care remains good.

- Personal care capacity and resilience continues to be a concern across Devon. We are working with Devon County Council and the Trust to fund alternative provision, with a focus on end of life care. This additional capacity will be available from 29th July.

- Staffing issues in MIUs are leading the Trust to propose short term changes to current provision (opening hours of Dawlish MIU and Totnes MIU; the availability of X-ray not affected). CCG are in ongoing conversations with the Trust to ensure all alternatives are being explored and any reduction in service is as minimal and short-term as possible.

- TSDFT theatre re-opening, planned for August, is now delayed until September.

- TSDFT 52-week wait performance, currently performing better than trajectory, is likely to deteriorate in August with outsourcing capacity already taken up by neighbouring Trusts.

Support required from CCG/system or barriers to progress

- Likely that TSDFT performance will continue to require exec-level focus and assurance, in partnership with NHSEI.

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Locality update report

Locality:	Western
Period covered by update:	To 10th July 2019
Locality clinical representative:	Dr Shelagh McCormick
Locality executive lead:	Jo Turl
Locality non-executive representative:	Nick Ball

Key achievements/progress

- Launch of Integrated Care Partnership procurement (community, mental health, learning disability and adult social care services – implementing Integrated Care Model – service commencement 1st July 2020)
- Primary Care Network Development including engagement between CCG, PCNs, Livewell Southwest and UHP
- Refreshed programme plans in ICM and Urgent Care with good engagement and commitment to implementation
- Children's Procurement – Implementation
- Improved Access - Since March DDOCS and Beacon Medical Group have been meeting the 75% uptake target
- Confirmation that resource will be forthcoming from STP prevention workstream for Social Prescribing

Key priorities for the next three months

- Development of GP prospectus for the City and 100 day delivery plan
- Agreement and contractualisation of ICM delivery in 19/20 with Livewell Southwest
- Agreement of MHIS schemes with LWSW for 19/20
- Primary Care Networks including early development of enhanced primary care teams (MDTs) and alignment of existing social prescribing programme and resources with Devon-wide approach and PCN engagement
- Integrated Care Partnership Procurement
- Integrated Care Model (5 priority programmes: Primary and community integration; multi-morbidity including LTC, frailty and dementia; population health management; wellbeing hubs; enhanced health in care homes)
- Implementation of demand plans through AEDB

- Population health management (Devon-wide and local projects)
- System pharmacy support offer to PCNs
- Engagement between ICM and Digital workstreams to progress shared use of clinical information systems across primary/community in particular

Issues of concern or risk

- Emergency Department
- Operational Plan delivery to achieve financial efficiencies
- Diagnostics
- Primary Care Provision
- Improved Access sustainability
- Pharmacy Workforce
- Population health management

Support required from CCG/system or barriers to progress

- Resolution to information governance issues preventing rollout of population health management (Devon Linked Data Set)
- Request for progress update on equity workstream

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GOVERNING BODY

Report title: Committee Chair Report – Primary Care Committee (Public)

Date of Governing Body:

Dates of Committees covered in this report: 4th July plus ratified minutes from 6th June

(Minutes of these committee meetings to be available as an addendum)

Chair's Name and Title: Judy Hargadon/Nick Kennedy

Contact Details: nick.kennedy3@nhs.net , judy.hargadon@nhs.net

Reports discussed and assurances received

- Members of the Committee discussed the following reports:

Finance Report

Ben Chilcott presented the Finance report for month 2. Ben reported that the report would become more reflective of spend as the year progresses.

Ben reported that the Mayflower procurement is due to go live this week.

The group discussed the spend with Roche Diagnostics for the provision of testing strips

Pharmacy Strategy

David Bearman and Sue Taylor attended the Committee to present on the Pharmacy Strategy. It was decided that the Pharmacy Strategy should be on the agenda for the next meeting to discuss how it links with Primary Care Networks. Jo Watson is to be invited to attend the next meeting.

Digital

John McCormick attended the Committee to present the Digital Strategy. Members of the group expressed how impressed they were with John's enthusiasm for driving digital projects forward.

Devon CQC Report (quarterly)

Paul Baker presented the quarterly Devon CQC report. Members noted that five new reports had been received since the last Devon wide report, with 3 receiving good ratings and 2 receiving outstanding rating.

Members noted that all Practices in Devon currently have good or outstanding ratings. Members acknowledged that this was a good achievement by Practices.

Primary Care Networks Guidance Update

Paul Baker presented on the updated Primary Care Networks guidance.

Paul said that the main challenge is keeping up with daily guidance changes and timelines are challenging with it being the first month of networks.

Primary Care Operational Group

Members of the Committee reviewed decisions made a Primary Care Operational Group and members endorsed the decisions made.

Paul particularly noted that a decision had been made virtually on Bramblehaeis to ensure deadlines were met and an engagement event is due to take place on 5th July regarding Hatherleigh and Shebbear.

Reports received and noted

- Members of the Committee received the following reports for noting:

Primary Care Highlight Delivery Status – Paul Baker presented the Primary Care Highlight report.

LMC Negotiation Meeting Outcome Report – Paul Baker presented the paper. Paul highlighted one point which was to put physical health checks for people with severe mental illness in place and reported significant steps had been taken.

Locality Flash Reports – Members noted the locality flash reports. Nick Ball asked for review of the RAG rating for South Devon.

Contracting Report – Paul Baker presented the contracting report. Members noted the report.

Forward Planner – Members reviewed and noted the Committee forward planner. Digital to be given a regular slot at Primary Care Committee

Risk Register Review (changes and areas of concern)

- The Risk Register was reviewed by members. Three risks reported, two with relatively high scores. No changes this month.

Committee Decisions

- The Committee endorsed decisions made at Primary Care Operational Group

Recommendations for Governing Body

- **None**

Recommendations for other Committees

- **None**

Terms of Reference or other committee effectiveness issues

- **None**

Management of Conflict of interests:

Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.

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