PUBLIC - NHS Devon CCG Governing Body

Governing Body Public

Conference Room 2&3, AHSN Offices, Vantage Point, Pynes Hill, Exeter, EX2 5FD

29 August 2019 15:00 - 29 August 2019 17:15

AGENDA

#	Description	Owner	Time
1	Welcome and Apologies Verbal	Chair	15:00
2	Register of Interests (ROI) Verbal Declarations of Interest NHS Devon Governing Bo... 5	Chair	15:05
3	Minutes of the last meeting and action log Paper 1 Draft minutes held in public 25.07.2019 v2 PJ.doc... 9 2 Master Action Log - PUBLIC v2 nc.xlsx 19	Chair	15:10
4	Patient Experience Story - Devon Virtual Voices Presentation	Non-Executive Lay Member with an Interest in Patient Involvement	15:15
5	Chair's Report Paper 1 cover sheet chairs report.docx 21 Chairs Report August 19 - PJ.docx 23	Chair	15.35
6	Accountable Officer's Report Paper 1 Cover sheet template (002) Interim AO Report Pu... 25 2 AO Report Public Devon CCG August 2019.docx 27	Accountable Officer	15.45
7	QUALITY AND PERFORMANCE		
7.10	Quality Assurance Committee Chair's Report Paper 2 QAC August to GB Committee Public Chair Repo... 33	Chair Quality Assurance Committee	15.55

#	Description		Owner	Time
7.20	**Quality and Performance Report** Paper [P] 01 Quality and Performance cover sheet.docx [P] 02 Quality and performance report August.docx	 37 39	Director(s) of Commissioning	16:05
8	**INFORMATION**			
8.10	**Finance Committee Chair's Report** Paper [P] finance committee chairs report 15 08 19.docx	 65	Chair Finance Committee	16.30
8.20	**Month 4 Finance Report** Paper [P] 1 NHS Devon Cover sheet Finance Report for Augu... [P] 2. FPC_Report_GB_Month 4_FINAL_2019-20 (GB...	 67 71	Associate Director of Finance (Northern & Eastern)	16.40
8.30	**Locality Updates (North, East, South and West)** Paper [P] 0 Locality Updates Cover Sheet.docx [P] 1. Northern Locality Report August 19v2.docx [P] 2 Eastern Locality Report August 19 v2.docx [P] 3. Locality update report- Southern - August 2019_... [P] 4 WL Update Report for Aug 2019 GB - 16.8.19.doc...	 91 93 99 103 107	Locality Triumvirate Representatives	16.50
8.40	**Primary Care Committee Chair's Report** Paper [P] Committee Chair Report - Public PCC August 19.do...	 111	Chair Primary Care Committee	17:05
8.50	**Clinical Policy Committee Annual Report 2018-19** Paper [P] 1 GB cover sheet - Clinical Policy Committee Annu... [P] 2 Clinical Policy Committee Annual Report 2018-19...	 115 119	Director of Commissioning	17:10

Declaration of Interests Register - NHS Devon Governing Body
Report generated by the governance team on 14 August 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
	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 GP Locality Clinical Director Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	28/07/2019	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
	Harris	Penny	Management Consultant	Attendee Governing Body Senior Leadership Team (SLT) Integrated Commisioning Executive (ICE)	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training		23/07/2019	24/07/2019	Finincial 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.	KERR Darnley Ltd
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 Non-ExecutiveDirector GO-OP, GO-OP is a Multistakeholder Co-operative Society (Somerset Rules), registered under the Co-operative and Community Benefit Societies Acts. GO-OPGO-OP will be the UK's first co-operatively owned and run Train Operating Company		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 and engagement	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	Spouse is owner of Pearson Creative	13/01/2017	14/08/2019	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. Will not be commissioned by emplovee	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	Simon	Head of Nursing and Quality/Deputy Chief Nursing Officer Interim Director of Quality Assurance (July 2019)	Member of Quality Assurance Committee Northern and Eastern Preparatory Group QEIA Panel Joint Clinical Effectiveness Group Attendee Governing Body		Spouse: Wife works for Devon County Council Public Health as Assistant Director of Public Health, Devon County Council	17/06/2015	08/08/2017	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
	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) Interim Director of Nursing (Caldicott Guradian) July 2019	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

NHS Devon Governing Body Meeting held in Public –DRAFT Minutes

Date: 25 July 2019 Time: 13:15

Location: Devon Suite, Exeter Court Hotel, Kennford, Exeter, EX3v 7UX

Item	Discussion	*Action*
1	**Welcome and apologies:** PJ welcomed everyone to the meeting and the following apologies were noted: JW, TP, SP and VP	
2	**Questions received** Mr Colin Pincombe, who was present at this meeting on behalf of the Friends of South Hams hospital brought to the attention of NHS Devon CCG on 23 July that an extension car park had been purchased and equipped by the Friends for the hospitals use and that it's opening awaits the CCGs approval of a peppercorn lease. JT responded that in principle the CCG were supportive of this, however there was some fine detail and risk assessment that needed to be undertaken by the CCG and NHS property services first before formal approval of this lease could be given, and JT agreed to liaise with Mr Pincombe outside of this meeting.	
3	**Register of Interest (ROI)** The ROI was reviewed and there were no amendments or new declarations made.	
4	**Minutes of the last meeting and action log** PJ led a page by page review of the previous minutes and there was a minor amendment to section 7 third paragraph which should read: • 'SM informed University Hospitals Plymouth (UHP) is not formally reporting against the ED standard as they are currently trialing new performance measures' • SMC noted that she was not in attendance at the Governing Body meeting held on held on 27 June. • It was noted in item 9.10 in the June Board Pack 'Procurement of an Integrated Care Partnership for Western Devon and Mayflower Medical' the summary of services was not clear. It has been confirmed that "Adult social care for Plymouth City Council" specifically relates to the delivery of services that meet adult social care statutory functions that have been delegated under the Care Act 2014 Subject to the above minor amendments the Governing Body agreed the minutes of the meeting held on 27 June were an accurate record of the meeting. The actions were updated in the action log and completed actions were formally closed.	

5	**Patient Experience Story – Improving relationships with the public** CB, introduced this patient experience story to share with the Governing Body the learning from this process. Sam Holden (SH), patient experience manager described the background following a complaint made by a client about their experience of using extended scope physiotherapy (ESP) provided by Sentinel and the CCGs referral support services. Even after an initial investigation this led to the client feeling that both the provider and the CCG were hiding information or covering for each other and caused a relationship breakdown. As a result of this, a comprehensive external review was undertaken (summary review circulated) and highlighted a series of key areas to be addressed and following the review improvements have been made including complaints training by the Ombudsman, the client working with the CCG on areas of improvement and how to see how we quality assure. The client is now also part of our review process for revised complaints policy which has helped improve relationships. SH offered comments and feedback which included: • Important to remember that although this was looked at through the lens of complaint, we did take learning from the patient's experience • Investigation identified communication issues and that learning had been drawn from this for first contact with clients and GPs • Acknowledgement that Sentinel had taken on board the issues highlighted and they have responded to the complaints make and the CCG continues to work with them on their improvements • Recognition of the importance of how we bring our GP colleagues on the journey when making commissioning decisions and we also need to think about how we present data for clinical pathways • Chair requested the clinical lead representatives for the localities to ensure we communicate effectively with our clinical members • Concerns raised the summary review was not redacted and SH confirmed that permissions from individuals had been given • Noted that commissioning decisions can cause conflict for the Devon Referral Support Services with interacting with GPs PJ thanked SH for presenting this patient experience and that we will continue to work hard to have good relationships with clinicians and we will look at how we can further support them. **The Governing Body welcomed the opportunity to listen to this patient experience and how we can use this to help with improving our engagement with the public.**	
6	**Chair's Report** PJ referred to this report in the board pack and drew attention to Devon System Non-Executives Development Day held on 3 July and was pleased to report that there was appetitive for involvement and engagement and reflections from the session included: • Useful to understand Non-Executive individual perspectives • Empathy • System working exciting and engaging • Debates around governance • Positive, constructive and enthusiasm • Time constraints for Non-Executive involvement • Wide range of view for support and system working • Chairs talking in real terms of system working, talk of realism	

	• NEDs involvement in Local Care Partnerships GA has been asked by Dame Suzi Leather, Devon STP Chair to participate in a small working group to agree how we might apply the learning. **The Governing Body received and noted the contents of the Chair's Report.**	
7	**Interim Accountable Officers Report** ST presented this report and gave thanks to Andrew Millward, Director of Communications and Human Resources and the wider communications team for the engagement work that has been undertaken for both our former CCGs before merging which has been rated as 'Green Star' one of the highest awards to be given by NHS England. A cohort of 'Celebrating You award' winners were chosen to attend the King's Fund Leadership Management summit on 10 July and feedback given has been positive. Their individual learning will be shared with the Senior Leadership Team and Governing Body. GA mentioned the recent political changes and our EU Brexit Plans in preparation for 31 October. SMa responded that an approach plan is being developed and will be presented to the Audit Committee. Regional workshops are being set up to address workforce issues which will be incorporated into national plans and updates will come back to the Governing Body regularly through the Accountable Officer reports and EU Brexit Planning will be overseen by the Audit Committee. **The Governing Body received and noted the contents of the Interim Accountable Officers Report.**	
8	**Finance Committee Chair's Report** There was nothing further to add to this report other than risk 19, intermediate care contracts had been closed. **The Governing Body received and noted the content of the Finance Committee Chair's Report.**	
9	**Month 3 Finance Report** JD presented the latest report which detailed the financial position for the first quarter of the financial calendar and an assessment of the CCGs risk in delivering its planned deficit of £27m. JD put into context the deficit plan and the challenges the Devon System face and noted that NHS England South West have agreed in principle the planned deficit, but this final approval nationally with NHS England and we are working on the basis that this planned deficit will be agreed. JD referred to the financial summary of expenditure on page 49 and the year to date deficit of £6.7m for Quarter 1 which is in line with the £27m forecast for the year. This figure is based on assumptions around delivery of our savings plans and that we are still pushing to improve our financial position. JD briefed the Governing Body around the difficulties in delivering a balanced plan and that our planning assumptions are critical to success in managing our demand in referral activity.	

JD drew attention to the month 2 provider activity summaries from page 50 which showed a mixed picture of below planned levels. Overall picture is showing 2.3% 12 month rolling average increase, butimportant to note there were quite marked variations by providers.

ST noted that there has been a 13% reduction in Independent Sector referrals which should result in lower activity and expenditure as these contracts are fully variable.

PJ queried the rates of outpatient activity and if these are equal the rates will stay the same, but if there is a drift in activity this will identify a mis match of specialty by specialty, and performance will inform us of this.

JD brought the Governing Body's attention to the significant issues that will impact on our ability to deliver our savings efficiencies and guided the members to the summary of QIPP plans on page 56. The upside risk has been assessed at £15m with a down side assessment of £50m shortfall. The likely level of risk has been set against quarter 1 and consistent with that identified in the openingplan and is set out in section 5 of the report of a total of £39.5m. All opportunities and programmes of work are being explored to identify further mitigation to reduce the current shortfall.

It was asked how we will measure success and JD confirmed this will show in activity reports and will be dependent on our transformation programme. A more detailed report would be presented to the next Governing Body. The understanding and monitoring of the risks the CCG are taking will be further scrutinised by the finance committee.

ACTION:
JD to develop a detailed assessment of our financial risks to be presented to the next Governing Body meeting.

JT mentioned that we don't have the relevant information at locality level to drive change at STP level and to also test where we are against operational delivery. She felt that the data needs to be examined further and paired against performance date.
NB asked what our response to our regulators is and the best estimate total for mitigated risk and JD responded that the expectation and response that our regulators is that we continue to work in mitigation that we will deliver the plan, or as close as possible.

PJ asked whether the CCGs running costs included STP administration costs and the assumption that the system contributes to this. JD replied that the STP running costs will be shared across the system. NK asked where the visibility of the STP administration costs were in the system and JD confirmed these were reported through the Programme Directors Executive Group.

GA queried winter pressures monies and the flows through the local authorities and JD confirmed this would be same process (to agree joint priorities between Health and Social Care Commissioners) as used for the Better Care Fund.

PJ thanked JD for this latest financial report and the opportunity for discussion around the table.

The Governing Body received and noted the month 3 financial position as at 30 June 2019 and the level of risk to delivery of the CCGs control total.

10	**Audit Committee Chair's Report and Risk Management Update** NB reported that at the last meeting in July the Audit Committee received and discussed the new style Assurance Framework which has been simplified by making it easier to read and linking to the corporate objectives. NB described how key risks are being managed by the Executive Directors and Senior Leaders and that the risk register will be presented to each Audit Committee to advise of any updates or changes. NK drew attention to assurance framework risk 13 (AF13) page 80 and the Governing Body decision to accelerate shift of resource to primary and community care. It was confirmed that this links to the financial framework that dovetails into the Long-Term Plan (LTP) NK also queried assurance framework risk (AF9) page 76 and are we actively pursuing a range of subject matter experts for our commissioning teams. It was acknowledged that we do have the right clinical expertise and clinical challenge we just need to prioritise our resource into the right areas. It was wondered what our learning is from outstanding CCGs and areas of excellence, what is best practice and meaningful for our populations. GS replied that we are putting in place a systemised process and that we will be following this up and taking forward. There was agreement that we need to do more beyond our own region in implementing best practice that was not our own. ST offered to visit areas of excellence and agreed that we must do more and that he would further discuss improving horizon scanning and behaviours linked to our values with the Executive Directors. **ACTION:** **ST to discuss improvements to horizon scanning and behaviours linked to our values with the Executive Directors.** **The Governing Body received and noted the contents of the Audit Chair's Report.**	
11	**Revised Terms of Reference (ToRs) – Remuneration and Workforce Committee** GS presented this report and explained the revisions which included and extension to the committee's remit to include assurance on wider workforce issues, the CCGs role as a partner in system working, reporting requirements and revised committee title to 'Remuneration and Workforce Committee'. The membership in section 4 was reviewed and it was suggested and agreed that it should read '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'. **Following this minor amendment, the Governing Body approved the Remuneration and Workforce Committee ToRs.**	
12	**Ipsos Mori 360 Action Plan** AM directed the members to the report in the pack and touched on the 'Green Star' rating that both our former CCGs have received where we were rated 'outstanding' for 8 of the 10 domains. AM referenced the Ipsos MORI's 360 survey completed by our stakeholders across the county which has showed an improvement whereby 84% of stakeholders said they had a very/good working relationship with the CCG and 67% saying the CCG was an effective local system leader. He did mention that NHS E would not be carrying out this survey in future,	

however the CCG will continue with a survey with our stakeholders to continue to build on enhancing our engagement.

The survey action plan was detailed on page 122 and focusses on 8 areas and AM provided an update on each of the areas as follows:

- GPs and Member practices
  Following a review of engagement with primary care 18 recommendations were identified for improvement with general practice and we have completed half of these. We are continuing to work closely with the LMC, and a single weekly GP update is now produced, and a schedule of engagement is underway including more visits and moving the Governing Bodies around the county across the localities.

- OSCs and Health and Wellbeing Boards
  Coordinated face to face briefings have been arranged along with joint meetings, and we propose to brief and share our plans with our local authorities' partners in advance before going live with any changes. A joint communications post with Devon County Council (DCC) has been created and we are also establishing chair and chief office meetings with chairs of individual groups.

- MPs
  The Chair and Interim Accountable Officer are meeting more regularly with our MPS. Information sharing has increased to inform the of key announcements and we are looking to coordinate an all Devon MP briefing session in London.

- Other Local Politicians at county, district and town level
  We have taken a pro-active approach in welcoming newly appointed local councilors to build relationships.

- Healthwatch
  Regular meetings with Healthwatch have been arranged along with two-way sharing of information and we are introducing key people to join the meetings to continue in developing our relationships.

- Patient groups, PPGs and voluntary sector organisations
  There is more work to do in this area and we are looking at how to increase the membership for PPGs. We have recruited to a new voluntary care sector lead as part of the STP.

- Local Communities
  We are continuing to build better relationships and we are thinking through how we involve more members from the CCG in this work.

- System Partner Organisations
  Relationships have been forged but we are starting to build upon this to make them strong and acknowledge that there is more to do.

CB welcomed this clear approach and the fantastic work that the communications team are doing and echoed that engagement does take resource but is incredibly effective.

JH commended the communications team on their 'green star' award and the comprehensive approach on how we use communications to our change programmes.

	AM noted that the communications team are working with our colleagues across Devon and there are around 25 assigned communicators across the CCG, local authority and providers with each of them having main priority areas of work. AM briefly touched on the digital priority area of work that is currently underway and explained the resourcing allocation and where it is used. It was wondered how the CCG Mori survey results compare nationally and AM confirmed that CCG is ranked just below average. SK felt that there was a need for increased communication and engagement with our clinical directors and AM gave assurance that there will be an offer of communication and engagement support to our primary care networks. SMa agreed that matrix communication should be our way if working and would be an important part of our commissioning responsibility. PJ was pleased to have seen and benefited from our communications and engagement in particular the consistent, honest and transparent messaging and briefings that we are sharing and talking with our stakeholders. **The Governing Body received and noted the contents of the IPSOS Mori 360 report and action plan.**	
13	**Long Term Plan** This item was not discussed.	
14	**Quality Assurance Committee Chair's Report** GA presented this report and highlighted the third-party delegation briefing report. She talked about the verification of expected deaths guidelines that had been developed that we are working with our partner organisations to support them in adopting or adapting the guidance for their own use. LW noted that all commissioning managers are aware of this guidance and will be putting this into practice. **The Governing Body received and noted the contents of the report and positions of assurance given by the Quality Assurance Committee.**	
15	**Quality and Performance Report** <u>Western</u> • Cancer performance on track for 2ww and 62 days and we are in a good position against the level of referrals. University Hospitals Plymouth (UHP) is showing 94% against the national target and rated amber against screening and work is underway at reviewing referrals and to understand any capacity issues to enable performance in this area to get back on trajectory. Annual cancer standard assessments are scheduled for next month. • RTT performance for UHP is showing the lowest performance achievement away from the national standard. A review is underway to understand in more detail the issues against activity and productivity. • 52 weeks – UHP are focusing on their trajectory of 49% and we are meeting with our regulators for further discussions. There are staffing issues in being able to recruit to consultant level which is a national issue and we are working with the independent sector in extending a common offer of support. JT could provide assurance that the remedial action plan would improve performance for UHP and we continuing to support UHP with this.	

	• ED (Emergency Department) performance – a pilot is currently underway in UHP to reduce pressure on ED attendance. <u>Wider Devon</u> • Cancer overall and 2-week waits have seen an improvement from 50% to 64%. Torbay was showing and improvement from 50% to 97.7% this was due to triple assessment clinics. 62-day cancer aggregate performance 75%-77% improvement. Northern Devon has seen a slight deterioration, and this remains a concern due to a backlog. • 52 weeks wait – Torbay is ahead of trajectory with UHP and RDE showing off track. We are probing for more details and our plans to help improve performance will include: o Continuing with collective outsourcing activity/ insourcing extra lists o Sharing capacity across our provider partners o Offering alternatives e.g. patient choice ST raised concerns around the cancer performance position, and it was confirmed that remedial action plans are in place and that the CCG are closely monitoring these. SK asked what the cross-county learning is and are we optimising and encouraging this. He felt that we need to further understand our data intelligence to help improve performance which is variable and move to towards a change in cultural ways of working. GA queried as to whether the workforce is being affected by the national NHS clinical pensions issue. Piers Tetley, Associate Director of HR is working with our local HR directors to collectively express our concerns to the health and social secretary around the frustrations with pensions. SMC responded that a senior clinician at Devon Partnership Trust is also leading on this and would be more than happy to provide an update to the Governing Body. JD noted that individual organisations are looking at individual solutions including HR support. However, a coordinated approach is being considered whilst we continue to closely watch what happens nationally and we also are mindful that we need to think about primary care. • A&E Devon system – the current position is fragile with performance deterioration seen for May and June. Prediction that July performance will improve and to note there are different issues in different areas. RDE deterioration is due to capacity and community and personal care plus has seen an increase in demand. SDTFT decline in performance in this area is contributed to process issues and we acknowledge that A&E performance continues to be challenging and we will be undertaking a deep dive review. LW declared that additional quality surveillance reviews will take place and the Governing Body were cognisant that we are still in the summer months, with winter just around the corner and acknowledged that we only have a few months to get on top of this and understand the drivers of poor performance. **The Governing Body received and noted the contents of the quality and performance report and the verbal updates on the latest position**.	
16	**Locality Updates** <u>Northern</u> AM stated there was nothing further to add to this report but drew attention to the social prescribing programme that has been launched and that Northern Devon are undertaking a	

	review of a selection of the key hospital services. He further mentioned that the Northern triumvirate would be reviewing the local care partnership plans for clarity. <u>Eastern</u> SK reported that RDE were operating at Opel 3 which was unprecedented with pressures seen in mental health and cardiovascular specialties. The eastern system is already planning for winter 19/20 and winter pressure monies have been identified and ideas and projects are being considered. Primary Care Networks (PCN) are under development and the importance of early engagement has been recognised, and clinical directors are being encouraged to nurture PCNs as they develop. <u>Southern</u> DG highlighted progress on the atrial fibrillation project and that PCN leads have been invited to join a local partnership delivery group to focus on PCN development and engagement. An area of concern was personal care capacity and opening times have been modified to support this. SMa noted that the performance and financial position for TSDFT is being reviewed to understand the problems and it is expected that the position for August will have improved. The Health and Wellbeing hub in Teignmouth continues to be developed. <u>Western</u> SMc informed the board that the prevention monies have been invested into social prescribing and deprived areas will be targeted. Digital is progressing at pace and Beacon are looking to roll out e-consult. Livewell have offered to train a rep for PCNs as a practice coach. ST was pleased to report that the development of a GP prospectus for the city and a 100-day plan in support of sustainability for primary care has started. It has been agreed for an operational delivery group against performance and delivery to be set up to focus on achieving targets and delivery against reductions. **The Governing Body received and noted the contents of the locality reports.**	
17	**Primary Care Committee Chair's Report** NK was delighted that GPs continue to have outstanding Devon CQC reports and were very impressed with the digital presentation that Dr John McCormick gave for driving digital projects forward. **The Governing Body received and noted the contents of the Primary Care Committee Chair's Report.**	
18	**Close of Meeting** The Chair closed this meeting. The meeting closed at 16.55pm	

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
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Dr Matt Fox (MF) A (attends in absence of DG)	Clinical Representative, Southern Locality, Devon CCG
David Greenwell – Dr (DG) **	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) A	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Commissioning - West, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Lorraine Webber (LW)**	Interim Director of Nursing, 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) **	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
Tracey Polak (TP) A (attends for VP)	Assistant Director Public Health, Devon County Council
Virginia Pearson – Dr (VP) A	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) ** **Minute Taker**	Executive Assistant, Devon CCG
James Peskett (JP) **	PA Consulting
Katherine O'Halloran (KOH)**	PA Consulting
Jade Quartermaine (JQ)** **admin support**	Senior Administrator, Devon CCG
Sam Holden (SH) ** - **item 4 only**	Patient Experience Manager, Devon CCG
Simon Polak (SP) A	Interim Director of Quality Assurance, Devon CCG
Minutes approved | Date:	Signed by chair:

NHS Devon Clinical Commissioning Group

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**		**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	Confirmation if action complete
1	23-May-19	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 mental health professionals practice and it is on the DPT Quality Committee. 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. 25.07.2019 - Mapping work being undertaken to identify the gap in statutory services and update report will be presented to Quality Assurance Committee in August.				**IN PROGRESS**
2	27-Jun-19	A Non-Executive Director is to be appointed to support the AEO in their role around the Emergency Preparndess, Prevention and Response Framework and plans for a no deal EU exit. SM and NB to pick this up outside the meeting.	29-Aug-19	Sonja Manton and Nick Ball	Discussions are in progress.				**IN PROGRESS**

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	Confirmation if action complete
1	23/05/2019	NC to liaise with the communications team to include an update on LMS and MVP in the next GP update.	27-Jun-19	Nikki Coombes	Post meeting update action completed and recommended for closure. 27.06.19 - Agreed to close.				**CLOSED**
2	23/05/2019	NC to add Better Care Fund (BCF) to Governing Body forward planner for 19/20.	27-Jun-19	Nikki Coombes	Post meeting update this action is recommended for closure. 27.06.19 - Agreed to close.				**CLOSED**
4	23/05/2019	NC to add digital interoperability to the Governing Body 19/20 forward planner.	27-Jun-19	Nikki Coombes	Post meeting update action completed and recommended for closure. 27.06.19 - Agreed to close.				**CLOSED**

NHS
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GOVERNING BODY

Report title: Chair's Report				
Date of committee: 29 August 2019 **Date report produced: 20 August 2019**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive:** **Name and Title:** **N/A** **Contact Details:** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date: 20 August 2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

- Governing Body Development
- Tour of Plymouth City
- Visit to St Leonard's Research Practice
- 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 and the Governing Body are asked to note the contents.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
None
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services		√
Health Inequalities		√
Equality (staff or public)		√
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.

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GOVERNING BODY – CHAIRS REPORT

1. Introduction

My thanks to Nick Ball for chairing this Governing Body in my absence. I hope that most of you have had a much deserved break this summer – thank you for working so hard over the last few months and I hope whatever break you manage to get this summer gives you the rest you need ahead of this autumn – the challenges and hard work will, I am sure, continue. Having spent some time together in development sessions it feels as though we are in a really strong place to fulfill our roles both corporately and individually as the leadership team of Devon CCG.

2. Governing Body Development

The Governing Body Development session last month was a very timely and useful opportunity to focus as a leadership team on the important issues for us as a Commissioner and the wider health system of Devon. We were able to spend some dedicated time focused on the strategic aims of both system wide commissioning and support and development of local care partnerships, and also to understand the short term priorities that we need to focus on. The executive team are currently developing an action plan following this development time and we will have the opportunity to review and discuss this later in the Autumn.

As part of the development session a report has been generated by PA consulting which has been distributed to members of Governing Body and ongoing development will be based on the recommendations included in that report.

3. Tour of Plymouth City

On 31 August Jo Turl and I were invited by Tracy Lee of Plymouth City Council to visit some really good examples of collaborative working within the city including George House Homeless Hostel (https://www.plymouthonlinedirectory.com/article/1746/George-House-Homeless-Hostel-BCHA), Manadon Sports Hub (https://www.manadonsportshub.co.uk/) and Four Greens Wellbeing Hub (https://www.fourgreens.org/).

4. Visit to St Leonard's Research Practice

On 13 September I met with Denis Pereira Gray and Kate Sidaway-Lee at St Leonard's Practice. They have done some excellent research on the value of continuity of care in General Practice and it's link to outcomes, including mortality rates (https://bmjopen.bmj.com/content/8/6/e021161) The challenge for us is how we can support the obvious benefits of continuity whilst developing the multi-disciplinary approach to Primary Care which is much needed to meet the growing demand and workforce challenges.

5. Governing Body Membership Update

Remuneration Committee approved the appointment process and remuneration of further Governing Body members as agreed by Governing Body and detailed below. The posts are now out to advert with interviews planned for September and hopefully a full complement of Governing Body members in place later in the autumn.

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

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GOVERNING BODY MEETING

Report title: Accountable Officer's Report				
Date of committee: 29 August 2019 **Date report produced: 15 August 2019**				
Author (s) Name and Title: Simon Tapley, Interim Accountable Officer Molly Bishop, Executive Assistant to Interim Accountable Officer Nicola Bonas, Deputy Head of Communications		**Supporting Executive:** **Name and Title:** Simon Tapley, Accountable Officer **Report Approved by:** **Name and Title:** Simon Tapley, Accountable Officer **Date** 15 August 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:

- Working together to develop our Long Term Plan for health and care in Devon
- Devon's primary care services recognised in national patient services
- Awards success for the CCG
- Devon Doctors providing the NHS 111 and out of hours service from 1 October 2019
- EU Exit Preparations
- Devon CCG Chief Nursing Officer Recruitment
- Key meetings and visits
- Integrated Commissioning Executive meeting 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.
Impact on Strategic Objectives
We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our 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.

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Accountable Officer's Report

1. CCG Executive Team Priorities

At the development session in July the Governing Body asked for a smaller more focused list of priorities. Listed below are the current top priorities that the executive team are concentrating on (please note these are in addition to providing a strong contribution to the system priorities):

1- Performance Improvement

- 52 week waits
- A&E improvement
- Diagnostics (this will materially improve the performance in 2ww and 62 day)

2 - Finance

- CHC
- Medicines Optimisation
- Demand Management
- Fair Shares

3 - Getting CCG fit for the future

- Strategic Commissioning
- LCPs (including capitated budgets)
- Increasing the capability & capacity of change management and improvement techniques to ensure the CCG staff have flexible tools to offer to LCPs as well as deliver the priorities of today
- Being more proactive in both policy shaping and understanding of policy and how this may effect the Devon system

2. Working together to develop our Long Term Plan for health and care in Devon

Engagement on the Devon NHS Long Term Plan started on Thursday 11 July and concludes on Thursday 5 September. The engagement has been structured into two Tiers, Tier 1 is strategic county-wide engagement being led by the Devon CCG communications and engagement team (Andrew Millward, Nick Pearson, Nicola Bonas and Jon Sewell). Tier 2 is locality-led engagement activity being undertaken by the four locality communications leads (Jacqui Gratton/Corinne Farrell for Southern Devon, Amanda Nash/Sarah Hyde for Western Devon, Jessica Newton for Northern Devon and

Jeff Chinnock for Eastern Devon. Peter Leggatt from DPT and Sarah Hyde from Livewell have been working with each locality).

The engagement activities undertaken so far is as follows:

Tier 1 – strategic county-wide engagement

Since the engagement started there have been approx.1200 responses and this figure increases daily. These have been generated from the following sources;

1.1 Better for You, Better for Devon survey – a short online survey (also accessible in hard copy) with 10 questions that relate to the Long Term Plan has been promoted and shared widely https://www.surveymonkey.com/r/betterdevon. So far this has generated 502 responses. We continue to promote and advertise this survey across Devon.

1.2 Devon Virtual Voices panel (survey 1) – our newly formed virtual panel is representative of the Devon population and panel members were recruited through face-to-face activities. There are 1734 members on the panel, and they have agreed to provide feedback periodically to the NHS via surveys. The first survey was on *the use of digital technology for follow-up appointments* and generated a 20% response rate (328 completed surveys). The highest number of responders were between the ages 55 to 75, which is largely representative of those who access outpatient appointments in Devon.

A second survey is scheduled for later in August and will be on *mental health.*

1.3 Devon Referral Support Services (DRSS) – have been undertaking a short telephone survey with patients booking appointments. So far this has generated 352 responses, but we anticipate this increasing further over the next three weeks.

1.4 Living Options – are undertaking a piece of work to engage with children and young people in Devon regarding mental and emotional health and wellbeing. A dedicated survey and series of focus groups are being carried out.

1.5 Public and Patient Participation Groups (PPGs) – the PPG Network and Forums have been distributing the online survey (including hard copies) with patients in practices.

1.6 CCG staff – are participating in a series of workshops to share their views on the Long-Term Plan.

1.7 Political engagement - there has been ongoing engagement and involvement of all three Health and Wellbeing Boards and scrutiny committees in Devon since Jan 2019, when the NHS Long Term Plan was launched nationally.

Tier 2 – locality-led engagement (Northern, Eastern, Southern and Western)

Each of the localities will be providing an interim engagement summary of emerging themes and key findings by Friday 16 August.

The themes they have been engaging on are:

2.1 Eastern Devon – using digital technologies to improve experiences, mapping findings from community conversations to LTP priorities, how quality care is provided and what a good day at work at the RD&E looks like. *Lead: Jeff Chinnock*

2.2 Northern Devon – access to services, hospital services, use of digital technologies, maintaining health and wellbeing and making North Devon a healthier place. *Lead: Jessica Newton*

2.3 Southern Devon – how sustainable communities are supported to identify their own community health and care needs, understanding how people want to receive specialist care and if technology can support better care. *Lead: Jacqui Graton and Corinne Farrell.*

2.4 Western Devon – how can technology help people access follow-up appointments and how would people like mental health, wellbeing and support services delivered, especially for those experiencing a crisis. *Lead: Amanda Nash and Sarah Hyde.*

The focus of the engagement in Devon has been on people already accessing services (those with lived experience or knowledge), general public representative of the Devon population, those who are already engaged with us or our partners, children and young people.

The engagement concludes on Thursday 5 September and Healthwatch Devon are undertaking an independent analysis and producing a final engagement report.

3. Devon's primary care services recognised in national patient services

GP practices across Devon have achieved excellent results in the annual national patient survey, where:

- 88% of patients described the overall experience of their GP practice as good or very good
- 90% of patients reported feeling that the healthcare professional at their last appointment recognised or understood any mental health needs they had (compared with 86% nationally)
- almost eight in ten patients (77%) reported a good experience of NHS services when they wanted to see a GP but their GP practice was closed
- 90% of patients felt that the healthcare professional at their last appointment recognised or understood any mental health needs they had, compared to 86% nationally

These results are testimony to the hard work and commitment by our GP practices and staff to improve patient experience, showing consistently high levels of patient satisfaction, with many indicators reported well above the national average.

4. Awards success for the CCG

Thumbs Up for Coby Campaign shortlisted at the Chartered Institute of Public Relations

awards

The #ThumbsUpForCoby campaign has been shortlisted for three Chartered Institute of Public Relations (CIPR) awards in the following categories for the South of England and Channel Islands: Public Sector Campaign of the Year; Regional Campaign of the Year; Best Use of Social Media. This was a powerful campaign led by the Devon Sustainability and Transformation Programme (STP) in partnership with Coby's parents to encourage parents to make sure their children get the flu vaccination. It reached more than one million people online and contributed to an increase flu vaccinations for 2-3-year-olds by 10%.

This was an important campaign not only for Coby's parents, but for families and children across Devon. This shortlist is testimony to the enthusiasm and hard work shown by all involved to make the campaign a success

Innovation in Respiratory Education and Service Delivery at the British Thoracic Society Summer Conference

We have won an award for an innovative project that improves peoples' inhaler technique at the national British Thoracic Society summer conference. The scheme won in the "innovation in respiratory education and service delivery" category for its cutting-edge approach that focuses on a range of respiratory issues and supports people through local pharmacies. Tony Perkins, a pharmacist at the CCG, picked up the award on behalf of the CCG and Devon Local Pharmaceutical Committee (LPC) as he presented the project at the event. I would like to thank Tony, and all those involved in this project on their contributions in making it a success.

Devon Doctors have been the main provider for the Integrated Urgent Care Service (IUCS) in Devon for three years, with the NHS 111 telephony service for Devon sub-contracted to Vocare.

From 1 October 2019, Devon Doctors will begin directly providing the Devon NHS 111 telephony service. This follows a collective review of the Integrated Urgent Care Service (IUCS), specifically the provision of NHS 111 and out-of-hours care, the aim of which was to:

- Ensure a high-quality and efficient service
- Ensure diversity in roles and job security
- Ensure a sustainable model for the future service, to deliver the ambitions of the Long Term Plan for the NHS

As a result of this change, Devon Doctors will provide the entire IUCS service directly, from initial NHS 111 call right through to clinical consultation at either CAS, treatment centres or by home-visiting clinicians.

6. EU Exit Preparations

The CCG continues to work closely with the Local Health Resilience to ensure a state of preparedness for the EU Exit. The latest forum was held on 9 August and was attended by the CCG's Head of Governance. Risk areas are being considered and reported to the CCG Executive Team, and there is a governance process in place which provides:

- An allocated responsible person who can offer internal intelligence in domain areas;
- National questions to date (these questions may be subject to change pending guidance from our regulators in response to ministerial agreement).
- Process and responsible individuals for uploading the SITREP

7. Devon CCG Chief Nursing Officer Recruitment

On Friday 12 July we said farewell to Lorna Collingwood-Burke, our Chief Nursing Officer, as she retired after 25 years in Devon's NHS. Following her retirement, interim arrangements have been put in place prior to the recruitment of a permanent Chief Nursing Officer (CNO) in the Devon system.

The arrangements described are to ensure the CCG meets its statutory accountabilities whilst providing continuity and sustainability to the CCG and Nursing and Quality directorate. Two interim positions will cover the CNO portfolio carried out by Lorraine Webber and Simon Polak, their responsibilities are outlined as follows:

Interim Director of Nursing – Lorraine Webber

As the lead executive nurse and board nurse, this role will take overall accountability and responsibility for the Nursing and Quality Directorate reporting to Governing Body on all aspects of assurance. Lorraine will be responsible for:

- Governing Body member (voting member)
- Primary Care Quality
- Caldicott Guardian
- Safeguarding, Adults and Children
- Quality assurance and surveillance across the system
- Duty of Candour

Interim Director of Quality Assurance – Simon Polak

The key function is to lead the scrutiny and assurance function on all aspects of equality and patient experience. Simon will be responsible for:

- Infection Prevention and Control and Healthcare Acquired Infections
- Ensuring the smooth management of the Quality Assurance Committee reporting to the Governing Body
- Governing Body (attendee)
- Equality, diversity and inclusion
- Patient experience including PALs and Complaints, and the operational management of Serious Incidents
- Patient Placements (CHC and IPP)
- Learning disabilities mortality review (LeDeR)
- Workforce

Interim Deputy Directors of Nursing

- Vanessa Crossey
- Sara Wright

8. Key meetings and visits

- Dr Paul Johnson and I met with Councillor Bob Deed, Leader of Mid Devon District Council, as an introductory meeting to discuss future ways of working.
- I chaired the System Improvement Board at Torbay and South Devon NHS Foundation Trust where we discussed performance; system-wide action plans for 4-hour performance; domiciliary care; care home admissions and community nursing review. We also undertook a deep dive into demand analysis and transformation delivery plans.
- I met with Tracey Lee, Chief Executive at Plymouth City Council to discuss primary care in Plymouth

9. 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 progress on Local Care Partnership development and strategic commissioning.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Public Chair Report – Quality Assurance Committee

Date of Governing Body: 29 August 2019

Dates of Committees covered in this report 08 August 2019

(Approved minutes of the 08 August 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).

- **Written Statement of Action for Special Education Needs and Disabilities update**
- QAC discussed the final version of the written statement of action (WSOA), noted that there is learning from the process and propose a six-monthly update to monitor this.

- **Learning Disabilities Mortality Review (LeDeR)**
- QAC noted the learning points raised within the report and are assured that the LeDeR process is delivering learning for the system partners regarding the quality of care. QAC have requested that LeDeR is added onto the QAC forward planner to provide six monthly updates.

- **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); Care Homes Dashboard.**
- QAC noted the reduction of overdue serious incidents open for DPT and are assured that the CCG have processes in place to monitor DPTs position. QAC have requested a detailed report following the deep dive to be presented at QAC to include a new trajectory from DPT.
- QAC noted the new care home report and were assured of the contents, however they have asked for further assurance on the overall picture to be brought to September's QAC.

- **Primary Care Quality Development Update**
- QAC are assured on the processes in place to monitor the quality of primary care and supports the recommendation that the CCG Primary Care Committee should receive a paper outlining the quality reporting arrangements.
- QAC supports the recommendation for external bodies to attend future Committees to share quality data regarding primary care.

- **Infection Prevention and Control Report**
- QAC noted the contents of this report.

- **CCG Mortality Review Group Report**
- QAC noted the contents of the revised report provided as a hard copy.

- **Mental Health (IAPT/GAP) and Devon Partnership NHS Trust**
- QAC supports the recommendations for the CCG to work collaboratively to undertake the tasks outlined within the report.
- QAC requested that the whole picture of both mental health providers is brought back to QAC in September 2019 to provide assurance.

Reports received and noted

- **Joint Clinical Executive Group notes of meeting**

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 11 July 2019.
- QAC noted that the risk data had been extracted on 25 July 2019.
- QAC noted that there were currently 24 risks aligned to QAC. Of those risks, two risks are categorised in the very high category.
- QAC are not assured with the level of information provided for risk 100 and recommend it is reviewed and the risk score considered.
- QAC noted that two risks (risk 17 and 82) remain not updated in a timely manner.
- QAC noted that there was one new risk (risk 110) which had been recommended to be added.
- QAC noted that there were five risks (risk 45, 44, 15, 74 and 75) recommended for closure, however do not support closure until there is assurance that those risks are captured in the performance risk register.

Committee Decisions

- None.

Recommendations for Governing Body

- To note the reports received and positions of assurance by Quality Assurance Committee.

Recommendations for other Committees

- QAC support the recommendation that the CCG Primary Care Committee should receive a paper outlining the Quality reporting arrangements.

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.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Quality and Performance report				
Date of committee: **Date report produced:09/08/2019**				
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** **John Dowell– Interim Deputy Chief Officer** **Contact Details:** **Report Approved by:** **Name and Title:** **Date 09/08/2019**		
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
We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
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

August 2019

Summary

Performance summary

Based predominantly on June 2019 data Devon is performing well against the mental health standards, including: IAPT waiting times and recovery and early intervention. Improvements have also been seen in dementia diagnosis rates and delayed transfers of care remain within target.

However, Devon are not meeting local trajectories for many of the key constitutional standards, including: referral to treatment times, diagnostic waits, cancer waiting times and waiting times in A&E departments. Devon are also regional and national outliers for many of these measures. This summary will focus on the issues and actions being taken to recover this position.

In order to improve services for patients in Devon the Governing Body has requested a focus on 2-3 key areas this year. The recommendation to Governing Body is that we focus our collective efforts on people waiting more than 52 weeks, diagnostic waiting times (which will have an impact on cancer waiting times) and waiting times in A&E.

Referral to treatment times

In June performance against the 18-week standard is 80.4% against a trajectory of 81.3%. There are 199 people waiting over 52 weeks against a trajectory of 143. At the System Performance Group (SPG) in August all four trusts confirmed that they will be able to maintain/recover their 18-week position, however additional actions are needed to reduce the number of people waiting over 52 weeks back to trajectory for most providers.

Additional actions agreed at SPG this month to improve the 52-week position are:

- A proposal to manage the people waiting more than 52-weeks centrally through the Devon Referral Support Services (DRSS) was agreed to come to the next SPG for sign-off. This will mean that long waiters across all four trusts will be managed collectively and capacity at all providers, including the independent sector, can be maximised. Experience of undertaking this in Q4 last year suggests this will have a positive impact.
- Capacity needed at the independent sector on an annual basis will be modelled in order to agree block arrangements with these providers, which will provide certainty of capacity and value for money. This is due to come back to SPG in September.
- Routine spinal patients at University Hospitals Plymouth (UHP) are now being offered treatment at Newhall. The impact on the number of people waiting more than 52 weeks is currently being modelled.
- Kernow CCG is exploring the potential for Royal Cornwall Hospitals Trust (RCHT) to treat some of the long waiting orthopaedic patients from the UHP list.
- Negotiation with Care UK to treat orthopaedic patients with a higher anaesthetic risk score will be undertaken this month.
- The medical directors will review the protocol for patients who are on an elective pathway but do not wish to receive their treatment in the foreseeable future. This will be reviewed at clinical cabinet and brought back to SPG for agreement in September.

Diagnostic waiting times

In June performance against the 6-week standard is 13.9% against a trajectory of 8.9%. The only provider on trajectory is Torbay and South Devon FT (TSD). The main areas of concern are long waits for MRI, CTs and endoscopies.

The Devon STP has access to £2m this year to support better achievement of waiting times for cancer. It was agreed at SPG that the best use of this funding will be to support additional capacity for diagnostics in order to bring overall waiting times down. In order to sign of the proposed use of the £2m at the next SPG the following actions were agreed:

- Work up proposal for mobile endoscopy to support both RD&E and TSD.
- Negotiate with Care UK to provide endoscopy support for UHP.
- Work up proposal to upgrade MRI at RDE, such that it can undertake contrast MRI.

Cancer waiting times

In June performance against the cancer 2 week wait standard is 84% against a trajectory of 92%. Breast symptomatic performance is 67% against a trajectory of 86%. Cancer 62-day performance is 74% against a trajectory of 75%, however overall numbers of people waiting is not reducing so this position is fragile.

The most significant areas of concern and actions being undertaken are as follows:

- Breast symptomatic at UHP is 8.9% in June, however performance in July increased to 39% and is currently at 92% in August. Some of this improvement is due to seasonality however the trust has been to TSD to review the triple assessment clinics and will implement this approach, which will have a positive impact on waiting times, currently being modelled. The current mean waiting time is 9 days and the upper quartile is 12 days. There are 5 patients waiting over 3 weeks, which are all patient choice.

- Waiting times for the 62-day cancer standard at RD&E are below trajectory due to shortages in urology and upper GI consultant roles. The RD&E are meeting with NHSE and the CCG to discuss best practice and how this can be adopted. The trust will report progress to the next SPG.
- Cancer 2 week waits at TSD are below trajectory, with workforce constraints in dermatology, colorectal and urology. There is a meeting to discuss remedial actions for dermatology which will be reported back through SPG next month.

A&E waiting times

In July performance against the 4hr standard was 87.7% against a trajectory of 88%. Northern Devon Healthcare Trust (NDHT) are the only provider meeting their trajectory. All other trusts reported increases in length of stay, which are in the main related to the increased acuity of patients who are admitted. This has a detrimental effect on 4-hour performance as many of the patients waiting over 4 hours in A&E are waiting to be admitted to beds. Staffing, particularly nursing, was also reported as an issue across all providers.

Actions agreed through the A&E Delivery Boards to improve 4-hour performance are as follows:

- The international recruitment of nurses will see an additional 118 nurses within the acute hospitals within the next 2-9 months.
- The CCG have commissioned a new model for the Integrated Urgent Care Service (IUCS) which will start on 1st October. This will mean more patients calls are answered sooner, a greater number with receive clinical triage and therefore less are expected to be referred to ambulance and A&E services.
- The western system has approved 5 demand management schemes which will come into effect from September and will be focussed on supporting the most high-risk patients better in the community e.g. enhanced support from GPs in the top 10 care homes, increased capacity in the complex care team to take referrals before seeing a GP, community frailty service. UHP are a pilot site for Same Day Emergency Care (SDEC) and are currently baselining activity.
- The eastern system are implementing an enhanced model of community health and social care. The RD&E are also focussing on SDEC and expect to be back on trajectory within the next few months.
- The southern system are focussing on increasing weekend discharges and have recruited to a weekend discharge team that will pilot a more focussed approach for the next 3 weekends. The CCG on-call Director will be informed at the weekends how many discharges are expected.

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.

Children & Young People (CYP)

Quality assurance will be sought by the CCG at Joint Technical Working Groups (JTWG) and Contract Quality Review Meetings (CQRMs). CFHD meetings will start formally 27th August (CQRM). The first data book has been received and whilst the submitted data remains performance focussed, there has been an increase in safety and quality related data over the last month, including complaints, incident reporting, patient experience & training compliance levels.

Serious Incident Analysis Reports

Devon Partnership Trust (DPT) continue to experience a number of overdue Serious Incident analysis reports. DPT executive level communication with the CCG includes a plan to reduce overdue reports. In addition, a deep dive into the SI process is being undertaken in August 2019 supported by the CCG, and NHS England /Improvement (NHSE/I). This will be reported through to the CCG Quality Assurance Committee. Other actions include increased visibility at Trust level meetings to seek assurance on culture and sharing of learning, weekly calls and monthly senior meetings with DPT to ensure improvement at pace, but also evidence of changes being embedded within the organisation.

Continuing 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. The first Local Quality Surveillance Group in the South locality is making good progress on identifying and working as a system on a number of quality improvements. 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 Update:

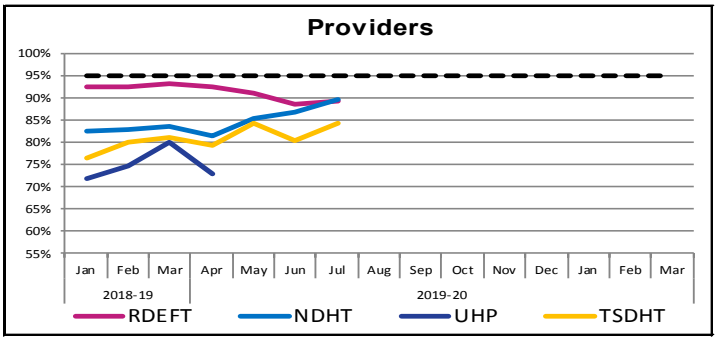
Quality reporting recommendations have been agreed by the Quality Assurance Committee and will commence with a monthly flash report to the CCG Quality Assurance Committee on key areas for exception and a full briefing report each quarter. The report(s) will also be presented to the Primary Care Committee for information. A review of the annual Patient Access Survey is currently being undertaken and will be reported as soon as completed. A number of surgeries have received an Outstanding CQC rating in July and the best practice is being shared in a number of forums and across Primary Care Networks.

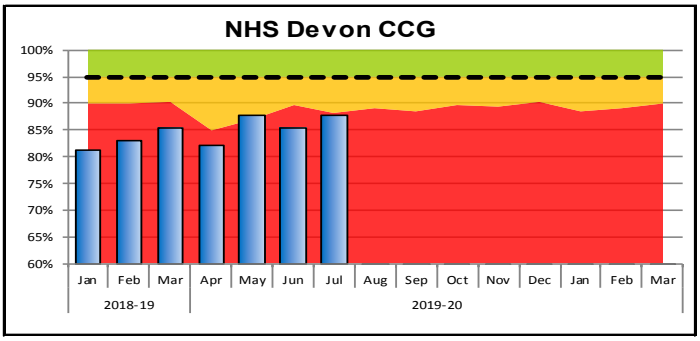
Performance and Quality indicators

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

Trust	Trajectory	July	2019/20
RDEFT	91%	89.3%	90.3%
NDHT	84%	89.4%	85.8%
UHP	81%	N/A	N/A
TSDFT	78%	84.3%	82.0%

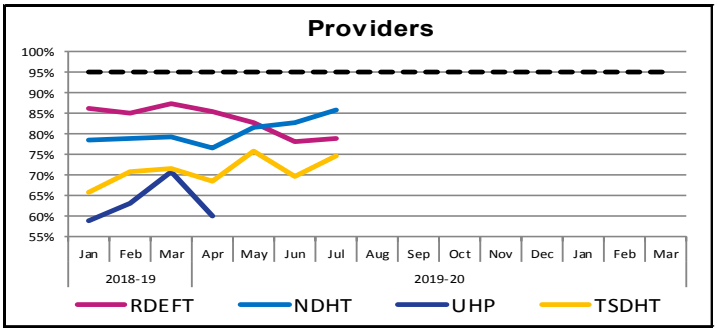
CCG	Trajectory	July	2019/20
NHS Devon	88%	87.7%	85.5%
ENGLAND		87.7%	87.0%

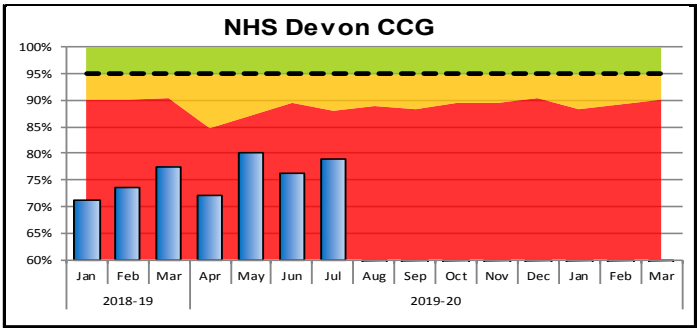




Trust	Trajectory	July	2019/20
RDEFT	91%	78.8%	81.3%
NDHT	84%	85.9%	81.9%
UHP	81%	N/A	N/A
TSDFT	78%	74.8%	72.3%

CCG	Trajectory	July	2019/20
NHS Devon	88%	79.0%	76.5%
ENGLAND		81.2%	80.0%





Performance Commentary

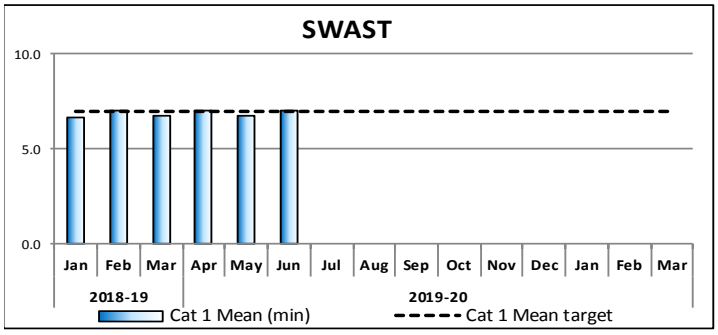
In July the STP 'all types' position was 87.7%, up from 85.4% in June, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. NDHT continue to improve at 89.4%, RD&E increased to 89.3% and TSD rose from 80.3% to 84.3%.

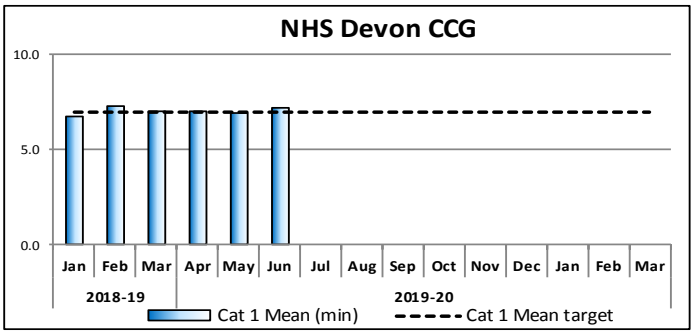
Quality Commentary and Improvement Actions

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 there are still numbers of patients attending emergency departments that 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. At all times issues of patient safety and experience of care are being considered.

SWAST Cat 1 Mean response time

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





Performance Commentary

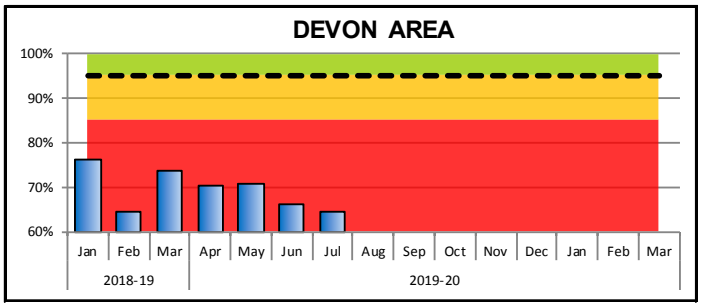
At STP level the 7-minute response time target was met in June.

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.
All associate commissioner and quality leads have been requested to ensure a consensus approach to the provider's risk is maintained, with all commissioning organisations asked to ensure a regional risk impact score of 20 is held locally.
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	July	2019/20
DEVON	95%	64.6%	68.1%
ENGLAND	95%	80.5%	84.9%



Performance Commentary

The proportion of calls answered within 60 seconds fell in July to 64.6% from 66% in June. Performance remains well below the target of 95%.

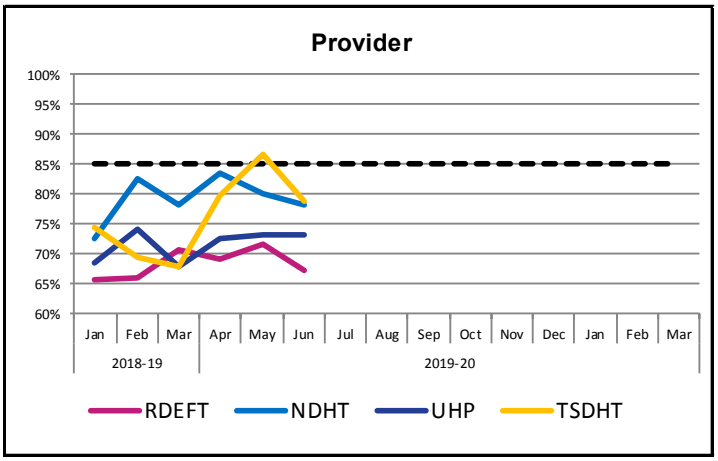
Quality Commentary and Improvement Actions

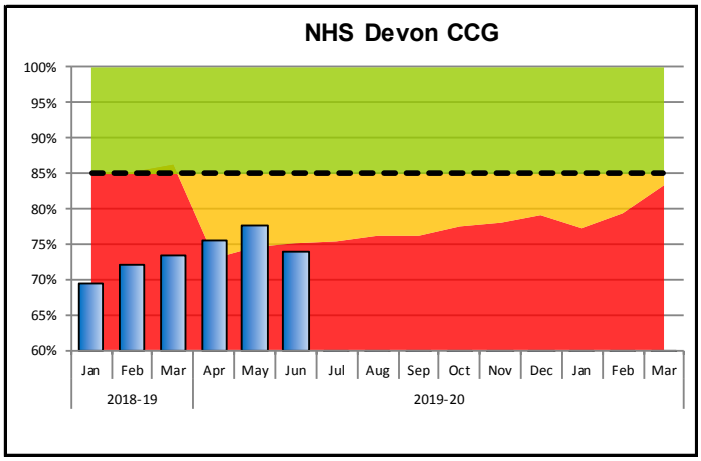
It remains evident that a number of calls are abandoned by patients before answering: it is not clear if this is due to length of wait to be answered or another reason. Collating information and experiences from these patients continues to be challenging as it is not clear if these patients then access alternative services such as ED or primary care. Incident reviews and end to end reviews enable the CCG 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.
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	June	2019/20
RDEFT	75%	67.2%	72.9%
NDHT	85%	78.1%	78.1%
UHP	69%	73.2%	73.8%
TSDFT	80%	78.8%	79.0%

CCG	Trajectory	June	2019/20
NHS Devon	75%	73.9%	75.7%
ENGLAND	85%	76.7%	76.7%





Performance Commentary

Performance fell at STP level in June, from 77.7% to 73.9%. TSD, who achieved the target in May, saw performance fall to 78.8% whilst RD&E dropped from 71.6% to 67.2%. NDHT performance fell to 78.1% and the UHP position remained static at 73.2%.

NDHT was the only provider to see the 62-day incomplete backlog fall in June.

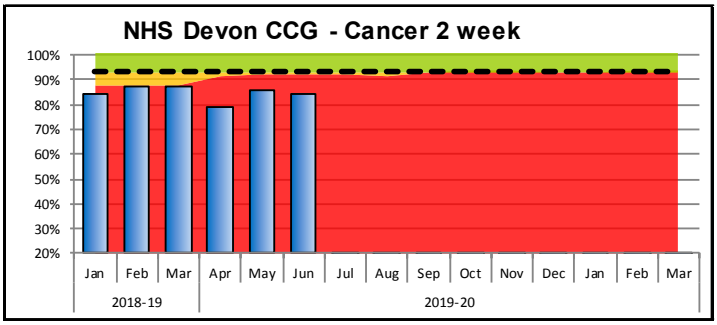
Quality Commentary and Improvement Actions

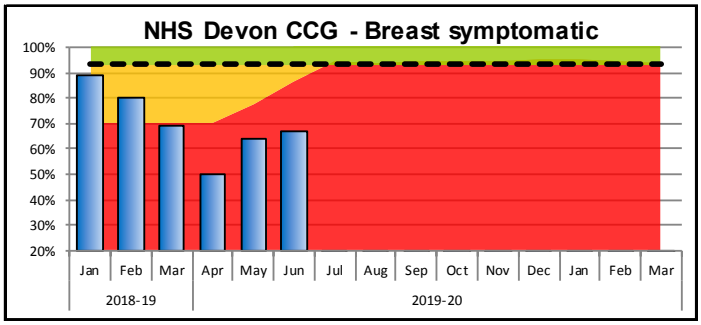
The CCG's strategic plan clearly sets out key areas of work that aim to provide sustainable achievement of the 62-day standard, leading to improved safety and experience for patients. Each provider's improvement plan is overseen by the CCG. There is growing evidence within the system of improved collaboration between providers, as well as new models of care to improve services for patients. This includes nurse led clinics overseen by consultants.

If extended waits are experienced 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 communicated with to ensure they remain safe.

Cancer Targets (June-2019)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	84.3%	81.8%	95.9%	94.5%	69.5%
93%	2 week breast	66.8%	92.1%	82.1%	8.9%	98.1%
90%	62 day screening	87.2%	88.9%	N/A	83.3%	92.9%
85%	62 day consultant	83.0%	89.2%	83.0%	66.7%	100.0%
96%	31 day first	94.5%	93.2%	96.3%	94.2%	97.3%
94%	31 day surgery	93.7%	95.7%	91.7%	92.0%	96.8%
98%	31 day drugs	99.7%	99.1%	100.0%	100.0%	100.0%
94%	31 day radiotherapy	91.8%	97.1%	100.0%	79.3%	100.0%





Performance Commentary

Across the wider range of cancer targets TSD performed well achieving all but one (the 2ww target, where performance slipped from 77.5% to 69.5%). NDHT and RD&E also performed relatively well but there was more mixed performance at UHP who met only two targets.

Breast symptomatic performance improved slightly in June although UHP remained very low at 8.9% and NDHT performance fell below target at 82.1%. RD&E remain slightly under the 93% standard at 92.1% but TSD continue to perform well at 98.1%

Performance against the main 2ww standard fell from 85.9% to 84.3%. NDHT and UHP continue to achieve the target but RD&E remain at 82% and TSD fell back to 69.5% after good improvement in May.

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. All providers acknowledge the impact of delays on patient experience, including increased levels of anxiety within their harm reviews.

There are cancer specific recovery plans in place for each provider. The symptomatic breast pathway has a system-wide plan to improve the performance and harm reviews are being undertaken regularly for those patients having to wait. 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.

Work with providers and primary care continues to drive improvement. This includes a focus on improving referral pathways where conversion rates are low.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

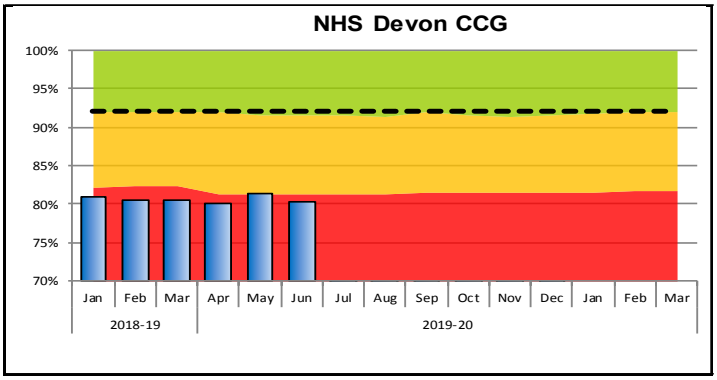
Trust	Trajectory	June	2019/20
RDEFT	82.6%	81.7%	81.8%
NDHT	79.1%	80.7%	79.9%
UHP	77.7%	77.0%	76.9%
TSDFT	81.0%	81.5%	81.4%

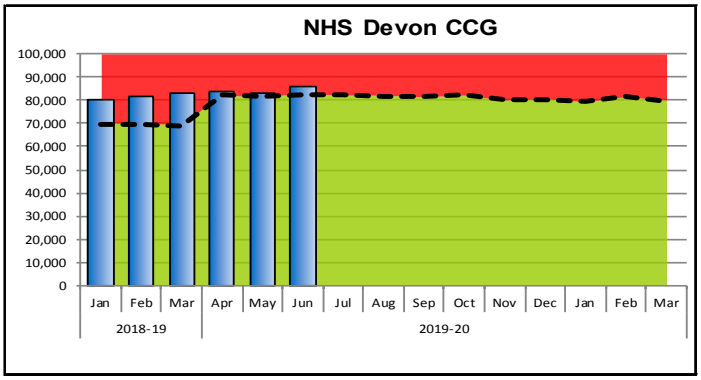
CCG	Trajectory	June	2019/20
NHS Devon	81.2%	80.4%	80.6%
ENGLAND	92.0%	86.3%	86.6%

RTT incomplete waits volume

Trust	Trajectory	June
RDEFT	34,857	36,355
NDHT	11,564	11,429
UHP	28,496	28,899
TSDFT	18,416	19,636

CCG	Trajectory	June
NHS Devon	82,603	85,931





Performance Commentary

The STP level RTT position decreased in June from 81.3% to 80.4%. Whilst NDHT continued to see improvement, moving from 79.9% to 80.7%, UHP fell slightly from 77.3% to 77.0%, TSD decreased from 81.9% to 81.5% and RD&E fell from 82.4% to 81.7%. NDHT remained above their improvement trajectory with TSD exactly on plan and UHP and RD&E slightly under.

The incomplete waiting list rose by around 650 patients at RD&E, almost 300 at UHP and 100 at TSD, although the NDHT size was flat. UHP, TSD and RD&E are all above their respective waiting list trajectories.

Quality Commentary and Improvement Actions

There is evidence of improved performance in some pathways across the STP that has led to positive patient experience, however some specialities continue to be challenged. This includes urology and cardiology. Providers have given assurance that actions are in place to monitor for patient harm, as well as ensuring communication and a continued positive experience. Providers are working together to reduce exceptionally long waits, utilising staff across Trusts, as well as sharing resource and infrastructure. Further work to support primary care includes developing advice and guidance.

Where harm has been identified during an extended wait, providers are reporting and investigating incidents to establish if this was due to the waiting time. The CCG reviews the incidents to seek assurance that providers are investigating robustly and learning from incidents to drive improvements for patients. This includes reducing time delays as well as improving processes for checking for harm if delays are experienced.

UHP has identified a significant 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 clinical, 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 September 2019. The provider continues to demonstrate an appropriate move to day and outpatient surgery for patients where it is clinically appropriate and safe, improving the timeliness for patients and a positive experience.

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

RTT Incomplete Pathways long waiters

40-52 week waits

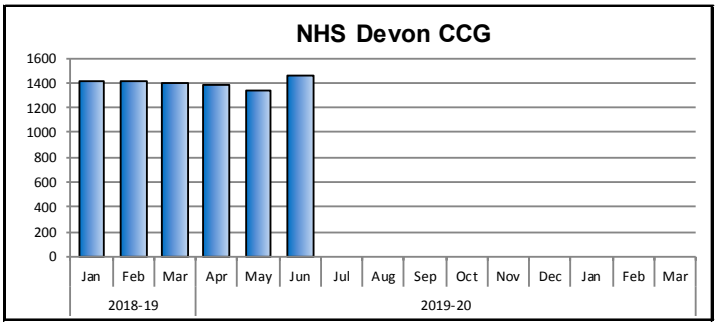
Trust	June	2019/20
RDEFT	554	1671
NDHT	110	337
UHP	694	2006
TSDFT	310	932

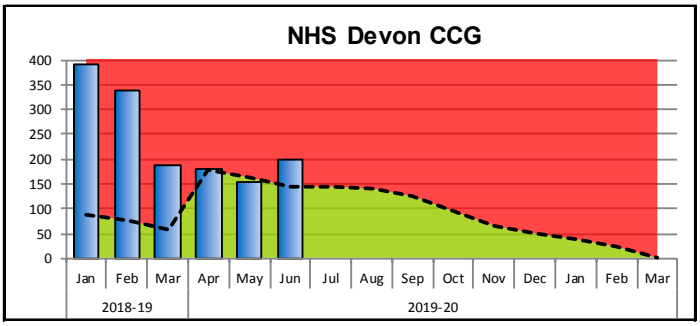
CCG	June	2019/20
NHS Devon	1464	4184

Over 52 week waits

Trust	Trajectory	June	2019/20
RDEFT	5	73	210
NDHT	0	10	35
UHP	46	61	167
TSDFT	110	83	213

CCG	Trajectory	June	2019/20
NHS Devon	143	199	531





Performance Commentary

Over 52 week waits rose in June moving from 153 to 199 at STP level. All providers saw increased breaches although the rise at TSD was greatest (59 to 83), whilst NDHT (8 to 10), RD&E (71 to 73) and UHP (57 to 61) saw smaller increases.

Quality Commentary and Improvement Actions

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. Assurance on further improvement to this process continues, and an increase in sharing of learning and experience between providers is emerging.

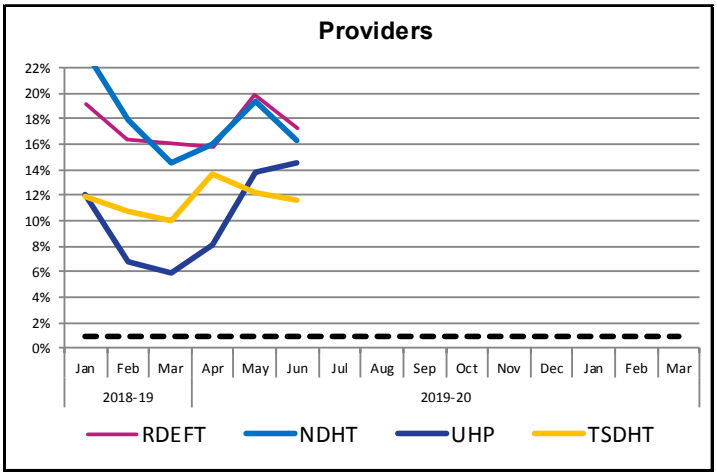
Elements of planned care work continue to be outsourced to the independent sector, with the aim of improving choice and experience and reducing potential risk from a long wait. The CCG's continue to seek assurance that provider Trusts are undertaking surveillance to ensure quality is maintained when outsourcing service provision. Patient choice continues to impact on this standard and leads to many patients choosing long waits, including 52 week waits. Providers evidence actions to reduce the number of patients waiting for lengthy time periods, for example communicating effectively with patients and encouraging them not to wait for long periods. However, providers and the CCG acknowledge patients have this option and it is essential the patient voice is heard alongside the performance metrics.

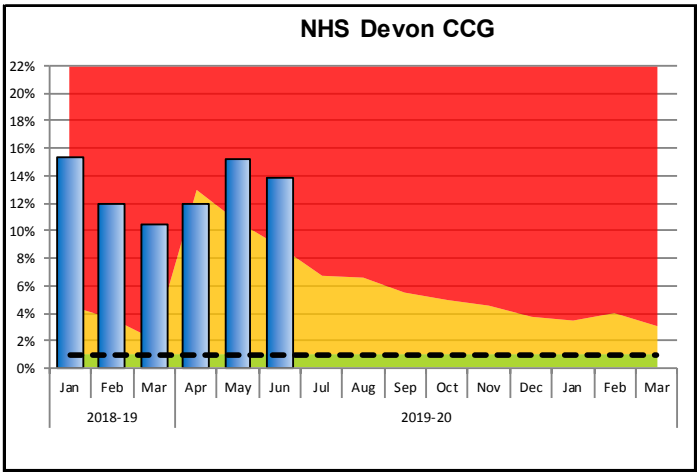
Quality and equality impact assessments have been undertaken by providers when planning their activity improvement trajectories. These are reviewed by the CCG Quality, Equality Impact Assessment (QEIA) Panel. These assessments enable consideration of the potential positive or negative impacts to patient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

Diagnostic 6 week wait

Trust	Trajectory	June	2019/20
RDEFT	7.1%	17.3%	17.7%
NDHT	15.0%	16.3%	17.2%
UHP	6.1%	14.5%	12.2%
TSDFT	11.8%	11.7%	12.5%

CCG	Trajectory	June	2019/20
NHS Devon	8.9%	13.9%	13.7%
ENGLAND	1.0%	3.8%	3.8%





Performance Commentary

The STP position improved slightly from 15.2% to 13.9% in June as there were reductions in breaches at NDHT (moving from 19.3% to 16.3%), RD&E (19.9% to 17.3%) and TSD (12.1% to 11.7%), although there was a further increase at UHP (13.8% to 14.5%). RD&E and UHP are significantly above improvement trajectories, with NDHT just over and TSD remaining within plan. The majority of breaches continue to be for imaging and endoscopy.

Quality Commentary and Improvement Actions

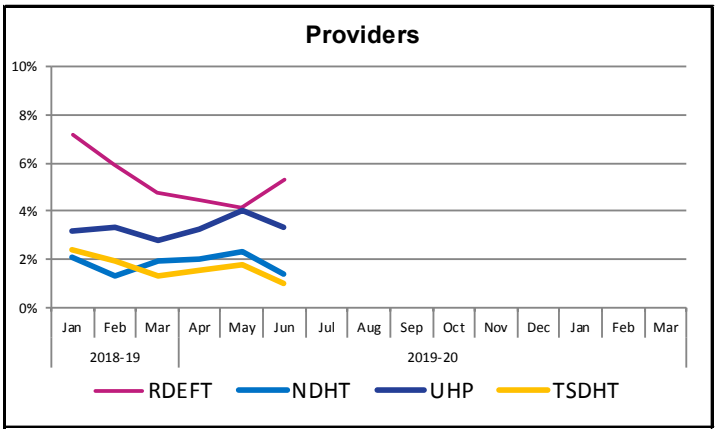
Through the System Performance Group, chaired by the CCG, the providers have reported initial collaborative steps with the aim of improving diagnostic wait times for patients. Such as sharing teams and other resources, as is already in place between NDHT and RDEFT which supports wider system collaboration.

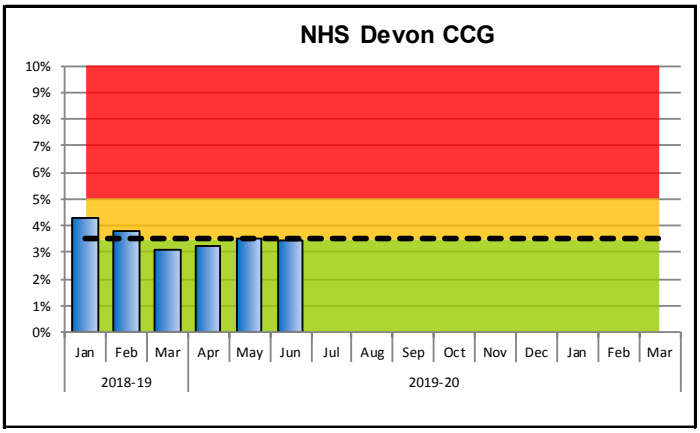
Plans to improve diagnostic pathways to ensure a more local and sustainable position are in place across Devon, with the aim of reducing risks associated with delays as well as patient experience. In the interim, all providers continue to rely heavily on external sourcing for diagnostics but have evidenced their governance processes around this.

Acute Delayed Transfers of care

Trust	Target	June	2019/20
RDEFT	3.50%	5.3%	6.9%
NDHT	3.50%	1.4%	2.8%
UHP	3.50%	3.4%	5.3%
TSDFT	3.50%	1.0%	2.1%

CCG	Target	June	2019/20
NHS Devon	3.50%	3.42%	5.1%





Performance Commentary

The acute delayed transfers of care (DTOC) June position was slightly better than target at 3.4%. NDHT and TSD remain under 3.5% and UHP improved from 4.0% to 3.4%. The RD&E rate, which had been consistently improving, increased from 4.1% to 5.3%.

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 remains a key element of escalation discussions.

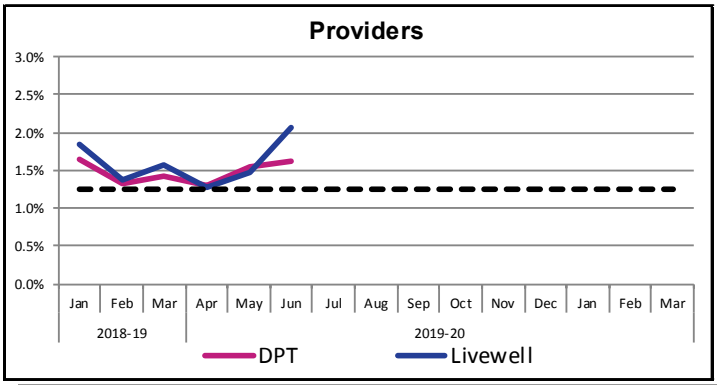
Each locality considers their local system capacity to ensure patients are transferred in a timely way, including processes for ensuring patient discharges during the weekend periods. Some key areas impacting on patient transfer delays have been identified and are now incorporated into provider improvement plans and reviewed by the CCG.

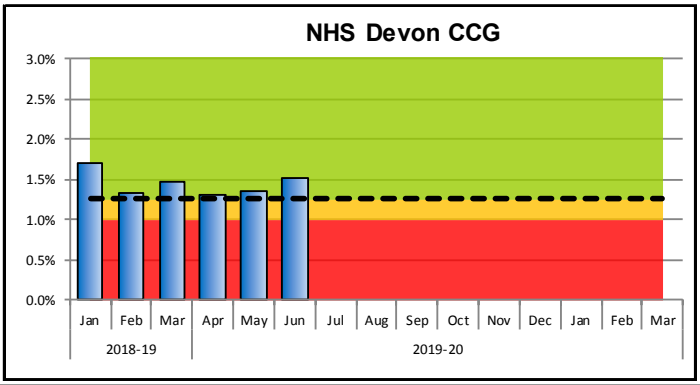
These include issues with discharge medicines not being ready in a timely manner, access to social care support, challenge in accessing appropriate patient transport and the timely repatriation of patients back to county of origin. End-to-end reviews from two providers provided recommendations leading to actions to improve flow. These include initiatives aimed at improving patient flow with regards to the discharge process. Learning from the provider reviews will be shared across the STP.

IAPT Monthly Access rate

Trust	Target	June	2019/20
DPT	1.25%	1.6%	4.5%
LIVEWELL	1.25%	2.06%	4.80%

CCG	Target	June	2019/20
NHS Devon	1.25%	1.5%	4.2%





Performance Commentary

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

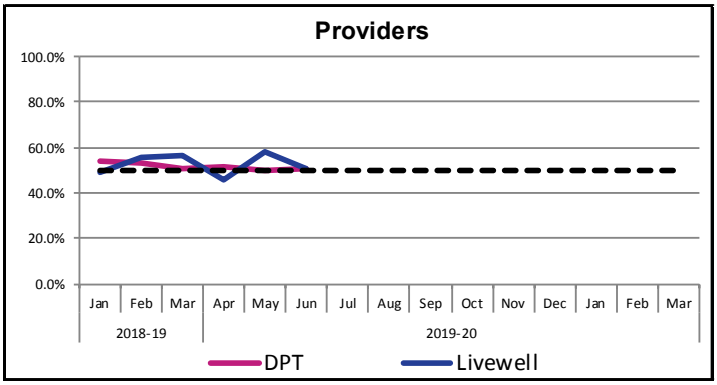
Quality Commentary and Improvement Actions

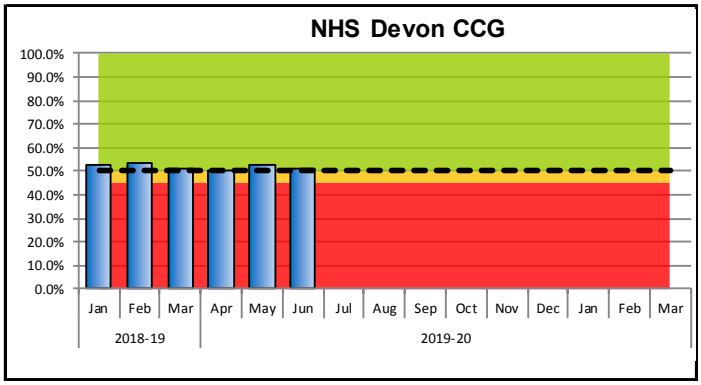
The CCG receives assurance through several routes, including feedback via the yellow card system from professionals working in the system. Themes are shared with providers for review, response and to support their improvement plans. Challenges remain in relation to patient experience, because whilst many patients are assessed and receive treatment in a timely manner, others may wait for long periods of time raising issues around equitable service provision. Whilst quality is monitored through routine CCG assurance routes, the CCG has increased their actions to seek information and assurance. This includes attendance at provider quality meetings to seek further assurance.

IAPT Recovery rate

Trust	Target	June	2019/20
DPT	50%	50.8%	50.7%
LIVEWELL	50%	50.4%	51.3%

CCG	Target	June	2019/20
NHS Devon	50%	51.4%	51.5%





Performance Commentary

The STP was above the target for IAPT recovery in June, with both providers above target.

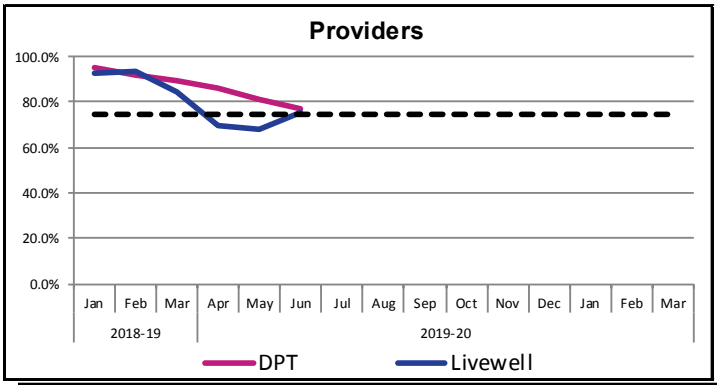
Quality Commentary and Improvement Actions

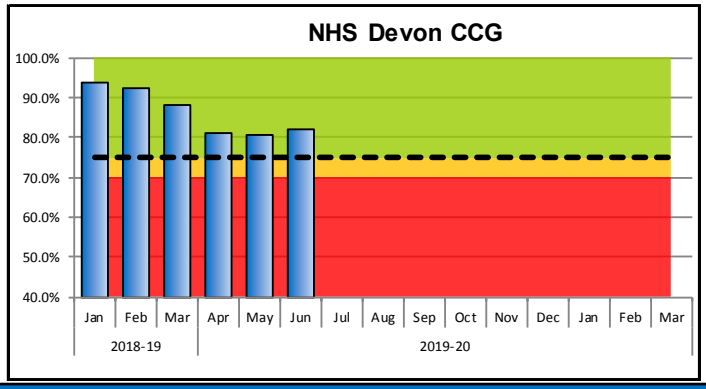
The CCG continues to review all information from provider meetings and other sources to inform the range of indicators within the quality assurance process.

IAPT waiting 6 weeks

Trust	Target	June	2019/20
DPT	75%	76.9%	81.6%
LIVEWELL	75%	75.9%	71.9%

CCG	Target	June	2019/20
NHS Devon	75%	82.0%	81.3%





Performance Commentary

Both providers achieved the target in June.

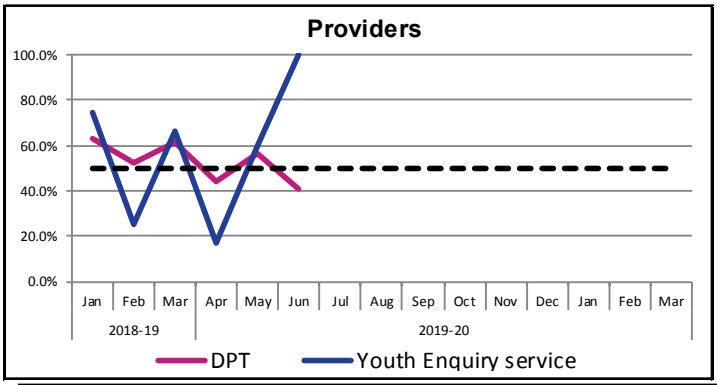
Quality Commentary and Improvement Actions

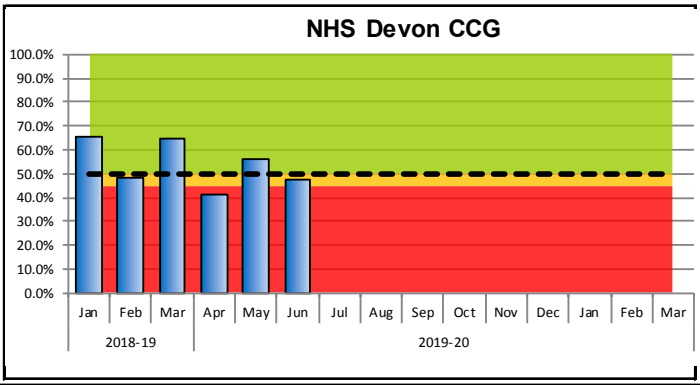
Quality assurance continues through the quality assurance framework process and the CCG is currently reviewing challenges raised by Primary Care for those patients who may not be eligible for Community Mental Health Services but present as too complex for depression and anxiety services. Findings from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

Mental Health Early Intervention

Trust	Target	June	2019/20
DPT	50%	41.2%	46.9%
THE ZONE	50%	100.0%	50.0%

CCG	Target	June	2019/20
NHS Devon	50%	47.4%	48.5%
ENGLAND	50%	76.7%	75.1%





Performance Commentary

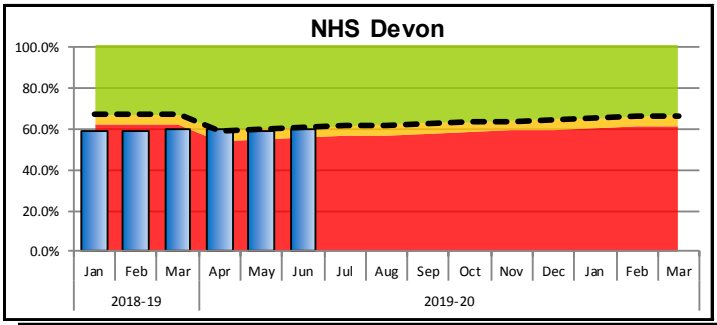
This is a two-part indicator for patients with suspected first episode psychosis or at risk mental state on a completed pathway receiving NICE-recommended care package and allocated to and engaged with an EIP care co-ordinator. Performance fell in June to 47.4%, with the Zone achieving the national target but DPT falling under at 41.2%.

Quality Commentary and Improvement Actions

Providers have continued to demonstrate the positive impact of early intervention services however, challenges in achieving timely access to services for some patients continues. The CCG receives minimal information from patients about access to these services 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

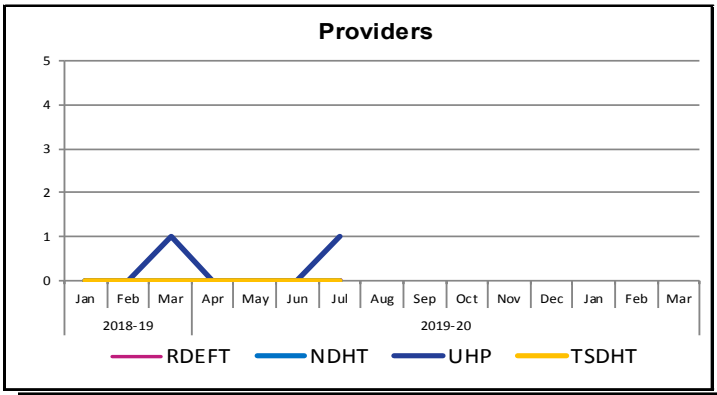
The dementia diagnosis dashboard provides information on diagnosis rates by locality and individual GP practice. Early identification and diagnosis of dementia can positively impact on both patients and their family and carer's as treatments, education and support options can be offered. STP wide actions are therefore required to improve experience for patients and their carer's so a system wide approach to improvement remains key. An example of this is to ensure correct coding of patients diagnosed with dementia within primary care. Following analysis with DPT and LWSW, letters to GP practices to support correct coding of those patients who have a confirmed diagnosis have now been sent.

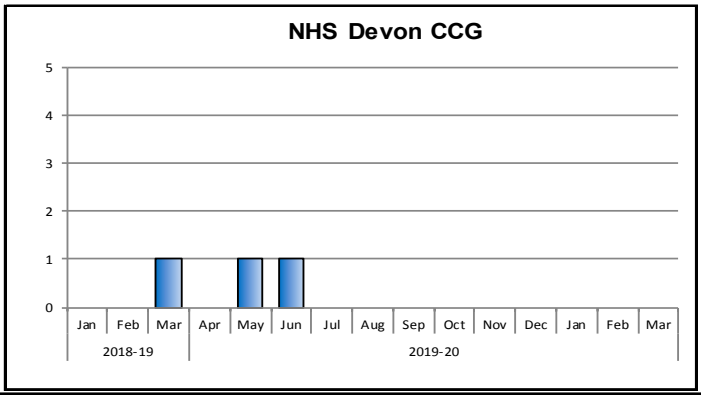
The CCG are also seeking input from clinical colleagues to develop a proposal for improving the early identification and diagnosis of dementia in care home residents.

MRSA breaches

Trust	Target	July	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	1	1
TSDFT	0	0	0

CCG	Target	July	2019/20
NHS Devon	0	0	2





Performance Commentary

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

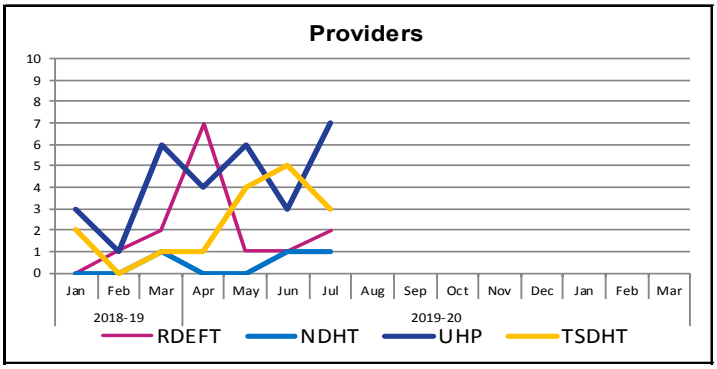
Quality Commentary and Improvement Actions

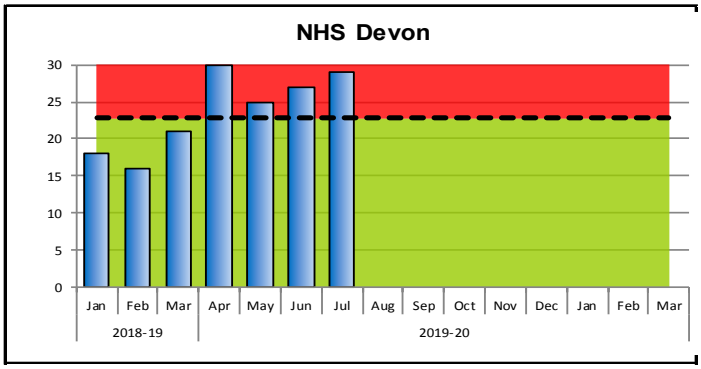
Local reviews of any MRSA case that occurs continues. An ongoing outbreak situation (non-MRSA) in a vulnerable population in Exeter has resulted in a number of members of the population being swabbed for MRSA colonisation, with appropriate treatment if colonisation is found. This is a protective measure which aims to reduce the likelihood of MRSA infection in this population.

C-Diff breaches

Trust	Target	July	2019/20
RDEFT	<31	2	11
NDHT	<9	1	2
UHP	<63	7	20
TSDFT	<36	3	13

CCG	Target	July	2019/20
DEVON STP	<274	29	111





Performance Commentary

There were 10 C-Diff cases acquired within the acute providers and 27 across the STP in June. In July a further 13 cases were seen within acute providers and 29 for the STP.

Quality Commentary and Improvement Actions

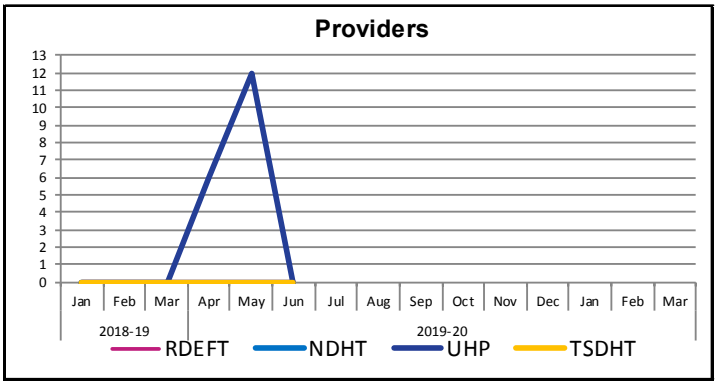
There has been a PII of C difficile at TSDFT in May/June in the community hospital setting, involving three cases. Ribotyping has shown links between cases confirming this as an outbreak. A robust action plan is in place.

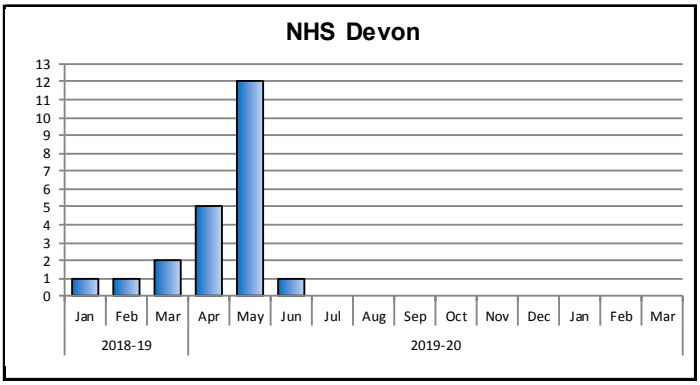
There has been a significant increase in C difficile cases across Devon since April 2019. This is partially due to changes in reporting requirements (community acquired cases <28 days post hospitalisation are now included, an increase of 40% in some areas) but this does not fully explain the increase seen. Provider investigations, including ribotyping, are under way and more clarity may be gained once these reviews are complete.

Mixed Sex accommodation breaches

Trust	Target	June	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	0	18
TSDFT	0	0	0

CCG	Target	June	2019/20
NHS Devon	0	1	18





Performance Commentary

UHP saw 12 breaches in May, all of which were attributed to NHS Devon. There were no provider breaches in June although the CCG saw one out of area breach.

Quality Commentary and Improvement Actions

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.

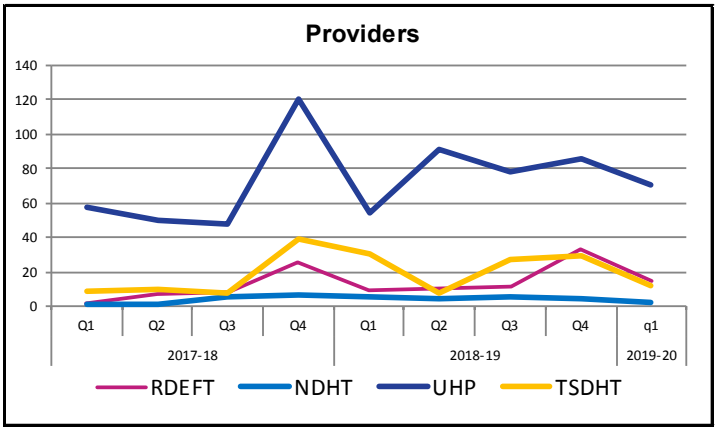
Providers have been asked to submit copies of their Locally Agreed Clinically Appropriate Breach Decision Matrices.

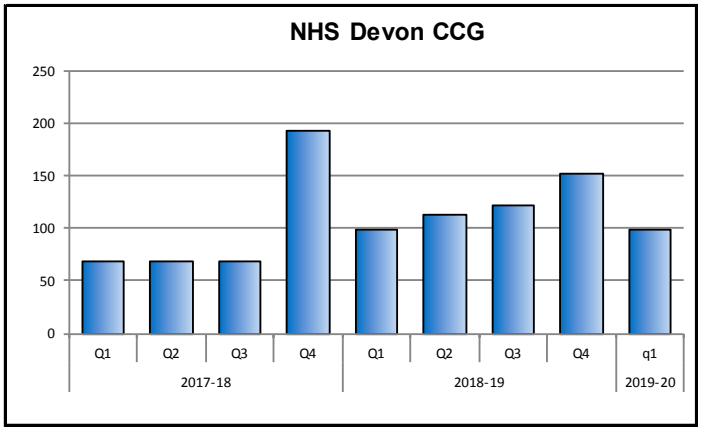
These will be reviewed in August to ensure that the CCG agrees with the decision processes in place and to ensure that clinically appropriate breaches are being adequately considered in relation to both potential patient safety and harm risks and any avoidable impact of patient privacy and dignity.

Cancelled operations not treated with 28 days of cancellation

Trust	Target	Q1	2019/20
RDEFT	0	15	15
NDHT	0	2	2
UHP	0	70	70
TSDFT	0	12	12

CCG	Target	Q1	2019/20
NHS Devon	0	99	99





Performance Commentary

There is a zero breach tolerance for last minute cancelled operations not treated within 28 days of cancellation. Quarter one showed a decrease from quarter four 2018/19 and there were reductions at all providers. Breaches remain highest overall at UHP and comparatively low at NDHT.

Quality Commentary and Improvement Actions

Providers have developed improved systems and processes, however there continues to be evidence of information from providers in relation to quality impacts, including experience, for patients who experience cancelled operations and a further delay of 28 days or more.

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

Domain	Indicator	Area	Period	England value	Target		99P: NHS Northern, Eastern and Western Devon CCG	
	999a: Annual assessment	Annual assessment	2018-19				RI	
	102a: Percentage of children ..	Child obesity	2015-16 to 2017-18	34.2%			29.4%	(23/186)
	103a: Diabetes patients that h..	Diabetes	2017-18	38.7%			38.1%	(158/186)
	103b: People with diabetes dI..	Diabetes	2017-18 (2016 cohort)	8.54%			7.44%	(104/186)
	104a: Injuries from falls in peo..	Falls	18-19 Q3	2051			1690	(45/186)
Better Health	105b: Personal health budgets	Personalisation and choice	18-19 Q4	75			645	(2/186)
	106a: Inequality in unplanned ..	Health inequalities	18-19 Q2	2109			2182	(92/186)
	107a: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	0.962	0.965	●	0.984	(84/186)
	107b: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	8.71%	10%	●	9.60%	(130/186)
	108a: The proportion of carers..	Carers	2018	0.59	1.000	●	0.60	(90/186)
	105c: Percentage of deaths wi..	End of life care	2017	7.40%			6.76%	(33/186)
	121a: Provision of high quality..	Provision of high quality care	18-19 Q3				83	(35/186)
	121b: Provision of high quality..	Provision of high quality care	18-19 Q3				70	(9/186)
	121c: Provision of high quality..	Provision of high quality care	18-19 Q3				85	(10/186)
	122a: Cancers diagnosed at e..	Cancer	2017	52.2%			66.8%	(19/186)
	122b: People with urgent GP r..	Cancer	18-19 Q4	77.3%	85%	●	70.8%	(183/186)
	122c: One-year survival from ..	Cancer	2016	72.8%	75%	●	74.2%	(36/186)
	122d: Cancer patient experien..	Cancer	2017				8.9	(35/186)
	123a: Improving Access to Ps..	Mental health	18-19 Q3	51.8%	50%	●	60.8%	(119/186)
	123b: Improving Access to Ps..	Mental health	18-19 Q3	4.48%			3.87%	(148/186)
	123c: People with first episod..	Mental health	2019 03	75.9%	53%	●	70.8%	(140/186)
	123e: Mental health crisis tea..	Mental health	2017-18				0.00%	(114/180)
	123f: Mental health out of are..	Mental health	2019 02	124			675	(180/186)
	123g: Proportion of people on ..	Mental Health	18-19 Q4	30.3%	50%	●	17.2%	(155/186)
	123i: Delivery of the mental he..	Mental Health	18-19 Q4				Green	
	123j: Ensuring the quality of m..	Mental Health	2019 01	Null			0.84	(22/186)
	124a: Reliance on specialist in..	Learning disability	18-19 Q4				40	(48/186)
	124b: Proportion of people wit..	Learning disability	2017-18	51.4%			63.8%	(81/186)
Better Care	124c: Completeness of the G..	Learning disability	2017-18	0.49%			0.64%	(65/186)
	125a: Neonatal mortality and ..	Maternity	2016	Null			3.82	(69/194)
	125b: Women's experience of ..	Maternity	2018	82.7			84.2	(67/186)
	125c: Choices in maternity ser..	Maternity	2018	60.4			60.1	(106/186)
	125d: Maternal smoking at del..	Maternity	18-19 Q3	10.5%	6%	●	10.8%	(92/186)
	126a: Estimated diagnosis rat..	Dementia	2019 03	68.7%	67%	●	69.8%	(181/186)
	126b: Dementia care planning..	Dementia	2017-18	77.5%			77.2%	(123/184)
	127b: Emergency admissions ..	Urgent and emergency care	18-19 Q2	2409			2186	(68/186)
	127c: Percentage of patients ..	Urgent and emergency care	2019 03	86.6%	95%	●	86.7%	(84/186)
	127e: Delayed transfers of car..	Urgent and emergency care	2019 03	10.2			11.0	(130/186)
	127f: Population use of hospit..	Urgent and emergency care	18-19 Q2	499			427	(31/186)
	128b: Patient experience of G..	Primary care	2018	83.8%			88.0%	(13/186)
	128c: Primary care access – p..	Primary care	2019 03	99.8%			100.0%	(1/193)
	128d: Primary care workforce	Primary care	2018 09	1.05			1.21	(31/186)
	128e: Count of the total invest..	Primary care	18-19 Q4				Green	
	129a: Patients waiting 18 wee..	Elective access	2019 03	86.7%	92%	●	80.3%	(187/186)
	130a: Achievement of clinical ..	7 day services	2017-18				2	(56/186)
	131a: Percentage of NHS Con..	NHS Continuing Healthcare	18-19 Q4	6.91%	15%	●	0.00%	(1/186)
	132a: Evidence that sepsis aw..	Patient safety	2018				Amber	
	133a: Percentage of patients ..	Diagnostics	2019 03	2.47%	1%	●	10.5%	(192/186)
	141b: In-year financial perfor..	Financial sustainability	18-19 Q4				Amber	
Sustainability	144a: Utilisation of the NHS e-..	Paper-free at the point of care	2019 03	99.8%	100%	●	88.0%	(184/186)
	145a: Expenditure in areas wit..	Demand management	18-19 Q3				Red	
	162a: Probity and corporate g..	Probity and corporate governa..	18-19 Q4				Fully compliant	
	163a: Staff engagement index	Workforce engagement	2018	3.82			3.86	(21/188)
Leadership	163b: Progress against the W..	Workforce engagement	2018	0.14			0.17	(158/188)
	164a: Effectiveness of workin..	CCGs' local relationships	2018-19				82.7	(181/186)
	165a: Quality of CCG leaders..	Quality of leadership	18-19 Q4				Amber	
	166a: Compliance with statuto..	Patient and community engag..	2018				Green star	

Direction of change arrows
- Increase
- Decrease
- Equal
- No data

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

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

RateText
- Null
- Green Star
- Green
- Amber
- Red
- Requires Improvement
- Fully compliant

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

Summary

Domain	Indicator	Area	Period	England value	Target			89Q: NHS South Devon and Torbay CCG
	999a: Annual assessment	Annual assessment	2018-19				RI	
Better Health	102a: Percentage of children ..	Child obesity	2015-16 to 2017-18	34.2%			30.0%	(32/186)
	103a: Diabetes patients that h..	Diabetes	2017-18	38.7%			36.6%	(184/186)
	103b: People with diabetes di..	Diabetes	2017-18 (2016 cohort)	8.54%			9.30%	(82/186)
	104a: Injuries from falls in peo..	Falls	18-19 Q3	2051			1909	(79/186)
	105b: Personal health budgets	Personalisation and choice	18-19 Q4	75			238	(8/186)
	106a: Inequality in unplanned ..	Health inequalities	18-19 Q2	2109			1832	(68/186)
	107a: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	0.962	0.965	●	0.969	(87/186)
	107b: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	8.71%	10%	●	10.8%	(171/186)
	108a: The proportion of carers..	Carers	2018	0.59	1.000	●	0.68	(108/186)
Better Care	105c: Percentage of deaths wi..	End of life care	2017	7.40%			7.48%	(92/186)
	121a: Provision of high quality..	Provision of high quality care	18-19 Q3				63	(35/186)
	121b: Provision of high quality..	Provision of high quality care	18-19 Q3				72	(3/186)
	121c: Provision of high quality..	Provision of high quality care	18-19 Q3				64	(26/186)
	122a: Cancers diagnosed at e..	Cancer	2017	52.2%			52.2%	(97/186)
	122b: People with urgent GP r..	Cancer	18-19 Q4	77.3%	85%	●	70.0%	(188/186)
	122c: One-year survival from ..	Cancer	2016	72.8%	75%	●	74.8%	(19/186)
	122d: Cancer patient experien..	Cancer	2017				8.0	(13/186)
	123a: Improving Access to Ps..	Mental health	18-19 Q3	51.8%	50%	●	48.0%	(180/186)
	123b: Improving Access to Ps..	Mental health	18-19 Q3	4.48%			2.86%	(191/186)
	123c: People with first episod..	Mental health	2019 03	75.9%	53%	●	66.4%	(179/186)
	123e: Mental health crisis tea..	Mental health	2017-18				0.00%	(114/180)
	123f: Mental health out of are..	Mental health	2019 02	124			889	(186/186)
	123g: Proportion of people on ..	Mental Health	18-19 Q4	30.3%	50%	●	30.6%	(89/186)
	123i: Delivery of the mental he..	Mental Health	18-19 Q4				Green	
	123j: Ensuring the quality of m..	Mental Health	2019 01	Null			0.94	(20/186)
	124a: Reliance on specialist in..	Learning disability	18-19 Q4				40	(49/186)
	124b: Proportion of people wit..	Learning disability	2017-18	51.4%			68.9%	(42/186)
	124c: Completeness of the G..	Learning disability	2017-18	0.49%			0.67%	(20/186)
	125a: Neonatal mortality and ..	Maternity	2016	Null			3.68	(63/194)
	125b: Women's experience of ..	Maternity	2018	82.7			87.2	(19/186)
	125c: Choices in maternity ser..	Maternity	2018	60.4			67.2	(13/186)
	125d: Maternal smoking at del..	Maternity	18-19 Q3	10.5%	6%	●	13.7%	(138/186)
	126a: Estimated diagnosis rat..	Dementia	2019 03	68.7%	67%	●	68.8%	(188/186)
	126b: Dementia care planning..	Dementia	2017-18	77.5%			76.8%	(134/194)
	127b: Emergency admissions ..	Urgent and emergency care	18-19 Q2	2409			1897	(38/186)
	127c: Percentage of patients ..	Urgent and emergency care	2019 03	86.6%	95%	●	81.6%	(141/186)
	127e: Delayed transfers of car..	Urgent and emergency care	2019 03	10.2			9.1	(96/186)
	127f: Population use of hospit..	Urgent and emergency care	18-19 Q2	499			387	(4/186)
	128b: Patient experience of G..	Primary care	2018	83.8%			87.4%	(31/186)
	128c: Primary care access – p..	Primary care	2019 03	99.8%			100.0%	(1/183)
	128d: Primary care workforce	Primary care	2018 09	1.05			1.20	(34/186)
	128e: Count of the total invest..	Primary care	18-19 Q4				Green	
	129a: Patients waiting 18 wee..	Elective access	2019 03	86.7%	92%	●	80.9%	(184/186)
	130a: Achievement of clinical ..	7 day services	2017-18				2	(58/186)
	131a: Percentage of NHS Con..	NHS Continuing Healthcare	18-19 Q4	6.91%	15%	●	0.00%	(1/186)
	132a: Evidence that sepsis aw..	Patient safety	2018				Amber	
	133a: Percentage of patients ..	Diagnostics	2019 03	2.47%	1%	●	10.3%	(181/186)
Sustainability	141b: In-year financial perfor..	Financial sustainability	18-19 Q4				Amber	
	144a: Utilisation of the NHS e-..	Paper-free at the point of care	2019 03	99.8%	100%	●	98.8%	(188/186)
	145a: Expenditure in areas wit..	Demand management	18-19 Q3				Green	
Leadership	162a: Probity and corporate g..	Probity and corporate governa..	18-19 Q4				Fully compliant	
	163a: Staff engagement index	Workforce engagement	2018	3.82			3.83	(41/188)
	163b: Progress against the W..	Workforce engagement	2018	0.14			0.11	(83/188)
	164a: Effectiveness of workin..	CCGs local relationships	2018-19				82.7	(181/186)
	165a: Quality of CCG leaders..	Quality of leadership	18-19 Q4				Amber	
	166a: Compliance with statuto..	Patient and community engag..	2018				Green star	

Direction of change arrows
- Increase
- Decrease
- Equal
- No data

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

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

RateText
- Null
- Green Star
- Green
- Amber
- Requires improvement
- Fully compliant

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

Appendix B. Key performance indicators – NHS Devon CCG

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%	80.4%										80.6%				80.6%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	391	339	188	179	153	199										531				531
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	<=1%	15.3%	11.9%	10.5%	12.0%	15.2%	13.9%										13.7%				13.7%
Cancer - percentage seen within 2 weeks - urgent referral to first seen	>=93%	84.4%	87.6%	87.1%	78.8%	85.9%	84.3%										83%				82.9%
Breast symptomatic- percentage seen within 2 weeks	>=93%	89.1%	80.0%	69.0%	50.2%	64.3%	66.8%										60%				60.2%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	>=85%	69.3%	72.1%	73.5%	75.4%	77.7%	73.9%										76%				75.7%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.7%	92.1%	86.7%	95.6%	89.2%	87.2%										91%				90.7%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	87.0%	82.6%	85.5%	76.5%	81.1%	83.0%										80%				80.3%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	94.5%	93.1%	93.2%	92.8%	95.7%	94.5%										94%				94.3%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	88.5%	87.9%	88.4%	93.0%	92.0%	93.7%										93%				92.8%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.7%	99.7%	99.7%	99.3%	99.4%	99.7%										99%				99.4%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	92.9%	93.7%	91.2%	92.8%	90.2%	91.8%										92%				91.6%
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	71.3%	73.7%	77.4%	72.0%	80.3%	76.3%	79.0%									76%				76.5%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	>=95%	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%	87.7%									85%				85.5%
Ambulance Category 1 Mean response Duration (min)	7	6.8	7.3	7.0	7.0	6.9	7.2										7.0				7.0
Ambulance Category 1 90th response Duration (min)	15	12.0	13.1	12.3	13.1	12.5	13.5										13.0				13.0
Ambulance Category 2 Mean response Duration (min)	18	28.5	28.3	27.3	26.0	26.1	26.3										26.1				26.1
Ambulance Category 2 90th response Duration (min)	40	58.7	59.5	56.0	53.7	54.3	54.6										54.2				54.2
Ambulance Category 3 90th response Duration (min)	120	169.7	161.3	156.5	162.4	155.1	158.4										158.6				158.6
Ambulance Category 4 90th response Duration (min)	180	220.2	214.4	200.1	196.4	186.4	197.0										193.3				193.3
Cancelled Operations - Number of patients not treated within 28 days of cancellation	0			152			99										99				99
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%	1.4%	1.5%										4.2%				4.2%
IAPT recovery rate - percentage of people who are moving to recovery	50%	53.0%	53.7%	51.4%	50.7%	52.4%	51.4%										51.5%				51.5%
IAPT - started treatment with 6 weeks of referral	75%	94.0%	92.3%	88.0%	81.3%	80.4%	82.0%										81.3%				81.3%
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%	98.3%	89.8%										93.5%				93.5%
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%	89.0%	86.8%										89.0%				89.0%
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%	47.4%										48.5%				48.5%
Dementia diagnosis rate	62%	59.1%	58.9%	59.6%	59.5%	59.3%	60.0%										59.6%				59.6%

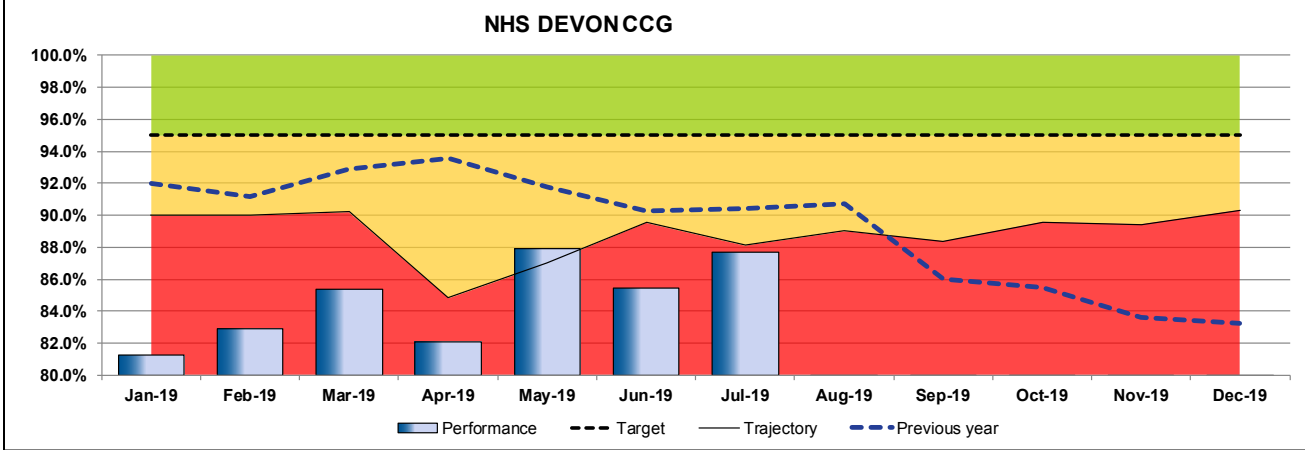
QUALITY MEASURES

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	0									2				2
Clostridium difficile - number of hospital infections	316	18	16	21	30	25	27	29									111				111
Mixed sex accommodation (MSA) - number of hospital breaches	0	1	1	2	5	12	1										18				18
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%										5.1%				5.1%
Delayed transfers of care (all) - Percentage of delays per Occupied bed	3.5%	5.3%	4.9%	3.9%	4.2%	4.6%	4.6%										6.7%				6.6%

4 hour waits A&E &MIU

NHS Devon CCG

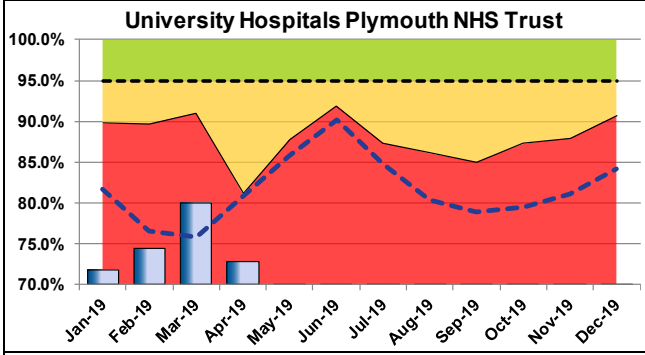
STP footprint	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>95%	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%	87.7%					
Trajectory		90.0%	90.0%	90.2%	84.8%	87.0%	89.5%	88.1%	89.0%	88.4%	89.6%	89.4%	90.3%
NHS England		84.4%	84.2%	86.6%	85.1%	88.0%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

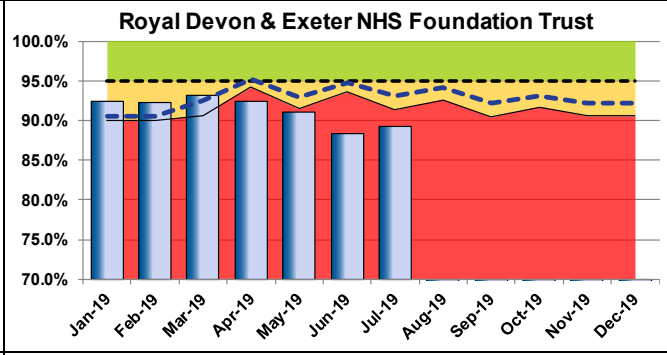


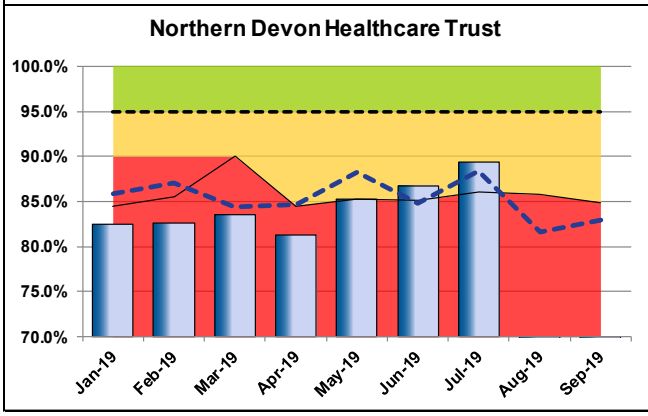
Comment:
Performance continues to be volatile against the A&E 4-hour target. In July the STP position was 87.7%, up from 85.4% in June, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. RD&E performance increased from 88.3% to 89.3%, NDHT improved from 86.8% to 89.4% and TSD from 80.3% to 84.3%.

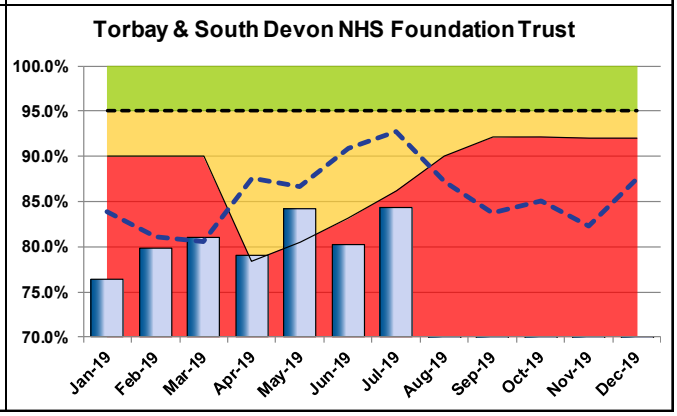
Provider level

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%	89.3%					
	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%	89.4%					
	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%	84.3%					
	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%





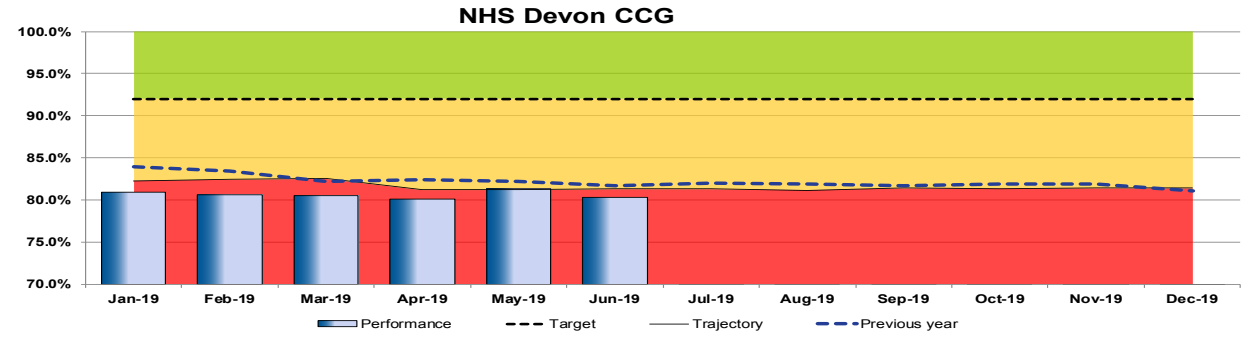




18-week RTT (incomplete pathway)

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%	80.4%						
Trajectory		82.3%	82.4%	82.5%	81.2%	81.2%	81.3%	81.3%	81.2%	81.4%	81.4%	81.4%	81.4%
NHS England		86.7%	87.0%	86.7%	86.5%	86.9%	86.3%						
RTT total waiting list	78,364	80,089	81,661	82,913	83,546	83,041	85,931						
Trajectory		75,616	75,353	74,733	82,086	81,536	82,603	82,054	81,730	81,454	82,036	79,922	80,442

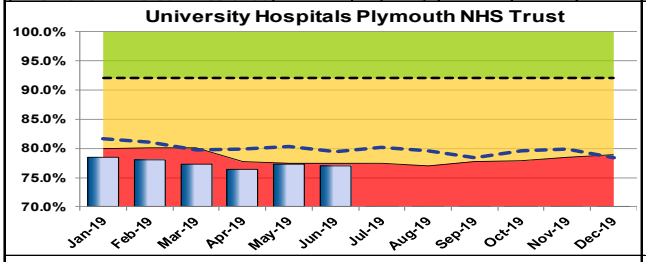


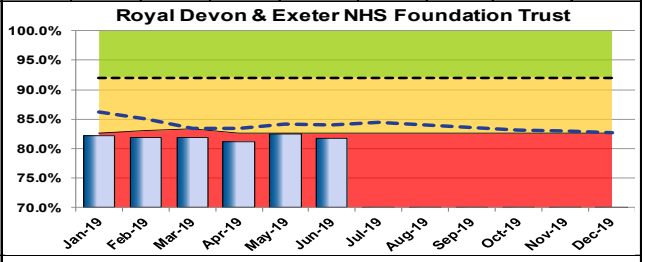
The STP level RTT position decreased in June from 81.3% to 80.4%. Whilst NDHT continued to see improvement, moving from 79.9% to 80.7%, UHP fell slightly from 77.3% to 77.0%, TSD decreased from 81.9% to 81.5% and RD&E fell from 82.4% to 81.7%. NDHT remained above trajectory with TSD exactly on plan and UHP and RD&E slightly under.
The incomplete waiting list rose by around 650 patients at RD&E, almost 300 at UHP and 100 at TSD, although the NDHT size was flat. UHP, TSD and RD&E are above their respective waiting list trajectories.
Over 52 week waits rose in June moving from 153 to 199 at STP level. All providers saw increased breaches although the rise at TSD was greatest (59 to 83), whilst NDHT (8 to 10), RD&E (71 to 73) and UHP (57 to 61) saw smaller increases.

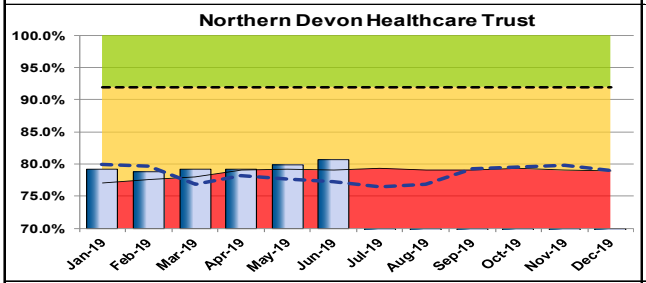
18-week RTT (incomplete pathway).....continued

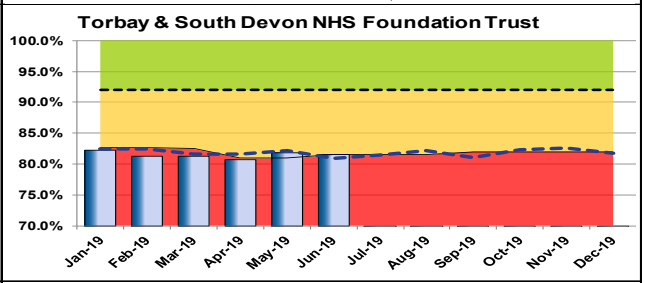
Provider level

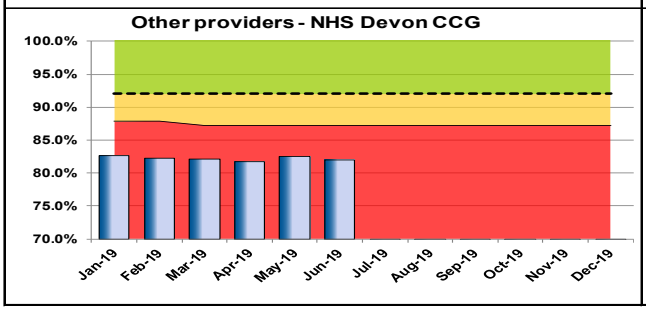
Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	78.4%	78.0%	77.3%	76.4%	77.3%	77.0%						
	Trajectory	80.0%	80.0%	80.1%	77.7%	77.5%	77.5%	77.4%	77.0%	77.8%	77.9%	78.5%	78.9%
	Waiting list	27,356	27,872	27,922	28,195	28,611	28,899						
	Trajectory	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%	81.7%						
	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	36,355						
	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%	80.7%						
	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	11,429						
	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%	81.5%						
	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	19,636						
	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%	82.0%						
	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%







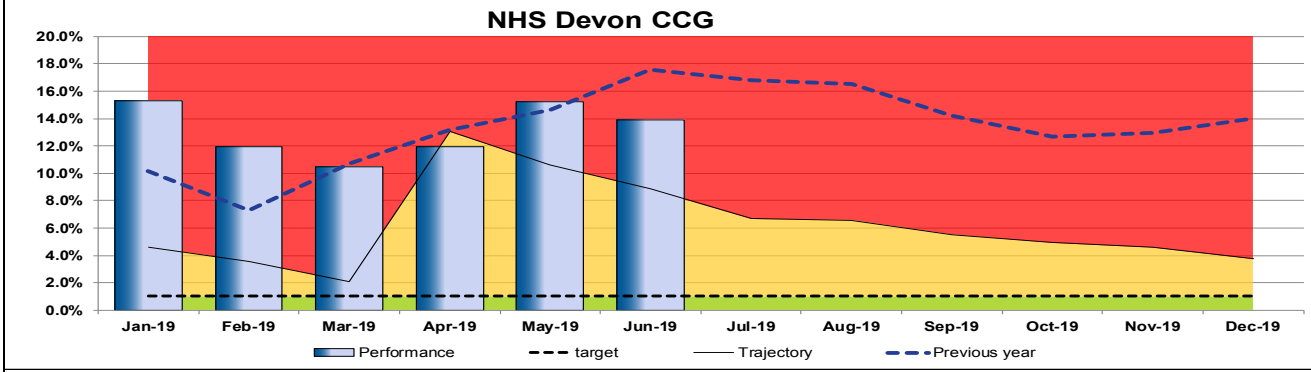




6 Week Diagnostics

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%	13.9%						
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%	4.1%							

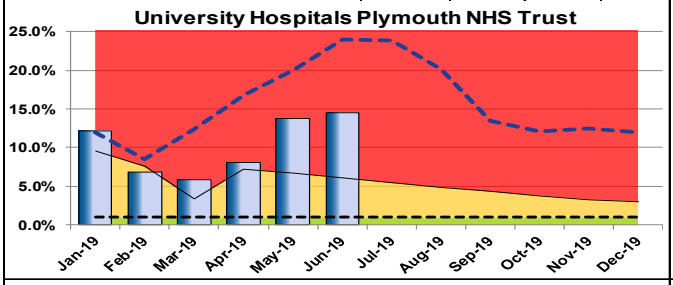


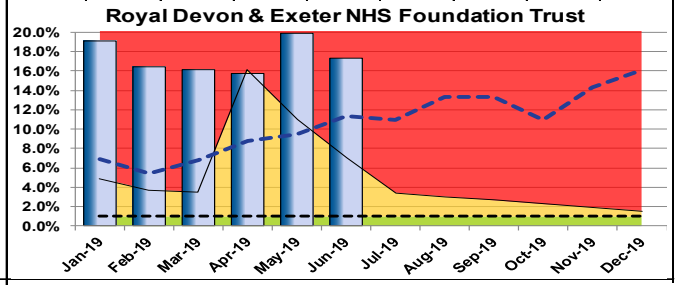
The STP position improved slightly from 15.2% to 13.9% in June as there were reductions in breaches at NDHT (moving from 19.3% to 16.3%), RD&E (19.9% to 17.3%) and TSD (12.1% to 11.7%), although there was a further increase at UHP (13.8% to 14.5%). RD&E and UHP are significantly above improvement trajectories, with NDHT just over and TSD remaining within plan. The majority of breaches continue to be for imaging and endoscopy.

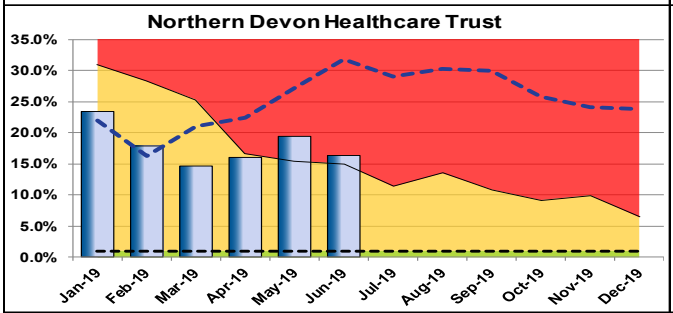
6 Week Diagnostics……continued

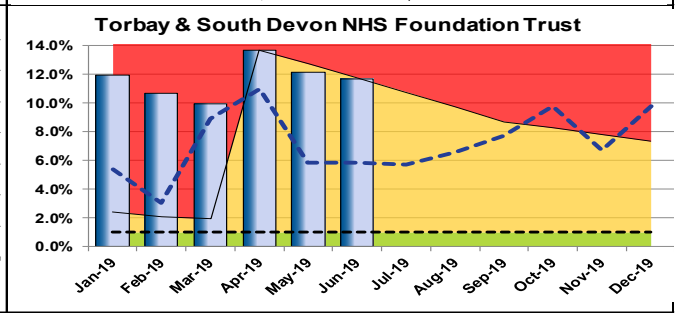
Provider level

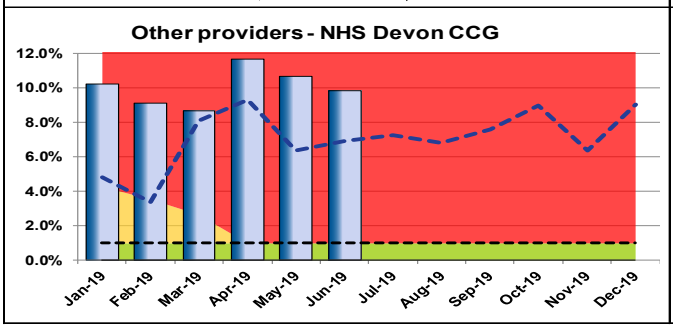
Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	12.1%	6.8%	5.9%	8.1%	13.8%	14.5%						
	Trajectory	9.6%	7.5%	3.4%	7.2%	6.7%	6.1%	5.4%	4.9%	4.4%	3.8%	3.3%	3.0%
RDEFT	Actual	19.1%	16.4%	16.1%	15.7%	19.9%	17.3%						
	Trajectory	4.9%	3.7%	3.5%	16.1%	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%	16.3%						
	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%	11.7%						
	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%	9.8%						
	Trajectory												







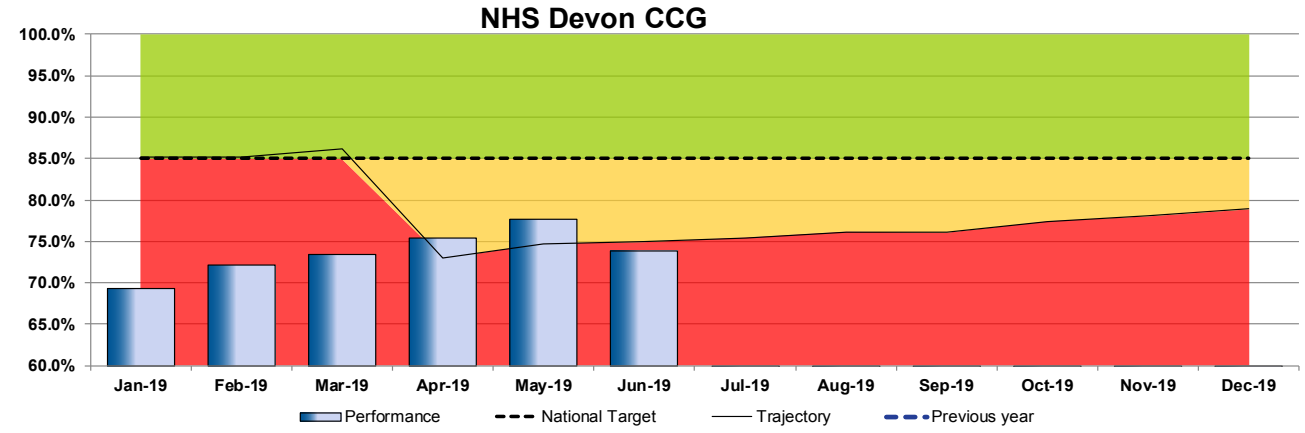




62 day standard Cancer waits

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%	73.9%						
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%	77.5%							



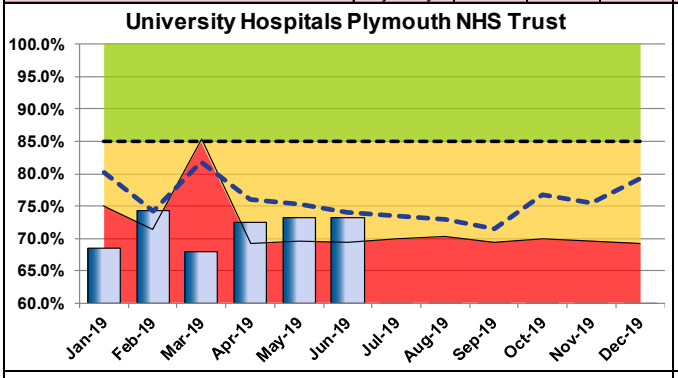
Performance fell at STP level in June, from 77.7% to 73.9%. TSD, who achieved the target in May, saw performance fall to 78.8% whilst RD&E dropped from 71.6% to 67.2%. NDHT performance fell to 78.1% and the UHP position remained static at 73.2%.

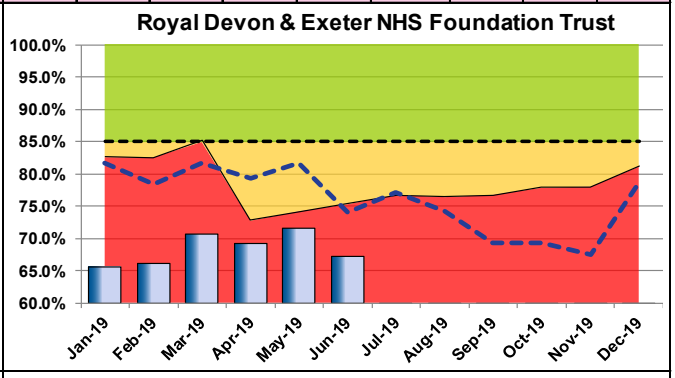
NDHT was the only provider to see the 62-day incomplete backlog fall in June.

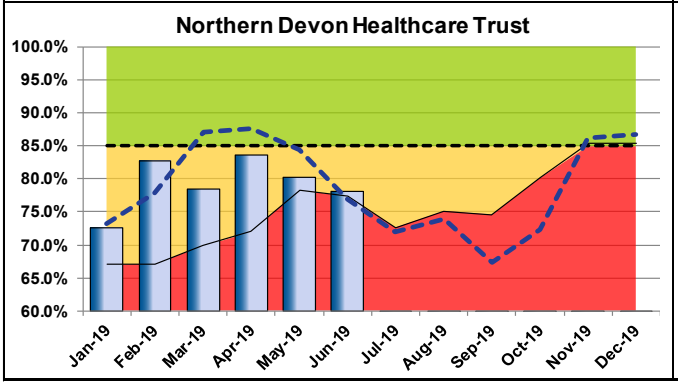
62 day standard Cancer waits……continued

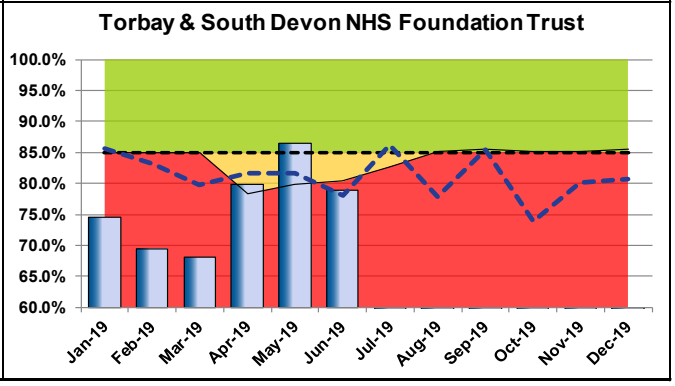
Provider level

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%	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%	67.2%						
	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%	78.1%						
	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%	78.8%						
	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

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 29 August 2019

Dates of Committees covered in this report: 15 August 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
- Single action Wavers

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
- Long term financial plan

Risk Register Review (changes and areas of concern)

- One risk recommended for closure – Risk No. 8
- One risk recommended for increase - Risk 2 increased from 16 to 20
- One risk recommended for increase – Risk 111 increased to 16

Committee Decisions

Recommendations for Governing Body

• **Closure of risk 8**
Recommendations for other Committees
Terms of Reference or other committee effectiveness issues

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.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY MEETING

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 29th August 2019 **Date report produced: 16th August 2019**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date:** 16th August 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The report details the financial position to the 31st July 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 July 2019 (month 4 management accounts).

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:

The Governing Body is asked to note the month 4 position as at 31st July 2019 and the level of risk to delivery of the CCG's control total.

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our 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 Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 4 – 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 31st July 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.

Since this initial assessment The Devon System has been through an intensive programme, supported by NHSE & I colleagues, to reach a more acceptable position in relation to financial performance against control total. This has seen a planned improvement in the gross system deficit from £115m to £70m (a distance of £25m 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.

Financial Position

This report sets out the financial performance of the CCG to the end of July 2019 (month 4 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	9,000	9,000	0
Year end forecast	27,000	27,000	0

Although the overall year to date (YTD) position balances to the planned deficit of £9.0m, there are several variances to report at Month 4. 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 against the plan, therefore resulting in 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/Sustainability 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	9.0	9.0	0.0%	RED
3	Forecast Outturn in year deficit	27.0	27.0	0.0%	RED
4	QIPP - Year To Date Delivery (% achieved)	-16.3	-6.3	38.6%	RED
5	QIPP - Forecast Outturn Delivery	-80.9	-80.9	100.0%	GREEN
6	Running Costs	25.4	22.6	89.0%	GREEN
7	Risk adjustment to deficit (% of allocation)	0.0	39.5	2.3%	RED
8	Cash Position (% drawn down)	33.3%	33.4%	100.3%	AMBER
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 31st July 2019 by main service heading is as follows:

Month 04 July	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	301,563	301,485	-78	904,689	904,659	-30
Mental Health Services	67,378	67,621	242	202,134	201,852	-283
Community Health Services	89,515	89,546	31	268,544	268,604	60
Placements	40,625	41,401	776	121,870	121,908	38
All Other Healthcare	12,029	10,612	-1,417	-681	-572	109
Primary Care Services						
Prescribing	64,663	65,105	442	193,990	193,990	0
Other Primary Care	69,931	69,934	3	213,209	213,210	0
Primary Care Subtotal	134,595	135,039	445	407,199	407,200	0
Subtotal	645,704	645,703	-0	1,903,756	1,903,651	-105
CORPORATE						
Running Costs	7,508	7,508	0	22,527	22,633	106
TOTAL COMMISSIONED SERVICES	653,212	653,212	-0	1,926,283	1,926,283	0
Allocation excl b/fwd position	644,212	653,212	9,000	1,899,283	1,926,283	27,000
2018/19 Surplus/Deficit	9,000	-	9,000	27,000	-	27,000

There are a number of YTD variances to report at Month 4 including an overspend in mental health of £0.242m and £0.776m in continuing healthcare. This overspend has mainly been offset using reserves, resulting in the planned YTD deficit of £9.0m. This is discussed and set out in later sections.

When set against our available in year revenue resources of £1,899m 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 sections below show the quarter one position against total contract plans. The CCG continues to work closely with providers to ensure a joint understanding of activity variances.

RD&E Activity Summary – month 3

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	2,733	2,232	-501	-18%	7,962	7,639	-323	-4%
Day Case	11,649	10,351	-1,298	-11%	8,906	8,116	-789	-9%
Non-Elective	11,727	11,554	-173	-1%	22,506	21,655	-851	-4%
A&E	22,147	22,231	84	0%	3,018	3,171	153	5%
New Outpatients	32,176	34,321	2,145	7%	4,325	4,377	52	1%
Follow-up Outpatients	54,514	54,341	-173	0%	3,798	3,718	-80	-2%
Outpatient Procedures	25,835	23,138	-2,697	-10%	4,457	4,108	-350	-8%
Drugs & Devices					3,904	3,700	-204	-5%
CQUIN					785	765	-20	-3%
Other					7,683	8,135	452	6%
Total					**67,343**	**65,383**	**-1,960**	**-3%**

Overall at Month 3 there is a £1,960k underspend against plan. There is £2,188k of un-coded activity within the actual position.

The elective inpatient & day case activity is 13% below plan equating to an underspend of £1,112k. The main contributing specialty continues to be Trauma & Orthopaedics with a £332k underspend.

The Non-Elective activity is 1% below plan equating to an underspend of £851k. Similar to the position for elective & day case, the main contributing specialty is Trauma & Orthopaedics with an underspend of £241k. A&E activity is on plan with a small overspend relating to the case-mix of £88k.

Outpatient attendances (first and follow-up) are 2.3% over plan and this overperformance is all related to first appointments which are 7% above planned levels. Financially there is a small underspend of £28k. Ophthalmology has an underspend of £133k, Dermatology is under plan by £76k but this is partially offset by overspends within the specialities of General Medicine & General Surgery with variances of £47k & £66k respectively.

Outpatient Procedures are 10% below plan with a corresponding underspend of £350k. Midwifery & Obstetrics have a combined underspend of £266k (however a change of reporting has led to an overspend for Maternity of £151k showing within the Other point of delivery which will reduce this.) In addition Ophthalmology is £73k underspent against plan at Month 3.

NDHT Activity Summary – month 3

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	803	819	16	2%	2,259	2,018	-241	-11%
Day Case	4,731	4,857	126	3%	2,478	2,561	83	3%
Non-Elective	5,295	5,498	203	4%	9,887	11,335	1,448	15%
A&E	11,009	11,368	359	3%	1,426	1,429	3	0%
New Outpatients	9,861	10,017	156	2%	1,658	1,632	-26	-2%
Follow-up Outpatients	21,640	19,997	-1,643	-8%	1,748	1,665	-84	-5%
Outpatient Procedures	8,543	9,031	488	6%	1,101	1,134	32	3%
Drugs & Devices					1,778	1,356	-423	-24%
CQUIN					165	165	0	0%
Other					13,716	13,682	-34	0%
Total					**36,217**	**36,977**	**759**	**2%**

Un-coded activity remains an issue within NDHT with 15% of day case, 45% of inpatient elective, 37% of A&E and 50% of non-elective activity uncoded to month 3 and an average tariff applied. Month 3 is currently showing an overspend of £759k, however due to the level of un-coded activity the financial position cannot be fully validated.

A&E activity is 2% above plan (actual variance is 16 attendances) whilst non-elective activity appears high against plan, 4% above for activity and 15% for spend. General Medicine and Obstetrics have the highest variance to plan at 145 and 149 admissions respectively).

Day case activity is 3% above plan for both activity and spend, and Clinical Haematology and Gastroenterology remain the main over performing specialities. Whilst inpatient electives are also slightly above the activity plan the spend is 11% under plan, balancing out the day case overperformance.

First outpatients are 2% above the activity plan but 2% underspent. T&O and Clinical Physiology have the highest variance against plan at £37k and £34k - with limited capacity NDHT are prioritising first outpatient appointments for these specialties. For follow-up outpatient there has been a large decrease in general surgery appointments (which NDHT are reviewing) and this masks increases in T&O, Paediatrics and Orthoptics. For outpatient procedures, which are up by 6% on the activity plan and 3% on spend, ENT is the largest area of overperformance.

UHP Activity Summary – month 3

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	1,590	1,509	-81	-5%	5,411	5,198	-213	-4%
Day Case	7,990	8,477	487	6%	5,868	5,736	-132	-2%
Non-Elective	10,376	9,672	-704	-7%	21,066	21,349	283	1%
A&E	33,038	31,792	-1,246	-4%	4,233	4,039	-194	-5%
New Outpatients	18,569	18,433	-136	-1%	2,767	2,695	-72	-3%
Follow-up Outpatients	40,695	38,992	-1,703	-4%	3,287	3,029	-258	-8%
Outpatient Procedures	17,086	19,847	2,761	16%	2,679	2,881	202	8%
Drugs & Devices					3,883	3,403	-480	-12%
CQUIN					629	620	-9	-1%
Other					4,934	4,648	-286	-6%
Total					**54,756**	**53,597**	**-1,158**	**-2%**

Expenditure on combined day case and elective inpatients is 3.1% behind the financial plan and 7.6% ahead of the activity plan. The difference between these values is due to a different case-mix of patients being treated than was expected with overperformance in lower cost specialities such as Endoscopy and Dermatology, and underperformance in higher cost specialities such as Orthopaedics and Cardiology.

Combined outpatient activity is 1.2% above plan whilst the spend is 1.5% less than had been expected. This variance is driven by UHP seeing more non face to face contacts than had been expected. Outpatient procedures are above plan for both activity and spend.

Non-elective activity is 7% under plan for activity but slightly over plan for cost. Please note this does not account for blended payments. A&E activity is below plan for both activity and cost.

TSD Activity Summary – month 3

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Day Case	8,396	9,012	616	7%	5,407	5,789	382	7%
Inpatient	897	805	-92	-10%	3,401	2,796	-605	-18%
Non-Elective	7,433	6,515	-918	-12%	16,818	15,396	-1,422	-8%
A&E	17,913	17,960	47	0%	2,704	2,708	4	0%
New Outpatients	24,235	23,203	-1,032	-4%	3,713	3,571	-142	-4%
Follow-up Outpatients	56,256	55,157	-1,099	-2%	5,197	4,960	-237	-5%

Due to continued reporting issues at TSD the reported position is a view of the total provider rather than the subset of CCG operational plan activity. We are working with the Trust to ensure that this is resolved for month 4 data.

As a provider TSD are 7% (616) above plan for day cases although inpatient electives are down by 10% (92). For outpatients both first and follow-ups are under plan. Non-elective activity is showing a position 12% below plan although A&E attendances are flat. The overall provider level financial position against activity plans is a £2.3m underspend.

Referrals

Below is a summary by provider of the month 3 referral position, highlighting any key areas of variance. These figures are for NHS Devon CCG referrals.

RD&E Referral Summary – month 3

	18/19	19/20	Var	Var %
GP	19,185	19,722	537	2.8%
Other	7,956	8,114	158	2.0%
Total	**27,141**	**27,836**	**695**	**2.6%**

RD&E continue to show growth in referrals overall, up 2.6% at the end of quarter one. GP growth is 2.8% and within the other category consultant to consultant growth is highest at 6.8% (175 referrals). The majority of the overall growth is for routine referrals, with 2ww showing marginal growth on 2018/19. At specialty level cardiology, orthopaedics, dermatology and gastroenterology are showing the highest levels of growth.

UHP Referral Summary – month 3

	18/19	19/20	Var	Var %
GP	14,456	15,303	847	5.9%
Other	7,729	7,680	-49	-0.6%
Total	**22,185**	**22,983**	**798**	**3.6%**

Overall UHP referral growth is 3.6% all of which is being driven by 2ww cancer increases (at 24% compared to routine growth of -1.9%). The majority of the 2ww growth is related to GP referral increases for Dermatology, Colorectal Surgery & ENT, whilst 2ww consultant referrals are showing growth in Gastroenterology (although there is a corresponding reduction in routine referrals leaving total consultant referred Gastroenterology referrals showing 3.4% growth overall).

For routine referrals Trauma & Orthopaedics is seeing 17.4% growth (446 referrals) at UHP but this is related to the impact of the Plymouth Orthopaedic Partnership with Care UK. However, the combined position of Care UK and UHP GP referrals still shows 10.7% growth YTD. In addition to growth in Dermatology 2ww referrals there is also growth in routine referrals of 12.9% (82 referrals).

NDHT Referral Summary – month 3

	18/19	19/20	Var	Var %
GP	6,204	5,409	-795	-12.8%
Other	2,164	2,550	386	17.8%
Total	**8,368**	**7,959**	**-409**	**-4.9%**

NDHT have seen 4.9% less referrals at the end of quarter one than in quarter one 2018/19. A 6.3% increase in 2ww cancer referrals has been balanced out by a 7.4% decrease in routine referrals.

However, then looking at specialty level there are some large decreases which do not match the DRSS reported position. For instance, ophthalmology has seen a significant reduction in referrals (44%), as has Cardiology which has seen a decrease of 32%. This is being reviewed with the Trust for data quality issues. If these two specialties are discounted from the overall position there is a small growth in referrals.

TSD Referral Summary – month 2

	18/19	19/20	Var	Var %
GP	7,383	7,177	-206	-2.8%
Other	7,232	7,544	312	4.3%
Total	**14,615**	**14,721**	**106**	**0.7%**

Due to delays in ASI referrals being updated in referrals data the month 2 TSD position is included in this report. The overall position for NHS Devon CCG is growth of 0.7% with GP referral down by 2.8% and, within this, 2ww cancer referrals down by 1.8% and routines down by 3.2%. Of the 'other' referral growth consultants are showing 2.1%.

At specialty level ophthalmology (-17.9%) and orthopaedics (-9.5%) are showing the biggest reductions whilst cardiology (19.9%), gynaecology (10.6%) and dermatology (7.6%) are showing the highest growth.

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 4 there is a YTD overspend of £0.532m 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. Other mental health contracts are showing a YTD underspend of £0.290m, which is a combination of 2018/19 year end accruals and slippage on current year contracts. The position is forecast to be £0.283m underspent at the year end.

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. There are no significant variances to report as at M4.

3.4 Placements

Continuing healthcare is overspent by £0.776m at month 4 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 4 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.

The CCG received further GP Forward View allocations in month 4 in which expenditure plans are currently being drawn up.

Primary Care Prescribing

The spend increased in the May data and when compared to the profile does show an overspend for this year. We have reported an overspend for M04 but continued with a breakeven position for year end. This allows for the QIPP yet to be delivered. Work has taken place on the QIPP plans, with financial amounts allocated against some schemes. Work will continue to complete this plan and ensure that all schemes are included. 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 and have been reported.

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. These are forecast to come in on budget as at M4.

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. The variance reported is due to the use of the reserves and the profiling of the QIPP delivery.

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 4 is estimated at £22.6m which would be an underspend of £2.8m 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			16,599
Primary care commissioning			161,805
Running costs allocation			25,405
Total revenue resources			**1,899,283**
Total forecast expenditure			1,926,283
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 4 is estimated at £39.5m as follows.

Devon CCG		Month 3	Month 4
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 implemeted	24,500	27,000
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 arranegements in place	1,000	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.	4,000	4,000
Continuing Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arrenegmnts are in place through the Control Centre and this will be proactively managed during the year	3,500	3,000
Primary Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arramgements are in place to monitor delivery but the latest assessment doesn't meet the required target.	2,000	2,500
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	1,000
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	5,000
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 acute services, continuing healthcare, primary care and other programme services reflect an updated assessment following review of the month 4 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 31st July 2019 is shown in appendix 1.

6.2 Capital

NHS England have informed the CCG that the bid for the requested £168k of capital, for business as usual projects, 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	96.26%	98.69%
NHS Creditors - % of bills paid within target	93.08%	99.53%

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.

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 4 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 31 JULY 2019	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	2,794
Intangible Assets	10
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	2,804
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	12,169
Trade & Other Receivables - Non NHS	4,280
Other Current Assets	-
Cash & Cash Equivalents	803
Non-current Assets held for Sale	-
Total Current Assets	9,092
Total Assets	11,897
CURRENT LIABILITIES	
Trade & Other Payables - NHS	- 16,316
Trade & Other Payables - Non NHS	- 88,278
Other Liabilities	- 956
Borrowings / Cash in Transit	- 16,369
Provisions	- 231
Total Current Liabilities	- 122,149
Total Assets less Current Liabilities	- 110,252
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 95
Total Non Current Liaibilities	-
Total Assets Employed	- 110,348
FINANCED BY TAXPAYERS EQUITY	
General Fund	110,348
Total Taxpayers' Equity	110,348

Appendix 2: Cash

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

Measure	Month 4
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 £1,921.880m for Devon CCG the year.*	33.4% of the MCD has been utilised as at month 4 (33.3% is expected based on a straight-line trajectory at month 4).
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 £3,899 for July.
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: Locality Update Reports				
Date of committee: **Date report produced:**				
Author (s) Name and Title: **Locality Triumvirates**		**Supporting Executive:** **Name and Title: Dr Paul Johnson, Chair** **Contact Details:**		
		Report Approved by: **Name and Title:** Locality Triumvirates **Date 19 August 2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Western and Southern Devon Localities.				
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:				

Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
None
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services		
Health Inequalities		
Equality (staff or public)		
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
Devon
Clinical Commissioning Group

Locality update report

Locality:	Northern
Period covered by update:	May to July 2019
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 funded 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.

- **One Northern Devon** has put forward proposals to build social prescribing teams in each of the four PCNs in a hub and spoke model with the PCN link worker as the 'hub' and Better Care Fund supported community development workers based in each of the main communities as the 'spokes'. In addition to these new roles, it is important that existing voluntary sector roles are valued and utilised and these will also be invited to be part of the social prescribing team to reduce duplication and make best use of local resources.

- **Northern Devon Healthcare Trust** performance continues to improve under the managerial and clinical support from **Royal Devon & Exeter NHS Trust.** Although many statutory performance markers have not been met, we have seen a fourth month of steady 'on plan' improvement with important

- The smooth development of **Primary Care Networks** is a credit to local practices. For the next six months they will work through our Northern GP Collaborative Board. It is expected that they will be central to our Northern

Local Care Partnership. Four GP practices have a CQC rating as 'Outstanding' with all other practices rated as 'Good'.

- The locality has successfully recruited another **Strategic Clinical Adviser** and more GPs are also looking to join the team. These positions are temporary, but the additional capacity will help our local commissioning team engage more fully with local providers around the redesign of services.

- 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 and having completed both the quantitative survey and the qualitative small group sessions is now preparing a proposal document based on what local people have said about their service needs.

- 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 relevance in the Urgent Care arena.

- Engage with emerging PCNs and Clinical Directors (CD) in the development of PCNs central role in the delivery of out-of-hospital services and the development of '**Single System Services**'. Our diabetes transformation plan is one such initiative. As local commissioners we are promoting the disintegration of the Primary-Secondary Care divide in early discussions around a possible unified physiotherapy service.

- Promote the increased public and practice usage of eConsult as a virtual front door triage and consultation tool. 50% of local practices have eConsult but uptake by the public remains low in those practices.

- 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. A wide variation in daily activity and attendance can create challenges for a smaller unit

- Despite good Delayed transfer of care (DToc) figures in-patient bed capacity can still be a challenge early in the week.

- Dementia screening and assessment in the Emergency Department at NDDH is not as consistent as it should be. There is potential for missed diagnosis and lack of awareness/support for patients. The Locality Dementia Diagnosis rate sits at 62.7% of predicted cases and although this is above the Devon average there may be a significant number of people and carers who would benefit from further support.

- 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.

- Primary Care premises related issues and workforce challenges are present and requiring additional focus.

- 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.

- A few reports are still 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.

- Clarity around the future development of a Devon-wide Integrated Care System would help developing local collaboratives, in particular our Local Care Partnership and One Northern Devon, to better plan local services in response to local needs. A local area's established position within a wider system helps promote local initiatives' sustainability through security of funding streams and awareness of national and county priorities.

NHS
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Clinical Commissioning Group

Locality update report

Locality:	Eastern
Period covered by update:	August 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 & identified 12 Clinical Directors (CD). There are 3 networks in Eastern Devon , 4 in Exeter and 4 in Mid Devon . The GP's now meet regularly together at the eastern GP collaborative board chaired by Dr Jennie Button and met last month with myself and medical leaders from the acute medical trust. It's proposed to build a clinical interface group in the East and explore the possibility of redeveloping clinician-to-clinician links in a number of acute specialties.

Eastern PCN CD's have again been invited to a refreshed version of the Eastern locality delivery group on September 4th and the meeting will spend some time developing a mutual understanding of the 19/20 STP operating plan. It will then will spend 2 hours looking at the delivery of the integrated care model in the East & it's hoped to share experiences from the South Devon integrated team "coastal" model .We shall introduce the Eastern "care homes services" team who have been supporting an educational programme in care homes in Mid Devon and the adult safeguarding agenda in all 3 of Eastern's sub localities since 2013. The primary care networks have been engaging their pharmacists, who will likely play a key part in supporting care home residents; at band 8A and RD+E have been recruiting new pharmacy staff at band 6. The clinical directors are expected to benefit from the specialist help of the care home services team particularly with respect to their "enhanced care in care homes" work which will form some of their focus from April 2020. Latterly we have invited a number of our market towns community leaders and we hope to update all attendees with experiences from several of the community conversations' and community developments, which have happened since many of the market towns community beds were closed.
We are currently reviewing the attendees to be invited to this development group.

The Eastern locality forum (ELF) group met on 22/7/19. The group discussed the current STP NHS 10 year plan engagement process. The approach proposed currently in East Devon is to engage on outpatient service redesign, using digital technologies to improve experience.
Conversations were had about how the STP 10 year plan engagement programme would be conducted through surveys, who these surveys would be targeted at and how the forum would subsequently learn for the responses in September 19.
The forum then focussed on the structure and functions of the local care partnership itself, as it has existed through ELF so far .It was agreed that perhaps the group are trying to do two different things which is causing confusion. One is to manage demand by bringing the health & care systems together, the other is trying to improve on health inequalities in our locality
The group agreed to further link with leaders of local community conversations and to reconvene in September to learn form engagement programme feedback and to agree to focus on ions or two priorities to work on going forwards.

The 3 GP member forum engagement meetings happened in July. Dr Paul Johnson was able to address all 3 forums, Glynis Atherton our Eastern GB NED was able to attend and members were able to question Paul regarding CCG/STP changes and proposed developments. Of particular note was a comment from the Eastern GP collaborative chair regarding how the CDs could link better to resources available within the CCG and understand what is happening in the CCG. At present it felt to her that there is a disconnect between CCG strategy and what they are actually doing in the market towns.

The eastern system continues 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 this year and notably from the PCN's clinical directors through the collaborative board and a broader spectrum of additional & innovative services to manage predicted demand is anticipated.

The locality has now just 3 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 hopefully from each of the three district GP forum groups.
Several applications have been received for these interim posts however consideration is being given to the proposed clinical workforce review & whether

further appointments will in fact be made in the context of this review.

Further establishing the shape and framework of the Eastern locality care partnership structure notably 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. We plan presentations re e consults , EPIC , My Chart , epic-care , understanding future demands on healthcare and something from NHSE/I re digital aspirations .

Continue preparation for a Governing body (GB) development and "showcase" opportunity for November in E. locality. Considerations are being given perhaps to visiting Okehampton and to understand the community developments since the "your future care" programme.

Agreeing joined-up plans re: winter pressures monies. The clinical directors of the primary care networks have been given an extended opportunity to contribute bids for the winter pressure funding and consideration will be given to these plans shortly.

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 rollout of comprehensive assessment, due to IG issues and software development time. Further understanding re whether the preliminary work using black pear software is to be taken forwards. Will the Epic EPR meet this need ultimately?

Insufficient medical input into the Urgent Community Response Teams may be addressed through the winter pressures funding.

Challenges developing joined up plans re: winter pressures monies within the time frames. It is hoped the time extension will mitigate this.

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. I understand this is now developing through Alex Degan our new Primary care medical director.

Further integration of health and social care staff particularly in Exeter . Non elective admission rates could be much better managed with a more co-located health and social care offer and conversations need to be had with respect to how IT systems can be better linked to enable information sharing more proactively.

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.

NHS
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Locality update report

Locality:	Southern
Period covered by update:	August 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 - Health and Wellbeing Centres

- Teignbridge district council approved bid for purchase of the site on Brunswick Street for a Health and Wellbeing Centre. We will be meeting with NHS England in September to discuss further.
- The business case for Dartmouth Health and Wellbeing Centre has been approved by South Hams District Council, and GPs from Dartmouth Medical Practice have formally announced they will relocate to the new site after terms were agreed with Devon CCG

Integrated Care Model - Personal Care Sufficiency

- We have worked with Devon County Council and the Trust to fund alternative personal care provision, with a focus on end of life care. This additional capacity was made available from 29th July.

TSDFT performance

- We have completed the deep dive into A&E performance, and this will be presented to the System Improvement Board in August in order to ensure all parties are clear on the key issues and agree clear and specific actions to address these.

Quality

- There has been an increase in the number of Yellow Cards received in the South locality. The main themes are prescribing issues, workload shift and discharge, alongside an emerging theme of access to services. Patient Safety and Quality leads work with the providers to highlight areas of concern from Yellow cards and work is ongoing to address these issues.
- The Quality Surveillance Group (QSG) held on 12 August 2019, attended by local system providers, NHS England, Health watch and Care Quality Commission

(CQC) and chaired by the CCG. This included updates on actions and learning from the recent IT outage which impacted on several core care delivery systems at Torbay Hospital and in particular the electronic prescribing system. Business continuity plans were enacted and enabled swift actions and monitoring of patients across departments.

- Ongoing community nursing developments have been discussed. The aim of the current work is to support teams in better understanding their local demand and activity so that they can work as effectively as possible.

Key priorities for the next three months

ICM

- Progress plans for development of health and wellbeing centre in Teignmouth. Meeting with NHSE in September.
- Complete design phase for Dartmouth Health and Wellbeing Centre, ahead of planning proposal early in 2020.
- Monitor and evaluate the new personal care provision for end of life clients with a view to inform future commissioning intentions for the longer term.

Long Term Conditions (LTCs)

- Diabetes: Review of multi-disciplinary foot clinic data. Local implementation group to review entire patient pathway in line with the Devon Diabetes Strategy and agree a South Devon work plan.
- Respiratory: review data and action plan.
- Cardiovascular disease (CVD): Roll out of Atrial Fibrillation project subject to outcome of prescribing analysis.

TSDFT performance

- Dawlish and Totnes MIU to return to full opening hours after temporary reduction whilst recruitment drive takes effect
- Demand management action plans for emergency care (ED and 999);
- Additional support for TSDFT to be provided in view of ECIST recommendations and findings – commissioning managers to work on key projects with them.
- Mitigating the risks arising from the further delay to theatres reopening

Integrated Urgent Care Services

- 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.
- Continue to work with DDoC on their proposals for a more sustainable model, ensuring all relevant stakeholders are included and any risks raised in impact assessment are mitigated.

Winter Funding

- A&E Delivery Board to agree proposals for use of winter funding for Torbay and South Devon

Local Care Partnership (LCP) development

- Continue to evolve Local Care Partnership arrangements in line with wider Integrated Care System development.

Long term plan

- Feedback from local engagement due after engagement period ends on 5th September.

Issues of concern or risk

- TSDFT Performance and financial position. Despite the heightened governance we have put in place around weekend performance, it has not yet had the desired impact.
- Personal care capacity and resilience continues to be a concern across Devon. Additional agency capacity has been secured and we will continue to explore how to make this a viable and sustainable option.
- TSDFT theatre re-opening, planned for August, is now delayed until September.
- The Trust are six weeks into the short-term change to current MIU provision in Dawlish and Totnes. A progress report will go to CCG executives in early September to ensure actions are on track to deliver expected outcomes.

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.
- Progressing the developments for modernising health and care services in Teignmouth will require additional capacity and resources including at executive level.

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Locality update report

Locality:	Western
Period covered by update:	To 7 August 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
- Agreement of priorities for delivery by LSW across ICM and urgent care for 19/20
- Improved Access – Beacon/Plymstock pilot of NHS 111 direct booking now live with plan to roll out to other sites once pilot is reviewed. Review of commissioning arrangements post-March 2020 and updating of MOUs in progress.
- Launch of Mayflower procurement – service commencement 1 April 2020.

Key priorities for the next three months

- Development of GP prospectus for the City and 100 day delivery plan
- Trajectories and metrics for Livewell's of ICM and Urgent Care delivery in 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 – CCG, LSW and UHP Pharmacy leads have met with PCNs to discuss offer. Support and integrated working with individual PCNs to be established.
- Engagement between ICM and Digital workstreams to progress shared use of clinical information systems across primary/community in particular (kick off meeting)
- Roll out of pilot eConsult Beacon hub as part of Digital Accelerator programme.

Issues of concern or risk

- Emergency Department performance
- 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

NHS
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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: 1st August plus ratified minutes from 4th July

(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

Finance report for month 3 was presented to Committee. Finance report is currently being developed with the team at NHSE to give a more accurate reflection of spend.

Primary Care Strategy

Committee members discussed the Primary Care Strategy, which is currently in draft format. A Primary Care workshop is planned for 6th September to further develop the strategy.

GP Patient Survey

Committee members were presented with the results of the GP patient survey. Committee members discussed the range of scores between practices and agreed that a report outlining specific practice scores would be reported to subsequent meeting. Discussion took place around Primary Care Team visiting low scoring practices to (in the first instance) offer support.

Yellow Card Report

Committee members received information on yellow cards and how the process for reporting. Members discussed how feedback from yellow card reports should be given to Practices.

Primary Care Operational Group

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

Members discussed the very challenging timescale for members of the Operational Group to make decisions and heard that the process is going to be reviewed.

Language and Translation Services

Committee members were informed that Language Empire had been awarded the contract for translation services, with sign language to be procured separately. Language Empire to mobilise in 8 weeks.

Reports received and noted

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

Primary Care Highlight Delivery Status – Members reviewed the Primary Care Highlight report. Members discussed RAG rating of the reports and this will be reviewed.

LMC Negotiation Meeting Outcome Report – Paul Baker presented the paper. Paul highlighted that annual physical health checks was now RAG rated green. Paul also noted that shared care guidelines has been brought to a successful conclusion.

Locality Flash Reports – Members noted the locality flash reports. Members discussed the template and agreed to review this going forward. Members asked that RAG rating be undertaken by Deputy Director for Primary Care in future periods to ensure consistency of approach.

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. No new risks and no risks recommended for closure. Risk 83 was proposed for a reduction in likelihood score from 4 to 3. Members agreed to the reduction in score.

Committee Decisions

- The Committee endorsed decisions made at Primary Care Operational Group
- The Committee endorsed the procurement of Language and Translation services

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.

NHS
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GOVERNING BODY

Report title: Clinical Policy Committee Annual Report 2018-19				
Date of committee: 29 August 2019 **Date report produced:** 3 June 2019				
Author (s) Name and Title: Rebecca Heayn, Clinical Effectiveness Governance Manager (on behalf of the Clinical Policy Committee) **Contact Details:** 01392 675226 rebecca.heayn@nhs.net		**Supporting Executive:** **Name and Title:** Sonja Manton, Director of Commissioning **Contact Details:** sonja.manton@nhs.net **Report Approved by:** as above **Name and Title:** **Date** 12 June 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

NHS Devon CCG Governing Body is presented with the Annual Report of the Clinical Policy Committee for information and assurance of the CCG's process for clinical policy formation.

Through the Clinical Policy Committee NHS Northern, Eastern and Western (NEW) Devon CCG and South Devon and Torbay CCG worked together to carry out their responsibilities for making local decisions about the funding of medicines and treatments in the NHS.

It is acknowledged that from 1 April 2019 NEW Devon CCG and South Devon and Torbay CCG formally merged to become a single organisation, NHS Devon CCG. However, the Clinical Policy Committee has operated Devon wide since the inception of the CCGs in 2013. This annual report relates to activity during 2018-19. It is the 6th annual report of the committee.

Five meetings were held last year, considering 16 evidence assessments which resulted in 24 commissioning policy recommendations. One previous commissioning policy was also unpublished in light of changes in clinical practice as a result of NICE drug recommendations.

Engagement with local clinical specialists takes place as part of the assessment process, and they are invited to attend meetings to contribute to discussions.

Agendas of meetings, attendance and a full log of interests declared are included in the appendices of the report. (Appendices 2, 3 & 4)

In addition to its existing role in the development of commissioning policy recommendations, the CCGs identified that the Clinical Policy Committee is a potential expert resource to help the organisations form its position regarding some aspects of the commissioning arrangements for clinical services.

Two of the agenda items at the meeting in January 2019 were focused on this additional role of the committee:

- consideration of a range of new treatment options surgical treatment options for benign prostatic hyperplasia together at one time to make recommendations on which of these should form part of the commissioned services for this condition, together with any recommendations that can be made regarding sub groups of patients, clinical scenarios, and the level of service provision that it would see as sensible within the Devon STP area. These recommendations would then be used in the discussions at senior level for this service across Devon.
- recommendations for monitoring patients for the development of hydroxychloroquine retinopathy in response to the publication of new professional society guidelines, which initial scoping revealed had the potential for far reaching consequences, to develop the detail of the commissioning pathway and any associated specifications.

Dr Nick D'Arcy and Dr Andrew Harrison were welcomed as new voting members to the committee in May and July 2018 respectively, to fill an existing vacancy plus the vacancy resulting from Dr Mick Braddick stepping down from the committee due to retirement in March 2018.

In addition to the voting members, the committee is supported by advisory members. This includes two lay public members, who ensure that the public interest of the local population is represented in discussion and decision making. The lay public members also sit on the clinical policy engagement and consultation panel, which continues to support the CPC and the CCGs by providing a separate opportunity to reflect on the policy recommendations and consider the public interest issues. The panel determines the need for any further engagement or formal consultation to be carried out prior to a final decision being taken by the CCGs. The process and any resulting engagement or consultation precedes the CCG taking a final decision on whether to accept a clinical policy recommendation. The annual report of the panel is presented separately.

All policy recommendations have a Quality and Equality Impact Assessment (QEIA) undertaken as an integral step in the process following the recommendation of the committee. These are considered by the clinical policy engagement and consultation panel, submitted to the QEIA authorisation panel for approval, and submitted to the CCG along with the final policy recommendation for approval.

Following the formal merger of the CCGs, the terms of reference, appeals process, communication framework and other support materials have been refreshed.

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 Clinical Policy Committee operates a formal process for the declaration and handling of conflicts of interests. Committee members, secretariat, guests and clinical specialists are required to complete a Declaration of Interests form prior to the start of each meeting. A record of declared interests is kept by the secretariat and full details are made publicly available in the minutes of the meeting. A register of all declared interests for the year is also included in the Annual Report.

Committees that have previously discussed/agreed the report and outcomes:		
Clinical Policy Committee – 22 May 2019 Commissioning Directorate Business Meeting – 1 July 2019		
Key recommendations and actions requested:		
To receive the Annual Report of the Clinical Policy Committee for information and assurance of the CCG's process for clinical policy formation.		
Impact on Strategic Objectives		
We will continue to commission safe, effective and accessible services We will improve the physical and mental health of our population We will make best use of our resources		
Reference to other documents or accompanying papers:		
Clinical Policy Committee Annual Report 2018-19		
Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality of Services		✓
Health Inequalities		✓
Equality (staff or public)		✓
Resource and Finance		✓
Legal	Through the Clinical Policy Committee, the CCG carries out its responsibilities for making local decisions about the funding of medicines and treatments in the NHS in line with statutory responsibilities, as summarised in the NHS Constitution – *"You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you."* This includes ensuring there is a clear rationale for decisions taken and a robust governance process.	

Engagement and Consultation	The process is supported by the Clinical Policy Engagement and Consultation Panel, which exists to support the CCGs to determine the need for any further engagement or formal public consultation on recommendations made by the Clinical Policy Committee. The lay member led panel routinely considers the wider public interest issues to determine the need for any further engagement or formal public consultation on the proposed policy recommendation. This process and any resulting engagement or consultation precedes the CCG taking a final decision on whether to accept a clinical policy recommendation.	
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.

Northern, Eastern and Western Devon
Clinical Commissioning Group

South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Annual Report

2018-19

Date: 31 March 2019

Contents

Dr Jo Roberts
Chair's introduction

This is the sixth annual report of the Clinical Policy Committee. Those who have read previous reports will have a sense of familiarity with the content of the report which goes some way to underlining the enduring requirement to take the difficult decisions on commissioning of drugs and treatments. This year in particular seems to have encompassed a wide range of interventions, including new drugs in common conditions such as asthma and diabetes, specialist interventions such as fertilisation failure in assisted conception, and commissioning criteria for a range of common surgical interventions.

This year also saw the committee develop a role that was wider than its previous policy recommendations on single interventions by helping the CCGs form its commissioning intentions for the Devon health system. We reviewed in a single process multiple existing and new interventions for benign prostatic hyperplasia and the implications for service configurations. We also considered the options for and impacts of commissioning a service for monitoring for hydroxychloroquine retinopathy. These felt like a natural extension to the committee's remit, making use of the considerable expertise that exists on the committee for reviewing evidence, assessing value, considering the opinions of specialist clinicians and having regard to the patient impacts.

It is noteworthy that during a period of arranging to merge the two CCGs in Devon and the consequent reconfiguration of committee structures, the CPC remained a constant and is planned to continue, although recognising that it needs to align with the STP's agenda and offer support to their clinical decision-making process. Of course in some respects the CPC was ahead of the game in that it has had a Devon-wide (joint CCG) remit to its work since its inception in 2013.

The future of CPC is probably one of further development and extension of role that will continue to evolve with the structures of the health service in Devon. In my view the need for CPC to continue remains, but as ever it needs to evolve to meet the demands of a changing commissioning landscape.

I know that the clinical effectiveness team that supports CPC and the committee members themselves have the skills and commitment to support any necessary evolution. I would like to thank them for their professionalism and dedication without which my job would be impossible

As a final note this will be my last chairman's introduction to the annual report as I have announced my intention to step down during the forthcoming year having chaired the committee for six years. I am confident that the committee will be a key component of decision making on the availability of drugs and treatments for the local population within the new landscape of the NHS in Devon.

Dr Jo Roberts
Chair, Clinical Policy Committee
Clinical Lead for Medicines Optimisation
NEW Devon and South Devon and Torbay CCGs

1. Introduction

1.1 Through the Clinical Policy Committee NHS Northern, Eastern and Western (NEW) Devon CCG and South Devon and Torbay CCG work together to carry out their responsibilities for making local decisions about the funding of medicines and treatments in the NHS.

1.2 The Committee make recommendations to the Clinical Commissioning Groups Governing Bodies, or appropriate groups with delegated authority, for approval following clinical discussion of the issues.

1.3 The Committee make recommendations to members of the Clinical Commissioning Groups on whether specific treatments represent good value, appropriate, evidence-based choices for adoption into primary care treatment plans via formularies and clinical management pathways.

1.4 This annual report gives an account of the activity and governance of the Clinical Policy Committee in 2018-19.

1.5 It is acknowledged that from 1 April 2019 NHS Northern, Eastern and Western (NEW) Devon CCG and South Devon and Torbay CCG are formally merging to become a single organisation, NHS Devon CCG. However the Clinical Policy Committee has operated Devon-wide since the inception of the CCGs in 2013.

2. The Process

Committee process and meeting arrangements

2.1 The terms of reference of the Clinical Policy Committee are as given in **Appendix 1**.

2.2 The process is guided by the National Prescribing Centre principles and rationale for local decision making.

2.3 The process and organisation is hosted by NEW Devon CCG and run by the Clinical Effectiveness Team. The Clinical Policy Committee is chaired by Dr Jo Roberts, Clinical Lead for Medicines Optimisation for NEW Devon and South Devon and Torbay CCGs. In his absence, voting member Dr Nick D'Arcy has deputised as chair to ensure the smooth and continued operation of the committee and to avoid important discussions being deferred.

2.4 Five committee meetings were held in 2018-19, the agenda for which are shown in **Appendix 2**.

2.5 The committee members' attendance at meetings for the last year is shown in **Appendix 3**, along with details of guests who attended for the discussion of specific items or to support the work of the committee.

The work programme

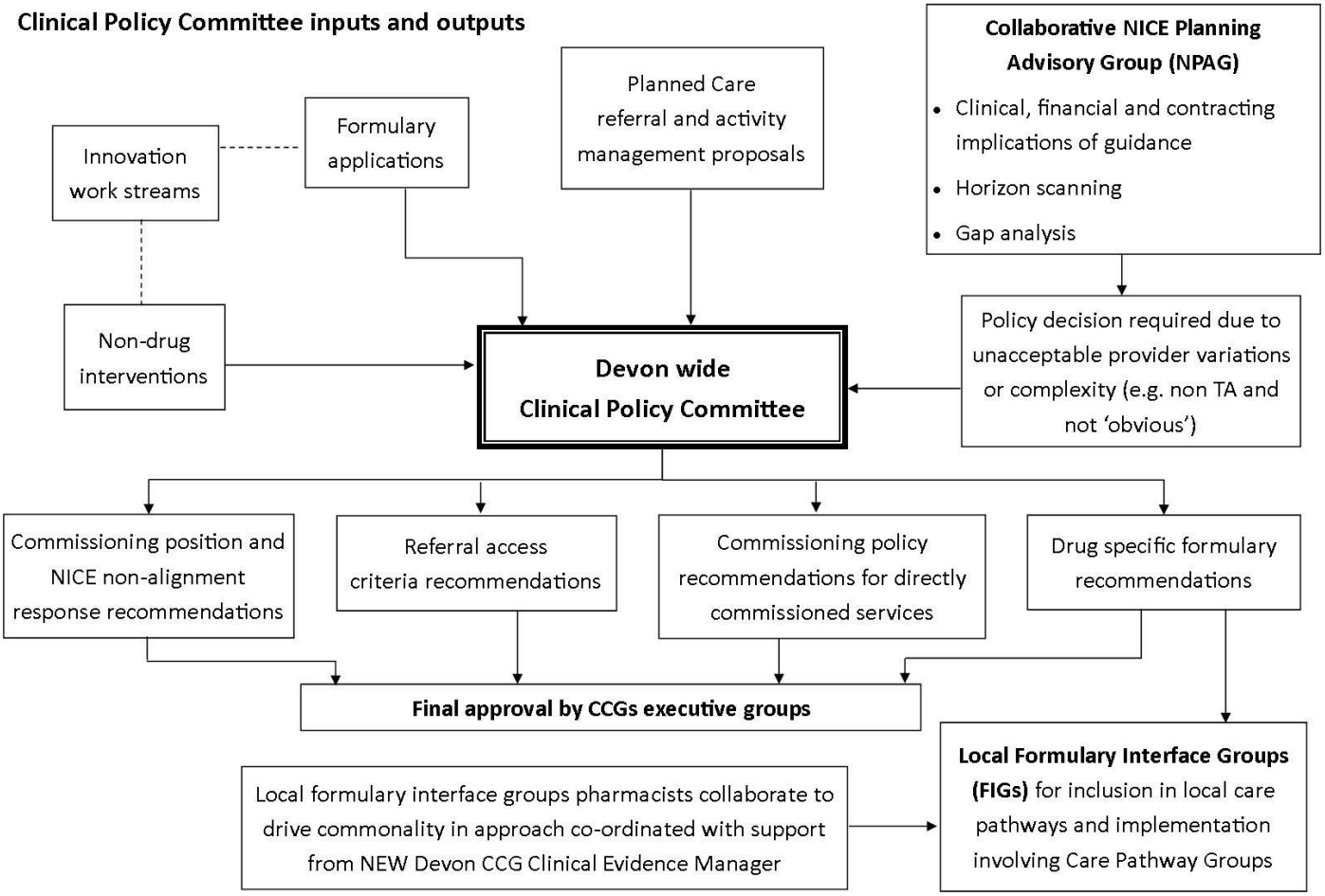
2.6 The work programme of the Clinical Policy Committee is managed by the Clinical Effectiveness Team, NEW Devon CCG.

2.7 In the last year, assessments have been undertaken and presented to the committee by four members of the Clinical Effectiveness Team:

- Matt Howard, Clinical Evidence Manager
- Hilary Pearce, Clinical Effectiveness Pharmacist
- Naomi Scott, Healthcare Evidence Reviewer
- Graham Simpole, Joint Formulary Support Pharmacist

2.8 The work programme is proactive and responsive to a number of sources as shown in figure 1, below.

Figure 1: Clinical Policy Committee inputs and outputs



Changes in membership

2.9 Dr Nick D'Arcy and Dr Andrew Harrison were welcomed as two new voting members to the committee, joining in May 2018 and July 2018 respectively, to fill an existing vacancy plus the vacancy resulting from Dr Mick Braddick stepping down from the committee due to retirement in March 2018.

Declaration of Interests

2.10 The Clinical Policy Committee operates a formal process for the declaration and handling of conflicts of interests.

2.11 Committee members, secretariat, guests and clinical specialists are required to complete a Declaration of Interests form prior to the start of each meeting. This specifies the drug/technology due to be considered along with details of any comparative products, and the respective pharmaceutical company/manufacturer. It also seeks to capture any interests relating to particular clinical areas where non-drug items are due to be discussed.

2.12 Details are also captured and recorded of any other healthcare industry contact members have had since the last meeting.

2.13 All declared interests are considered by the Chair and appropriate disclosures made to the committee at the beginning of the meeting. Where there are no interests to declare, a 'nil' return is required.

2.14 Following consultation with other members the Chair will decide to what extent a member who has declared an interest should participate in the discussion and determination of the issue. It is recognised that individuals may have some interaction with the healthcare industry and while these should be declared it does not necessarily preclude membership and involvement in discussions.

2.15 It is also acknowledged that members of the Clinical Policy Committee should act in accordance with the Principles of Public Life (the Nolan Principles) as set out in the Constitutions of the CCGs.

2.16 A record of declared interests is kept by the secretariat and full details are made publicly available in the minutes of the meeting. A register of all declared interests for the year is included in **Appendix 4**.

Public Involvement

2.17 The committee has two voluntary public members, known as lay public members.

2.18 Lay public members help ensure that the committee balances the healthcare needs of specific patient groups with the requirement to resource a comprehensive health service. They serve to assist with the broader public perspective during the decision making process, ensuring that the public interest is acknowledged and taken into account when the Committee makes its decisions.

Clinical Policy Engagement and Consultation Panel

2.19 The lay public members are also integral to the Clinical Policy Engagement and Consultation Panel, which exists to support NEW Devon and South Devon and Torbay CCGs to determine the need for

any further engagement or formal public consultation on recommendations made by the Clinical Policy Committee.

2.20 Meeting approximately two weeks following the Clinical Policy Committee, the lay member led panel routinely considers the wider public interest issues to determine the need for any further engagement or formal public consultation on the proposed policy recommendation.

2.21 This process and any resulting engagement or consultation precedes the CCGs' executive decision-making group taking a final decision on whether to accept a clinical policy recommendation.

2.22 The minutes of meetings are published on the website and regular updates are reported to the Clinical Policy Committee as a standing agenda item.

2.23 Full details of the panel process, terms of reference, minutes and register of interests is made publicly available via the NEW Devon CCG website, on behalf of both CCGs in Devon.

Quality and Equality Impact Assessment (QEIA)

2.24 All Clinical Policy Committee policy recommendations have a Quality and Equality Impact Assessment (QEIA) conducted on them as an integral step in the process of policy formation, prior to approval by the CCGs.

2.25 The QEIA tool tests the impact of a proposed change through a narrative account and a guided rating scale, across a number of core components. These include the impact of the proposal on patient safety, the clinical effectiveness of patient care, the patient experience of care delivery and the impact of the proposal on other services, patient groups, staff or the organisation. For example, this may include financial or reputational impact. The tool also assesses the impact on those in specific groups as outlined in the Equality Act 2010 and other hard to reach groups.

2.26 Impact is rated using a scale from negative to positive to allow for risks and benefits to be quantified. The total impact is calculated through an estimate of the number of patients affected and the total time for which they will be affected.

2.27 The QEIA also includes details of the measurements that could be used to determine the impact of the proposed change. This may include an examination of prescribing or activity data, regular formulary review/applications, the numbers of patient contacts with the CCGs, incidents reported and applications to the Individual Funding Panel for use outside of the policy criteria.

2.28 A flowchart showing how the clinical policy engagement/consultation, QEIA and CCG approval processes operate is shown in **Appendix 5**.

Reporting

2.29 The Clinical Policy Committee makes clinical policy recommendations to the Governing Bodies of the CCGs, or appropriate groups with delegated authority, for approval following clinical discussion of the issues.

2.30 In addition to this, ratification of any other formal matters arising from the Clinical Policy Committee, including changes to terms of reference or process, is undertaken by the Governing Bodies of the CCGs, or appropriate groups with delegated authority.

2.31 Reporting of any identified risks is undertaken to the CCGs by the Clinical Effectiveness Governance Manager, NEW Devon CCG in accordance with the organisations' risk reporting procedures.

Appeals process

2.32 The committee operates an appeals process for which a panel of people independent of the original decision are constituted to decide on the validity of the appeal.

2.33 The appeals process of the Clinical Policy Committee is as set out in **Appendix 6**.

2.34 An appeal may be made by the original applicant(s) – a clinician who has participated in the process leading to the original recommendation, either through submitting written evidence and clinical views at the appropriate times during the preparation of committee papers or attending the committee meeting at which the recommendation was made.

2.35 The grounds for appeal are (1) whether fair process has been followed by the Clinical Policy Committee in making their recommendation and (2) a material inaccuracy in or omission from the evidence considered by the committee that would make a substantive difference to the appraisal in relation to the medicine or treatment on which a recommendation was made.

2.36 Appeals which are upheld are referred back to the Clinical Policy Committee for reconsideration of the original application and the findings of the Appeals panel.

2.37 The Appeals panel has not been required to address any appeals during 2018-19.

NICE Planning Advisory Group (NPAG) updates

2.38 The Clinical Policy Committee has continued to receive regular updates during 2018-19 in respect of the CCGs' NICE planning processes. This includes receipt of the minutes and verbal reports from the Chair on the commissioning implications of published Technology Appraisals and Clinical Guidelines.

Devon Formulary Interface Group (FIG) report

2.39 The Clinical Policy Committee received the 2017-18 Annual Report of the Devon Formulary Interface Groups (FIGs).

2.40 The aim of the Devon Formulary is to promote prescribing which is safe, clinically appropriate and cost-effective in both primary and secondary care, providing guidance on locally recommended drug choices. The Formulary is delivered through the two FIGs which reflect natural healthcare communities. Representatives from both primary and secondary care sit on each FIG.

2.41 The content of the Devon formulary continues to be reviewed and updated by the two FIGs with agreement reached by consensus. The FIGs represent the collaboration of representatives from both the Devon CCGs, the four major hospitals in Devon, Devon Partnership Trust, and Livewell Southwest.

2.42 Relevant local specialists are invited to engage in the review process and attend meetings to join in discussions. This enables the Devon formulary recommendations to reflect local clinical practice and service provision.

2.43 The formulary remains broadly consistent across the county, whilst allowing variation to reflect and support the different needs of the local healthcare communities clustered around the major hospitals.

2.44 It was noted that:

- In order to demonstrate compliance with the CCGs' statutory responsibilities 72 NICE TAs and three HSTs were added to the Devon formulary during the period of this annual report.
- The diligence and quality of documentation produced by the Clinical Effectiveness Governance team in supporting the FIGs was acknowledged and commended.
- In terms of reviewing and updating formulary content, sections are identified by in-house horizon scanning and stakeholder requests, and a few examples have been noted in the report to give a flavour of the breadth and depth of topics that were discussed
- The FIGs considered a range of product applications for new formulations, or combinations of existing formulary medicines, preferred brands, and new dressings; as well as changes to product status or prescribing advice. In addition, the output of the Clinical Policy Committee is reflected in the formulary.
- The FIGs utilise a virtual eFIG process to progress some decisions at pace, or to free up face to face time for more complex discussions. Several decisions were taken using this process during the period of this report.

- The FIGs also considered national guidance from NHS England on low value items that should not be routinely prescribed in primary care. 12 of the 18 items were considered by the FIGs during the period of this report, with the formulary updated where necessary.
- Use of the formulary and referral website increased by approximately 15% over the previous year, with over 1.2 million page views in 2017-18.
- The accompanying app was downloaded 2,198 times in that time, taking total downloads since launch to around 7,000 by the end of March 2018
- At the end of 2017 the Clinical Effectiveness Formulary Team undertook a user survey in an effort to understand and improve user experience and satisfaction. Two hundred and eleven responses were received which were generally very positive, however a number of next steps were identified including some technical updates for improved functionality. Work is ongoing in this area.

3. Meeting arrangements

3.1 Meetings are usually held in Exeter, in facilities of Devon County Council as a strategic partner.

3.2 It was previously acknowledged that this fixed location is better able to accommodate guests, has the most effective teleconferencing facilities and is generally able to be more responsive to any issues arising as it is the secretariat's office base.

3.3 Where alternative meeting locations have been necessary, the meeting facilities at The Watermark have been used. These are operated by Ivybridge Town Council.

4. Commissioning recommendations

4.1 Recommendations made by the Clinical Policy Committee in 2018-19 for approval by the CCGs' executive group are as detailed below:

*****following approval by the CCGs and completion of all governance processes (including determination of appropriate place in formulary where applicable)

Topic	Date of CPC recommendation	Date of publication*	Final commissioning decision
Lurasidone for schizophrenia	23 May 2018	25 June 2018	The routine commissioning of lurasidone is not accepted for patients with schizophrenia.
Fluticasone furoate and vilanterol trifenatate (Relvar® Ellipta®) combination inhaler for asthma	23 May 2018	25 July 2018	The routine commissioning of Relvar® Ellipta® combination inhaler is accepted for the regular treatment of asthma in adults and adolescents aged 12 years and older.
Bevacizumab for diabetic macular oedema	23 May 2018	Existing policy unpublished	There are three drugs which have received recommendations in NICE technology appraisals (TAs), two drugs with a similar mechanism of action to bevacizumab – ranibizumab (Lucentis®) TA274 and aflibercept (Eylea®) TA346 – and an implant of the corticosteroid dexamethasone (Ozurdex®) TA349. These are well established in practice and therefore the rationale for the existing policy now lacks clinical relevance.
Opicapone for Parkinson's Disease	18 July 2018	3 October 2018	The routine commissioning of opicapone for Parkinson's disease is accepted for patients who have not been able to tolerate entacapone.
Fluticasone furoate, umeclidinium and vilanterol (Trelegy® Ellipta®) combination dry powder inhaler for COPD	26 September 2018	15 November 2018	The routine commissioning of Trelegy® Ellipta® is accepted for maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD).
Insulin Degludec (Tresiba®) for use in patients with type 2 diabetes	26 September 2018	15 November 2018	The routine commissioning of Insulin degludec is not accepted in Devon for the treatment of type 2 diabetes.

Topic	Date of CPC recommendation	Date of publication*	Final commissioning decision
Insulin Degludec (Tresiba®) for use in patients with type 1 diabetes	26 September 2018	15 November 2018	The commissioning of Insulin Degludec (Tresiba®) for patients with Type 1 diabetes is accepted for patients who fulfil one of the following criteria despite optimised treatment with another long acting insulin analogue: • Children and adolescents who have a history of diabetic ketoacidosis and/or hyperglycaemia (blood glucose exceeding 14.0 mmol/L) with capillary blood ketones exceeding 1.5 mmol/L • Adults who experience frequent or severe hypoglycaemia
Cosmetic treatments	26 September 2018	22 November 2018	Cosmetic treatment is not routinely commissioned.
Reversal of male and female sterilisation	26 September 2018	22 November 2018	The reversal of male and female sterilisation is not routinely commissioned.
Assisted conception (update)	26 September 2018	7 January 2019	Amendments to the existing policy relating to fertilisation failure and eligibility criteria for assessment and treatment, for clarity and consistency.
Adult Snoring Surgery (in the absence of Obstructive Sleep Apnoea)	30 January 2019	8 March 2019	Surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate are not routinely in the management of simple snoring. Policy position adopted from NHS England Evidence-Based Interventions Guidance for CCGs.
Knee arthroscopy for patients with osteoarthritis	30 January 2019	8 March 2019	Arthroscopic knee washout (lavage and debridement) is not routinely commissioned as a treatment for osteoarthritis. Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking. Policy position adopted from NHS England Evidence-Based Interventions Guidance for CCGs.

Topic	Date of CPC recommendation	Date of publication*	Final commissioning decision
Dilatation and curettage for heavy menstrual bleeding in women	30 January 2019	8 March 2019	Dilatation and curettage is not routinely commissioned for diagnosis or treatment for heavy menstrual bleeding in women. Policy position adopted from NHS England Evidence-Based Interventions Guidance for CCGs.
Injections for nonspecific low back pain without sciatica	30 January 2019	8 March 2019	Spinal injections of local anaesthetic and steroid are not routinely commissioned for patients with non-specific low back pain. Policy position adopted from NHS England Evidence-Based Interventions Guidance for CCGs.
Arthroscopic shoulder decompression for subacromial shoulder pain	30 January 2019	8 March 2019	Arthroscopic subacromial decompression surgery for pure subacromial shoulder impingement should only be offered for patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment. Policy position adopted from NHS England Evidence-Based Interventions Guidance for CCGs.
Trigger finger release in adults	30 January 2019	31 March 2019	Trigger finger surgery should only be offered in specific cases according to NICE accredited guidelines by the British Society for Surgery to the Hand, where alternative measures have not been successful and persistent or recurrent triggering, or a locked finger occurs. Policy position adopted from NHS England Evidence-Based Interventions Guidance for CCGs.
UroLift for the treatment of lower urinary tract symptoms caused by benign prostatic hyperplasia	30 January 2019	*Pending completion of CCGs governance and approval processes*	Recommendation that the routine commissioning of UroLift is accepted for the treatment of patients with lower urinary tract symptoms caused by benign prostatic hyperplasia.

Topic	Date of CPC recommendation	Date of publication*	Final commissioning decision
GreenLight XPS for the treatment of lower urinary tract symptoms caused by benign prostatic hyperplasia	30 January 2019	*Pending completion of CCGs governance and approval processes*	Recommendation that the routine commissioning of GreenLight XPS is accepted for the treatment of patients with lower urinary tract symptoms caused by benign prostatic hyperplasia.
Holmium laser enucleation of the prostate for the treatment of lower urinary tract symptoms caused by benign prostatic hyperplasia	30 January 2019	*Pending completion of CCGs governance and approval processes*	Recommendation that the routine commissioning of Holmium Laser Enucleation of the Prostate (HoLEP) is accepted for the treatment of patients with lower urinary tract symptoms caused by benign prostatic hyperplasia who have a large prostate that, due to its size, would only otherwise be suitable for treatment with an open prostatectomy.
Aquablation for the treatment of lower urinary tract symptoms caused by benign prostatic hyperplasia	30 January 2019	*Pending completion of CCGs governance and approval processes*	Recommendation that Aquablation (transurethral water jet ablation) for the treatment of lower urinary tract symptoms caused by benign prostatic hyperplasia is not accepted for routine commissioning.
Rezum for treatment of lower urinary tract symptoms caused by benign prostatic hyperplasia	30 January 2019	*Pending completion of CCGs governance and approval processes*	Recommendation that Rezum for the treatment of lower urinary tract symptoms caused by benign prostatic hyperplasia is not accepted for routine commissioning.
Monitoring for hydroxychloroquine retinopathy	30 January 2019	No policy output; recommendations used to develop the detail of the commissioning pathway and any associated specifications	The provision of a service for monitoring for hydroxychloroquine retinopathy within Devon was discussed following consideration of the Royal College of Ophthalmologists (RCO) guidance for hydroxychloroquine retinopathy updated in 2018. The committee agreed that the current situation of providing no monitoring for patients was not acceptable; appropriate high-risk patients should be referred to ophthalmologists to decide the appropriate pathway. Local rheumatologists' approach regarding use in rheumatoid arthritis and lupus was supported; further review of the place in therapy for hydroxychloroquine is not required.

Topic	Date of CPC recommendation	Date of publication*	Final commissioning decision
Breast reduction surgery	27 March 2019	*Pending completion of CCGs governance and approval processes*	Recommendation that breast reduction surgery is not routinely commissioned. This policy has been reached after consideration of guidance for breast reduction surgery published by NHS England.
The routine referral and specialist management of meibomian cysts (chalazia) (update)	27 March 2019	*Pending completion of CCGs governance and approval processes*	Sets out the circumstances under which the routine referral and specialist management of meibomian cysts is commissioned. Updated following consideration of NHS England Evidence-Based Interventions Guidance for CCGs
Semaglutide for type 2 diabetes	27 March 2019	*Pending completion of CCGs governance and approval processes*	Recommendation that the routine commissioning of semaglutide is accepted for patients with type 2 diabetes as described for GLP-1 mimetics in NICE guideline NG28.
FreeStyle Libre device for interstitial glucose monitoring in diabetes (update)	27 March 2019	*Pending completion of CCGs governance and approval processes*	A 6-month trial of FreeStyle Libre is routinely commissioned for patients with diabetes attending specialist secondary care clinics for their diabetes and who have been assessed by their specialist to meet one of the criteria described in the policy. This would be continued if the patient demonstrates the applicable continuation criteria at a 6-month clinic assessment. Updated following consideration of NHS England criteria for reimbursement.

5. Communication

Commissioning policies

5.1 All commissioning policies, categorised by body system, are made publicly available on the NEW Devon CCG website, which hosts these policies on behalf of both CCGs in Devon.

5.2 A communication framework is in place for the timely and effective dissemination of concise, targeted information to the key individuals and groups who need to know about the decisions. The Clinical Policy Committee Communication Framework is as shown in **Appendix 7**.

5.3 This operates in accordance with the Planned Care Control Centre communications and engagement plan which sets out the communication and engagement activity required at Planned Care Control Centre level and the respective routes and responsibilities. For example, the specific processes for the communication of a policy without Clinical Referral Guidance, a policy with Clinical Referral Guidance and Clinical Referral Guidance without an associated policy.

5.4 The aim of the plan is to keep processes clear and simple, to have consistency of approach, to ensure accuracy, clarity, timeliness and appropriateness of information shared, and to reduce the number of individuals involved in leading on communications and engagement.

5.5 The agreed communication process also ensures that the Patient Advice and Complaints and Communications teams of the CCGs are fully aware of the intended publication of a clinical policy and any other relevant or supporting information to enable them to be prepared and best able to respond to any patient or public queries.

Governance documentation

5.6 Full details of the Clinical Policy Committee including governance documentation (minutes of meetings, terms of reference, appeals process and communication framework) is publicly accessible on the NEW Devon CCG website.

5.7 This annual report will similarly be made publicly available once ratified.

5.8 Details of the Clinical Policy Engagement and Consultation Panel process, terms of reference, minutes and register of interests are also publicly accessible on the NEW Devon CCG website.

5.9 A new website is being launched following the merger of the CCGs from 1 April 2019. Content currently published on the NEW Devon CCG website, on behalf of both CCGs in Devon, will be migrated to the new website to ensure that this continues to be publicly accessible.

6. Reflective practice

6.1 The CCGs identified that the Clinical Policy Committee is a potential expert resource to help the organisations form its position regarding some aspects of the commissioning arrangements for clinical services, in addition to its existing role in the development of commissioning policy recommendations.

6.2 Two of the agenda items at the meeting in January 2019 were focused on this additional role of the committee:

- surgical treatment options for benign prostatic hyperplasia. The intention was that the committee considers a range of new treatment options together at one time and makes recommendations on which of these should form part of the commissioned services for this condition, together with any recommendations the committee can make regarding sub groups of patients, clinical scenarios, and the level of service provision that it would see as sensible within the Devon STP area. These recommendations would then be used in the discussions at senior level for this service across Devon.
- recommendations for monitoring patients for the development of hydroxychloroquine retinopathy. This was considered in response to the publication of new professional society guidelines which initial scoping revealed had the potential for far reaching consequences, both for decisions to adopt and also to not adopt. It was not intended to directly produce a policy but to use the recommendation of the committee to develop the detail of the commissioning pathway and any associated specifications.

7. Conclusion

7.1 Through the Clinical Policy Committee the CCGs in Devon discharge their responsibilities for making local decisions about the funding of medicines and treatments collaboratively, ensuring consistency in local decision making for patients in Devon.

7.2 It is acknowledged that from 1 April 2019 NHS Northern, Eastern and Western (NEW) Devon CCG and South Devon and Torbay CCG are formally merging to become a single organisation, NHS Devon CCG. However the Clinical Policy Committee has operated Devon-wide since the inception of the CCGs in 2013.

7.3 The Clinical Policy Committee has considered 16 evidence assessments in 2018-19 resulting in 24 commissioning policy recommendations. It has also unpublished one previous commissioning policy in light of changes in clinical practice as a result of NICE drug recommendations.

7.4 The Clinical Policy Committee are asked to receive this annual report as a record of activity and the governance arrangements underpinning the Committee.

7.5 The CCGs Governing Bodies, or appropriate groups with delegated authority, are asked to accept and ratify this annual report to endorse the role of the Clinical Policy Committee. Following ratification the report will be made publicly available via the CCG website.

7.6 It is planned that the Terms of Reference, including membership and reporting arrangements, are reviewed in the context of the merger of the CCGs after 1 April 2019 and revised accordingly. Other supporting materials, such as the Communication Framework and Appeals process will also be refreshed.

7.7 Similarly, all current clinical commissioning policies will be rebranded with the NHS Devon CCG organisational logo from 1st April 2019 and migrated to the new website. There will be no changes to the content of the policies which are not being reviewed at this time.

Northern, Eastern and Western Devon
Clinical Commissioning Group
South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Terms of Reference

1. Purpose of the Group

1.1 The Clinical Policy Committee (CPC) exists to enable Northern, Eastern and Western (NEW) Devon and South Devon and Torbay Clinical Commissioning Groups (CCGs) to collaboratively discharge their responsibilities for making local decisions about the funding of medicines and treatments in the NHS.

1.2 The commissioning organisations have a legal duty to have in place arrangements for making decisions and adopting policies on whether particular health care interventions are to be made available for patients for which the commissioner is responsible. This duty includes the requirement to provide a written statement of the reasons for a general policy on whether a specific intervention is to be made available.

2. Functions

The Clinical Policy Committee will:

2.1 Make recommendations to the Clinical Commissioning Groups Governing Bodies, or appropriate groups with delegated authority, for approval following clinical discussion of the issues.

2.2 Make recommendations to members of the Clinical Commissioning Groups on whether specific treatments represent good value, appropriate, evidence-based choices for adoption into primary care treatment plans via formularies and clinical management pathways.

2.3 Provide a written rationale for the determination of commissioning decisions and recommendations.

2.4 Establish processes for the dissemination of commissioning decisions and recommendations, including the publication of decisions on publicly accessible websites.

2.5 Make recommendations for commissioned services in the context of non-alignment with non-mandatory NICE guidelines.

2.6 Note reports, from the Clinical Commissioning Groups' NICE planning processes on the commissioning implications of published Technology Appraisals and Clinical Guidelines.

3. Membership

3.1 It is the role of the Chair of the Committee to confirm that the members have all the relevant competencies in order for the Committee to undertake the business on the agenda. The committee membership will reflect the descriptions provided in the Local decision-making Competency Framework of the National Prescribing Centre whilst recognising that the scope of the Clinical Policy Committee extends beyond that of medicines. Members will be expected to contribute the competency sets defined in this guide and summarised in Appendix one.

3.2 A current membership list will be maintained by the committee secretariat and published on the website.

3.3 The committee will comprise 18 members as follows:

- Registered Medical Professionals appointed by the Clinical Commissioning Groups (x8) [of whom 1 Chair]
- Lay Public Members (x2)
- Patient Safety and Quality (x1)
- Public Health (x1)
- Contracting (x1)
- Head of Clinical Effectiveness
- Head of Medicines Optimisation
- Secondary Care Clinician (x2) from NHS trusts in Devon
- Secondary Care Chief Pharmacist (x1)

3.4 The eight (8) nominated Registered Medical Professionals will act with delegated executive authority from the Clinical Commissioning Groups' Governing Bodies to make commissioning recommendations (voting members).

3.5 The other committee members will contribute to the decision making process in an advisory capacity.

3.6 The committee includes lay membership to ensure the public interest is reflected in decision making.

3.7 Committee members are expected to aim to attend 100% of meetings. Attendance will be monitored on a rolling annual basis by the secretariat and any identified low attendance (below 66%) highlighted to the Chair to follow up with the member.

3.8 Follow up will be at the Chairs discretion but will take into consideration such matters as the reasons for non-attendance, any issues with fulfilling the role, and the nomination of a suitable deputy for planned non-attendance.

3.9 Voting members may nominate deputies, who should be current, non-lay, advisory members of the committee. A deputy can only deputise for one voting member at any given meeting.

3.10 Deputies may also attend the committee to represent non-voting members. It is the responsibility of the committee member to ensure that the deputy is appropriately briefed and possesses the required competencies.

4. Meetings and Conduct of Business

4.1 The frequency of meetings of the committee shall be determined by need, but it is expected that there will be a minimum of six meetings per year.

4.2 The quorum will consist of half of the members being present to include a minimum of 4 voting members. The chair will ascertain who the voting members are before transacting committee business.

4.3 Decision making will compromise two stages:

- All members of the Group may participate in discussions and debate about the possible outcomes of a commissioning decision.

- Final policy recommendations will be formed through a voting process of the Registered Medical Professionals with delegated executive authority from the Clinical Commissioning Groups' Governing Bodies (voting members). Where a consensus is not apparent the Chair will consider whether further discussion is likely to lead to a consensus before taking a majority view from the voting members to be final. At the Chair's discretion a secret ballot may be held. The Chair has a vote. In the absence of a majority view further debate will continue until a majority view can be obtained or the Chair decides to exercise a casting vote.

4.4 Decisions will be reached after considering an assessment of the information which is known about the proposed intervention. This will be presented in a standardised format and will present information on:

- The reason for the proposal – clinical need and impact on patient care
- Technical details of the intervention
- Details of the health problem for which the intervention is proposed, including an estimate of likely numbers affected
- National strategic direction
- Evidence supporting efficacy of the intervention
- Information known about the safety of the intervention
- Current service
- Details of stakeholder engagement undertaken in relation to the intervention or service
- Cost effectiveness and resource impact

4.5 Where a product contains the same active ingredient and delivers a therapeutically equivalent dosage to an existing formulary product in a cost advantageous manner the formulary team should make proposals to the Formulary Interface Groups (FIGs) directly about inclusion or exclusion of the product. Deletions from the formulary which would cause a tension with NICE guidance, existing CPC policy, NHS England policies or result in inequity of access across Devon to specific pharmacologically active therapies should be referred to the Clinical Policy Committee.

4.6 The diversity of work managed by the Committee will require specialist input in order to cover all facets and interests. Therefore clinical specialists and service providers will be invited to attend the committee to present the case for commissioning and contribute to the decision making process.

4.7 Minutes will be produced and published on the website of the secretariat host organisation following approval at the subsequent meeting.

4.8 Decisions are effective from the date of publication.

4.9 Meetings may be attended in person or via teleconferencing where services exist.

4.10 The committee will operate an appeals process in respect of recommendations made by the committee. A panel of people independent of the original decision will be constituted to decide on the validity of the appeal. Appeals which are upheld will be referred back to the committee for reconsideration.

5. Officers of the Committee

5.1 A Chair shall be jointly nominated by the Governing Bodies of the Clinical Commissioning Groups. When absence is anticipated the Chair will nominate an existing committee member to deputise for that meeting. Otherwise the committee will nominate a Chair from those committee members present on the day.

5.2 A secretariat from the host Clinical Commissioning Group will provide administrative, professional and technical support such as taking minutes, recording and following up administrative actions, and presenting scientific and professional assessments to the committee.

6. Governance/ Reporting arrangements

6.1 The Committee will operate under joint delegated authority from and report to the Governing Bodies of Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group.

6.2 The Terms of Reference will be reviewed annually.

7. Declaration of Interests

7.1 All members of the committee and attendees will be expected to complete a declaration of interests. The Chair will consider these and ensure that declarations are made known to the committee members to indicate any potential conflicts of interest.

7.2 All declarations of interests will be reported in the minutes, along with details of any resulting actions and how any identified conflicts were agreed to be managed within the context of the meeting. A register of all interests will be kept by the Committee Co-ordinator.

ROLES AND FUNCTIONS OF GROUP MEMBERS

(Reference: Local decision-making Competency framework – for groups involved in making local decisions about the funding of medicines and treatment in the NHS, National Prescribing Centre 2012)

Specific responsibilities of members of the Clinical Policy Committee

Committee Role	Responsible Functions
Chair	**Facilitates decision making process** Agreeing agenda. Ensuring appropriate range of competency exists within the Group. Draws together differing expertise and opinions. Communicates complex decisions in a manner that reflects Group responsibility using language understood by all audiences. **Group (internal) communication** Communicates within the Group to ensure that relevant views are considered at appropriate points in the meeting. **Deliberation, reasoning and ethical judgment** Ensure clear articulation of reasons for and against a proposal.
All	Engagement in deliberative processes to support ethical judgment in decision making. Understands and questions personal assumptions and assumptions of other members of the committee. Understanding of the organisations' ethical framework. Understands the wide variety of evidence and the role it may play in making judgements.
Voting Members	Engage in and facilitate deliberative processes to support ethical judgement in decision-making. Make a population based commissioning decision based upon judgment and opinion formed in the deliberative processes. Ensure that commissioning decisions are recognised by the Clinical Commissioning Group governing body.
Patient safety and quality	Understands the principles of safe and effective commissioning. Understand the governance and safety arrangements that may be necessary to ensure the intervention or service is commissioned appropriately. Ability to summarise succinctly, with underpinning evidence, complex legislative, governance and safety implications to inform decision making. Understands the impact on quality of care, resources and expenditure that a proposal may have.

	Understands the NHS requirements for engagement with patients and the public and where appropriate the use of formal consultation.
Head of Clinical Effectiveness	Understand the assessment of evidence and issues important in the interpretation of clinical evidence and cost effectiveness information. Understands quantitative and qualitative research methodologies. Ability to engage in technical clinical discussions with clinicians. Ability to compare needs and benefits of treatments across groups of patients within the context of the health needs of the population. Understands the appropriate use of data sources used to inform the decision making process.
Head of medicines optimisation & Secondary care chief pharmacist	Specialist knowledge on range of procurements and supply systems for medicines. Specialist knowledge on the licensing, legislation and systems governing prescribing, supply and administration of medicines and treatments. Understands the principles and governance arrangements necessary for the safe and effective use of medicines.
Contracting	Understands the financial and contractual arrangements across the range of service providers. Assesses the contractual and financial implications of decisions and imbeds the commissioning intent into the contracting processes. Understands the relationship between finance and commissioning. Understands the interdependence of the local health economy and takes into consideration the impact that changes made in one part may have on other parts.
Public Health	Understand epidemiological data and its appropriate use in decision making. Ability to assess and compare the needs of individual patients or groups of patients within the overall context of the health needs of the population. Understands and has access to sources of relevant clinical economic and population information including information provided by stakeholders.
Lay Public Members	Ensures that in all aspects of the clinical policy committee business, the public interest of the local population is represented in discussion and decision making. Brings an understanding of what patients, carers and the public may consider to be important when considering the advantages, disadvantages and availability of treatments. Ensures an open and accountable debate which is inclusive of all sectors of the community we serve.

	Keeps at the forethought of commissioning the benefits to the community as a whole of an inclusive, patient centred local NHS that uses its resources fairly and wisely.
Clinical Effectiveness professional and scientific support (in attendance)	**Assessment of evidence** Scopes the problem to identify best available evidence. Synthesises evidence from a range of standard sources. Maps epidemiology of the disease in question. Assesses impact of different options at individual patient, pathway, and population level. Interprets and presents the clinical and non-clinical evidence so the Group members can understand the process. Writes and presents reports clearly and succinctly using appropriate terminology that the committee can understand. **Financial and commissioning information data** Provides financial, contractual and performance data. Communicates options and works with commissioning, contracting and finance staff following the meeting to ensure the commissioning intention is realised. **External Communication and engagement** Engagement with stakeholder groups. **Governance and Safety** Assess evidence relating to safe use of the technology. Assess the impact of procurement and supply arrangements. Assess the impact on patient adherence with treatment. Presents information in a format understood by decision-making group.
Secretariat (in attendance)	**Administration** Administers the decision making process to ensure the Group meets at appropriate times, members have the relevant information, actions and decisions are recorded. Ensuring compliance with legal and ethical responsibilities relevant to local decision making. Information governance, data protection, management of documents and records. Organise agenda, plan meetings, circulate papers, record keeping, post meeting actions. Produce and distribute minutes. Maintain audit trail of documents. Enquiry handling.

	Screening Requests Assessment of topic for suitability for submission to CPC. Identify when written submission is lacking essential information. Knows about the suite of existing commissioning policies. **External Communication and engagement** Engagement with stakeholder groups. Communication of decisions. Handles Freedom of Information (FOI) requests.

May 2018

Northern, Eastern and Western Devon
Clinical Commissioning Group

South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Wednesday 23rd May 2018, 09.30-12.30

Committee Suite, County Hall, Exeter EX2 4QL

AGENDA

Number	Item	Lead	Appendix	Time
1	Welcome and announcements • Apologies • Committee membership updates • Confirmation of voting members and Declarations of interest • Notification of Any Other Business	Jo Roberts	Verbal	9.30
2	Minutes of the meeting held on 21st March 2018 and matters/actions arising	Jo Roberts	Appendix 1	9.35
Items for commissioning recommendation				
3	Fluticasone furoate and vilanterol trifenatate (Relvar Ellipta) combination inhaler for asthma	Matt Howard	Appendix 2	9.40
4	Lurasidone for schizophrenia	Graham Simpole	Appendix 3	10.00
Other items for consideration				
5	Bevacizumab for diabetic macular oedema policy unpublished	Rebecca Heayn	Appendix 4	10.30
6	Annual Report 2017-18	Rebecca Heayn	Appendix 5	10.40
7	Update from NICE Planning Advisory Group (NPAG)	Chris Roome	Appendix 6	10.55
8	Update from Clinical Policy Engagement and Consultation Panel	Mac Merrett	Appendix 7	11.05
9	Any Other Business		Verbal	11.15
Meeting close				

Northern, Eastern and Western Devon
Clinical Commissioning Group

South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Wednesday 18th July 2018, 09.30-12.30

Committee Suite, County Hall, Exeter EX2 4QL

AGENDA

Number	Item	Lead	Appendix	Time
1	Welcome and announcements • Apologies • Committee membership updates • Confirmation of voting members and Declarations of interest • Notification of Any Other Business	Jo Roberts	Verbal	9.30
2	Minutes of the meeting held on 23rd May 2018 and matters/actions arising	Jo Roberts	Appendix 1	9.35
Items for commissioning recommendation				
3	Rivaroxaban for the prevention of recurrent deep vein thrombosis and pulmonary embolism	Naomi Scott	Appendix 2	9.40
4	Opicapone for Parkinson's Disease	Graham Simpole	Appendix 3	10.10
Other items for consideration				
5	Update from NICE Planning Advisory Group (NPAG)	Chris Roome	Appendix 4	10.40
6	Update from Clinical Policy Engagement and Consultation Panel	Mac Merrett	Appendix 5	10.50
7	Clinical Policy Engagement and Consultation Panel Annual Report 2017-18	Rebecca Heayn	Appendix 6	11.00
8	Any Other Business		Verbal	11.15
Meeting close				

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group
South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Wednesday 26th September 2018, 09.30-12.30

Committee Suite, County Hall, Exeter EX2 4QL

AGENDA

Number	Item	Lead	Appendix	Time
1	Welcome and announcements • Apologies • Confirmation of voting members and Declarations of interest • Notification of Any Other Business	Jo Roberts	Verbal	9.30
2	Minutes of the meeting held on 18th July 2018 and matters/actions arising	Jo Roberts	Appendix 1	9.35
Items for commissioning recommendation				
3	Assisted conception: fertilisation failure and abandoned cycles	Hilary Pearce	Appendices 2a, b, c & d	9.40
4	Assisted conception: eligibility criterion for "previous children"	Hilary Pearce	Appendices 3a, b & c	
5	Fluticasone furoate, umeclidinium and vilanterol (Trelegy® Ellipta®) combination dry powder inhaler for Chronic Obstructive Pulmonary Disease (COPD)	Graham Simpole	Appendix 4	10.40
6	Cosmetic treatments policy	Rebecca Heayn	Appendix 5	11.10
7	Reversal of male and female sterilisation policy	Rebecca Heayn	Appendix 6	11.20
8	Insulin Degludec (Tresiba®) for use in patients with type 1 diabetes	Naomi Scott	Appendix 7	11.30
9	Insulin Degludec (Tresiba®) for use in patients with type 2 diabetes	Naomi Scott	Appendix 8	
Other items for consideration				
10	Update from NICE Planning Advisory Group (NPAG)	Chris Roome	Appendices 9a & 9b	12.20
11	Update from Clinical Policy Engagement and Consultation Panel	Mac Merrett	Appendix 10	12.25
12	Any Other Business		Verbal	12.30
Meeting close				

Clinical Policy Committee

Wednesday 30 January 2019, 09.30-12.30

Committee Suite, County Hall, Exeter EX2 4QL

AGENDA

Number	Item	Lead	Appendix	Time
1	Welcome and announcements • Apologies • Confirmation of voting members and Declarations of interest • Notification of Any Other Business	Nick D'Arcy	Verbal	9.30
2	Minutes of the meeting held on 26th September 2018 and matters/actions arising	Nick D'Arcy	Appendix 1	
3	Format and structure of the meeting	Nick D'Arcy	Appendix 2	
Items for commissioning recommendation				
4	Monitoring for hydroxychloroquine retinopathy	Hilary Pearce	Appendix 3	9.45
5	Surgical treatment options for lower urinary tract symptoms caused by benign prostatic hyperplasia • Overview • Holmium laser enucleation of the prostate (HoLEP) • GreenLight system • UroLift system • Prostatic arterial embolisation (PAE) • Tranurethral water jet ablation (Aquablation) • Rezum system	Naomi Scott	 Appendix 4a Appendix 4b Appendix 4c Appendix 4d Appendix 4e Appendix 4f Appendix 4g	10.15
6	NHS England Evidence-Based Interventions Guidance for CCGs	Rebecca Heayn	Appendix 5	12.00

Continued over

Number	Item	Lead	Appendix	Time
Other items for consideration				
7	Update from NICE Planning Advisory Group (NPAG)	Chris Roome	Appendices 6a & 6b	12.10
8	Update from Clinical Policy Engagement and Consultation Panel	Mac Merrett	Appendix 7	12.20
9	Any Other Business		Verbal	12.25
Meeting close				

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group
South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Wednesday 27 March 2019, 09.30-12.30

Henlake Suite, The Watermark, Ivybridge PL21 0SZ

AGENDA

Number	Item	Lead	Appendix	Time
1	Welcome and announcements • Apologies • Confirmation of voting members and Declarations of interest • Notification of Any Other Business	Nick D'Arcy	Verbal	9.30
2	Minutes of the meeting held on 30th January 2019 and matters/actions arising	Nick D'Arcy	Appendix 1	
Items for commissioning recommendation				
3	Semaglutide for the treatment of type 2 diabetes	Graham Simpole	Appendix 2	9.40
4	Review of FreeStyle Libre for interstitial glucose monitoring in diabetes	Naomi Scott	Appendix 3	10.10
5	Review: Policy for the referral and specialist management of meibomian cysts (chalazia)	Matt Howard	Appendix 4	10.40
6	Review: Policy for Breast reduction	Naomi Scott	Appendix 5	11.10
Other items for consideration				
7	Rebranding of current clinical commissioning policies from 1 April 2019	Rebecca Heayn	Appendix 6	11.40
8	Devon Formulary Interface Groups Annual Report 2017-18	Matt Howard	Appendix 7	11.50
9	Update from NICE Planning Advisory Group (NPAG)	Chris Roome	Appendix 8	12.00
10	Update from Clinical Policy Engagement and Consultation Panel	Mac Merrett	Appendix 9	12.10
11	Any Other Business		Verbal	12.20
Meeting close				

APPENDIX 3

ATTENDANCE OF COMMITTEE MEMBERS

Name	Role	Organisation	Meetings attended/ possible
Dr Jo Roberts VOTING MEMBER	Chair, GP Clinical Commissioner	South Devon & Torbay CCG	3 / 5
Dr Glen Allaway VOTING MEMBER	GP Clinical Commissioner	NEW Devon CCG	5 / 5
Dr Andrew Craig VOTING MEMBER	GP Clinical Commissioner	NEW Devon CCG	4 / 5
Richard Croker	Deputy Director for Medicines Optimisation	NEW Devon CCG	1 / 5
Dr Nick D'Arcy VOTING MEMBER	GP Clinical Commissioner	South Devon & Torbay CCG	4 / 5
Chris Roome (as delegate)	Head of Clinical Effectiveness	NEW Devon CCG	1 / 1
Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	Royal Devon & Exeter NHS Foundation Trust	2 / 5
Paul Foster	Chief Pharmacist	Torbay and South Devon NHS Foundation Trust	3 / 5
Tracey Foss (as delegate)	Chief Pharmacist	Royal Devon & Exeter NHS Foundation Trust	1 / 1
Dr Lucinda Harris VOTING MEMBER	GP Clinical Commissioner	South Devon and Torbay CCG	4 / 5
Chris Roome (as delegate)	Head of Clinical Effectiveness	NEW Devon CCG	1 / 1
Dr Andrew Harrison VOTING MEMBER	GP Clinical Commissioner	NEW Devon CCG	2 / 4
Barbara Jones	Head of Locality Contracting	NEW Devon CCG	3 / 5
Mac Merrett	Lay Public Member		5 / 5
Simon Polak	Deputy Chief Nursing Officer	NEW Devon CCG	1 / 5

Name	Role	Organisation	Meetings attended/ possible
Tracey Polak	Assistant Director/ Consultant of Public Health	Devon County Council	3 / 5
Chris Roome	Head of Clinical Effectiveness	NEW Devon CCG	5 / 5
Dr Alison Round VOTING MEMBER	GP Clinical Commissioner	NEW Devon CCG	4 / 5
Chris Roome (as delegate)	Head of Clinical Effectiveness	NEW Devon CCG	1 / 1
Dr Peter Rowe	Consultant Nephrologist	University Hospitals Plymouth NHS Trust	2 / 5
Mark Taylor	Lay Public Member		4 / 5
Dr Ben Waterfall VOTING MEMBER	GP Clinical Commissioner	NEW Devon CCG	5 / 5

ADDITIONAL ATTENDEES (EXPERTS, GUESTS AND SECRETARIAT)

Name	Role	Organisation
23 May 2018		
Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NEW Devon CCG
Keith Gilhooly	Consultant Psychiatrist	Devon Partnership NHS Trust
Rebecca Heayn	Clinical Effectiveness Governance Manager	NEW Devon CCG
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Graham Simpole	Joint Formulary Support Pharmacist	NEW Devon CCG
Chris Sullivan	Pharmacist	Devon Partnership NHS Trust
18 July 2018		
Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NEW Devon CCG
Rebecca Heayn	Clinical Effectiveness Governance Manager	NEW Devon CCG
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
William Knight	Consultant Neurologist	Torbay and South Devon NHS Foundation Trust
Naomi Scott	Healthcare Evidence Reviewer	NEW Devon CCG
Ray Sheridan	Consultant Physician	Royal Devon and Exeter NHS Foundation Trust
Graham Simpole	Joint Formulary Support Pharmacist	NEW Devon CCG
26 September 2018		
Umesh Acharya	Consultant in Obstetrics	University Hospitals Plymouth NHS Trust
Rebecca Cowie	Principal Embryologist	Royal Devon and Exeter NHS Foundation Trust
Sally Doidge	Principal Embryologist	University Hospitals Plymouth NHS Trust
Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NEW Devon CCG
Rebecca Heayn	Clinical Effectiveness Governance Manager	NEW Devon CCG
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Philip Hughes	Consultant Respiratory Specialist	University Hospitals Plymouth NHS Trust
Lisa Joels	Consultant Gynaecologist	Royal Devon and Exeter NHS Foundation Trust
Chris Moudiotis	Consultant Paediatrician	Royal Devon and Exeter NHS Foundation Trust
Hilary Pearce	Clinical Effectiveness Pharmacist	NEW Devon CCG
Naomi Scott	Healthcare Evidence Reviewer	NEW Devon CCG

Name	Role	Organisation
Graham Simpole	Joint Formulary Support Pharmacist	NEW Devon CCG
Roderick Warren	Consultant Physician	Royal Devon and Exeter NHS Foundation Trust
30 January 2019		
James Benzimra	Ophthalmologist Surgeon	Royal Devon and Exeter NHS Foundation Trust
Malcolm Crundwell	Consultant Urologist	Royal Devon and Exeter NHS Foundation Trust
Andrew Dickinson	Consultant Urologist	University Hospitals Plymouth NHS Trust
Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NEW Devon CCG
Michael Foster	Consultant Urologist	Northern Devon Healthcare NHS Trust
Richard Guinness	Consultant Radiologist	Royal Devon and Exeter NHS Foundation Trust
Richard Haig	Consultant Rheumatologist	Royal Devon and Exeter NHS Foundation Trust
Rebecca Heayn	Clinical Effectiveness Governance Manager	NEW Devon CCG
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Richard Miles	Consultant Interventional Radiologist	University Hospitals Plymouth NHS Trust
Konstantinos Papadedes	Ophthalmologist Surgeon	Royal Eye Infirmary, University Hospitals Plymouth NHS Trust
Hilary Pearce	Clinical Effectiveness Pharmacist	NEW Devon CCG
Naomi Scott	Healthcare Evidence Reviewer	NEW Devon CCG
Richard Seymour	Consultant Radiologist	Torbay and South Devon NHS Foundation Trust
Stephen Turner	Ophthalmic Surgeon	Torbay and South Devon NHS Foundation Trust
Elizabeth Wilkinson	Medical Ophthalmologist	Northern Devon Healthcare NHS Trust
27 March 2019		
Patrick English	Consultant in Diabetes and Endocrinology	University Hospitals Plymouth NHS Trust
Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NEW Devon CCG
Rebecca Heayn	Clinical Effectiveness Governance Manager	NEW Devon CCG
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Naomi Scott	Healthcare Evidence Reviewer	NEW Devon CCG
Graham Simpole	Joint Formulary Support Pharmacist	NEW Devon CCG

APPENDIX 4

DECLARATIONS OF INTEREST REGISTER (APRIL 2018 – MARCH 2019)

Declarations of interest made by committee members

Name of attendee	Role	Meeting Date	Declared interest
Dr Andrew Craig	GP Clinical Commissioner VOTING MEMBER	27 March 2019	One of the GLP- manufacturers provided sandwiches at a Clinical Governance afternoon in the practice. I cannot remember which one.
Dr Jo Roberts	GP Clinical Commissioner VOTING MEMBER	26 September 2018	Pfizer and Chiesi – have provided Medical and Educational Goods and Services (MEGS) to support COPD management Advisory Board Meeting Novo Nordisk – paid regarding NHS landscape.
Dr Alison Round	GP Clinical Commissioner VOTING MEMBER	26 September 2018	Paid employee of Royal Devon and Exeter NHS Trust as a salaried GP
Dr Peter Rowe	Consultant Nephrologist/ Secondary Care Clinician	26 September 2018	One interview with representative from Pfizer about apixaban, one presentation on serum free light chain assay by medical scientific officer.

Additional Declarations of Interest (Experts, Guests and Secretariat)

Name of attendee	Role	Meeting Date	Declared interest
Dr Patrick English	Consultant in Diabetes and Endocrinology	27 March 2019	I was paid to chair and present at a meeting by NovoNordisk in March 2018. They have previously sponsored me to attend the America Diabetes Association Conference in the USA though this was outside the 3 year window in 2010.
Dr Keith Gilhooly	Consultant Psychiatrist	23 May 2018	On two occasions in the past three years had chaired educational meetings on LAIs on behalf of Lundbeck who make aripiprazole LAI. For each received £300, but for one occasion the fee was donated directly to charity.

Name of attendee	Role	Meeting Date	Declared interest
Rebecca Heayn	Clinical Effectiveness Governance Support Officer	18 July 2018	A family member has been diagnosed with Parkinson's disease.
Dr William Knight	Consultant Neurologist	18 July 2018	Honorarium for Advisory Board participation Bial Phama 2017. In receipt of transport/hospitality to attend international meeting (EAN2017) Bial Pharma.
Dr Ray Sheridan	Consultant Physician	18 July 2018	P.I. for Opicapone drug trial in Exeter - I receive NO funding or salary based on this.
Dr Roderick Warren	Consultant Physician	26 September 2018	2016 – Novo Nordisk advisory board meeting (paid).
Dr Elizabeth Wilkinson	Medical Ophthalmologist	30 January 2019	I run the National Diabetic Eye Screening Conference in conjunction with Public Health England at the Royal Society of Medicine annually which receives sponsorships from imaging companies including Heidelberg, Zeiss and Topcon as well as private screening companies including EMIS, Digital Healthcare and Health Intelligence. This sponsorship is arranged through the Royal Society of Medicine and goes toward bursaries for the meeting. I have not personal benefit. Diabetic Eye Screening in Devon will be transferring to a private provider (Health Intelligence) in April. It is likely that I will be employed by them as Clinical Lead from April.

Register of committee members' contact with healthcare industry not related to discussion at CPC meeting

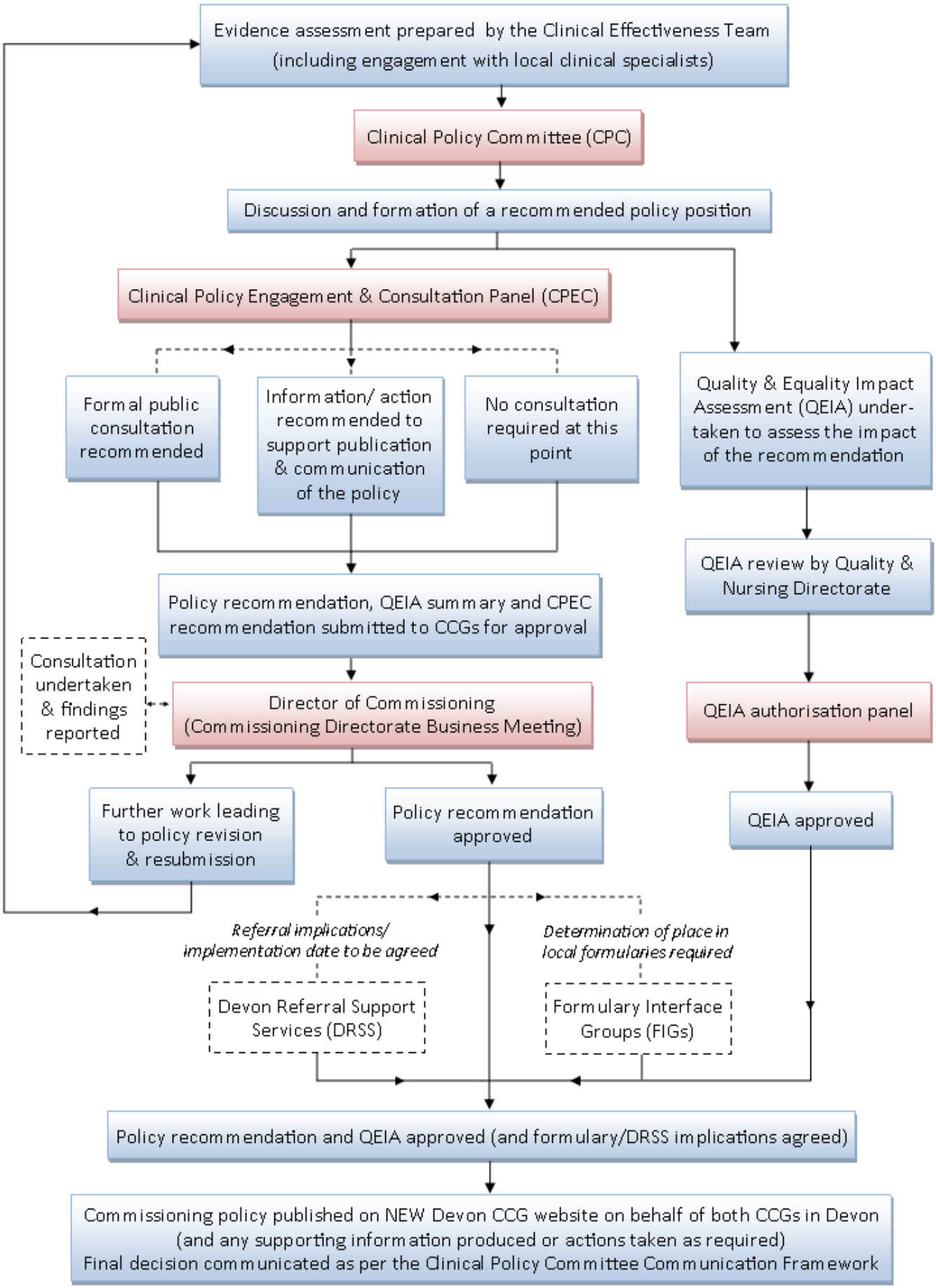
Name of attendee	Role	Details of contact	Date recorded
Dr Jo Roberts VOTING MEMBER	Chair GP Clinical Commissioner	Advisory meeting First Databank (FDB) re analyse Rx	April 2018
		Astra Zeneca diabetes outcomes- based pricing model	June 2018
		Was paid to attended advisory meeting for UCB pharmacy to discuss a drug called Romosozumab which has not yet been approved by the European Medicines Agency (EMA) or Food and Drug Administration (FDA). It will be assessed by NICE as part of a multiple technologies appraisal (MTA) of treaties for osteoporosis	
		Was paid to attend advisory meeting for Novo Nordisk This was almost entirely a discussion around changes in the NHS landscape including role of Sustainability and Transformation Partnerships (STPs) and commission moving forward some around Regional Medicines Optimisation Committee (RMOC). There was brief discussion about their Glucagon-like peptide 1 (GLP1) Semaglutide but I had to leave anyway at that point.	August 2018
		Attended Roche diagnostics meeting regarding C-reactive protein (CRP) project	October 2018
		Attended GSK update meeting	November 2018
		Attended GSK meeting regarding Medical and Educational Goods and Services (MEGS) for Chronic obstructive pulmonary disease (COPD) work	January 2019
		Was paid to attended Napp workshop regarding NHS landscape.	March 2019
		Attended Roche diagnostics meeting regarding CRP project.	
		Was paid to take part in webinar regarding change implementation in COPD Sponsored by GSK.	
		Was paid to attend GSK advisory board meeting regarding Trelegy.	

Register of lay committee members' declared interests not related to discussion at CPC meeting

Name of attendee	Role	Details of interests	Date recorded
Mac Merrett	Lay public member	Chair RD&E Cancer User Group. Vice Chair Peninsular Cancer Group. Sit on various Cancer groups within the Peninsular. Parish Councillor. Representative on the Cancer Alliance.	23/08/2015 amended 11/10/2016; 07/06/2017
Mark Taylor	Lay public member	Albany Medical Clinic (GP Practice Newton Abbot), member of Patient Participation Group. Foundation Trust member: • Royal Devon & Exeter • Torbay and South Devon • Devon Partnership • Royal Brompton and Harefield Vice-chair Step One Charity (incorporates St Loye's and Community Care Trust SW)	03/05/2017

APPENDIX 5

Clinical policy engagement/consultation and communication process (October 2018)



Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group

Clinical Policy Committee

Appeals process

1. Introduction

1.1 This Appeals process applies to the operation of the Clinical Policy Committee of Northern, Eastern and Western (NEW) Devon and South Devon & Torbay Clinical Commissioning Groups (CCGs).

2. Grounds for appeal

2.1 An appeal may be made by the original applicant(s). An applicant is considered to be a clinician who has participated in the process leading to the original recommendation, either through submitting written evidence and clinical views at the appropriate times during the preparation of committee papers or attending the committee meeting at which the recommendation was made.

2.2 The grounds for appeals are limited to the following:

- **Ground one: whether fair process has been followed by the Clinical Policy Committee in making their recommendation**

  The CCGs are committed to following a fair process throughout local decision making. This ground relates only to the fairness of the process followed. A decision with which an appellant does not agree is not unfair for that reason.

- **Ground two: a material inaccuracy in or omission from the evidence considered by the committee that would make a substantive difference to the appraisal in relation to the medicine or treatment on which a recommendation was made**

3. Appeals panel

3.1 Appeals will be considered by a panel. The panel will comprise at least 3 individuals independent of the original recommendation who will decide whether the appeal is upheld. These members will be aided in their discussion by the chair of CPC and the Head of Clinical Effectiveness, NEW Devon CCG. The majority view of the independent

members will decide the final outcome of the appeal. The independent members will be selected from the Governing Bodies of NEW Devon CCG and South Devon and Torbay CCG.

3.2 The independent members of the appeals panel will elect a chairperson for the consideration of each appeal.

3.3 The administration of the appeals panel will be managed by the Clinical Policy Committee secretariat on behalf of NEW Devon and South Devon & Torbay CCGs.

4. Process

4.1 Appeals should be submitted within two months of notification of the final policy decision of the CCGs following consideration of the Clinical Policy Committee recommendation.

4.2 Requests for appeal should be submitted to the Clinical Policy Committee secretariat in writing.

4.3 The request for appeal should clearly state the ground(s) on which the appeal is being made, the aspect(s) of the commissioning decision or process being appealed against, and the reasons why the aspects being appealed against fall within the specified ground(s) of appeal. Enough detail should be given to demonstrate an arguable case. The secretariat will provide appropriate documents on which to submit the appeal.

4.4 Reapplications will not be accepted within 12 months of the original decision unless the applicant can establish material changes in circumstances.

5. Decisions of the appeals panel

5.1 If the appeal is rejected the original policy decision will stand.

5.2 If the appeal is upheld the application will be referred back to a future meeting of the Clinical Policy Committee for reconsideration of the original application and the findings of the Appeals panel.

5.3 Decisions of the Appeals panel will be communicated to the appellant by the Chair of the Appeals panel.

5.4 If the appellant is unhappy with the decision of the Appeals panel they will have the opportunity to make a complaint in line with the NEW Devon CCG standard complaints procedure.

6. Reconsideration of applications by the committee

6.1 Where an appeal is upheld and the original application referred back to the Clinical Policy Committee for reconsideration, the appellant will be invited to:

- submit any supporting evidence or documentation to the secretariat for circulation to committee members prior to the meeting at which the appeal is scheduled
- attend the meeting at which the appeal is scheduled for the part of the meeting pertaining to the appeal
- present any data or points of argument that they wish during the meeting

6.2 In line with standard operating procedures, the appellant will be required to complete a declaration of interests form prior to attendance at the committee meeting.

6.3 The outcome of the committee's reconsideration will be communicated to the appellant and, following approval by the CCGs, to the local health community as per the Clinical Policy Committee communication framework.

7. Complaints

7.1 Complaints about the operation of the Clinical Policy Committee will be dealt with in line with the standard complaints procedure of NEW Devon CCG.

7.2 An appeal decision cannot be overturned through the complaints process.

8. References

National Institute for Health and Clinical Excellence. Developing and updating local formularies: Good practice guidance. December 2012.

National Institute for Health and Clinical Excellence. Guide to the technology appraisal appeal process. August 2010.

NHS South West. Cancer Drugs Fund Appeals and Complaints process. 2011.

North East Treatment Advisory Group. Process for appealing recommendations made by the North East Treatment Advisory Group. June 2012.

April 2015

Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group

Clinical Policy Committee

Communication Framework

The Clinical Policy Committee operates within the guiding principles published by the Department of Health for processes supporting local decision-making to ensure that all relevant policies and decisions are publicly available on the NEW Devon CCG website, along with details of the decision-making processes and governance arrangements.

A communication framework is in place as set out below for the timely and effective dissemination of concise, targeted information to the key individuals and groups who need to know about the decisions.

Local health community dissemination:

- Secondary care only intervention – communicated by standard distribution list to key individuals and groups across the Devon health community
- Referral criteria for routine procedures – communicated in accordance with the Planned Care Control Centre communications and engagement plan with advanced notification of the implementation date
- Primary care relevant drug intervention requiring further consideration through Formulary Interface Groups (FIGs) – communicated after FIG discussions
- Primary care relevant drug intervention that is **not** routinely commissioned – communicated by standard distribution list to include primary care practices

Public availability:

- Published on NEW Devon CCG website

Communication for local health system action:

- Specific communication direct to specialists involved with the process
- Communication to Formulary Interface Groups prompting local treatment pathway development incorporating the commissioning decisions
- Specific notification to CCG communications and patient advice/ experience teams to support the response to patient/public queries
- Engagement with Devon Referral Support Services (DRSS) and Planned Care Control Centre for articulation of commissioning decision into effective referral criteria and the agreement of an implementation date