PUBLIC - NHS Devon Clinical Commissioning Group (CCG) Governing Body

Microsoft Teams Link - details can be found in calendar invitation

18 June 2020 13:00 - 18 June 2020 15:00

AGENDA

#	Description	Owner	Time
1	Welcome and Apologies Verbal	Chair	13:00
2	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 04 June... 5	Chair	13:05
3	Minutes of last meeting Paper 1 Draft Public GB minutes 30.04.2020 v2.docx 10	Chair	13:10
4	Chair's Report Paper 1 cover sheet chair's report.docx 22 Chairs Report June 2020.docx 24	Chair	13:15
5	Accountable Officer's Report Paper 1 Cover sheet AO Report Public June 2020.docx 26 2 AO Report Public June 2020.docx 28	Accountable Officer	13:25
6	RESPONSE TO COVID-19		13:35
6.10	Mental Health Response Presentation 200531 MH Governing Body Presentation v3 (003).... 36	Director of Commissioning - Western	
6.20	Future plans Verbal	Accountable Officer	

#	Description		Owner	Time
6.30	Discharge update Paper 1 Cover Paper Governing Body 18.06.2020 Paper 1... 2 GBPaper300520_Paper 1 final.docx 3 Appendix 1 - Brief for the 7-day Discharge and Ac... 4 Appendix 2 - Acute and Mental Health Bed Occup...	56 58 61 64	Chief Operating Officer	
6.40	Recovery, Transformation and Service Change Paper to follow		Accountable Officer	
7	FINANCE, PERFORMANCE AND QUALITY			14:00
7.10	Month 2 Finance Report Paper to follow 1 FPC_Report_FPC_Month 2_FINAL_2020-21 cov... 2 FPC_Report_FPC_Month 2_FINAL_2020-21 (G...	67 70	Finance Director	
7.20	Performance and Quality Report Paper 2 GB Public Performance report 18062020_Paper 2...	88	Chief Operating Officer/ Interim Chief Nurse	
8	GOVERNANCE			14:20
8.10	Proposal for Commissioning Committee Paper 1 Commissioning Committee Cover Sheet -.docx 2 Commissioning Committee ToR.docx	110 112	Board Secretary	
8.20	Ambulance Joint Commissioning Committee Terms of Reference Paper 1 AJCC ToRs - cover sheet.docx 2 Appendix 1 Draft Ambulance Joint Commissionin...	116 118	Board Secretary	
9	COMMITTEE CHAIR'S REPORTS			14:35

#	Description	Owner	Time
9.10	Primary Care Committee Paper [P] 3. Committee Chair Report - Public PCC - May and... 127	Chair of Primary Care Committee	
9.20	Audit Committee Paper [P] 1 Audit Committee Chair Report 13.05.20.docx 131 [P] 2 Corporate Risk Register.pdf 134 [P] 3 Covid incident Risk Register.xlsx 140	Chair of Audit Committee	
9.30	Quality Assurance Committee Paper [P] QAC Part 1 Public Chair Report May 2020 v2.0.doc... 145	Chair of Quality Assurance Committee	
10	LOCALITY UPDATES		14:50
10.10	Northern, Eastern, Southern and Western Paper [P] 0 Locality Updates Cover Sheet.docx 148 [P] 1 Northern Locality Report June 2020 final v2.docx 150 [P] 2 Locality Update Report - Eastern May 2020.docx 154 [P] 3 NHS Devon CCG - south locality report (AutoRec... 157 [P] 4 NHS Devon CCG WL Update Report - June 2020... 162	Locality Clinical Lead Representatives	

Declaration of Interests Register - NHS Devon Clinical Commissioning Group
Report generated by the governance team on 04 June 2020

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
	Allcorn	Darryn	CCG and System Chief Nursing Officer Shared role with Phillip King to 20 June 2020	Member of Governing Body Member of Quality Assurance Committee Senior Leadership Team (SLT) CCG Executive Team Meeting	Honorary Associate Professor University of Exeter Seconded to NDHT		11/05/2020		11/05/2020	Direct	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
	Appleby	Gaynor	Non Executive Lay Member (Allied Health Professional)	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee Member of Remuneration and Workforce Committee	CQC Specialist Advisor Therapy Lead for Health and Social Care for North Devon		01/11/2019		05/05/2020	Non Financial	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
	Atherton	Glynis	Non Executive Lay Member- Quality Geographical remit - Eastern	Member of Governing Body Member Quality Assurance Committee (Chair) Member Primary Care Commissioning Committee Member of Remuneration and Workforce Committee (Chair)	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 Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geographical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee 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 Committee (Deputy for CFO) Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Member of Vacancy Control Panel	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	Non Executive Lay Member - Patient and Public Involvement Geographical remit - Northern	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC)	Self-Employment business consultant from September 2019 Associate for Research In Practice Feb 2020 Associate for Research In Practice Supplier/Associate for SWAHSN (Feb 2020) Associate for Devon Communities Together		04/04/2019		13/05/2020	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
	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 of 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 of Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019		12/03/2019				Plymouth City Council
	Davis	Alison	Associate Non-Executive Lay Member	Attendee Governing Body	Plymouth City Council – Foster panel Chair Torbay Council- Foster panel Chair Pathway Care Fostering- Ashburton- Independent Reviewing Officer University of Exeter – student mentor Somerset County Council- casual employee		19/10/2019		19/10/2019				NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015					Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council

	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Member of Primary Care Commissioning Committee (PCCC) Strategic Commissioning Programme Board	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 A & E Delivery Board (SD&T)	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 and Workforce Committee(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	Non Executive Lay Member - Primary Care and Prevention Geograhical remit - Southern	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) (Chair) Member of Remuneration and Workforce Committee		Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	10/03/2020	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 of Governing Body Senior Leadership Team (SLT) Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Strategic Commissioning Programme Board	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training		23/07/2019	24/07/2019	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.	KERR Darnley Ltd
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body (Chair) Member of Remuneration and Workforce Committee Transition Sub Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	GP Partner, Cricketfield Surgery (ceased December 2019) 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 and Workforce Committee 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-Executive Director 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 Introduced PPE supplier (Orthofix International) to Devon CCG. Company part owned by my cousin		26/09/2017	21/04/2020	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 Committee Member Strategic Commissioning Programme Board	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	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 Meeting Joint Staff Partnership Transition Sub Committee Senior Leadership Team (SLT) Member of Quality Assurance Committee Attendee Audit 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 and Workforce Committee (Non exec rem) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG)	Elected member, South West Regional Council of BMA Occasional Locum (self-employed) at Access Health Ltd Plymouth. GP Appraiser (NHS England) Working at Church View Surgery as self-employed sessional GP Elected to the Medical managers Committee of the BMA from September 2019	Partner is Medical Secretary and Board member of Devon LMC Partner is GP Partner, Church View Surgery, Plymstock Partner is Clinical Director of Mewstone Primary care Network(PCN)	26/09/2017	25/09/2019	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
	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 Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	04/03/2020	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	Pearson	Virginia	Chief Officer for Communities, Public Health, Environment and Prosperity/Director of Public Health, Devon County Council System Director of Population Health and Wellbeing, Devon STP	Co-opted Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Member of Integrated Commissioning Executive (ICE) Strategic Commissioning Programme Board	Member, STP Directors Group Member, STP Programme Delivery Executive Group Member, Devon Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Association of Directors of Public Health Member, British Medical Association Honorary Clinical Professor, University of Exeter College of Medicine and Health		02/02/2017	22/04/2020	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
	Pearson	Nick	Head of Communications and engagement	Senior Leadership Team (SLT) Primary Care Operational Group (PCOG) Member of 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 employee	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 and Interim Director of Quality Assurance (July 2019) 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 Committee CCG Executive Team Meeting Senior Leadership Team (SLT) Strategic Commissioning Programme Board Member of Remuneration and Workforce Committee Working with Industry Group	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 Meeting Senior Leadership Team (SLT) Attendee Audit Committee Attendee of Remuneration and Workforce Committee Strategic Commissioning Programme Board	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	Associate Director of HR and OD	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel	No interests declared			16/10/2018				NHS Devon CCG
	Thompson	Sarah	Interim Chief Operating Officer	Member Governing Body Member of Senior Leadership Team (SLT) Member of Integrated Commissioning Executive (ICE)	Managing Director SF Thompson Consulting Limited (Not trading) Volunteer for Redbourn Care Group and the Redbourn Community Volunteers in response to the COVID-19 pandemic		22/01/2020	21/04/2020	Direct	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
	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 Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting Strategic Commissioning Programme Board			13/08/2015	03/09/2019	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
	Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee	Co-opted Councillor on Budleigh Salterton Town Council (Independent Member – non-political)	Son employed by Care Quality Commission as an Information Analyst	16/10/2019	26/11/2019	Indirect interest		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
	Webber	Lorraine	Associate Director of Nursing Caldicott Guardian	Member of Quality Assurance Committee A & E Delivery Board QEIA Panel Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Member of Governing Body CCG Executive Team Meeting Member of Vacancy Control Panel Working with Industry Group	No interests declared		14/03/2017	29/08/2018				NHS Devon CCG
	Wheller	Kevin	Locality Chief Finance Officer (Northern & Eastern)	Attendee of Audit Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Northern and Eastern Preparatory Group Working with Industry 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 Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (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

Wooldridge	James	Associate Non Executive Lay Member	Attendee Governing Body	Managing Director of Recovery Devon CIC which is directly funded by Devon Partnership NHS Trust (DPNHST) Proprietor of Positive Notions. A private consultancy providing mental health training services to various organisations including but not limited to: DPNHST, University of Exeter, University of Plymouth, Livewell Southwest There may be an increased reputational benefit to my Positive Notions consultancy through membership of Devon CCG. I will advocate for various mental health groups and organisations including Recovery Devon CIC, that may be in receipt of commissioned funding from Devon CCG In receipt of individually funded treatment My general interest lies in mental health, wellbeing and recovery. I intend advocating for groups and organisations that adopt and demonstrate the values and principles associated with the recovery approach	28/10/2019	28/10/2019	Financial /non Financial Professional Interests/ General	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
DRAFT minutes held in PUBLIC

Date: 30 April 2020 Time: 11:20 – 13:34

Location: Via Microsoft Office Teams (this meeting was also recorded sound and vision)

Item	Discussion	*Action*	
1	**Welcome and Apologies** PJ, chair welcomed everyone to the meeting and noted this was the first meeting held in public since lockdown due to the coronavirus pandemic was announced. Owing to the technical limitations we were not able to have members of the public join the live meeting. However, an unedited record of the meeting would be made available to the public on NHS Devon CCG's website as soon as possible after the meeting. Apologies were noted from: • VP – Tracey Polak deputy • RH PJ gave a personal message about the reality of the situation of the pandemic and guiding colleagues through our response and changed ways of working. PJ praised the exceptional way the population had responded to social distancing. PJ also personally thanked the front-line staff of the NHS and the different ways they have adapted to interacting with patients whilst wearing of personal protective equipment (PPE). ST, accountable officer echoed the words of the chair and had immense pride of the role of the NHS and the staff members of the CCG and the applause for NHS carers. ST expressed how proud he was to lead an organisation that was flexible whereby some members of staff had been redeployed or had stepped up to support the incident management control centre. He was grateful to executive director colleagues in dealing and responding to the challenge including seven days per week working on an 8am to 8pm rota basis. ST was appreciative of the flexibility of the chair in providing clinical leadership, the non-executive directors and clinical colleagues for reaching out to the executive team. It is the role of the Governing Body to ensure we gain assurance daily that we are doing things in the right way in responding to the pandemic and he thanked the Governing Body for taking their role seriously.		

2	**Register of Interest (ROI)** The members reviewed the ROI and the following amendments were declared: • NK noted that he had introduced a PPE provider to the CCG with this company being partly owned by his cousin • GApp noted that she had been appointed as Therapy Lead for Health and Social Care for North Devon No conflicts were declared against the agenda. **The Governing Body received and noted the ROI and the additional declaration made.**		
3	**Minutes of the last meeting** There was no meeting held in public in March due to the CCG having to respond at pace to the onset of the coronavirus pandemic. PJ led a page by page review of the minutes of the meeting held on 27 February 2020 and it was agreed these were a true and accurate record of the meeting. At the last Governing Body meeting held on 27 February two members of the public asked questions. The chair gave individual verbal responses at this meeting and it was noted that we would formally write with our response following the meeting. Both formal responses have been completed <u>Action log</u> There were four open actions that had been completed and these were formally agreed for closure.		
4	**Governance arrangements during Covid-19 incident** The purpose of this paper was to provide the Governing Body with the detail of the governance arrangements as to how the CCG is responding to the incident. Our statutory committees have been stood down and are being kept under review should they need to take place. There is an exception that the Primary Care Committee may meet virtually if requested and an Audit Committee has been arranged for next week. The CCG is also considering reinstating the Quality Committee in the very near future. Structures and accountabilities have not changed, and a process has been put in place for logging decisions to ensure a comprehensive and robust record of decisions. Executive directors are using logbooks outside of formal meetings for those that relate to operational or tactical decisions. GS referred to the role of the non-executive directors and the importance of their contribution to the function of the CCG. GS gave an overview of the risk management arrangements and confirmed that following a review by NHS E/I we have received notification they are assured on our governance arrangements in responding to Covid-19. The non-executive directors are joining regular meetings with the chair and accountable officer in between formal Governing Body meetings and there are informal touch points on a weekly basis with the clinical lead representatives.		

	NB assured the Governing Body that underlying governance arrangements for decision making for the CCG remain unchanged including delegated authorities and noted there was flexibility built in if needed. GT was pleased with the governance report and decision log and asked for this to be ratified at the next governance meeting. He wondered if there should be a fourth risk around reputational risk in respect of Covid-19. GS responded that there wasn't a specific risk on the register relating to reputational risk, but this will be picked up when a risk has an impact to reputational risk and confirmed that reputation, impact and response to Covid-19 will be further discussed at the next Audit meeting. It was agreed that any decisions that have been taken outside of normal process would be ratified at the next scheduled relevant assurance committee or Governing Body and GS confirmed that no decisions to date have been made outside of process or the scheme of delegation. NB referred to the internal CCG modelling data and reputational risk if there was to be a second wave of the virus in Devon. The CCG has been looking at what are the likely scenarios going forward depending on the possible changes to social distancing measures. Our preparedness continues to be a priority and we continue to plan for a possible increase in cases and we have been reinforcing our messaging that people should 'stay home, protect the NHS and save lives' in order to minimise the risk of future waves. The chair stressed that during this pandemic the CCG has had to make decisions with the information made available at any one point in time. It will only be with retrospective knowledge and experience that we will be able to review and learn from the decisions we made. AM also reinforced that Devon CCG is confident that we are closely following national guidance and guidelines from the Department of Health and Social Care and the Government. **The Governing Body** • **Were assured of the current processes and arrangements that the CCG has implemented to oversee the current Covid19 response and seek any additional assurances as required.**		
5	**Scene setting including cases, issues and modelling** ST gave an update on Devon Covid-19 national statistics as at 29 April 2020: • 1,123 cases • 140 deaths associated with Covid-19 • 10 patients in critical care Devon remains low in cases compared to other regions and the South West is one of the lowest in the country. Social distancing is having an effect and we are regularly modifying our internal modeling based on national guidance to understand the risk when social distancing is relaxed. ST gave personal reflections in ways of working in our response to Covid-19 in the CCG and wider system.		

- Seen rapid adoption of technology and significant improvements in reducing face to face appointments
- Seen flexibility take place with workforce across boundaries and staff working at the top of their professional license
- Good mobilisation of the voluntary sector which has been accelerated across the county
- In and out of hours primary care working more closely together
- We have seen 7 day working across sectors including commissioners
- Identified further opportunities to manage waiting lists effectively
- Spotlight on the care market has identified sustainability and infection control mechanisms not adopted and there is specialism work to be done in this area
- Behaviours shown by the population have had both positive and negative effects. Emergency Department attendances reduced rapidly, and there is concern that some of this was due to some people not seeking support and advice for medical emergencies when they should have
- Established new safe thresholds of care and access to services
- Ability to reduce bed occupancy, at times been reduced to under 50% due to close working with our local authorities when out of pandemic
- Organisational autonomy within an agreed set of parameters has enabled the ability to move forward and implement things at a local level
- Collective CEOs have had regular daily check ins to rapidly turn around issues which has been a benefit to the system

ST referred to a letter which has been received from Sir Simon Stevens and Amanda Pritchard the leadership team of NHS E/I which detailed guidance on phase 2 of Covid-19 and restoration of services. Executives, leaders and deputies across the health and care system are working on how we restore services and in what order.

SM detailed the incident response and set up in line with expectation set out by the government as follows:

- Seven-day service set up running from 8am – 8pm including on-call
- Incident cells aligned with regional cells
- 8 incident cells supported by wider programmes of work including experts
- Mapped out detailed communications and engagement with partners to support the population and how to deal with issues escalated regionally and nationally
- Preparing and dealing with the peak and supporting hospitals to create capacity
- Focus on PPE to ensure we were adequately equipped
- Focus on primary care and testing
- Systems and process in place constantly evolving and in line with national expectation

GT wondered how we capture clinical leadership in moving forward and a recovery plan. ST responded that the CEO group has reflected on the need to understand the financial work and the changes and impact the pandemic has had and this is a reminder that we should focus on the right things and listen to clinical leadership with the driver not just about finances.

SK enquired about Simon Stevens letter and the relevance of this to Devon and asked for an early view. ST confirmed that there had not been enough time to review the letter fully, but initial reaction was that it was different in the South West as we not had a peak of the virus but when social distancing measures are lifted, we will need to respond appropriately.

	GAth asked about what support was in place to support care homes particularly around infection control and increase in cases. PK acknowledged that the scale of the virus was unprecedented and has put stress on care homes, however where there was an outbreak there has been a system response with Public Health England and teams to support and he explained the measures that had been put in place. He detailed the clinical cell which includes infection control experts which is staffed seven days per week to support care homes. CB asked about modelling in Devon for prisons given there are three in the county. PH confirmed that health and justice is modelling carefully what is going on in prisons, but the outbreak is low. The critical care cell is looking at an escalation plan specifically for prisoners who would test positive and would need access to hospital care and this is being dealt with at a regional level. **The Governing Body received and noted the update on our response to Covid-19, issues and modelling.**		
6	**Primary Care** JH started by saying that she had been impressed at the amount and level of detail in delivering day to day service and the changes to the way primary care has been delivered. Staff and patients have reacted positively to new patterns of delivery of care. She gave respect to primary care and the CCG and positive dialogue and the weekly primary care webinars have been key. At a recent primary care committee, they • Were assured about how decisions have been made on primary care • Considered and noted changes to aspects of some current contracts • Noted some discussions continuing around complex issues around the funding of hub work and considered the basic approach that the CCG will take in discussing with the practices and the Local Medical Committee • Continue following national policy and be flexible around specific local issues JT talked through a couple of slides and highlighted the significant amount of progress over the last four weeks these included the splitting of patient pathways and identified Covid and non Covid sites including assurance process. A home visiting service has been agreed and palliative care guidance has been distributed, weekly webinars have been run and we have moved into a new phase for Personal Protective Equipment, testing, IT support and Bank Holiday arrangements. JT drew attention to the key issues and talked through the bullet points she noted that primary care was getting busier and stepping back up business as usual in the team. The chair congratulated JT and the primary care team who have worked tirelessly over the past few weeks. DG raised a specific question whether working in the Covid primary care hubs was part of general practice and the reimbursement of funding. JT confirmed that it is about flexibility that we have given locally and repurposing of extended access and messaging to general practice is that this has been afforded nationally and locally and should be		

	used to support Covid work. The National team is looking at a funding package and we are awaiting to receive further guidance. JT personally thanked the IT team and Delt for their incredible support in getting laptops out to general practice and supporting the primary care webinars. Good practice and learning will be collated to share at the primary care webinars and included in bulletins and this will also be used in the recovery cell to embed learning for the future. **The Governing Body received and noted the update on Primary Care.**		
7	**Personal Protective Equipment (PPE)** PK talked through the slides included in the pack and put into context that it was hard to understand the part that PPE has played into responding to Covid in its use and keeping people safe. In the early days PPE was part of the clinical cell but soon became apparent that a PPE cell was needed to respond to the virus under the leadership of senior staff. The PPE cell is staffed and monitored 12 hours a day seven days a week and the team has been developed and expanded to respond to the demand. Four work streams are: 1. Monitoring of stock and coordination of mutual aid support 2. Coordinating donations and purchasing from alternative sources 3. Ordering of PPE 4. Achievements PK recognised that there had been some significant challenges and we have tried to respond quickly in changing circumstances. We have had early engagement with local authorities and had a great response from team Rubicon led by Army veterans. We have been creative around securing supplies of hand sanitisers from breweries, 3d printing and gathering stock from schools and universities. We are part of the Local Resilience Forum (LRF) and a priority framework has been developed for the greatest clinical need for PPE in line with national guidance and so far, no one has been denied mutual aid and we have been able to send PPE where it has been required. We have supported care homes through an initiative of weekly care home webinars. PJ acknowledged the challenge that PPE had been and that we have had to respond to national supplies and respond with local solutions and he personally thanked PK and the team. JH mentioned testing and recent television coverage that care homes have been deeply frustrated with PPE and testing issues and was this a typical situation. PK had not seen the specific coverage, but initial assessment of care home situations was that there are cases with specific problems which are not commonplace and where this happens, we are committed to following these up and respond to individual issues. We are taking a short, medium- and long-term view and planning for the next phase. Conversations are continuing around future predicted demand and we are taking a proactive approach.		

	The Governing Body received and noted the update on PPE.		
8	**Quality and Performance Report** STh introduced the paper which sets out the performance position to the end of last year and importantly makes clear the revised arrangements for the pandemic from the 1 April. She did not propose to go through the report in detail but noted that looking at one of the key performance indicators such as four hour waiting time in A&E it ended up closer to target at the end of last year but was a reality as a consequence of the impact of the early start of the pandemic and as a reduction of patients coming forward. From the 1 April 2020 a variety of guidance has been produced which tells us as commissioners to stand down our normal reporting arrangements but stay focused on our constitutional standards. The paper advises that the period from April to July there will be a different performance reporting regime. PK reported that some governance processes have been stepped down including quality assurance committee at the start of the pandemic. We have had a clear focus on mitigation of risk and quality occurrences of performance and PK has spoken with the regional team and we are in line with the broader picture. We have preserved safeguarding systems and they have not changed, and we have a greater degree of overview and Paul O'Sullivan as a commissioner has been leading a system wide discussion on children and Covid. We are responding in line with national guidance around safety systems, patient experience and Patient and Liaison Service (PALS) which has suggested a pause and we have followed suit, however if there are issues with specific concerns, we continue to look at those actively but by exception at this moment. PK meets on a weekly basis to review Serious Incidents (SIs) and these are reported to ST as accountable officer on a regular basis. We are maintaining and improving our links with colleagues in the system around quality and safety issues that have occurred not just in health but in social care element and there is representation from social care in our weekly webinars. PK also has frequent discussions with system directors of nursing in Devon to facilitate specific discussions Covid and Non Covid related services and there are also weekly calls with medical directors. In moving forward, we will be recommending that the quality framework should factor in a recovery phase. PK has spoken with GAth, chair of the Quality Assurance Committee and it has been agreed this should be one of the first governance assurance committees to be stepped back up as soon as possible. PK referred to the ethical framework and ethical standards group and that is part of our response with our clinical reference group who meet on a weekly basis to consider quality issues relating to clinical services that need further understanding and advice from this group. CB wondered if there were volunteers and safeguarding PK and AM assured the Governing Body that appropriate checks are in place for volunteers and re-joining nurses.		

	PJ thanked STh and PK for this report and the need for the Governing Body to be made aware of our core standards and that we don't lose sight of these as we return to business as usual. **Members of the Governing Body:** • **Noted the levels of performance compliance across a range of key targets at the end of February (Month 11).** • **Be aware of the likely impact of national guidance on the COVID-19 pandemic on performance in March (Month 12) that will be known on 14th May, with provisional commissioner level data released on 23rd April.** • **Noted the work of the Nursing and Quality Directorate in relation to performance.** • **Agreed the national arrangements for performance reporting and CCG accountability for performance for the period April to July 2020** *Jo Turl and Philip King left the meeting.*		
9	**Workforce including own staff and staff testing** AM started by thanking all staff for their flexibility and professionalism throughout this period and that we have seen many colleagues adapting to take on new roles. HR have been working with staff to identify those that continue to work as normal those to support our response to coronavirus and supporting the incident management cell and those that have been redeployed. AM highlighted how staff have changed to a different way of working: • 280 staff working in adapted roles to support the challenge of the virus • 120 have started redeployment in a range of roles such as Devon Doctors (DDoCs) and staff that can support the Nightingale unit in Exeter • 12 are due to be redeployed but there has been a delay with our provider organisations • We are working to support staff wellbeing and executive directors have been checking in with staff in part those who are being redeployed and there are regular team meetings via teams and bespoke guidance has been developed to support staff mental health • Thank you calls have taken place for redeployed staff • Signposted staff to employee access programme and national health and wellbeing support and a range of other support • Staff Partnership Forum – two-way dialogue underway to keep abreast of what is happening and staff welfare issues • Involved in bringing back staff scheme and staff are being matched in various organisations • Testing arrangements – employees have elected to be tested and 3 have been tested to date • Staff absence – originally when the virus started was high across Devon, approximately 3,000 but that has fallen to around 2,000 staff. For the CCG staff absence is low with 12 staff members now self isolating or absent for other reasons AM informed the members that the communications cell is operating strategically to offer advice and operationally have:		

	• Developed a staff update video that the accountable officer presents along with live fortnightly webinars • Organised live webinars for key audiences, MPs, GPs and practice staff and a new one for care homes • Worked closely with BBC, ITV and other media to be clear on advice for the public • Produced active social media approach including a daily bulletin that goes out across the system, including primary care, secondary care and mental health • Set up a communication cell comprising of a team of three who are now supporting the Exeter Nightingale Project PJ asked about the staff element and 'virtual teas' and request that this information is circulated to clinical leads and non-executive directors, so they have an opportunity to link with other members of staff. ST mentioned that we are starting to explore whether we produce communications in print to reach people who don't have digital solutions for our communications. JW reminded the members that when we engage with the public, we are mindful in the use of acronyms. **The Governing Body received and noted the update on workforce, staff and communications.**		
10	**Discharge Update** STh briefed the board that guidance on discharge came out in March and a discharge cell was established as part of response to the virus and this is called seven day discharge planning and out access of hospital care and the national guidance has been supplemented in the letter from Simon Stevens yesterday. We are mandated to continue this work for the foreseeable future. STh explained how the cell operates working seven days a week with our providers to maintaining bed occupancy levels which has been moved to 65% due to an increase of volumes of patients coming to hospitals. We also support coordinate and communicate across out of community care using all our capacity and when we are shaping our response we are thinking of opportunities and innovative solutions. PH or STh chair daily meetings with locality teams and systematically go through individual patient requirements making sure there are no blockages that cannot be resolved as a system. The cell includes staff from the continuing health care and market management who are handling complex discharges where they have established relationships. This cell is in the early stages and we accept there is learning experience to be captured on what we have learnt we will review and reflect these over the coming week. PH confirmed there was a commitment from everyone working with partners in making a difference and working together is critical. PJ asked about our dependency with local authorities and effective discharges. STh replied and explained arrangements and confirmed that we have joint appointment arrangements, and this works well for us and we are maximising this opportunity. **The Governing Body received and noted discharge update.**		

11	**Ethical Framework and Ethical decision making** PH informed the board of the importance that the decision-making process during a pandemic are consistent across our system, so we have assurance and fairness between Covid and Non Covid across all organisations. Recently an ethical framework has been developed by the CCG and PH mentioned that a Devon Ethical Reference Group had also been set up, Chaired by Dame Suzi Leather and both PJ and GAth were members. PH gave context and touched on a South West Regional Ethics Group for health and social care. There is a piece of work being developed by clinical leaders developing a systematic approach using a framework but there are gaps in this. We are looking at developing a Devon wide ethical framework, including principles a clear infrastructure and a set of decision-making tools. PH stressed that we were not currently in a surge of the pandemic and this is about precautionary planning based on Department of Health and Social Care ethical principles for pandemic flu. The CCG has asked the Devon Wide Ethical Reference group to act as our ethics committee subject to their approval and we are looking at what they may need to consider before they commit to this responsibility. PH offered to share the membership of the group which includes prominent professors and will be a strong committee. PH noted the work being undertaken is not able to be shared now and we are finalising some of the elements. It is a framework and toolkit for decision making around equal concern and respect for our local population. We are taking legal advice and will engage with the public and looking to adopt this across the system. The next steps are: • Clarify the Devon Ethical Group are happy to cover CCG business as well as System Wide • To finalise the framework • To finalise decision making tools The Ethical Framework and toolkit will be presented to the CCG Governing Body and our partner organisations boards for approval once it has been through the next steps. **The Governing Body received and noted the update on the Ethical Framework and Ethical decision making.**		
12	**Financial Update** JD referred to middle of March when the Chancellor of the Exchequer announced that there was no barrier to money for the NHS and that we would receive the resources needed to respond to the pandemic. We were also reminded during the period of response that we continue with good governance and control. JD announced that we were still required to produce our annual accounts for close for 19/20 and we have been working on these and JD was pleased to report they were submitted to NHS E and Auditors in time this week.		

	The accounts confirmed the CCG year end position of £66.5m deficit which is £39.5m off plan however we have been reporting this position for some time. We are collecting additional costs for the CCG relating to our Covid response and the CCG has systems and processes in place for this. For 19/20 there has been £564k of additional revenue costs and £757k capital costs incurred directly for the CCG and we are continuing to record these during the emergency response period, and this will be regularly reported to the Governing Body. The ongoing of payments to suppliers remain in place and we are working hard to ensure payments are being made promptly. We are making arrangements for financial planning and budgetary control and we are setting budgets based on expectations of our operating plan and we will continue to record additional costs relating to Covid. JD noted that the next phase of work will be to think about the long-term plan and impact of the response to Covid and what that will be for the rest of the financial year as we emerge from the emergency period and a further update on this will be given at the next Governing Body meeting. PJ on behalf of the Governing Body congratulated all the staff in finance team for keeping the financial systems going smoothly whilst dealing with the response to Covid. GT also thanked JD and the team for getting the accounts submitted on time and noted his disappointment in the deficit figure. GT suggested the last recommendation should be formally approved by the Governing Body rather than note the action which had been taken. The Governing Body agreed unanimously with this and showed their approval electronically to the Chair through the chat function on Microsoft Teams. **The Governing Body:** • **Noted the progress with the production of the CCG's annual accounts and the delivery of the forecasted financial position for 19/20.** • **Noted the arrangements in place for collection and claim of excess costs associated with the COVID-19 pandemic.** • **<u>Approved</u> the interim budgetary control approach based on the operational financial plan approved by the finance committee, and the ongoing work on financial and operational recovery on exit of the emergency response period.** SK wondered if were heading into a new way of funding CHC. JD responded and felt that a number of interim arrangements will be considered carefully at a national level whilst considering lessons learned.		
13	The meeting formally closed at 13:34pm and PJ thanked Governing Body members for their contributions and executive directors who prepared papers or verbal reports We are now more informed and assured of the CCG's function and position during this time and the next public Governing Body meeting will be held in May.		

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*
Alison Davis (AD) **	Associate Non-Executive Director, Devon CCG
Andrew Millward (AM) **	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) A	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Dr Matt Fox (MF) A (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
Gaynor Appleby (GApp) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT) **	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG
James Wooldridge (JW) **	Associate Non-Executive Director, Devon CCG
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Womersley – Dr (JWo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Lorraine Webber (LW) A	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
Philip King (PK) **	Interim Chief Nurse
Ruth Harrell - Dr (RH) A	Director of Public Health, Plymouth City Council
Sarah Thompson (STh) **	Chief Operating Officer, Devon CCG
Simon Kerr – Dr (SK) **	Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc) **	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) (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
Dave Spencer (DS) **** item 4 only**	Information Manager
Minutes approved | Date:	Signed by chair:

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Chair's Report				
Date of committee: 18 June 2020 **Date report produced: 08 June 2020**				
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: 08 June 2020**		
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:

- Introduction
- Devon STP Independent Chair
- Stakeholder Engagement
- Devon Ethical Reference Group
- System Chairs and Council Leaders meeting

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

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

N/A

Key recommendations and actions requested:
This report is for information 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.

NHS
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GOVERNING BODY – CHAIR'S REPORT

1. Introduction

It is difficult to know where to start. So much has happened over the last few weeks. The NHS in Devon has had to adapt to operate in an entirely new environment. Front line staff have had to manage new risks, both personal and professional. Our wider workforce has had to work in new roles, in new ways, embracing technology and being physically isolated from colleagues. Patients have had to utilise new ways of interacting with the health system.

So many of our staff have gone beyond expectation in the energy, time and focus they have put into ensuring the Devon health system could function as effectively as possible. They have adapted, met challenges and supported each other in ways we never thought would be necessary.

And the challenge we face shows no sign of abating. At the time of writing, coronavirus cases in Devon remain low, social distancing measures are being relaxed and people are starting to feel a sense of normality returning (albeit a new 'normal'). But the risk remains. We could still experience a further growth in coronavirus cases, the resources we made available such as the Nightingale Hospital in Exeter have to be ready to be used as and when needed.

Our hospitals need to learn how to balance infection control measures and non-covid demand in a safe and efficient way, and our role in supporting the system to maximise opportunities to meet the need and expectation of our population remains a challenge.

So my thanks to everyone in the CCG and working within the health and care setting for all of these things and for being determined to embed all the really positive changes we've seen result from this period, to learn from our experience and to ensure that our NHS is better, stronger and more resilient as a result.

2. Devon STP Independent Chair

Suzi Leather was appointed as Independent Chair of the STP on 1 August 2018 for a period of two years. Previously the Governing Body agreed to extend her contract of employment beyond the end of her current term. I now have confirmation from Elizabeth O'Mahony, Regional Director for NHS England, that Suzi's appointment will be extended for a further 12 months until 31 July 2021.

I am very pleased to say that Suzi has agreed to continue for the further year and will continue to bring her experience and consistent leadership to the role, and I look forward to continuing to work with Suzi as we establish the Devon Integrated Care System.

3. Stakeholder Engagement

During the pandemic, engagement with key political and local stakeholders has been key in ensuring the achievements and concerns of the NHS are shared widely and key influencers are informed of the health and care implications of the coronavirus and any local and national policy changes.

I have, along with Simon Tapley and Sonja Manton, been able to meet regularly with these stakeholders including:

- Weekly joint Devon County Council and CCG MP briefing virtual meetings
- MP briefing on CCG Covid modelling
- District Council Leaders virtual meeting
- Virtual engagement event with tourist industry representatives

I would like to thank our local political leaders and Members of Parliament for the support they have shown to the NHS throughout this pandemic.

4. Ethical Reference Group

Suzi Leather has convened a System Ethical Reference Group with membership from each of our NHS organisations, local authority and nationally renowned ethical specialists. This group has met four times to date and has considered a number of key strategic system issues including developing the Devon Ethical Framework which is undergoing a period of public engagement before coming to NHS boards and our Governing Body for review.

At last Governing Body the CCG agreed to request that the System Ethical Reference Group act as advisor to the CCG regarding ethical considerations of CCG decisions. The Ethical Reference Group reviewed this request and has agreed to provide that advice on issues related directly and indirectly to Coronavirus.

5. System Chairs and Council Leaders Meeting

System NHS organisation Chairs and Local Authority Leaders have continued to meet on a regular basis chaired by Suzi Leather. Discussions have understandably been varied but a particular focus recently has developed around ensuring that we learn from recent experience and review system leadership and governance structures to enable partners to continue their system collaboration. The intention remains to become an Integrated Care System by April 2021.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY MEETING

Report title: Accountable Officer's Report				
Date of committee: 18 June 2020 **Date report produced: 4 June 2020**				
Author (s) Name and Title: Simon Tapley, Accountable Officer Philip King, Interim Chief Nursing Officer Darryn Allcorn, Chief Nursing Officer Andrew Millward, Director of Communications and HR Sonja Manton, Interim Director of Commissioning Molly Bishop, Executive Assistant to Accountable Officer		**Supporting Executive:** **Name and Title:** Simon Tapley, Accountable Officer **Report Approved by:** **Name and Title:** Simon Tapley, Accountable Officer **Date** 8 June 2020		
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:

- COVID-19 – updates as follows
  - Testing
  - PPE
  - Care Homes
  - Workforce
  - Communications
- Q3 CCG Segmentation – Devon
- Queen's Birthday Honours 2020

Management of Conflict of interests:

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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.

NHS
Devon
Clinical Commissioning Group

Accountable Officer's Report

1. Introduction

I want to begin by acknowledging the hard work and dedication of our NHS and Care staff in Devon, particularly during the COVID-19 pandemic, who have continued to provide the best possible care for our patients. It is also important to recognise the work of the voluntary and business sector, not least for their contributions in the supply of personal protective equipment (PPE) and offers of accommodation, parking and transportation. During this challenging and unprecedented time, it is extremely heartening to see our staff and communities coming together to support our local population.

As we enter into a new phase of the pandemic, in accordance with national guidance and policy, we are beginning to review how we might start to stand-up services, recognising the transformational changes we have already been able to make during this time. As part of this, myself and my Director colleagues have taken some time out to reflect and look ahead at our priorities for the future, building on the fantastic work of our staff during this crisis.

2. CCG Response to COVID-19

In response to the COVID-19 pandemic, our CCG staff, alongside colleagues from our partner organisations across Devon, have been extremely adaptable to enable us to fulfil critical functions whilst still maintaining the business as usual. Following the establishment of the CCG Incident Management Team (IMT) in early March, we have formed a number of 'cells' to support us in our response to the pandemic, and we thought it useful for the Governing Body to note the work of some of these cells, below.

Workforce

CCG staff have been flexible and committed in supporting the system-wide COVID-19 response. 120 people have been redeployed to providers, including working with the RD&E to prepare and launch the Nightingale Hospital. At least 280 others are temporarily working in adapted roles within the CCG, including a number who are part of the Incident Management Team infrastructure. In addition, many of the CCG's GPs have been flexible in adapting their focus to ensure that their clinical skills and experience were put to the best use for the system.

We anticipate that CCG staff on redeployment will gradually start to return to the CCG as the number of COVID-19 patients decreases and the system begins to shift emphasis to recovery and restoration work. This will be done carefully, working with providers to

ensure a smooth transition and we will have flexible secondments that will allow us to scale back up again should there be another COVID-19 peak.

The CCG has engaged 20 nursing staff under the national Bringing Back Staff initiative. 6 are now employed by the CCG and provide clinical advice, guidance and training to care home staff and residents across Devon. The other 14 have been offered to system providers. The CCG is also liaising with the LMC to process up to 18 GPs under the scheme. These individuals will fulfil a variety of roles including supporting Primary Care with the COVID-19 response, dealing with backlogs in patient treatment and covering leave to enable frontline staff to rest and recuperate.

A project team is in place to plan for a return to the workplace so that the CCG is ready if national guidance changes. This team is working to ensure that physical environments are safe and COVID-compliant and associated workforce matters - such as risk assessments, working patterns, use of technology and new ways of working - are considered and planned for in advance.

The majority of staff are working from home and have been since late March. This was set up quickly and has generally been successful, particularly from a technological point of view. The CCG and staff partnership forum are working hard to support staff with their wellbeing. Guidance is available for staff and managers on maintaining positive mental health and CCG Wellbeing Champions have been featured in weekly staff communications. It is anticipated that staff will need more support in this area as the lockdown, and corresponding lack of face-to-face contact with colleagues, continues.

Testing

Testing for COVID-19 is a key aspect in the management of the pandemic. There are two basic forms of testing available – the antigen test detects whether someone is actively infected; and the antibody test confirms whether an individual has had the virus and has developed antibodies.

The national testing strategy defined five “pillars” in the approach to testing:

1. NHS Swab testing
2. Commercial swab testing
3. Antibody testing
4. Surveillance testing
5. Diagnostics national effort

Antigen testing (Pillars 1 and 2)

The antigen test, also known as the PCR test (polymerise chain reaction) detects genetic material and shows whether the virus is currently present.

The **NHS Swab testing** (pillar 1) is **delivered locally through Trusts** working together as part of the **Peninsula Pathology Network**. Patients and staff are tested either on-site or at one of the community options that the Trusts have and the acute trust labs process the results.

Our peninsula labs can sufficiently accommodate the current need for testing patients and staff. Approximately a third of the current capacity is being used and there is the ability to increase our capacity as required.

Trusts in the peninsula also have access to a small number of specific antigen tests that can be used to give rapid results (GeneXpert Test) – the allocation of these tests is determined nationally and although there is some concern about the equitable distribution of these tests across the peninsula, they are predominantly used at the point of emergency admission to hospital and no concerns in the capacity for these at the moment is indicated. This could be a different situation if Devon experiences a second surge and the pathology network would be well placed to work together to prioritise these.

The pathology network's aim has been to maximise access to local COVID-19 testing to support patients and minimise harm by ensuring the health and care system would not be overwhelmed by the likely unprecedented demands on service, exacerbated by potential staff absences.

The primary focus of pillar 1 was on patient care and key worker testing – the definition of 'key worker' used within the peninsula was a broad definition of health and care workers. As we have a relative high volume of capacity within our own labs, we are less reliant on commercial testing commissioned nationally (pillar 2) and are able to offer a wide cohort of support to local people and partners.

In early April, the Department of Health and Social Care set up further testing arrangements through Public Health England (Pillar 2). These Regional Testing Sites (RTS) were rolled out rapidly – initially at Seaton Barracks, Plymouth and subsequently at Honiton Road Park and Ride, Exeter. The RTS sites are now supported by Mobile Testing Units, currently run by the military and by home testing kits. People can book their tests through the national websites and phone numbers to access these.

With the addition of national testing, the local laboratories have had sufficient capacity to offer an enhanced testing programme across Devon, using the Pathology Network to maintain a consistency of offer. All Care Homes with symptomatic residents or staff are able to access rapid testing in parallel with the Health Protection Agency offer. In addition, we are now offering asymptomatic testing to social care providers unable to access the national portal, on the basis of prioritisation from local public health teams, with input from other intelligence sources. This has been very welcomed by the sector.

Antibody testing (Pillar 3)

The antibody or serology test confirms whether an individual has had the virus. It is reported as being highly accurate but at the present time, the implications of the result are not yet known – in terms of the half life of the antibody load, and whether the presence of antibodies will confer a degree of immunity to future infections and it does not allow an individual to relax their practice of social distancing or change safe practice guidelines. The test is helpful in terms of surveillance and our understanding of the spread of the virus.

The trusts within Devon and Cornwall have recently gained access to serology testing. UHP and RCHT are using the Abbot serology test and RD&E and TSDFT are using the Roche test. Each trust has successfully validated the tests and are in the process of rolling this out. The intention is for all health and care staff to be tested and to offer the test to patients who are having other investigations.

Test and Trace

The Government launched the National 'Test, Trace, Contain' initiative at the end of May 2020. The intention is that there will be three levels of escalation:

- call handlers to inform people that they have potentially come in to contact with someone who has tested positive;
- call handlers to contact those individuals with a positive test result to identify potential contacts; and
- specialist teams to manage sensitive outbreak situations such as schools for example

This specialist level will be handled by local Public Health teams and Public Health England. Each Local Authority area has been asked to agree a Local Outbreak Management Plan and appropriate governance structure.

The service is designed to contain the virus and enable people to live a safer and more normal life. This will require rapid testing, at scale, and therefore the work the Pathology network has done to date, will put the peninsula in a strong position to manage the anticipated surge in demand. The Test and Trace cell (part of the local resilience forum incident structure) will provide a forum to share knowledge, resource and draw on expertise.

Personal Protective Equipment (PPE)

The CCG's role during the first phases of the COVID 19 outbreak was to assist the Devon system of providers with securing enough PPE in a timely fashion and to provide coordination through daily Gold escalations for mutual aid. Soon after this the CCG's role developed to fulfil requests for 'urgent' PPE where providers have stock levels of less than 72 hours'. In effect the CCG took on the role of provider of last resort and the developing outbreaks in the Care Home Sector added further tasks and priorities to the work. NHS Devon CCG will generally supply stock to last the provider 72 hours. On occasion and with stock permitting we will provide more.

It is acknowledged that urgent requests may need to be fulfilled – these will be processed within 24 hours of receipt and delivered the next working day where possible, these will be booked in directly.

As COVID-19 has progressed, the "Palantir" have taken over supply to large secondary providers. Although this system has been increasingly effective, it is still necessary to ensure that more immediate deficits are met in a timely fashion.

However, the requirements of the care home market (somewhere in the region of 500 in Devon, twice that of any other CCG footprint in the South West) remains problematic and

requires direct intervention on occasions. The supply to small providers (care homes and primary care) comes through the “clipper” ecommerce solution. This remains challenging and requires regular intervention from the CCG.

A meeting is planned with Team Rubicon for Tuesday 9 June to discuss the medium to long-term plan regarding volunteer support of the PPE supplies and deliveries.

Fit testing continues at pace, with a number of new domiciliary care providers and PHB patients being supported. The CCG have initially used its contact with CHC cases to ascertain where fit testing is most needed, but the list of Aerosol Generating Procedures (“AGPs”) extends beyond simply the remit of CHC and we are continuing to work with local authorities and the care home market directly to bridge this gap as there is not single master list of where residents with these needs are located.

The Local Resilience Forum (LRF) is looking to stand down the PPE cell locally. Both CCG’s (Devon and Kernow) have stated they do not believe there is currently enough stability in the system to support this move. New organisations are being directed to the LRF for stocks such as the RNLI and schools.

The LRF only provide a very small number of FFP3 masks and no gowns and so the CCG continues to source supplies of these and is working towards the provision of more reusable equipment such as respirator hoods and washable gowns.

The announcement that all healthcare workers will be required to wear masks has caused some uncertainly in terms of further supply. The CCG are looking specifically at the effects on primary care, but there will need to be a further system wide discussion on how PPE figures in the new paradigm of what will be the usual business of health and social care.

Although, the likely risk of inadequate PPE supply has reduced slightly as there has a relative stabilisation of supply of some PPE in some areas, it remains a top priority and a significant risk to the healthcare system.

Care Homes support

Following a call to action from the Chief Nurse for England Ruth May, to all CCG Directors of Nursing, a range of support has been made available to care homes and their residents as part of the Clinical Commissioning Group’s (CCG) COVID-19 response. This has built upon some of the initiatives the CCG had already put in place of its own volition in order to respond swiftly to the problems faced by the sector.

We are working together with local authorities, GP practices and providers of community services. The support offer includes:

- Training on infection prevention & control, PPE and swab testing to all care homes
- FIT Testing for care staff where Aerosol Generating Procedures (AGP) are undertaken
- Medicines support and access to a central hub for advice

- Weekly webinar in partnership with CQC, Local Authorities and providers with topical sessions and an interactive question & answer session

We continue to work with general practices and community health service providers to implement the COVID-19 Care Home Support Model set out by NHS England which includes additional pharmacy input and advice, a named clinical lead and clinical support with individualised care planning for residents.

The CCG instigated the formation of a “Hub and Spoke model” with a new Care Homes and Home Care Cell providing a coordinating hub across the whole of Devon spanning health, local authorities and public health, with each of the four localities attending daily cell calls. This provides a daily point for escalation of any issues and a systemwide approach to support and resolution. A longer and broader weekly system meeting ensures sharing of learning and best practice across all problems and provides additional governance and assurance. In common with the CCG PPE cell, the Care Homes and Home Care cell provides a service and point of contact on a seven day a week basis.

The CCG’s trainers offered Infection Prevention and Control training to all of the nearly 500 homes across all areas of Devon within a window set by NHSE&I over seven working days. Further training continues to address providers who felt unable to take up the training within the deadline set through NHSE&I. It should be noted that Devon has nearly twice as many care homes as any other CCG footprint in the South West and so the effort made by a relatively small and dedicated group of staff, mostly CHC and associated staff groups, was incredible and highly effective.

Communications

Over the last few months the communications cell has focused on ensuring the **public** receive timely and up-to-date information. They have worked with local media to produce, TV, radio, digital and newspaper updates on topics such as personal protective equipment (PPE), testing, access to services and to share important Government advice locally. They have undertaken targeted campaigns to help people access their GPs via online consultations (video and telephone). During April and May Devon GPs conducted over 90,000 online consultations,13,000 via video.

Since March the CCG activity on social media has reached over a million people, off the back of 566 posted messages.

We have ensured **key partners** in hospitals, GP practices, care, community and mental health services have been provided with appropriate information, advice and guidance, producing 72 daily bulletins and hosting 20 webinars with GPs and care home providers, reaching over 2500 people.

We have worked with local authority partners to deliver MP briefings, including webinars, that have kept locally elected members connected with Devon’s health and care services.

The communications cell has worked closely with HR to ensure national guidance has been interpreted locally and shared with CCG **staff**. This has been via 30 weekly bulletins, 4 live webinars and 7 pre-recorded updates from the CEO and executive team.

These approaches have been positively received and we have had good feedback from staff.

3. CCG Q3 Segmentation – Devon

The NHS Oversight Framework 2019/20 outlined how support needs for CCGs (and providers) will be identified and how the different levels of available support will be applied. 'Segmentation' refers to the way in which the different levels of support are categorised and ensures that CCGs and providers are subject to a standardised approach. Regional teams will allocate each CCG to one of four segments, according to the level of support that is adjudged to be required – this is informed by the rating awarded to each in the CCG Annual Assessment 2018/19 ('Outstanding', 'Good', 'Requires Improvement' or 'Inadequate').

The four segments are as follows:

CCGs		
Segment/ category	**Description of support needs**	**Level of support offered**
1 (Maximum autonomy)	No actual support needs identified. Maximum autonomy and lowest level of oversight appropriate.	**Universal (voluntary) -** tools or resources available to commissioners to help them develop
2 (Targeted support)	Support needed in one or more areas but mandated action is not deemed necessary.	**Universal** **+ targeted** support as agreed with the CCG to address issues identified and help move it to segment 1.
3 (Mandated support)	The CCG has significant support needs and is placed in the dedicated support regime.	**Universal** **targeted** **+ mandated** support as determined by the regional team to address specific issues and help move the CCG to segment 2 or 1.
4 (Legal directions for CCGs; special measures for providers)	The CCG is failing or at risk of failure with very serious/ complex issues that mean it is placed under legal directions.	**Universal** **targeted** **+ mandated** support as determined to minimise the time the CCG is under legal direction.

Devon CCG has received confirmation that, following a review by the regional team, it has been allocated to **Segment 2.**

4. Queen's Birthday Honours 2020

In these challenging and unprecedented times, it is important to recognise the significant contribution of individuals within our communities and organisations to support our local population in Devon. As part of the process of recognition of these efforts across the country, the Queen's Birthday Honours, normally released in June, have been delayed until the autumn to capture and acknowledge those making exceptional efforts in response to the COVID-19 pandemic.

As such, we are encouraging staff and colleagues to put forward a nomination for any individuals whom they feel are deserving of national recognition for their contributions. The online application form and guidance to do this can be found on the Government website, here: https://www.gov.uk/government/publications/covid-19-honours-nomination-form

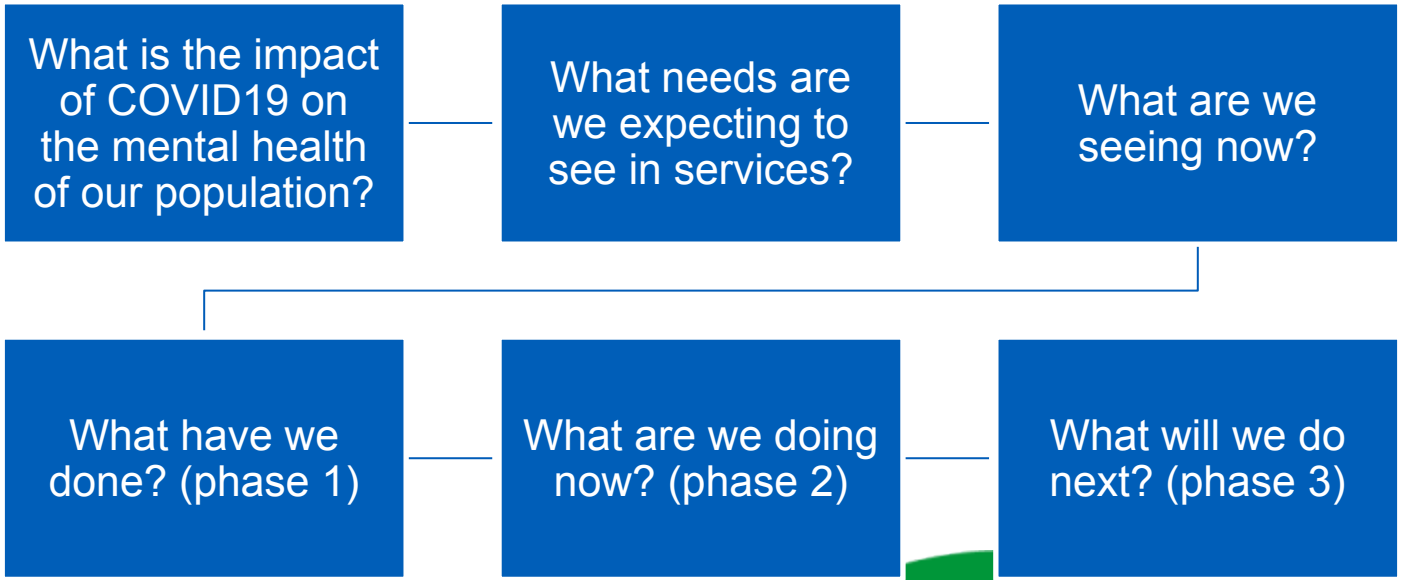
COVID19 and Mental Health in Devon

Presentation to Devon CCG Governing Body

June 2020

Purpose

This presentation aims to answer six questions in regard to COVID19 and mental health:



What is the impact of COVID19 on the mental health of our population?

What are we expecting?

Source: Lancet Psychiatry 2020 Published Online April 21, 2020
https://doi.org/10.1016/ S2215-0366(20)30171-1

Experts and Evidence: learning from epidemics and pandemics

"The mental health effects of the coronavirus disease 2019 (COVID-19) pandemic might be profound and there are suggestions that suicide rates will rise, although this is not inevitable."

Mental health consequences are likely to be present for longer and peak later than the actual pandemic

The pandemic will cause distress and leave many people vulnerable to mental health problems and suicidal behaviour

Those with mental illness might experience worsening symptoms

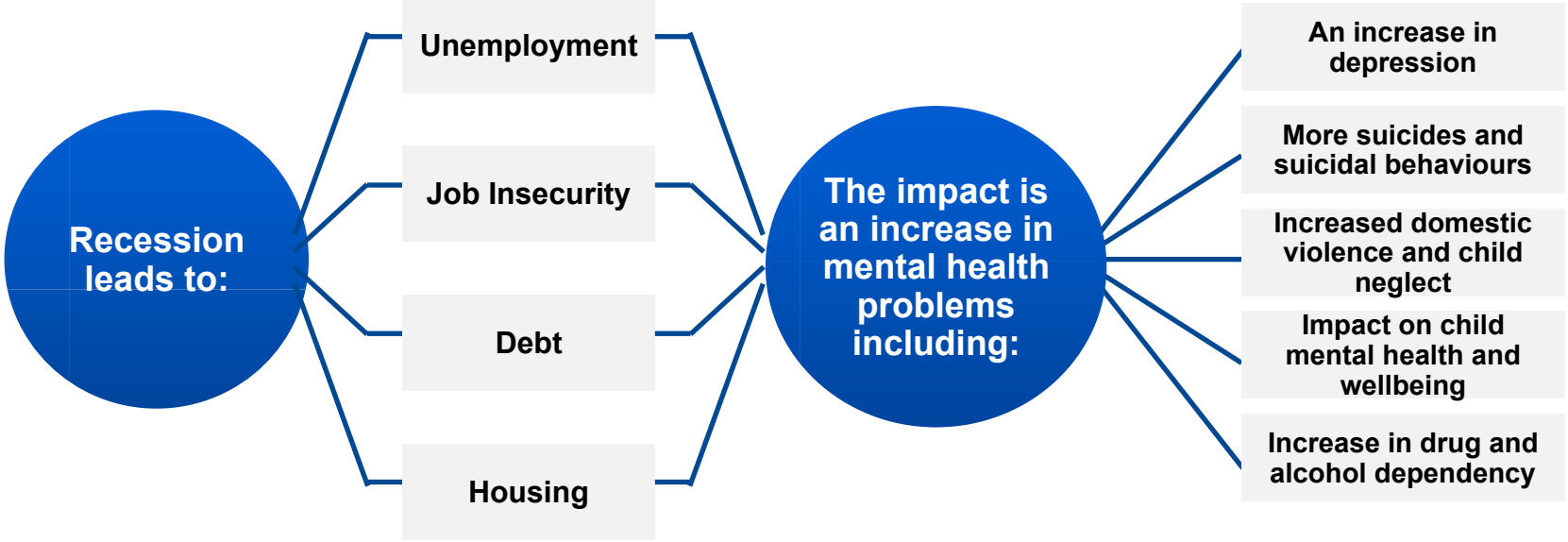
- The nature of this pandemic could adversely affect known precipitants of suicide such as:
  - domestic violence
  - alcohol consumption
  - social isolation and loneliness
  - bereavement
  - loss of employment
  - financial stressors

What are we expecting?

Source: Faculty of Public Health/ Journal of Public Health, Nov 2015
https://www.fph.org.uk

Experts and Evidence: Learning from previous economic recessions

Economic crisis increases the risk factors for poor mental health.
The effects of recession are likely to continue for many years.



Who is most affected?

Economic crisis is increases poverty and will impact people who are homeless or vulnerably housed, on low incomes and vulnerable groups the most, including children, young people, single-parent families, unemployed people, ethnic minorities, migrants and older people.

What is the impact of COVID19 on mental health of our population?

<u>Direct personal impact of COVID19</u>

- Morbidity and increased long term needs
- Trauma associated with care

<u>Impact of COVID19 on friends, families and health and social care workers</u>

- Trauma associated with care
- Emotional challenge of new/ changed roles
- Bereavement, possibly complex and traumatic

<u>Indirect community/ social impact</u>

Social distancing, self isolation, shielding may lead to:

- Increased isolation, anxiety, depression, stress
- Exacerbation of existing mental health needs
- Increased behavioural presentation of needs associated with learning disability/ dementia

<u>Wider societal/ economic impacts</u>

- Recession leading to loss or instability of employment, unstable housing and increased debt.
- Connected with increased depression, suicide, self harm, domestic violence, drug and alcohol misuse.

<u>Population Outcomes</u>

Increase volume of needs across all need types

Increased acuity of need across all need types

Increased needs over a long duration

Increased risk of adverse outcomes such as suicide, self harm

What demand are we expecting to see in services?

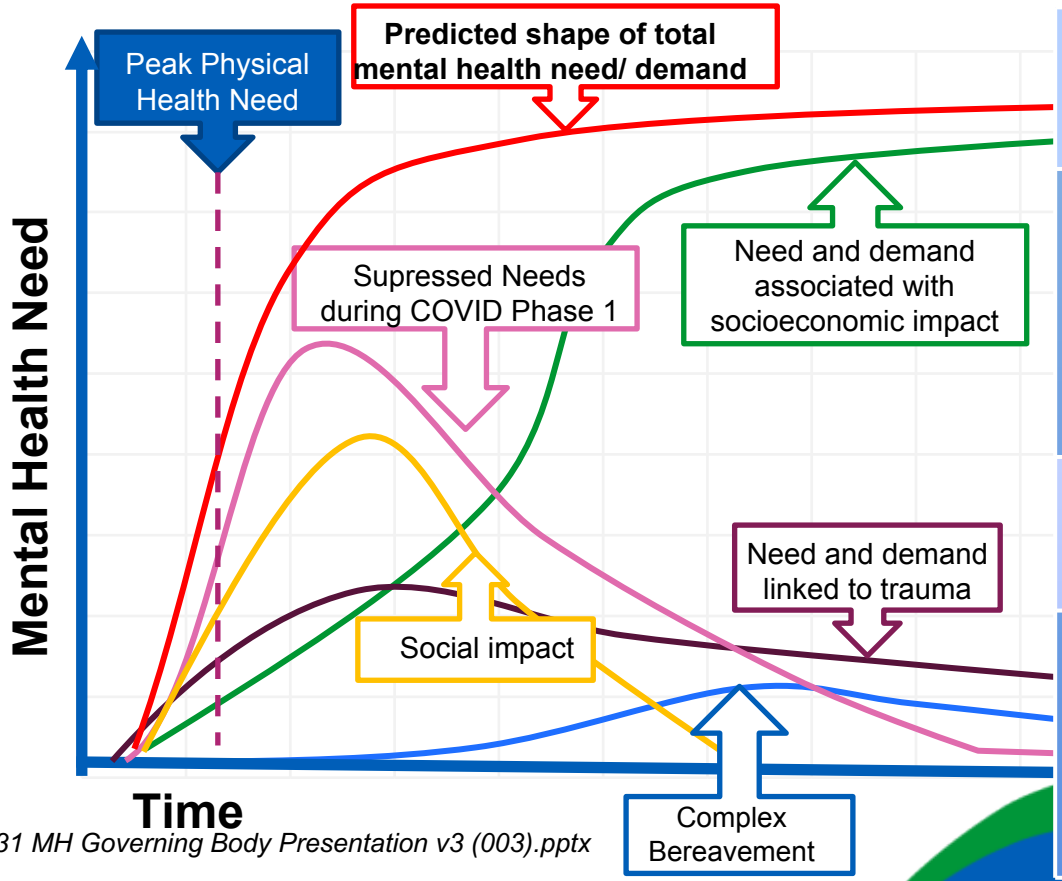
- Source: Centre for Mental Health,

What are we expecting?

Demand and capacity modelling:

National Centre for Mental Health's first assessment indicates 500,000 people likely to have mental health problems as a result of COVID nationally (Devon STP is c2.5% of national population- 12,500 people)

What are we expecting: Predictions



Direct personal impact of COVID19	**Population Outcomes**
Impact of COVID19 on friends, families and health and social care workers	**Increase volume of needs across all need types**
Indirect community/ social impact	**Increased acuity of need across all need types**
Wider societal/ economic impacts	**Increased needs over a long duration**
	Increased risk of adverse outcomes such as suicide, self harm

What are we seeing?

What do we know?

- Source: Qwell Data Release, 27 April 2020 (Qwell provider online mental health and wellbeing services through XenZone and Kooth)
- Source: NHS Futures Platform: Will Higham, Programme Director for Innovation, Rethink Mental Illness

National trends: needs in existing mental help service users

National Centre for Mental Health's first assessment indicates 500,000 people likely to have mental health problems as a result of COVID nationally
(Devon STP is c2.5% of national population- 12,500 people)

Adults- using online MHWB services

- 53% increased demand for mental health support online
- 17% decrease in concerns about family relationships
- 40% rise in sadness and depression
- 115% rise in pressure linked to a new work culture
- 30% increase in levels of loneliness
- 89% in sleep difficulties

Children & Young People- using online MHWB services

- 34% increase in demand for mental health support online
- 170% rise in sadness and depression
- 31% increase in levels of loneliness
- 121% in sleep difficulties
- 13% increase in suicidal thoughts
- 49% increase in eating difficulties

Adults with SMI

- 27% said their mental health was much worse
- Of those… 67% identified loss of activities as key factor
- Of those… 65% identified loss of contact with friends and family as a factor
- More than 33% have not booked or attended medical appointment because of COVID

Mental health providers have seen significantly reduced referrals March and April and significantly increased referrals in May

What have we done?

Phase 1 Response

What we have done?
Phase 1: Mental Health System Response

MHLDA Cell

- Bring together leadership from across the system
- Ensure mental health support, care and treatment operates in line with guidance
- Respond to challenges, escalate and accelerate
- Review impact of service change

Police and Ambulance

- Joint bids for short term additional police funding
  - Joint Police Response Vehicle- previously in Plymouth, now Exeter and Torbay
- Working to improve data collection and sharing to understand wider impact

Care Homes for people with Dementia

- Local Authorities collaborative work to support Care Homes for people with dementia.
- Task and Finish Group established to accelerate mapping and enhanced support to care homes supporting people with dementia.

Public Mental Health

- Shared oversight of suicide prevention and accelerated implementation of real time suicide surveillance
- Shared oversight of bereavement, substance misuse needs and support for victims of domestic violence

What we have done?

Phase 1: common prioritisation framework

Both mental health providers in Devon STP have adopted the same prioritisation framework which will be used as required across all services.

Principles:

Prioritisation should:

- Be undertaken only if demand for services is greater than the resource available to meet it
- Last only as long as necessary;
- Be kept under constant review with regard to a dynamic response to wider system demands;
- Be based on the minimisation of harm to the population.
- Be based on consideration of individual circumstances with regard to the acuity and risk presented and no blanket rules will apply.

What we have done?
Phase 1: Mental Health System Response

Inpatient Care
- Restructured provision to implement IPC guidance
- Re-purposed wards
- Identified isolation areas
- Developed an STP wide approach to separate covid patients to non covid-patients

Urgent Care
- 4 new urgent mental health hubs
- 24/7 crisis response for public and professionals implemented (accelerated First Response Service)

Psychological Therapies
- Moved to digital/ telephony only platform
- Staff WFH or social distancing in office premised
- Targeted support for all key workers

Children and Young People's Mental Health Services
- Maintained all services
- Moved to digital/ telephony offer wherever appropriate
- 24/7 crisis response for children and young people in place

Community Mental Health Services
- Restructured team provision to ensure resilience
- Supported people who need to use medications like clozapine to be safe
- Digital and telephony support

What are we doing now?
Phase 2

What are we doing now?

National Guidance: Second phase ask

We have:

- Reviewed Regional communications from NHSE/I Mental Health Team
- Assessed our compliance with the asks of MHLDA in the Sir Simon Stevens Letter and identified that we are:
  - Compliant/ near compliant (Green) 6/8 Asks
  - Progressing to compliance (Amber) 2/8 Asks

What are we doing next?
Phase 3

What are we doing next?

Phase 3: Planning and Preparation

Building on our:

- accelerated delivery
- collaborative learning
- partnership working
- uptake of digital working
- adaptability of our workforce

We will undertake:

- demand and capacity modelling
- service change evaluation
- review enabling changes - (digital, workforce, estates, finance)
- re-prioritise phasing of LTP MH deliverables
- analysis of population health management information

So that we can:

- work together with our populations to deliver wider ambitions for our population's mental health and wellbeing

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY MEETING

Report title: Report on the work of the COVID-19 Pandemic Incident: 7-day Discharge and Access to Out of Hospital Services Cell				
Date of committee: 18 June 2020 **Date report produced: 01 June 2020**				
Author (s) Name and Title: **Sarah F Thompson – Interim Chief Operating Officer** **Penny Harris – Director**		**Supporting Executive:** **Name and Title:** **Sarah F Thompson – Interim Chief Operating Officer** **Penny Harris – Director**		
		Report Approved by: **Name and Title:** **Sarah F Thompson – Interim Chief Operating Officer** **Penny Harris – Director** **Date: 08 June 2020**		
Governing Body Meeting **18 June 2020**	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The purpose of this paper is threefold:

- To describe the operational arrangements of the Cell.
- To identify how the work of the Cell impacts on discharges.
- To detail the current programme of work in relation to both discharges and access to out of hospital care.

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:
Members are asked to: • Note how the 7-day Discharge and Access to Out of Hospital Care Cell operates. • Be aware of the impact of the work of the Cell on discharges. • Support the current programme of work in relation to both discharges and access to out of hospital care.
Impact on Strategic Objectives
N/A
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 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

Report on the work of the COVID-19 Pandemic Incident: 7-day Discharge and Access to Out of Hospital Services Cell

Introduction

The purpose of this paper is threefold:

- To describe the operational arrangements of the Cell.
- To identify how the work of the Cell impacts on discharges.
- To detail the current programme of work in relation to both discharges and access to out of hospital care.

Background

The Cell was established at the request of Simon Tapley, Accountable Officer, in March 2020 as part of the COVID-19 Pandemic response in line with published national guidance on discharge dated 19th March ***COVID-19 hospital discharge service requirements***.

This guidance was updated on 29th April in the form of a letter from Simon Stevens, Chief Executive of the NHS, entitled ***Second Phase of NHS Response to COVID-19*** that requested a sustained approach to hospital discharge for both pandemic surge and for business as usual, and support for an increase in patients who have recovered from COVID-19 and need ongoing community health support.

A brief for the work of the Cell was agreed by the Executive Team and this is attached as Appendix 1. The Cell focuses on the active discharge of patients from all NHS Devon CCG commissioned providers (inclusive of community and integrated care providers and Livewell Southwest).

In acknowledgement of the need to plan for pandemic surge, the Executive Team set the following targets for the Cell as the basis for partnership working:

- Maximum daily bed acute hospital occupancy initially to be 50%, then increased to 65% to reflect the increase in hospital admissions.
- 'Green to Go' discharges to be managed within 24 hours.
- Delayed Discharges of Care (DTOC) to be managed within 10 days.
- A focus on 7, 14, and 21- day patients waiting to maintain discharge flow.

Over the period March to May 2020 the Executive leadership of the Cell was jointly held by Penny Harris, Director, and Sarah F Thompson, Interim Chief Operating Officer, over seven days of the week. From 1st June Sarah F Thompson has taken Executive leadership with wider Executive on-call support over weekends.

Operational arrangements of the Cell

Members of the Cell met daily Monday to Friday over the period March to May for the purposes of maintaining a daily dialogue on discharges with providers, data collection, data validation, discussion and agreement on action to be taken, and problem solving. The data drawn from these daily sessions was used to compile a daily discharge performance dashboard, and a Community Services daily situation report (SITREP).

Data collection, discussion, action, and problem solving were maintained over weekends and Bank Holidays with each locality arranging weekend cover to ensure ongoing discharges and continued reporting to executive level.

From 1st June, although Cell meetings were consolidated to Monday/Wednesday/Friday each week daily, monitoring continued with weekend data collection and arising actions being maintained.

As the Cell includes membership from the continuing care team and commissioner leadership for end of life services, this has enabled close working with Care Homes and in putting together complex packages of care to meet individual patient need.

The detailed work of the Cell is lead through the four locality Associate Directors and the locality huddle meetings which involve providers, Local Authority's and Primary Care Network (PCN) representatives. Progress is routinely shared and discussed at these meetings.

Impact of the Cell

The intensive operational arrangements of the Cell has enabled both CCG commissioners and individual providers to work together on a single version of the discharge data and to jointly agree actions to improve discharge flow. A more consistent approach to seven- day discharge arrangements across the Devon system has become more evident. There remain a number of challenges to weekend discharges that include access to Care Homes, complex packages of care, and interdependencies with other neighbouring CCGs.

Appendix 2 shows bed occupancy by provider over the period March to May together with the changing pattern of hospital admissions. The average acute hospital bed occupancy over the period has been 65%.

Current programme of work relating to discharges and access to out of hospital services

The work of the Cell has revealed that some localities require targeted system-wide action plans, such as to support the need for improved bed occupancy levels such as University Hospital Plymouth.

Issues that have arisen that have required dedicated work have included:

- Formulating a weekend list for each locality of Care Homes that can be accessed for discharge.
- Ensuring adequate planning ahead of weekends so discharges continue to flow.
- Arrangements for access to Care Homes with specialist dementia care.
- The utilisation of out of hospital services to support discharge such as reviewing the utilisation of the Exeter Hilton residential care beds, and access arrangements to the Plymouth Extra Care residential beds.
- Working with Kernow CCG to maintain discharge flow from University Hospital Plymouth.
- Collaborative working with other Cells (including the Care Home, Primary Care, and Recovery & Restoration Cells) and programmes (including Urgent Care) to enhance admission avoidance schemes, and to plan for changing patterns in hospital admissions.
- Ensuring that End of Life services, Night Sitting and Domiciliary care are accessible for pandemic surge.
- Ensuring that patient transport services are accessible for pandemic surge.

Work has commenced on modelling and data collection to compile locality Out of Hospital Services capacity plans for both pandemic surge and business as usual. These plans are required to ensure that there is a robust approach to out of hospital services that can be fully utilised and stretched where necessary.

NHS England/Improvement South West have required two returns from NHS Devon and providers on progress on implementation of the national discharge policy over the period. A review of 'progress and challenges' as the discharge policy becomes standard practice as part of Recovery & Restoration will be undertaken that will enable the sharing of best practice across the South West.

Recommendations

Members of the Governing Body are asked to:

- Note how the 7-day Discharge and Access to Out of Hospital Care Cell operates.
- Be aware of the impact of the work of the Cell on discharges.
- Support the current programme of work in relation to both discharges and access to out of hospital care.

Appendices:

Appendix 1: Brief for the 7-day Discharge and Access to Out of Hospital Services Cell
Appendix 2: Acute hospital Bed Occupancy March to May 2020

Appendix 1: 7-day Discharge Planning & Access to Out of Hospital Care Cell

Executive Joint Leads: Sarah F Thompson/Penny Harris

Purpose of the Discharge Planning & Access to Out of Hospital Care Cell:

On a 7-day basis to support, coordinate and communicate the active discharge of patients (in line with their individual discharge plans) from all NHS Devon CCG commissioned providers (inclusive of community and integrated care providers and Livewell (not-for-profit provider) so as to maintain minimal bed occupancy levels to prepare for/and to support surge during the pandemic.

To support, coordinate and communicate access to a wide range of out of hospital care to support the needs of patients discharged.

To monitor the use and capacity in community and other services against what is required to support discharge, and to consider how to flexibly use the capacity to support discharge arrangements.

Required actions that will be taken to achieve this:

A live daily discharge dashboard by locality will be used that links with the national daily SITREP reporting arrangements.

Locality team leaders will make contact with Provider Executive leads/or their representatives to maintain an accurate daily understanding of individual patient discharge plans.

From these direct conversations with providers and the completion of the dashboard a meeting will be held each day to:

- Identify and examine all discharges;
- Understand the actions that are being taken by providers (Local Authorities, community, integrated, acute and independent sector);
- Agree actions that the system can take to facilitate discharge including access to new capacity e.g. hotel accommodation;
- Take any action;
- Identify emerging trends in both blockages to discharge and in commissioning alternative pathways and to take action on those trends;
- To escalate issues as they arise in order to achieve a discharge/s.

By the close of each day the maximum number of hospital discharges should have taken place.

Escalation:

Escalation will be: firstly, to the Provider Executive lead; secondly, to the Executive lead, and finally to the respective CEO or the daily the Chief Executives.

Reporting arrangements:

- To the Incident Director – Daily verbal update as required by the Incident Director and Executive Director/s
- To the Incident Room Huddle meetings – Daily verbal update by the Executive Director/s
- Notes of daily Discharge Team meeting – Shared with Incident Room
- To the Executive Team (x2 per week) as required by Team A/B leader and Executive/s Director.

Skills and competencies required:

- Locality knowledge – health and social care.
- Established provider relationships with Provider Executive Discharge lead.
- Knowledge and understanding of the discharge process and discharge planning in each provider.
- Knowledge and understanding of the available capacity across the locality and Devon system to support discharge. This may be achieved through a Sub-Cell.
- Understanding of alternative innovative solutions to achieve discharge.
- Ability to develop new and different solutions to achieve discharge with other colleagues.
- Expertise in market management to open- up solutions. This may be achieved through an individual rather than at locality level.
- Experience of the assessment of risk and impact.
- Patient Transport
- Business Intelligence

Time commitment:

There is a daily time commitment to speak to providers and to complete the dashboard and to take all arising action.

Alternative solutions for discharge will need time to work up.

During the period of surge (modelled to be 4th May 2020) the cell will need to operate 7 days a week inclusive of Bank Holidays.

To gain experience of what this means in practice it is recommended that 7 day working commence 2 weeks before 4th May 2020 i.e. Monday 20th April.

Membership of the Cell:

- Executive Director/s x2
- Locality Associate Directors x4
- Locality commissioning discharge teams for each of the four localities
- Commissioning lead(s) for MH, Children and LD services
- Continuing Health Care for individual patient complex discharge management
- Representative from the CCG Market management team
- Patient Transport lead
- EOL commissioning lead
- Business Intelligence
- Business Manager
- Community contract leads as required

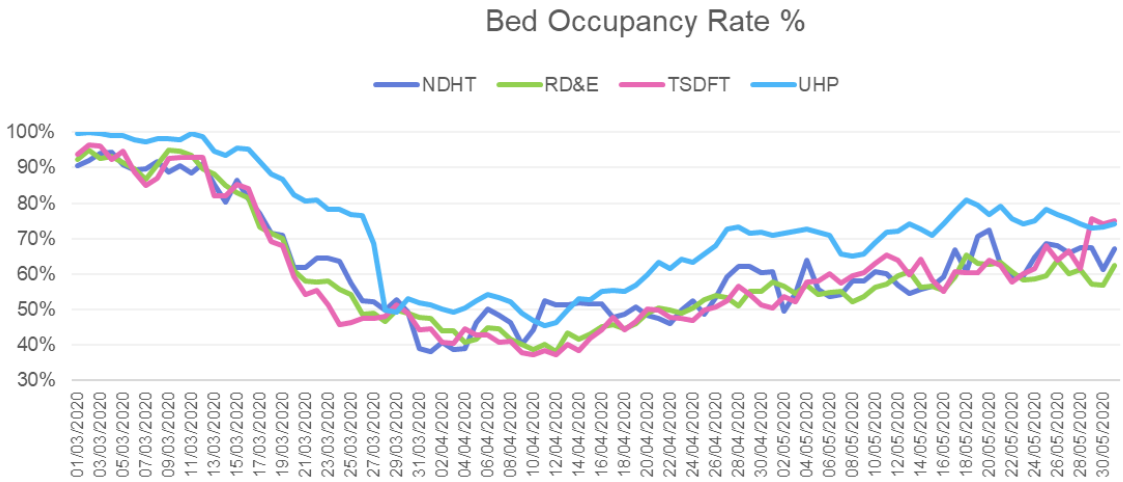
Sarah F Thompson & Penny Harris,
Executive Directors – 7-day discharge planning.

07 May 2020

Appendix 2: Acute and Mental Health Bed Occupancy March to May 2020

Acute Hospital Bed Occupancy

The chart below shows the Devon acute provider bed occupancy figures for the period 1st March to 31st May 2020.



Bed occupancy reduced significantly at all providers from the middle of March and remained under the 50% targeted level at RD&E, TSD and NDHT until late April, with UHP being slightly higher but remaining below 60% during this period.

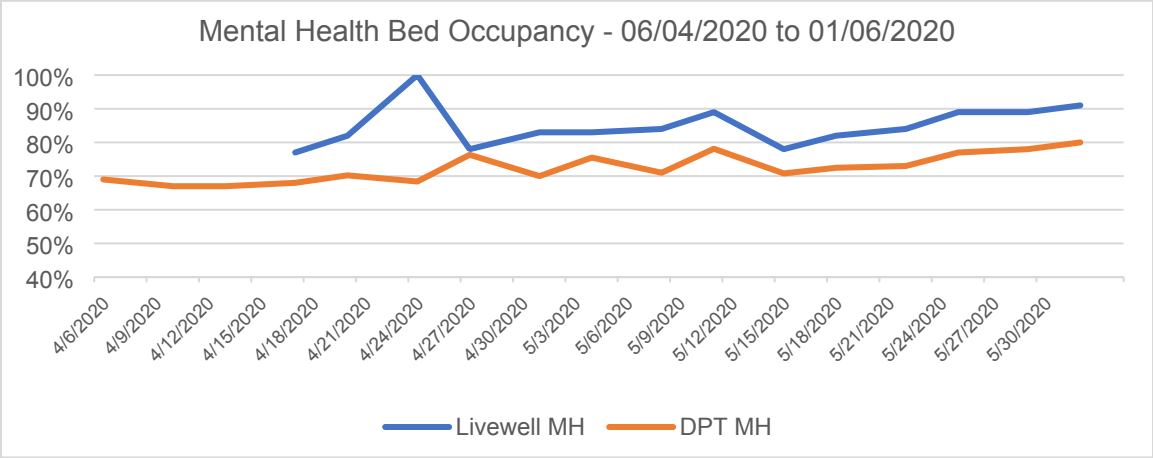
The rate has subsequently seen a gradual rise and at the end of May was averaging at the revised 65% target in total, although UHP and latterly TSD have seen occupancy increase to around 75%. This remains significantly lower than the pre-Covid-19 levels where all providers were consistently above 90%.

The table below shows the monthly bed occupancy split by provider and a total for the STP as a whole:

	NDHT	RD&E	TSDFT	UHP	Total
March	75%	74%	73%	86%	**78%**
April	49%	46%	45%	57%	**50%**
May	61%	58%	62%	73%	**65%**
Total	**62%**	**60%**	**60%**	**72%**	**65%**

Mental Health Bed Occupancy

The chart below shows the Devon mental health provider bed occupancy figures for the period 6th April to 1st June 2020.



Bed occupancy has remained relatively static at DPT and Livewell since the beginning of April, with slight increases seen at both providers towards the end of May.

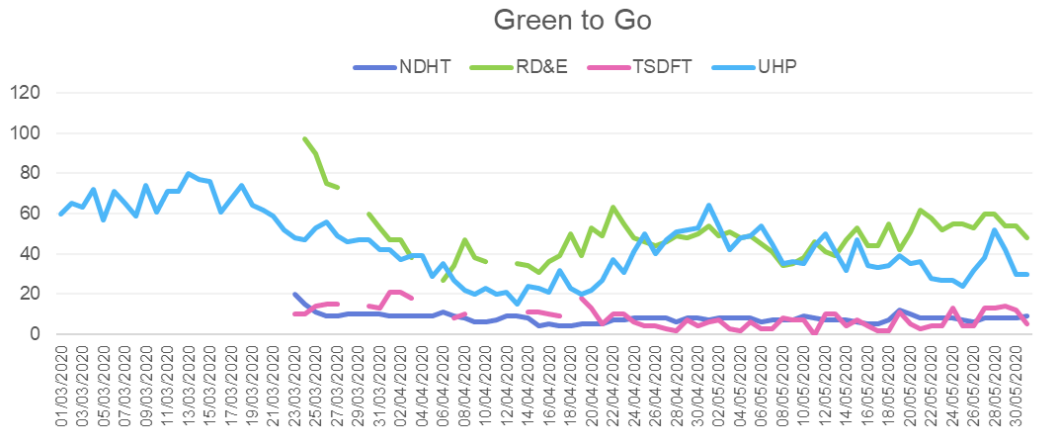
The table below shows the monthly bed occupancy split by provider and a total for the STP as a whole:

	Livewell	DPT	Total
April	84%	69%	**73%**
May	85%	75%	**78%**
Total	**85%**	**72%**	**75%**

Whilst occupancy was 75% in total for May, the latest week is showing DPT at 80% and Livewell at 91%, with the STP position of 84%.

Acute Hospital Green to Go

The chart below shows the Devon acute provider green to go numbers for the period 1st March to 31st May 2020.



Green to go numbers reduced significantly at RD&E and UHP from mid-March, reaching a low point in mid-April before rising again by the end of April. In May the RD&E numbers have been relatively stable at around 60-70% of pre-Covid levels, whilst UHP rose quickly back towards pre-Covid numbers but have subsequently fallen to around half of the level seen in early March.

TSD and NDHT both typically have low green to go numbers (less than 20 per Trust) but these have also reduced and, although the figures vary day to day, are around 50% of the pre-Covid level.

x

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 18th June 2020 **Date report produced: 12th June 2020**				
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:** 12th June 2020		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

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

The report details the financial position to the 31st May 2020 and includes reference to the impact of the COVID19 pandemic and the financial consequences for the CCG during 2020/21.

In light of the COVID19 pandemic the 2020/21 planning round for the NHS was suspended during March. In order to ensure the CCG entered the year we sought the Governing Body's approval to a draft budget based on the CCG's and STP's plan submission of the 5th March 2020. This was approved as a working budget at the Governing Body on 30th April 2020.

The draft plan was a deficit position of £47.8m with a savings requirement of £22.6m to deliver that position.

In May NHSE put in place a temporary financial regime covering the period 1st April to 31st July. This resulted in NHSE re-setting the CCG Allocation for a four-month period. The allocation is based on the CCG's forecast outturn expenditure for 19/20 uplifted for NHSE derived growth and inflation assumptions and adjusted for changes made to the NHS and Independent sector funding arrangements during the COVID19 emergency period (The NHSE Model).

On the above basis the CCG has received an allocation of £670.0m for the period to 31st March 2020 together with an expectation that budgets are set within the parameters stipulated by the NHSE Model. The allocation is roughly £20m higher than the previously in year planned allocation which recognises (subject to the revised 20/21 modelling) the underlying deficit position of the CCG.

NHSE expectation is that CCGs will breakeven for the revised period. Variances against plan (including exceptional COVID19 related expenditure) will be reviewed by NHSE on a monthly basis. Where costs are deemed reasonable a retrospective allocation will be issued.

NHSE have advised CCGs to report a breakeven position to their Governing Bodies pending the review by anticipating a retrospective resource allocation to match the in-year variance.

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 requested to:

Consider, review and discuss the month 2 year-to-date performance and the forecast four-month position including the current risks.

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	**Yes**
Quality	Safety: Effectiveness: Experience:	
Equality		
Resource and Finance	Risk to delivery of CCG control total	√
Legal		
Engagement and Consultation		
Risk	Risk to delivery of CCG control total	√

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 2 – 2020/21

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.

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NHSE expectation is that CCGs will breakeven for the revised period. Variances against plan (including exceptional COVID19 related expenditure) will be reviewed by NHSE on a monthly basis. Where costs are deemed reasonable a retrospective allocation will be issued. Detail of the variances driving the additional costs are set out in Appendix 3.

NHSE have advised CCGs to report a breakeven position to their Governing Bodies pending the review by anticipating a retrospective resource allocation to match the in-year variance.

Financial Position

The following detailed report reflects the budget set by the NHSE model compared with our expectations of commitments against that budget both year to date and forecast for the period to 31st July 2020.

May 2020 (Month 2)	Budget £'000	Actual £'000	Variance £'000	Additional Allocation £000	Revised Variance £'000
Year to date position	335,021	350,484	15,463	-15,463	0
Four month forecast	670,041	697,725	27,684	-27,684	0

The year to date and FOT variances arise mainly form additional costs linked to the COVID19 pandemic (£10.6m YTD to 31st May and £16.9m FOT to 31st Jul). These costs are detailed in section 4.

The remaining variances are detailed in the sections below with the significant variances being a product of prescribing, delegated commissioning and Better Care Fund costs being greater than budget, offset by underspends relating to Non-Contract acute activity and reduced Continuing Healthcare client numbers.

Savings Plan

The CCG's original plan included a saving requirement of £22.6m. The four month budget to the 31st July is based on 19/20 forecast expenditure and by inference does not include an implicit savings target. The CCG will be reviewing its original planning assumptions and actions to deliver savings as we move into the next stage of the financial framework post 31st July 2020.

Risk

The main risk to delivering against the temporary financial regime for the period to 31st July 2020 is the likelihood that some of the excess costs over an above the budget set are not funded by NHSE through the top up process. Whilst we have not received a response to our Month 2 submission we have anticipated that the excess will be funded in full.

Should the top up fall short of the excess costs experienced we will seek to understand the reasoning and address appropriate mitigating actions to meet the NHSE objectives of a breakeven position.

STP Plan

The STP planning process was put on hold in March. The CCG and STP partners are anticipating that the current financial regime may extend beyond the 31st July but are will be addressing the next steps through the restoration and recovery programme.

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

Given the planning process for 20/21 has been suspended the indicators below are only indicative measures against the draft plan submitted at the beginning of March.

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	6.7	15.5	229.4%	RED
3	Forecast Outturn in year deficit	13.5	27.7	205.4%	RED
4	Running Costs	7.2	7.5	104.3%	RED
5	Risk adjustment to deficit (% of allocation)	0.0	0.0	0.0%	GREEN
6	Cash Position (% drawn down)	16.7%	24.1%	144.3%	RED
7	BPPC (% paid - value)	95.0%	100.0%	105.2%	GREEN

NO.	INDICATOR	Devon CCG
CCG Additional Indicator		
8	Delivery of plan YTD	RED
9	Delivery of plan FOT	RED

3. Detailed Financial Performance

The year to date financial position to the 31st July 2020 by main service heading is as follows. The current year forecast is the forecast to the 31st July.

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 MAY 2020 Month 02 May	NHS DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES										
Acute Services	153,137	150,716	29	150,745	-2,392	306,274	301,486	29	301,514	-4,760
Placements	21,459	21,174	1,472	22,646	1,187	42,919	42,519	2,773	45,292	2,373
Commuinity and Non Acute	44,625	46,166	3,563	49,729	5,104	89,249	92,336	6,956	99,292	10,043
Mental Health Services	35,307	35,921	409	36,330	1,023	70,614	72,072	677	72,750	2,135
Other Commissioned Services	8,538	6,501	2,837	9,338	801	17,075	13,487	2,935	16,422	-653
Primary Care Services										
Prescribing	33,431	38,866	-	38,866	5,435	66,862	77,732	-	77,732	10,870
Delegated Commissioning	27,286	28,709	-	28,709	1,423	54,572	57,311	-	57,311	2,739
Other Primary Care	8,168	8,203	2,162	10,365	2,197	16,335	16,565	3,361	19,927	3,592
Primary Care Subtotal	68,884	75,778	2,162	77,940	9,055	137,768	151,608	3,361	154,969	17,200
Commissioned Services Subtotal	331,950	336,256	10,472	346,728	14,778	663,900	673,508	16,731	690,239	26,339
CORPORATE										
Running Costs	3,070	3,667	89	3,755	685	6,141	7,350	136	7,486	1,345
EARMARKED RESERVES AND CONTINGENCIES										
Earmarked Reserves	-	-	-	-	-	-	-	-	-	-
Contingency	-	-	-	-	-	-	-	-	-	-
Other Reserves	-	-	-	-	-	-	-	-	-	-
Reserves Subtotal	-	-	-	-	-	-	-	-	-	-
Total Operating Costs	335,021	339,923	10,561	350,484	15,463	670,041	680,858	16,867	697,725	27,684
CCG Control Total	-335,021	-339,923	-10,561	-350,484	-15,463	-670,041	-680,858	-16,867	-697,725	-27,684
2020/21 Surplus/Deficit					0					0

Further detail of the budgets making up the main service areas is provided in Appendix 3.

3.1 Acute Services

Acute services includes contracts with our main system acute providers as well as contracts with acute providers in Cornwall, Somerset, Bristol and London. It also includes our contract with South West Ambulance and contracts for acute procedures undertaken in the independent sector and by other Non-NHS providers.

For the majority of NHS Acute services the contracts payments to providers for the period to 31st July 2020 has been determined by NHSE through a methodology linked to a projection of their underlying expenditure. The CCG's budget under the temporary financial arrangements has been set to match the payments.

Contracts with the main independent sector providers have been negotiated and paid for nationally for the COVID19 period and the CCG budget for these services has been removed within the temporary arrangements.

The underspend of £2.4m at Month 2 and forecast underspend of £4.8m relates to reduction of Non-contract activity compared to the budget set. The underspend is offset by some small variances in other contracts where the budget does not match the commitments.

The finance and business intelligence teams are working with our main providers to establish a form of activity monitoring during this period in order to assist planning for restoration and recovery.

3.2 Mental Health Services

The Mental Health budget commissions 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 CAMHS 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. This section also includes spend relating to adult placements for mental health and learning disability services.

In 2020/21 the CCG had planned to invest £11.9m (5.63% increase) in Mental Health Services. Whilst the temporary financial arrangements are in place and planning on hold the proposed investments are on hold, but with the expectation that MHIS will still be honoured over the course of the remainder of the financial year.

At month 2 there is an overspend of £1.0m for all mental health services with a forecast overspend of £2.1m. Some of this relates to costs incurred in relation to the response to the pandemic and are covered in section 4.

The other variances are driven mainly by the temporary budget setting process when compared to actual commitments the largest of which relates to Learning Disability placements where the budget compared to commitments and other pressure presents a £0.5m adverse variance at Month 2 projected to be £0.9m after 4 months.

There is also a £0.1m overspend on CAMHS commitments to Month 2 projected to be £0.4m after 4 months where the budget does not reflect the full year effect of commitments made in 19/20.

3.3 Community Health Services

Community healthcare services include contracts with STP partners for the provision of community healthcare (including community hospitals and children's services) as well as Minor Injury Units.

It also includes provision for community based acute procedures delivered through GP practice specialisms and other Non-NHS providers as well as Joint arrangements with Local Authorities under the provisions of the Better Care Fund.

The majority of the year to date overspend of £5.1m and projected overspend of £10.0m relate to COVID19 costs detailed in section 4. The remaining variance covers the following areas.

The budget received for the contact with Livewell Southwest does not reflect the level of growth and investment agreed during the original planning round including the full year effect of contract variations in 19/20. This presents an overspend of £0.5m year to date and a projected variance of £0.8m.

The budget received for the Better Care Fund does not reflect that national agreements regarding uplifts and gives rise to an overspend of £0.9m year to date and a forecast of £1.8m.

3.4 Placements

Placements includes Continuing Care budgets comprising of Continuing Care Admin, Continuing Healthcare (CHC), Interim Funding, Joint Funding, Children's Continuing Care, Funded Nursing Care (FNC) & Individual Patient Placements (IPP) Physical Disability.

This area in total is overspent by £1.2m at Month 2 with a projected overspend of £2.4m, largely as a result of exceptional costs during the current pandemic and relate to uplifts to market rates.

The following table provides an analysis of the forecast variance.

Continuing Care FOT Variance	
Variance Type	**£m**
Additional Covid related costs e.g. fee uplifts	2.8
Budget variances (NHSE/I model vs local plan)	1.0
Non delivery of QIPP savings plan	0.8
Cost reduction due to client number movements (partly Covid related)	-2.6
FNC Uplift over and above plan assumption	0.2
IPP cost pressures	0.1
Total	2.4

This is a challenging time for the financial management of the placements area. The COVID19 emergency is having a number of specific effects on costs and on the focus of the service which will impact on how the financial position unfolds during 2020/21, including actions that would have been made to deliver efficiencies that have needed to be put on hold.

Specifically, a number of investments have been necessary to support the care market and ensure efficient flow across the health and care system. At the same time NHSE have implemented new discharge guidance which affects the traditional flow and reporting of costs in the placement's arena.

The reported forecast outturn position is an estimate regarded as the likely scenario, but there are a range of factors exist which could potentially result in significant changes to that estimate, including

- Fluctuations in the number of clients eligible for financial support
- Unexpected exceptional levels of support required for some clients
- Potential extension of COVID19 related market investments
- Uncertainty relating to when and how the services will return to a traditional state following the COVID19 emergency

3.5 All Other Healthcare

All other healthcare picks up the remaining community based provision of healthcare services including hospice care and other voluntary sector grant based commissioned services. This area also includes Patient Transport and NHS 111.

The overspend recorded in this area relates solely to COVID19 specific costs and in particular the set up of the Nightingale Hospital in Exeter. The remaining variances that offset these costs are as a result of the budget setting methodology compared to actual commitments.

3.6 Primary Care Services

Primary Care includes expenditure on primary care prescribing, GP Medical Services (delegated from NHSE), enhanced services, Out of Hours and other primary care related expenditure including GP IT.

There are some significant variances to budget expected outside of the direct costs relating to COVID19 which are as follows:

Prescribing

The Month 2 Prescribing figure is reported as a £5.4m overspend year to date £10.8m overspent by Month 4. The methodology used to set the budget did not take account of non-recurrent benefits achieved in 19/20 which resulted in a lower opening budget than anticipated. The position is further worsened by the following in year pressures.

- £3m underachievement on the set QIPP plan of £9m, as COVID19 has prevented work on this for the first 4 months.
- The final March prescribing costs showed an increase of £2m not provided for in 19/20 or the budget methodology.
- Warfarin spend at £492k due to changes for patients during COVID19
- Category M and No Cheaper Stock Obtainable (NCSO) costs predicted to add pressures of £2.5m.

Delegated Commissioning

The £1.4m year to date and £2.7m forecast overspends are as a result of the budget methodology not accurately reflecting the recurrent commitments and pressures anticipated in 20/21.

3.7 Running Costs

The pay and associated costs for the CCG are categorised into administrative (running costs) and programme costs according to whether they relate to healthcare services and are solely concerned with management of the organisation.

Each year the CCG receives a specific allocation for its running costs and has to report against it separately and mustn't overspend against the limit set.

In previous financial years the CCG has underspent against its allocation, giving additional flexibility to support healthcare services. In 2019-20 this equated to approximately £3m.

The CCG's allocation for 2020-21 was set to reduce from £25.4m last year to £22.4m for this financial year but as part of the framework set for this period to 31st July this has been revised. The CCG is reporting expenditure for the 4 months at £7.5m, of which £0.1m was specific short-term exceptional cost in relation to COVID19.

This at present is running at a higher rate than the adjusted methodology but is in line with NHS England expectations and within our original allocation as a proportion of the full year.

3.8 Resource Allocation

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

Planned revenue resources	£'000
Allocation after place based pace of change	1,759,720
Primary care commissioning	170,193
Running costs allocation	22,411
Recurrent adjustments	-1,768
Non recurrent adjustments (Months 5 to 12)	-1,280,516
Total revenue resources to month 4	**670,040**

The resources exclude the assumed additional allocation to cover the overspend position reported. The high level parameters under which the allocation was set are as follows:

Plan modelled as follows:

1. Block payments to NHS providers based on Month 9 2019/20 Agreement of Balances exercise
2. No payments to acute independent providers
3. Payments to other independent providers based on 2019/20 average monthly spend (uplifted)
4. Other activity increased in line with 2020/21 national planning assumptions except:
   - Prescribing growth increased by 0.7% to reflect additional Category M prescribing pressures
   - FNC increased to reflect (i) 2019/20 rate settlement and (ii) further 2% for additional price growth in 2020/21

4. COVID19 Specific Costs

Since the beginning of the COVID19 pandemic the response to emergency has necessarily required investment in staff, equipment and in response to national initiatives to assist the transformation of heath services in preparedness for the impact on the health of the population.

The CCG has incurred costs of £10.6m to date and is predicting costs of £16.9m by the end of the 4 month period. The year to date costs can be summarised as follows:

COVID 19 Commitment Analysis	YTD £m	FOT £m
Nightingale Hospital	1.6	1.6
CHC - Market Enhancements	1.8	3.4
Primary Care	1.7	2.9
PPE, Staffing and other costs	1.9	2.2
	7.0	10.1
Hospital Discharge		
New Devon CCG	0.4	0.4
Devon Council	1.7	3.2
Plymouth Council	1.0	2.0
Livewell Southwest (Social Care)	0.5	1.2
	3.6	6.8
Total	10.6	16.9

The CCG has put in controls to ensure that COVID19 expenditure is appropriately procured and approved before commitments are made.

Expenditure on the Nightingale hospital has largely come to an end for the CCG now that the facility is under the control of the Royal Devon and Exeter NHS FT.

The impact of the national initiative to ensure the care sector remains stable during the COVID19 period has had a consequently effect on the cost care packages funded through Continuing Care Homes. We continue to work with out Local Authorities on the developing strategies for the market management of the care home sector.

The CCG implemented a Standard Operating Process for COVID spend for Primary Care, and this has provided a framework within which this cohort of expenditure is managed.

In addition to these measures a national initiative to speed up discharge from Hospital and reduce the burden of assessment on decisions supporting discharge NHSE and Local Authority's regulators agreed a hospital discharge programme supported by £1.3bn of NHSE funding. It allows Local Authorities to reclaim the cost of discharge packages and enhanced costs of care to prevent hospital admissions to be reclaimed via the CCG.

Hospital discharge costs in relation to Torbay Council are incurred by Torbay and Southern Devon NHS FT and are reclaimed by them directly from NHSE.

5. Risks

The main risk to delivering against the temporary financial regime for the period to 31st July 2020 is the likelihood that some of the excess costs over and above the budget set are not funded by NHSE through the top up process. Whilst we have not received a response to our Month 2 submission we have anticipated that the excess will be funded in full.

Should the top up fall short of the excess costs experienced we will seek to understand the reasoning and address appropriate mitigating actions to meet the NHSE objectives of a breakeven position.

As the financial framework beyond July is unknown there is a risk that the exit run-run rate exceeds the remaining allocation for the financial year.

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 May 2020 is shown in appendix 1.

6.2 Capital

The CCG has requested capital allocations in line with previous years to cover the CCG's IT requirements, £0.1m for business as usual laptop replacements, as well as the £0.2m capital grant contribution to Delt infrastructure. NHS England is currently reviewing the capital bids and will inform us of the outcome in due course.

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	99.57%	99.88%
NHS Creditors - % of bills paid within target	97.23%	100.00%

The target of 95% has been met for the number of invoices paid within 30 days.

6.4 Cash

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

7 Recommendations

The Governing Body is requested to:

Consider, review and discuss the month 2 year to date performance and the forecast four month position including the current risks.

Appendices

Appendix 1: Statement of Financial Position

AS AT 31 MAY 2020	Devon CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	2,020
Intangible Assets	3
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	2,023
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	5,013
Trade & Other Receivables - Non NHS	20,923
Other Current Assets	-
Cash & Cash Equivalents	3,160
Non-current Assets held for Sale	-
Total Current Assets	29,496
Total Assets	31,519
CURRENT LIABILITIES	
Trade & Other Payables - NHS	90,599
Trade & Other Payables - Non NHS	- 116,171
Other Liabilities	- 1,028
Borrowings / Cash in Transit	- 6,357
Provisions	-
Total Current Liabilities	- 32,957
Total Assets less Current Liabilities	- 1,438
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 89
Total Non Current Liaibilities	-
Total Assets Employed	- 1,526
FINANCED BY TAXPAYERS EQUITY	
General Fund	1,526
Total Taxpayers' Equity	1,526

Appendix 2: Cash

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

Measure	Month 2
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 £1,947.828m for Devon CCG the year.*	24.1% of the MCD has been utilised as at month 2 (16.7% is expected based on a straight-line trajectory at month 2). Over utilisation is due to the requirement by NHS England to pay Providers one month's block payment in advance.
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 £17,912 for May.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has not 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*

Appendix 3: Operating Expenditure

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 MAY 2020 Month 02 May	DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
ACUTE CARE										
NHS Royal Devon & Exeter Foundation Trust	46,052	46,052	-	46,052	-	92,104	92,104	-	92,104	-
NHS University Hospitals Plymouth NHS Trust	38,061	38,083	-	38,083	22	76,121	76,165	-	76,165	44
NHS Northern Devon Healthcare Trust	20,147	20,138	-	20,138	-9	40,294	40,294	-	40,294	-
NHS South Devon Healthcare Foundation Trust	33,709	33,709	-	33,709	0	67,419	67,419	-	67,419	0
NHS Taunton and Somerset	1,609	1,609	-	1,609	0	3,218	3,218	-	3,218	0
NHS South Western Ambulance Trust	8,416	8,416	-	8,416	0	16,832	16,832	-	16,832	-0
Independent Sector	346	336	-	336	-9	691	673	-	673	-19
Other Acute	4,798	2,373	29	2,402	-2,395	9,595	4,781	29	4,810	-4,785
Subtotal	153,137	150,716	29	150,745	-2,392	306,274	301,486	29	301,514	-4,760
PLACEMENTS										
Continuing Healthcare	19,527	19,261	1,335	20,596	1,068	39,055	38,691	2,501	41,192	2,137
Funded Nursing Care	1,735	1,665	123	1,788	52	3,471	3,330	245	3,575	104
Individual Patient Placements	197	249	14	263	66	393	499	27	525	132
Subtotal	21,459	21,174	1,472	22,646	1,187	42,919	42,519	2,773	45,292	2,373
COMMUNITY & NON ACUTE										
Livewell Southwest	7,384	7,824	811	8,635	1,250	14,768	15,647	1,752	17,399	2,631
Royal Devon and Exeter Community	9,789	9,789	-	9,789	-0	19,578	19,578	-	19,578	-0
Northern Devon Healthcare Community	5,102	5,102	-	5,102	-0	10,204	10,204	-	10,204	-
South Devon Healthcare Community	11,752	11,752	-	11,752	-	23,503	23,503	-	23,503	-
Children and Families Health Devon	1,938	1,946	-	1,946	8	3,875	3,891	-	3,891	16
MIU Contracts	130	143	-	143	12	260	290	-	290	30
Plymouth Integrated Fund	1,119	1,559	1,003	2,562	1,443	2,239	3,118	1,955	5,073	2,834
Better Care Fund_Devon CC	4,957	5,278	1,733	7,011	2,054	9,913	10,556	3,233	13,789	3,876
Better Care Fund Torbay	377	549	16	565	188	755	1,098	16	1,114	359
Other Community Services	2,076	2,225	-	2,225	149	4,153	4,450	-	4,450	297
Subtotal	44,625	46,166	3,563	49,729	5,104	89,249	92,336	6,956	99,292	10,043
MENTAL HEALTH SERVICES										
Devon Partnership NHS Trust	21,657	21,657	-	21,657	-	43,314	43,314	-	43,314	-
Livewell MH Services	6,834	6,833	-	6,833	-0	13,667	13,667	-	13,667	-0
Children and Families Health Devon	1,762	1,762	-	1,762	-	3,525	3,525	-	3,525	0
Individual Patient Placements	4,185	4,634	319	4,952	767	8,370	9,318	587	9,905	1,534
Other Mental Health	869	1,035	90	1,125	256	1,738	2,249	90	2,339	601
Subtotal	35,307	35,921	409	36,330	1,023	70,614	72,072	677	72,750	2,135

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 MAY 2020 Month 02 May	DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
OTHER COMMISSIONED SERVICES										
NHS 111	622	604	-	604	-18	1,243	1,207	-	1,207	-36
Integrated Urgent Care Service	148	74	-	74	-75	297	147	-	147	-150
Hospices	1,394	1,363	-	1,363	-32	2,789	2,722	16	2,738	-51
Patient Transport Services	1,357	1,374	43	1,417	60	2,714	2,822	43	2,864	150
All Other Commisionned Services	5,016	3,086	2,794	5,881	865	10,032	6,590	2,876	9,466	-566
Subtotal	8,538	6,501	2,837	9,338	801	17,075	13,487	2,935	16,422	-653
PRIMARY CARE										
Prescribing	33,431	38,866	-	38,866	5,435	66,862	77,732	-	77,732	10,870
Enhanced Services	2,340	2,489	-	2,489	148	4,680	4,978	-	4,978	298
Delegated Commissioning	27,286	28,709	-	28,709	1,423	54,572	57,311	-	57,311	2,739
GP Out Of Hours	2,358	2,258	313	2,571	213	4,716	4,516	313	4,829	113
Other Primary Care	3,469	3,456	1,849	5,305	1,836	6,939	7,071	3,048	10,119	3,180
Subtotal	68,884	75,778	2,162	77,940	9,055	137,768	151,608	3,361	154,969	17,200
TOTAL COMMISSIONED SERVICES	331,950	336,256	10,472	346,728	14,778	663,900	673,508	16,731	690,239	26,339
RUNNING COSTS										
Pay	2,309	2,904	52	2,956	648	4,618	5,830	121	5,951	1,333
Non Pay	777	763	36	800	22	1,555	1,521	15	1,536	-19
Income	-16	-1	-	-1	15	-32	-1	-	-1	31
Subtotal	3,070	3,667	89	3,755	685	6,141	7,350	136	7,486	1,345
EARMARKED RESERVES AND CONTINGENCIES										
Earmarked Reserves										
Contingency										
Other Reserves	-	-	-	-	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-	-	-	-	-
NET TOTAL OPERATING COSTS	335,021	339,923	10,561	350,484	15,463	670,041	680,858	16,867	697,725	27,684
CCG Control Total	-335,021	-339,923	-10,561	-350,484	-15,463	-670,041	-680,858	-16,867	-697,725	-27,684
2020/21 Surplus/Defecit	-	-	-	-	- 0	-	-	-	-	-0

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY - PUBLIC

Report title: Performance and Quality Report				
Date of committee: 18 June 2020 **Date report produced:** 9 June 2020				
Author (s) Name and Title: Sarah F Thompson – Interim Chief Operating Officer Lorraine Webber – Associate Chief Nursing Officer & Deputy Caldicott Guardian Alison Wilkinson – Deputy Chief Operating Officer Kelvin Grabham – Associate Director of Business Intelligence		**Supporting Executive:** **Name and Title:** Sarah F Thompson – Interim Chief Operating Officer **Report Approved by:** **Name and Title:** Sarah F Thompson – Interim Chief Operating Officer Darryn Allcorn – Chief Nursing Officer Philip King – Interim Chief Nursing Officer **Date:** 9 June 2020		
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 the paper is three-fold:

- To present the 1st April 2019 to 31st March 2020 final performance outturn position that was impacted upon by the COVID-19 pandemic in the last month of the year March (month 12).
- To provide a final quality and safety performance outturn position for the year 2019/2020.
- To present performance during the month of April (month 1) of financial year 1st April 2020 to 31st March 2021 in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic* for the period 1st April to 31st July 2020.

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:
Members of the Governing Body are asked to: • Agree the outturn performance position for the year 2019/20 that included the impact of the COVID-19 pandemic in month 12 (March). • Agree the outturn quality and safety performance position for the year 2019/20. • Note month 1 (April) Constitutional Standards performance. • Note month 1 (April) Nursing and Quality performance. • Note the approach being taken on CCG performance reporting from 1st August 2020 to 31st March 2021 and request a further update at the July Governing Body.

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:
Appendix 1 - Performance report

Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	No
Quality of Services	Underachievement against waiting times targets, in particular those related to cancer and very long wait patients, could have quality implications. However, this is reviewed regularly with providers and assurances sought by the patient safety and quality team.	
Health Inequalities		√
Equality (staff or public)		√
Resource and Finance		√
Legal		√
Engagement and Consultation		√
Risk	Reputational risk due to non-achievement of trajectories	

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 CCG
GOVERNING BODY (PUBLIC)
18th June 2020

Performance Report

1. Introduction

This paper builds on the last performance paper presented to the Governing Body on 30th April. The purpose of the paper is three-fold:

- To present the 1st April 2019 to 31st March 2020 final performance outturn position that was impacted upon by the COVID-19 pandemic in the last month of the year March (month 12).

- To provide a final quality and safety performance outturn position for the year 2019/2020.

- To present performance during the month of April (month 1) of financial year 1st April 2020 to 31st March 2021 in line with national guidance published on the 28th March 2020 entitled ***Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*** for the period 1st April to 31st July 2020.

2. Performance for the period April 2019 to March 2020 (Month 12)

Appendix 1 details the performance position at month 12 consistent with previous reports to the Governing Body and identifies the changes that occurred between months 11 and 12 when the Governing Body last received a report.

The COVID-19 pandemic started to impact on clinical services from March as providers prepared to receive and treat high volumes of COVID-19 positive patients in line with national guidance. During this period Devon CCG worked closely with all providers to agree and record the routine elective services that were subject to change as the result of the emerging pandemic. Access to urgent cancer, urgent diagnostics and urgent care services were maintained throughout. These unprecedented circumstances had greatest impact on the following key performance targets:

Referral to treatment times (RTT)

The Sustainability and Transformation Partnership (STP) level RTT position fell in March, from 77.0% to 73.5% with all providers seeing a worsening position. All providers failed to meet the standard and ended the year below their planned trajectory. Provisional April figures are detailed later in this report.

There were 249 people waiting in excess of 52 weeks at the end of March, which represents an increase on the previous month (192).

Diagnostic waiting times

The STP position deteriorated in March, to 13.6% against the national 1% target and a local improvement trajectory of 6.5%.

A&E waiting times

A&E performance rose in March, from 83.4% in February to 86.4%, as lower attendance numbers and reducing bed occupancy supported an improved position at all providers. Type 1 performance was at its highest level since May 2019. However, as a system Devon remained below the 95% national standard level and the improvement trajectory for the month and year.

Other targets

March showed an improved performance against the majority of cancer targets, with Northern Devon Healthcare NHS Trust (NDHT) achieving all measures except for screening (which is affected by small numbers), University Hospital Plymouth NHS Trust (UHP) achieving six of the eight targets and Torbay and South Devon NHS Foundation Trust (TSD) achieving five. There was a slight increase in performance against the 62-day target in March, with the STP position rising from 73.2% to 74.3%, though only NDHT achieved the 85% target. Performance against the 2 week wait standard rose slightly, from 86.2% to 86.6%, but remained below the 93% standard. Breast symptomatic performance achieved the 93% target in March, with all providers meeting the standard.

A surge in calls to 111 during March (up 50% over February volumes) led to a drop-in performance, with an average of just 42.4% of calls answered within 60 seconds. Call volumes reduced in April and performance improved to 56.2%.

In terms of key mental health targets, both Devon providers met the Improving Access to Psychological Therapies (IAPT) access rate target and the 75% six week wait target, though the STP remained below the 50% target for IAPT recovery – Devon Partnership Trust (DPT) achieved the cumulative year-to-date target at 50.6%, but Livewell Southwest (LSW) were below target, at 41.1%.

3. Quality & Safety Performance for the period April 2019 to March 2020 (Month 12)

Urgent & Emergency Care – during 2019/20 the nursing & quality teams undertook a range of enhanced quality surveillance across urgent & emergency care settings and were required to participate in and provide evidence as part of NHS England/Improvement (NHSE/I) risk summits and single item Quality Surveillance Groups (QSGs) in a number of localities. A suite of quality & safety assurance resource tools was developed and included 12-hour breach reviews, observational reviews, end to end reviews and ‘front door’ analysis. All providers were supportive and received feedback on all elements of our work. South Western Ambulance Service NHS Foundation Trust (SWASFT) risks associated with ambulance delays were under close scrutiny and local analysis with available intelligence and qualitative information was reviewed.

Planned Care & Diagnostics – supporting the development of a system approach to ensuring patient safety while waiting for treatments and ensuring our reviews of provider actions included patient experience of waiting list and delay. Detailed analysis of serious incidents occurring over a 12-month period, that included potential diagnostic delays and diagnostic reporting delays, was undertaken.

Mental Health (MH) – supporting improvements to earlier dementia diagnosis. Additionally, the MH pathway work to understand quality impacts of MH patients experiencing 12hr delays in emergency departments (ED). A significant review in one locality was commissioned independently to understand any key themes and learning from a number of serious incidents that related to individuals presenting at ED and subsequent attempting or completing a suicide.

Quality Equality Impact Assessments (QEIAs) - developing a formal process across the system to support commissioning decisions and enable providers to have guidance and support on their service change plans.

Leder Review Programme – Learning from Learning Disability Deaths national programme implemented.

Healthcare Associated Infection (HCAI) – Continuous oversight of HCAI against national targets for both acute and community settings. Introduction of enhanced infection prevention & control support for primary & community care through a community infection management service and System Infection Prevention and Control (IPC) Lead role. E-Coli reduction plans and actions to reduce.

4. Constitutional Standards Performance from 1st April 2020

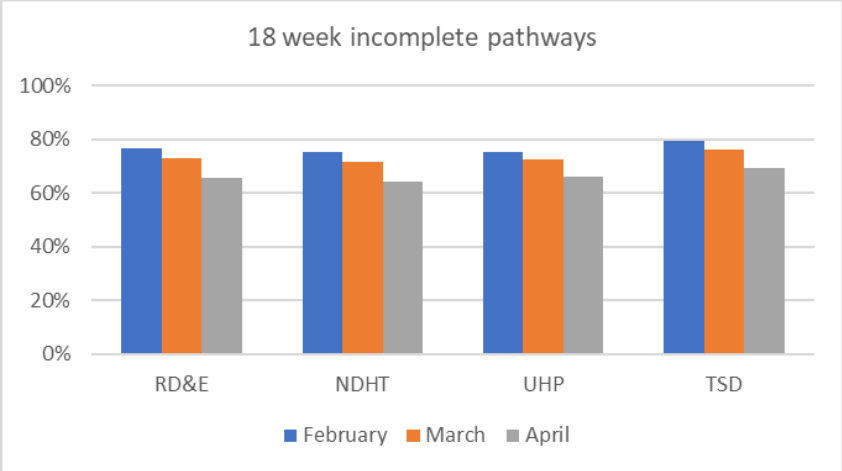
In line with national published guidance, non-essential data collections were suspended over the period 1st April to 31st July 2020. However, Constitutional Standards remain. This section of the report summarises the latest available performance information.

It should be noted that validated national data has not yet been released and so all figures are provisional and subject to change. Also, providers are not currently running full validation processes, so there may be an element of data quality issues which adversely affect***s*** performance. However, these figures give an indication of the movement in performance since 2019/2020 year end.

Importantly, access to urgent cancer services has remained in place, together with care for all clinically urgent cases. Within the Devon system the Cancer Alliance have worked with secondary care providers to ensure that services continue to be delivered to patients with life-threatening cancer who need access to surgical and critical care capacity/support and these patients are given equal priority with COVID-19 patients. The capacity to do this has been provided in collaboration with local independent sector hospitals and the CCG is working with the regional NHSE/I team to secure this capacity going forward.

Referrals to Treatment (RTT) Waiting Times

April provisional data shows a further fall in RTT to 66%:



As activity reduced and waiting times increased it might be expected that waiting list sizes would also rise. However, due to significant reductions in GP generated elective referrals reflecting the position nationally, combined with continuation of treatment for urgent conditions, waiting lists reduced in April as the table below demonstrates:

	RD&E	NDHT	UHP	TSD
March	33,255	12,310	29,243	19,952
April	31,812	12,260	27,384	19,878
Variance	**-1,443**	**-50**	**-1,859**	**-74**

Long wait patients increased, however, with over 52 week waits rising at all providers in April, as can be seen in the table below.

	RD&E	NDHT	UHP	TSD	Total
March	102	7	126	53	288
April	257	39	231	93	620
Variance	**155**	**32**	**105**	**40**	**332**

Diagnostic Waiting Times

Diagnostic waiting times have also been significantly affected by the Covid-19 pandemic. Following a deterioration in March, April saw a further large reduction in performance and the table below shows all providers except the Royal Devon and Exeter NHS Foundation Trust (RD&E) seeing 6 week breach rates increase above 40% (please note the RD&E already had the highest breach rate but have brought back activity for high-volume modalities slightly more quickly than other providers).

	RD&E	NDHT	UHP	TSD
March	20%	8%	13%	11%
April	30%	41%	46%	48%
Variance	**10%**	**33%**	**33%**	**37%**

A&E Waiting Times

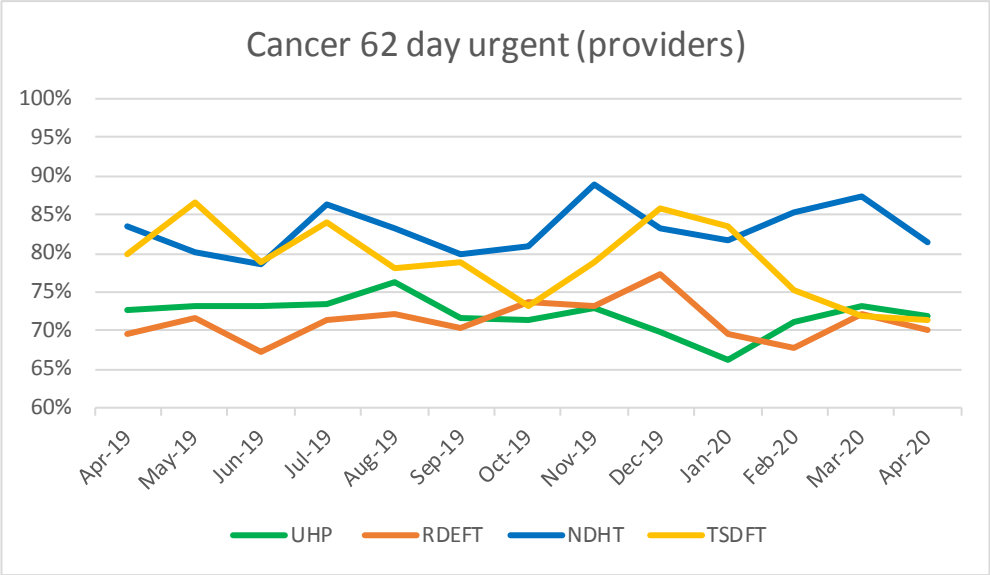
In contrast with the position against elective waiting times, performance against the A&E 4-hour wait target improved as a lower number of patients presented in emergency departments from late March and into April. Overall attendance volumes fell by 40% in April and the STP 'all types' position improved to 94.4%, up from 86.5% in March. NDHT rose 7.4% to 93.8%, RD&E increased 8.4% to 94.9% and TSD improved 8.0% to 94.2%.

Provisional May figures show a similar position at 94.0% with all providers continuing to perform above 90%

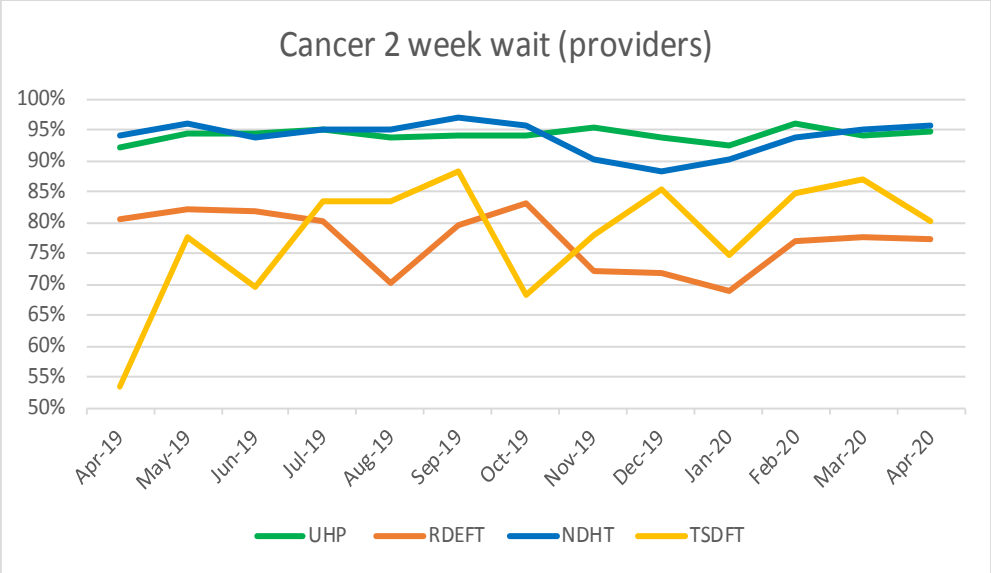
Cancer Waiting Times

Performance against the cancer waiting times standards was relatively stable in March but the provisional April position shows a slight deterioration as a result of the prioritisation of cancer services during the Covid response.

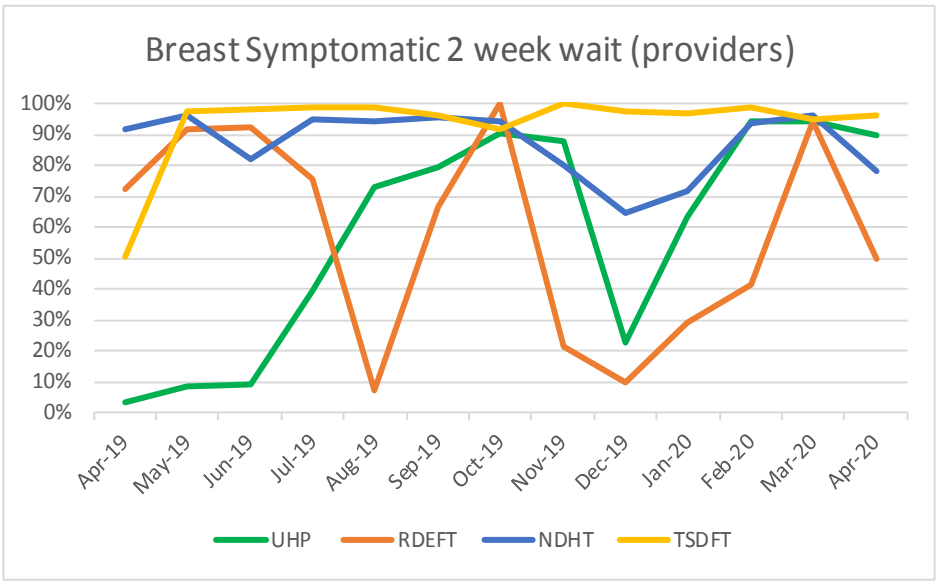
The April position for the Cancer 62-day standard shows all providers seeing a reduction in performance with RD&E at 70.2%, NDHT at 81.5%, UHP at 71.9% and TSD at 71.4%. However, this falls within the variation seen in previous months and is similar to the level seen in April 2019, with the possible exception of Torbay and South Devon NHS Foundation Trust. All providers remain below the 85% national standard.



Provisional 2 week wait performance has remained relatively stable in April, with TSD showing a reduction from 87% in March to 80%, RD&E falling slightly from 77.7% to 77.3%, but UHP and NDHT remaining above the 93% standard and seeing an improved position to 94.7% and 95.8% respectively.



Provisional April breast symptomatic performance shows all providers except for TSD seeing a worsening position, with RD&E seeing the greatest reduction, from 94% in March to 50% in April, whilst NDHT reduced from 96.3% to 77.8%. UHP saw a slight reduction from 94% to 90% but TSD continue to perform above the 93% target at 97%. At RD&E although there have been signficant drops in referrals for the majority of 2 week wait specialties, breast referrals remained close to 2019 levels which, when combined with capacity issues that have affected performance throughout the year, has caused pressure on performance in April.



5. Nursing and Quality Performance from 1st April 2020

Quality Surveillance during COVID-19 pandemic

Throughout the COVID-19 response many of the CCG quality surveillance functions have continued despite limited access to the usual intelligence and information. However, as many provider functions begin to restore activity, the CCG is returning many of the clinical and non-clinical staff within the nursing & quality directorate back into full restoration of safety systems and quality assurance. These staff will support all restoration and transformation programmes across the system and will support the CCG in patient quality & safety functional and process transformation, learning from what has worked well over the last 10 weeks.

Safeguarding – focus on Domestic Abuse & Sexual Violence

Lockdown during the COVID-19 pandemic has increased the incidence and severity of domestic abuse and sexual violence (DASV). This has been reflected in a 49% increase in calls to the national domestic abuse helpline and a similar rise in call to the perpetrator support helpline. Devon and Cornwall police and local domestic abuse (DA) specialist services have also seen a rise. There is often an inconsistent response by health staff across Devon to DA victims. Many staff lack the confidence and competence to screen for and respond to signs of abuse and providers lack policies and training programmes that equip their staff to respond not only to patients but also the many staff who are affected by DASV. Utilising STP and Pathfinder monies, the CCG is hoping to appoint on Monday 1st June to a 2 year DASV Lead post to improve the health response across Devon, working with acute, community, mental health and primary care staff so that all victims and perpetrators will be identified and supported to remain safe and receive the help they need.

Care Home Support

A range of support has been made available to care homes and their residents as part of the CCG's COVID-19 response. In providing this support we are working together with local authorities, GP practices and providers of community services. The support offer includes:

- Training on infection prevention & control, Personal Protective Equipment (PPE) and swab testing to all care homes;
- FIT Testing for care staff where Aerosol Generating Procedures (AGP) are undertaken;
- Medicines support and access to a central hub for advice;
- Weekly webinar in partnership with the Care Quality Commission (CQC), Local Authorities and providers, with topical sessions and an interactive question & answer session.

Work with general practices and community health service providers to implement the COVID-19 Care Home Support Model set out by NHS England includes additional

pharmacy input and advice, a named clinical lead and clinical support with individualised care planning for residents.

Across system partners, a care home and home care cell has been implemented, led by the CCG, which provides a daily point for escalation of any issues and a systemwide approach to support and resolution.

Re-establishing the Devon Quality Surveillance Group (QSG)

As a system it is a mandated requirement to have a QSG in order to promote quality improvement with providers, commissioners and service users. It should bring together all parts of a health and care system to share intelligence, risks and learning and have a proactive approach in responding to the quality needs of the people of Devon. In re-establishing the Devon QSG over the next few weeks, the CCG and System Chief Nursing Officer will take a key leadership role in ensuring system partner engagement and shaping the quality strategy and governance for Devon.

6. CCG Performance Reporting from 1st August to 30th March 2021

Advice on the ***Second Phase of NHS Response to COVID-19*** was received from Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer, on 29th April. There remains no change to the current national performance reporting guidance and, at time of writing, no advice on arrangements from 1st August.

As the NHS must be able to operate with both COVID and non-COVID capacity going forward and on a 'business as usual' and state of readiness for pandemic surge, then these will have an impact on performance going forward. In the absence of any further national steer at this time, it is assumed that reporting Constitutional Standards will remain in place for the year 2020/21 and be part of Recovery and Restoration.

On this basis, the CCG is giving leadership to a piece of work on the range of performance compliance that can be achieved using innovation and new ways of working for discussion with partners.

7. Recommendations to members

Members of the Governing Body are asked to:

- Agree the outturn performance position for the year 2019/20 that included the impact of the COVID-19 pandemic in month 12 (March).
- Agree the outturn quality and safety performance position for the year 2019/20.
- Note month 1 (April) Constitutional Standards performance.
- Note month 1 (April) Nursing and Quality performance.
- Note the approach being taken on CCG performance reporting from 1st August 2020 to 31st March 2021 and request a further update at the July Governing Body.

Appendix 1
Performance Report
June 2020

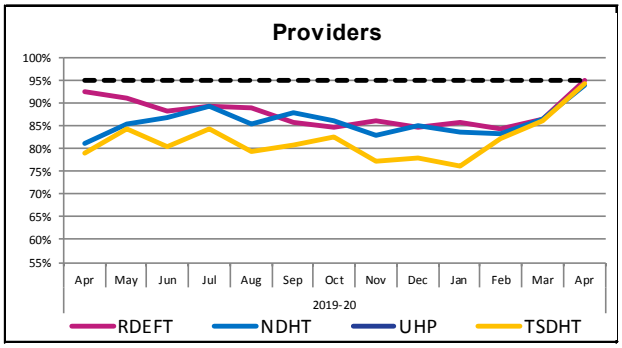
Performance and Quality indicators

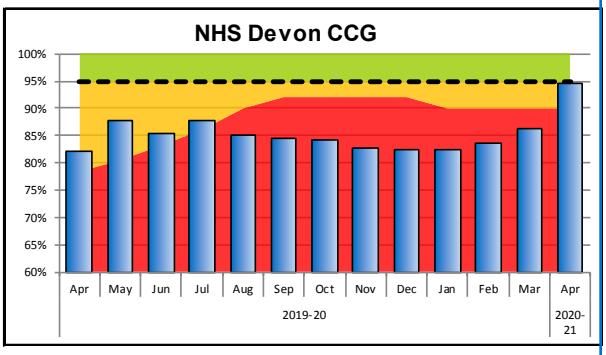
A&E Performance - Percentage of patients waiting less than 4 hours.

All types (including MIU and WiC)

Trust	Trajectory	April	2020/21
RDEFT	94%	94.9%	94.9%
NDHT	84%	93.8%	93.8%
UHP	81%	N/A	N/A
TSDFT	78%	94.2%	94.2%

CCG	Trajectory	April	2020/21
NHS Devon	94%	94.4%	94.4%
ENGLAND		85.8%	85.6%

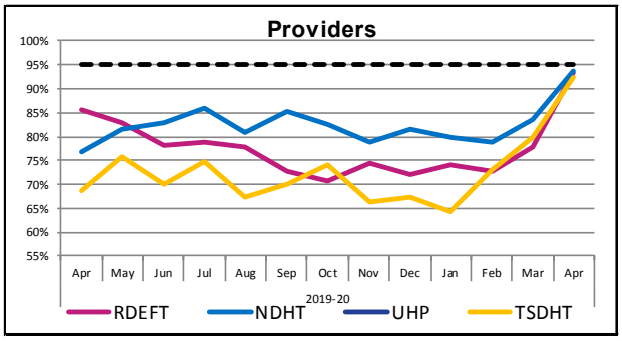


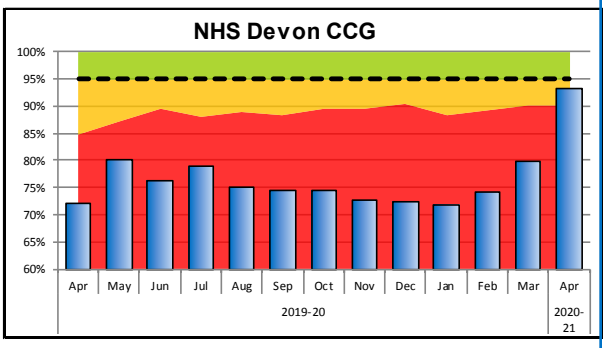


Type 1 A&E only

Trust	Trajectory	April	2020/21
RDEFT	94%	93.5%	93.5%
NDHT	84%	93.8%	93.8%
UHP	81%	N/A	N/A
TSDFT	78%	92.5%	92.5%

CCG	Trajectory	April	2020/21
NHS Devon	94%	93.2%	93.2%
ENGLAND		78.9%	77.9%





Performance Commentary

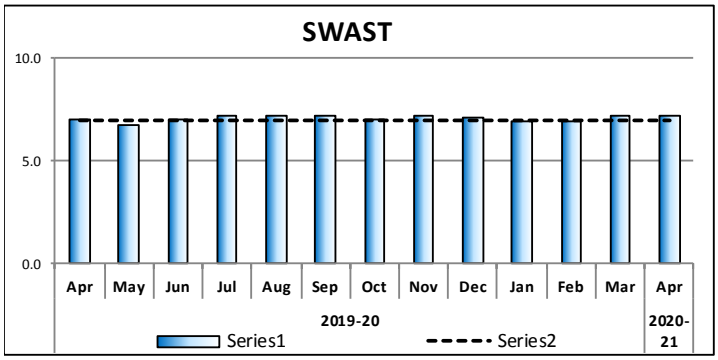
Overall attendance volumes have fallen by 40% in April with performance improving against the A&E 4-hour target across all providers.

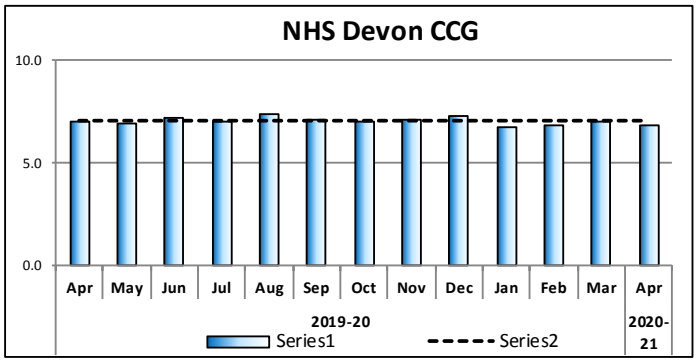
The STP 'all types' position was 94.4%, up from 86.5% in March. NDHT rose 7.4% to 93.8%, RD&E increased 8.4% to 94.9% and TSD improved 8.0% to 94.2%.

Type 1 performance also increased, rising from 80% to 93%.

SWAST Cat 1 Mean response time

Trust	Target	April	2020/21
NHS Devon	7.00	6.80	6.8
SWAST	8.00	7.20	7.2



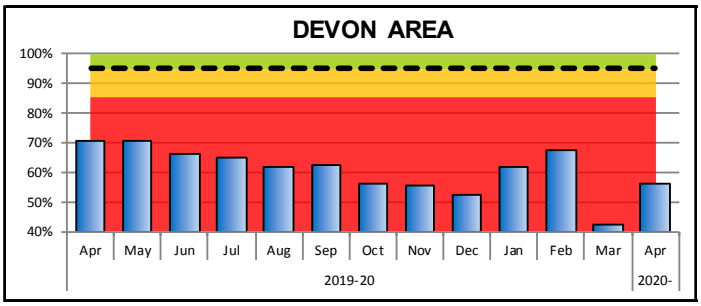


Performance Commentary

At STP level the 7-minute response time performance was within target in April at 6.8 minutes for Devon compared to 7.0 in March.

NHS 111 answering calls within 60 Seconds

Trust	Target	April	2020-21
DEVON	95%	56.2%	56.2%
ENGLAND	95%	65.1%	74.5%



Performance Commentary

The proportion of calls answered within 60 seconds increased from 42.4% in March to 56.2% in April. However, performance remains well below the target of 95%

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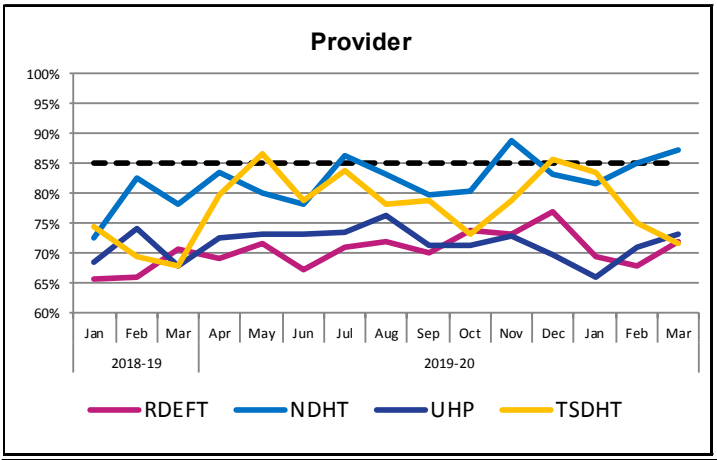
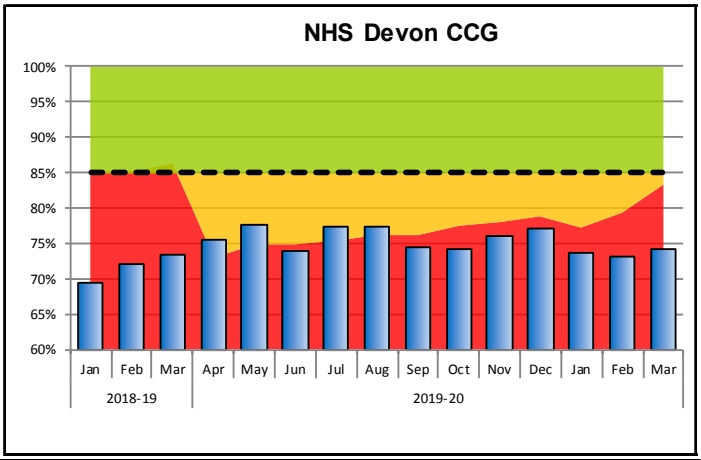
Cancer 62 day Urgent Referral

Trust	Trajectory	March	2019/20
RDEFT	80.2%	72.1%	71.3%
NDHT	86.1%	87.3%	83.4%
UHP	85.4%	73.2%	72.1%
TSDFT	85.3%	71.8%	79.4%

CCG	Trajectory	March	2019/20
NHS Devon	83%	74.3%	75.4%
ENGLAND	85%	73.8%	73.8%



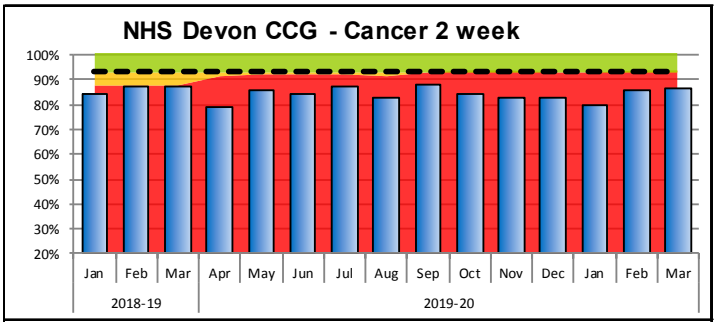


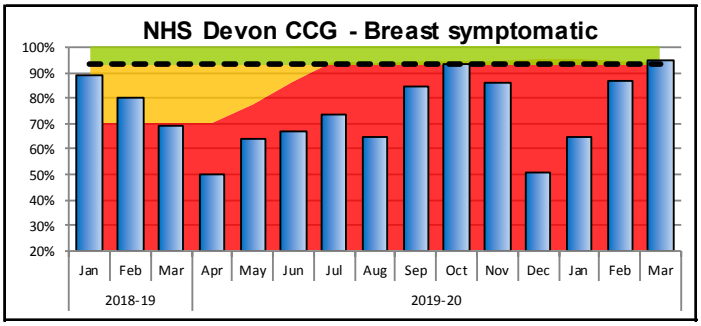
Performance Commentary

There was a slight increase in performance in March with the STP position rising from 73.2% to 74.3%. Only NDHT achieved the 85% target at 87.3%. RD&E rose from 67.8% to 72.1%, UHP increased from 71.1% to 73.2% but TSD deteriorated from 75.3% to 71.8%.

Cancer Targets (March-2019)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	86.6%	77.7%	95.0%	94.0%	87.1%
93%	2 week breast	95.0%	94.1%	96.2%	94.0%	95.1%
90%	62 day screening	81.8%	80.9%	0.0%	92.3%	76.5%
85%	62 day consultant	79.7%	72.1%	85.5%	71.1%	66.7%
96%	31 day first	97.0%	95.0%	100.0%	95.7%	99.0%
94%	31 day surgery	95.9%	92.6%	100.0%	94.4%	100.0%
98%	31 day drugs	99.7%	99.2%	100.0%	100.0%	100.0%
94%	31 day radiotherapy	98.8%	99.3%	100.0%	97.2%	97.7%





Performance Commentary

March showed an increased performance against the majority of cancer targets with NDHT achieving all measures except for screening which is affected by small numbers. UHP achieved six of the eight targets, whilst TSD achieved five. However, performance was more mixed at RD&E where only three targets were met.

Performance against the main 2ww standard rose slightly from 86.2% to 86.6%, remaining under the 93% target. UHP and NDHT met the standard and whilst RD&E and TSD were under 93% both Trusts improved their position from February.

Breast symptomatic performance achieved the 93% target in March with all providers meeting the standard. The March position was 95% compared to 87% in February with the RD&E position improving significantly, from 42% in February to 94% in March.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

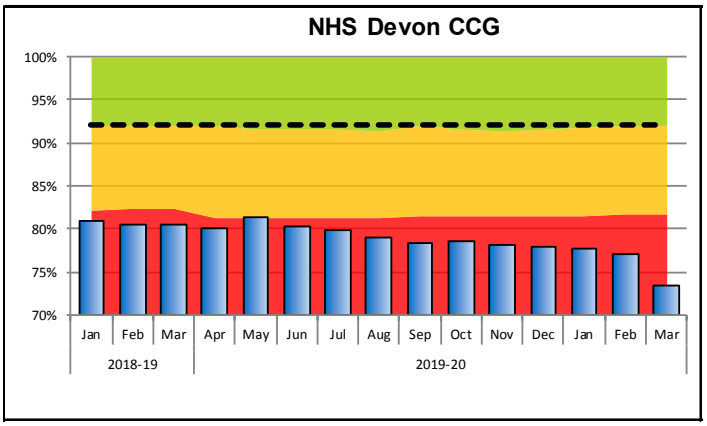
Trust	Trajectory	March	2019/20
RDEFT	82.6%	73.1%	79.1%
NDHT	79.1%	71.5%	77.0%
UHP	77.7%	72.6%	76.0%
TSDFT	81.0%	76.2%	80.1%

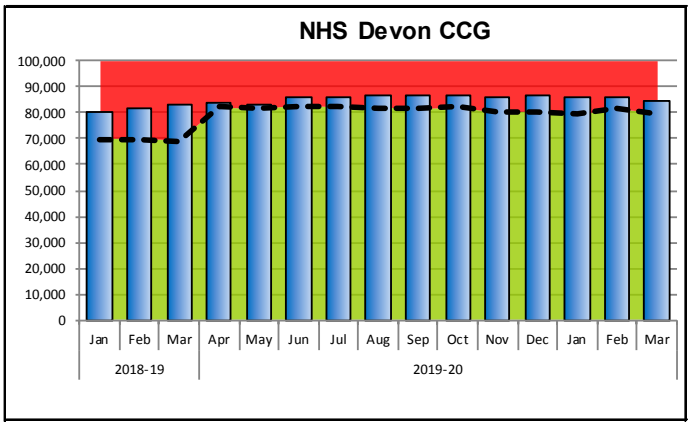
CCG	Trajectory	March	2019/20
NHS Devon	81.2%	73.5%	78.5%
ENGLAND	92.0%	79.7%	84.5%

RTT incomplete waits volume

Trust	Trajectory	March
RDEFT	34,293	33,255
NDHT	10,479	12,310
UHP	27,217	29,243
TSDFT	18,140	19,952

CCG	Trajectory	March
NHS Devon	79,790	84,576





Performance Commentary

The STP level RTT position fell in March from 77.0% to 73.5% with all providers seeing a worsening position. UHP performance decreased from 75.3% to 72.6%, RD&E dropped from 76.8% to 73.1%, TSD reduced from 79.5% to 76.2% and NDHT fell from 75.3% to 71.5%. All providers are under their planned trajectories and provisional April figures show the STP position falling further, to 66.5%

RTT Incomplete Pathways long waiters

40-52 week waits

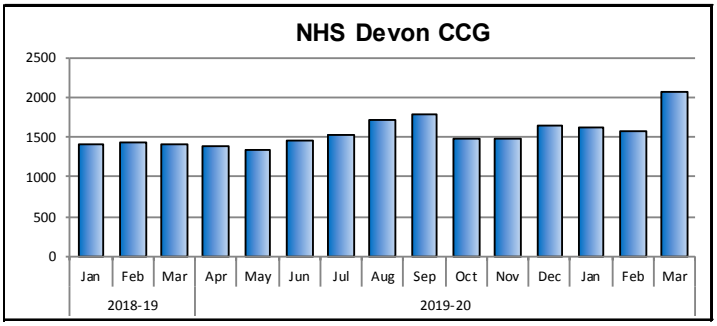
Trust	March	2019/20
RDEFT	839	7637
NDHT	299	1868
UHP	831	8547
TSDFT	335	3960

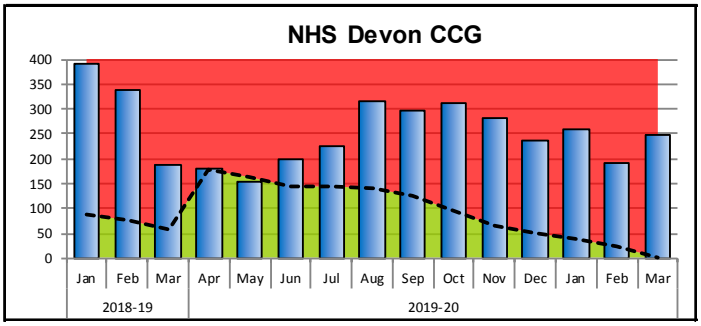
CCG	March	2019/20
NHS Devon	2062	19067

Over 52 week waits

Trust	Trajectory	March	2019/20
RDEFT	0	102	1237
NDHT	0	7	106
UHP	0	126	1162
TSDFT	0	53	885

CCG	Trajectory	March	2019/20
NHS Devon	0	249	2898





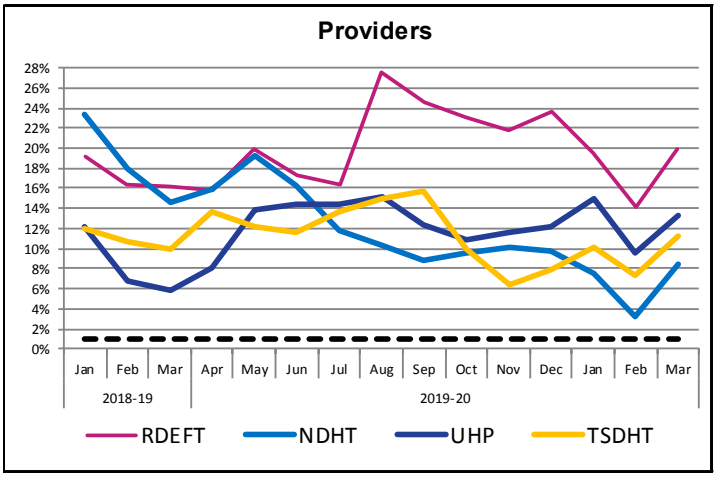
Performance Commentary

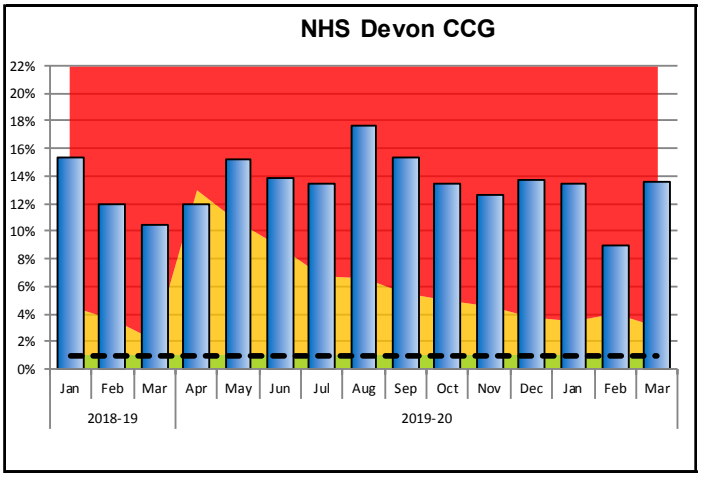
There were 249 people waiting over 52 weeks in March, an increase on the previous month (192). All providers except NDHT saw an increase in breaches with RD&E rising from 67 to 102, UHP from 120 to 126 and TSD from 42 to 53 breaches. April is expected to show a further increase.

Diagnostic 6 week wait

Trust	Trajectory	March	2019/20
RDEFT	0.8%	19.8%	20.4%
NDHT	5.5%	8.4%	11.3%
UHP	2.7%	13.2%	12.6%
TSDFT	6.2%	11.3%	11.5%

CCG	Trajectory	March	2019/20
NHS Devon	3.1%	13.6%	13.7%
ENGLAND	1.0%	1.1%	3.5%





Performance Commentary

The STP position deteriorated in March to 13.6% against the national 1% target and a local improvement trajectory of 6.5%. The provisional April position shows a significant further deterioration to 46.2%.

All providers saw a worsening position in March with NDHT moving from to 3.3% to 8.4%, RD&E from 14.1% to 19.8%, UHP from 9.6% to 13.2% and TSD from 7.4% to 11.3%.

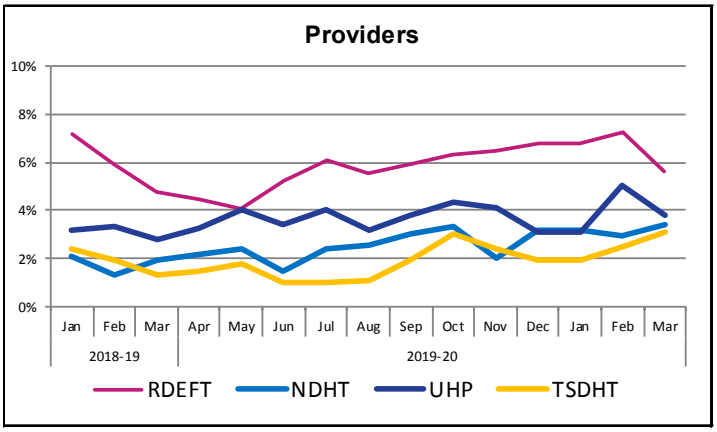
Performance Commentary

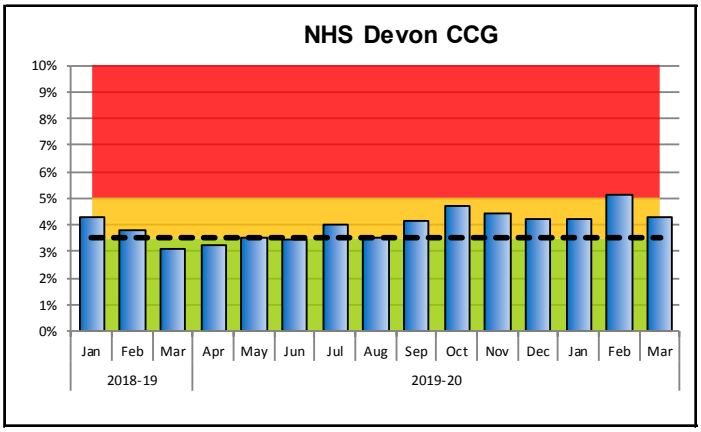
In March acute delayed transfers of care (DTOC) were above the 3.5% target at 4.3%. However, RD&E and UHP both saw their rates improve to 5.7% and 3.8% respectively, whilst TSD (3.1%) and NDHT (3.4%) remain comparatively low. April data is expected to show a much improved position.

Acute Delayed Transfers of care

Trust	Target	March	2019/20
RDEFT	3.50%	5.7%	5.2%
NDHT	3.50%	3.4%	2.3%
UHP	3.50%	3.8%	3.6%
TSDFT	3.50%	3.1%	1.4%

CCG	Target	March	2019/20
NHS Devon	3.50%	4.28%	3.6%

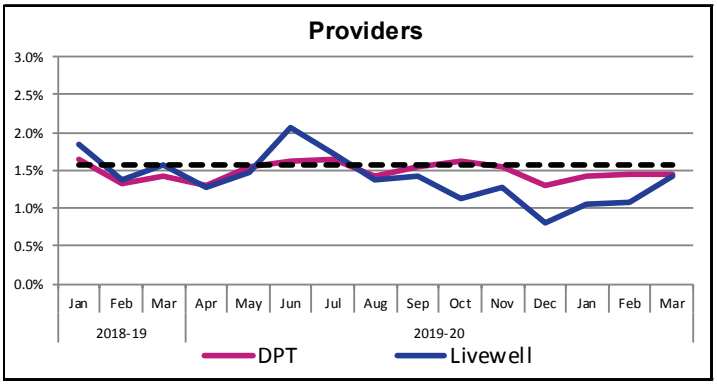


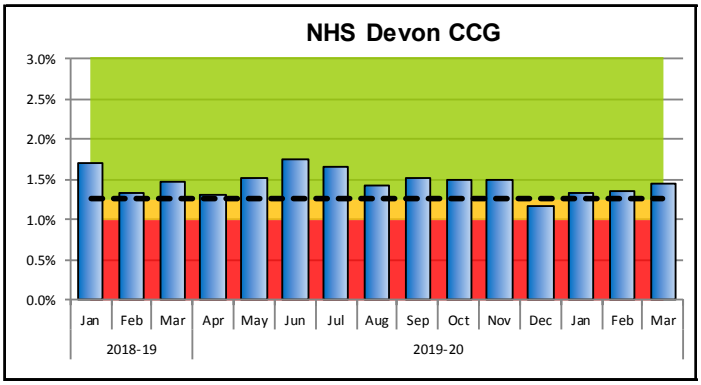


IAPT Monthly Access rate

Trust	Target	March	2019/20
DPT	1.25%	1.4%	16.4%
LIVEWELL	1.25%	1.42%	16.08%

CCG	Target	March	2019/20
NHS Devon	1.25%	1.44%	17.4%





Performance Commentary

Year-end performance for the IAPT access rate indicator has achieved target at 17.4% with both DPT and Livewell meeting the standard.

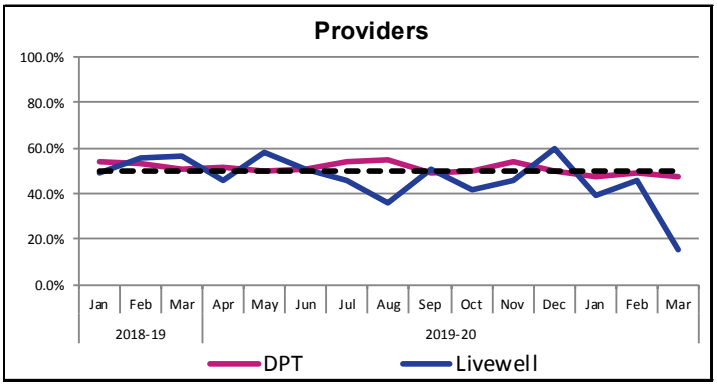
Performance Commentary

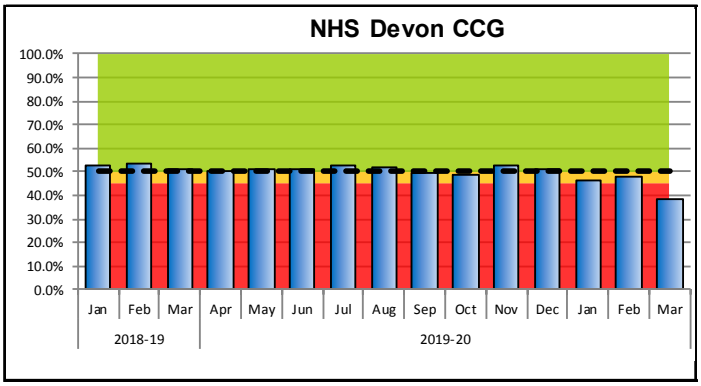
The STP remained below the 50% target for IAPT recovery at 38.3% with deteriorations in performance at both providers. DPT achieved the cumulative year-to-date target at 50.6% but Livewell were below target at 41.1%.

IAPT Recovery rate

Trust	Target	March	2019/20
DPT	50%	47.1%	50.6%
LIVEWELL	50%	15.3%	41.1%

CCG	Target	March	2019/20
NHS Devon	50%	38.3%	49.1%

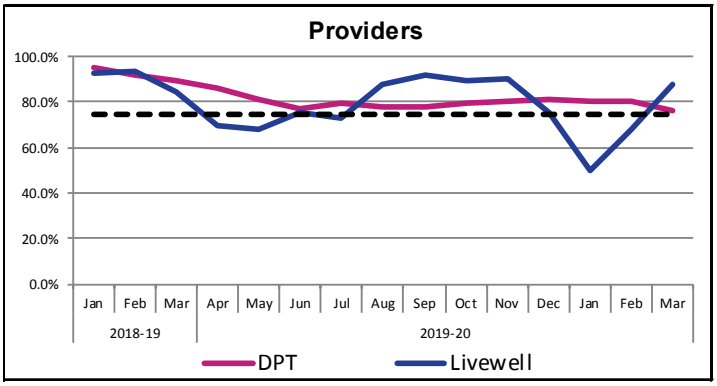


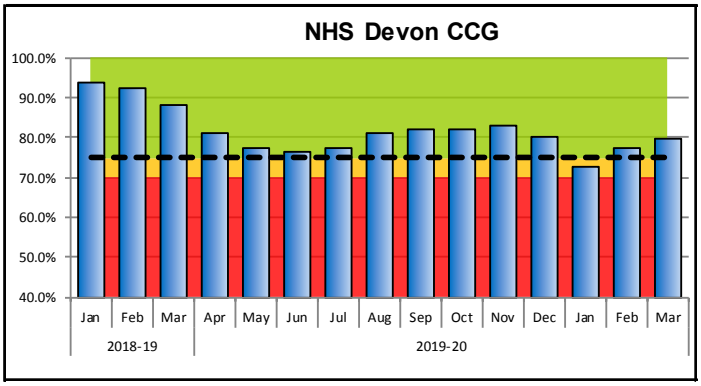


IAPT waiting 6 weeks

Trust	Target	March	2019/20
DPT	75%	80.4%	80.2%
LIVEWELL	75%	87.9%	77.7%

CCG	Target	March	2019/20
NHS Devon	75%	79.8%	79.3%



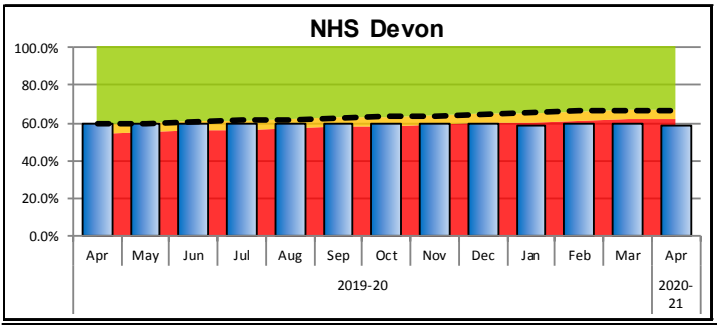


Performance Commentary

Both DPT and Livewell achieved the year-end target at 80.2% and 77.7% respectively.

Dementia Diagnosis Rate

CCG	Trajectory	April	2020/21
NHS Devon	66.7%	58.3%	58.3%
ENGLAND	67.0%	65.4%	65.4%



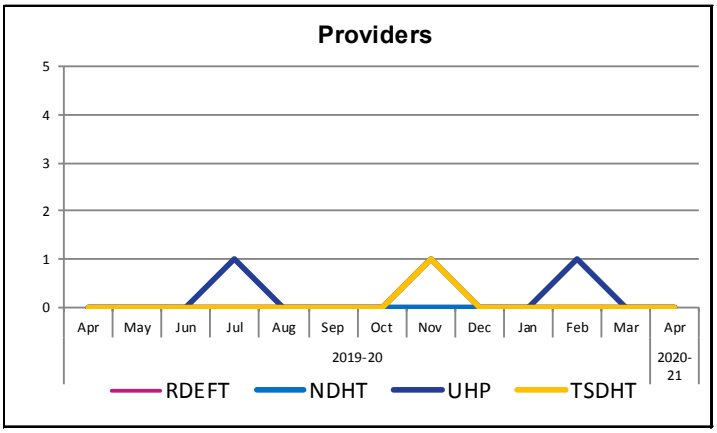
Performance Commentary

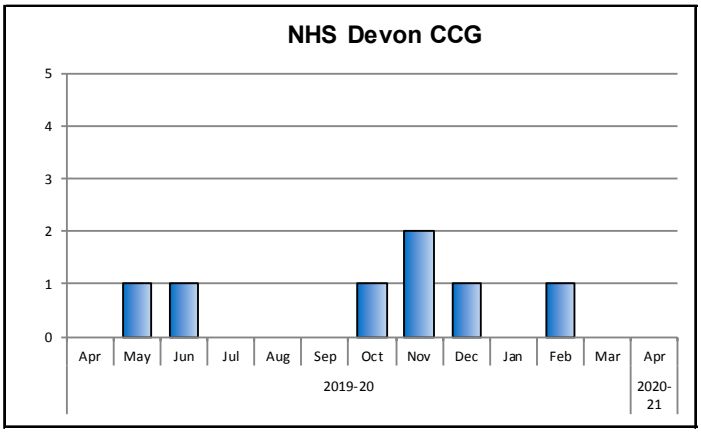
STP level performance remained static in April and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (42.2%), Mid Devon (51.1%) and Plymouth (56.5%). Conversely Exeter is at (69.3%), Torbay (60.3%) and East Devon at (63.7%).

MRSA breaches

Trust	Target	April	2020/21
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	0	0
TSDFT	0	0	0

CCG	Target	April	2020/21
NHS Devon	0	0	0





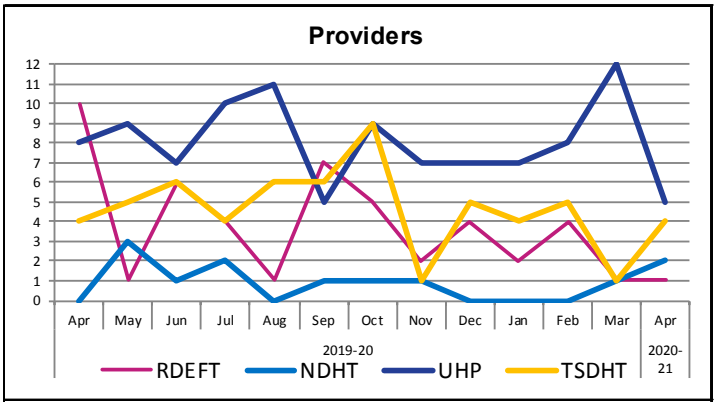
Performance Commentary

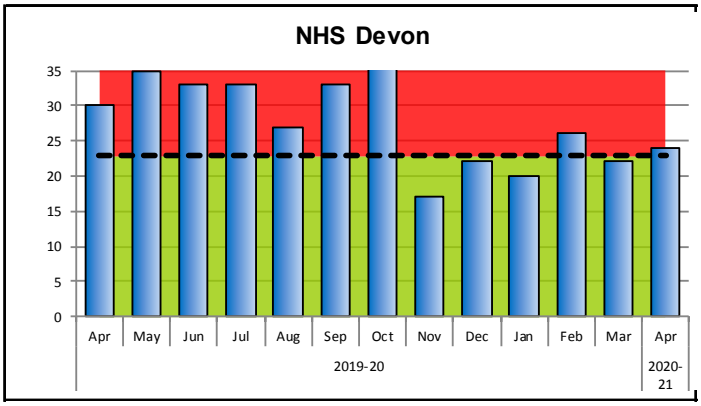
There was one reported case of MRSA in February at UHP and no cases in March or April.

C-Diff breaches

Trust	Target	April	2020/21
RDEFT	<31	1	1
NDHT	<9	2	2
UHP	<63	5	5
TSDFT	<36	4	4

CCG	Target	April	2020/21
DEVON STP	<274	24	24





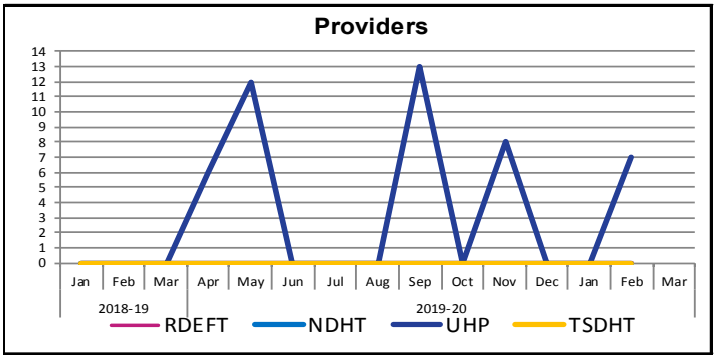
Performance Commentary

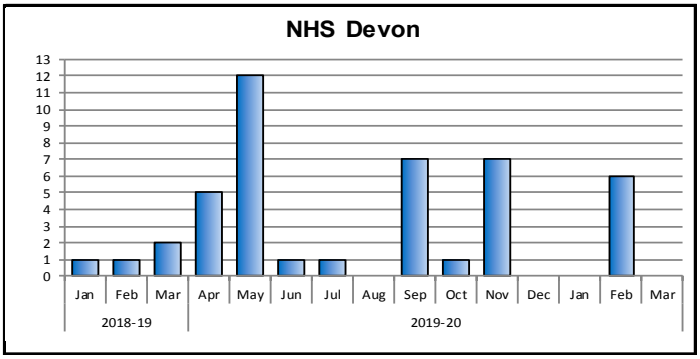
There were 12 C-Diff cases acquired within the acute providers and 24 across the STP in April.

Mixed Sex accommodation breaches

Trust	Target	February	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	7	46
TSDFT	0	0	0

CCG	Target	February	2019/20
NHS Devon	0	6	40





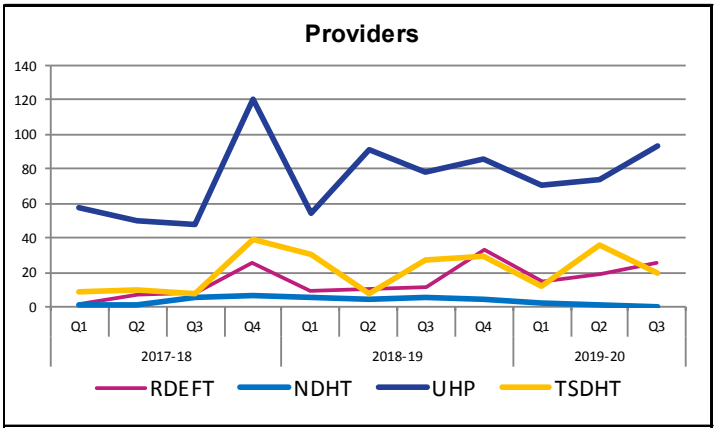
Performance Commentary

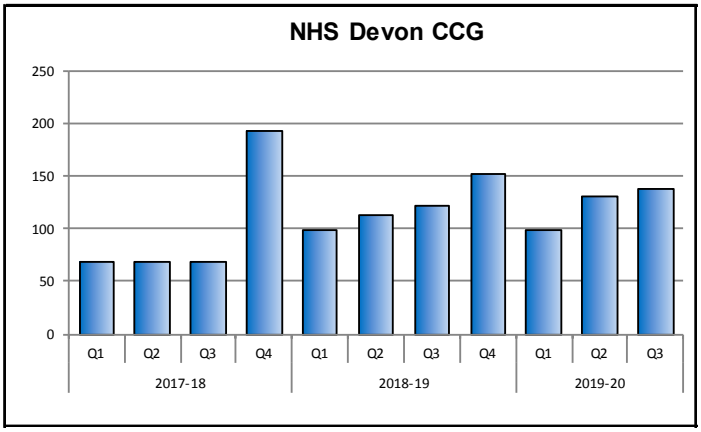
There were seven breaches in February at UHP, six of which were NHS Devon patients. Please note that mixed sex accommodation national breach reporting has been suspended during the Covid-19 pandemic.

Cancelled operations not treated with 28 days of cancellation

Trust	Target	Q3	2019/20
RDEFT	0	26	60
NDHT	0	0	3
UHP	0	93	237
TSDFT	0	19	67

CCG	Target	Q3	2019/20
NHS Devon	0	138	367





Performance Commentary

There is a zero breach tolerance for last minute cancelled operations not treated within 28 days of cancellation. Quarter three showed a slight increase from quarter two with rises at UHP and RD&E. Please note that national reporting of cancelled operations has been suspended during the Covid-19 pandemic.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Proposal for Commissioning Committee				
Date of committee: 18th June 2020 **Date report produced: 11th June 2020**				
Author (s) Name and Title: **Ginny Snaith, Board Secretary** **Contact Details: g.snaith@nhs.net**		**Supporting Executive:** **Name and Title: Simon Tapley, Accountable Officer** **Contact Details: simon.tapley@nhs.net** **Report Approved by:** **Name and Title: Simon Tapley, Accountable Officer** **Date 11 June 2020**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

Following discussions in a number of forums and a Development Session at the Governing Body, this paper has been produced to propose the establishment of a Commissioning Committee to strengthen the CCG's governance of decision making. It is recognised that arrangements for commissioning at place are still in development and that these will be key in ensuring an integrated approach to working across health and social care. However, the proposed Commissioning Committee can be implemented immediately and adapted if required as local arrangements are established.

The Commissioning Committee will:

- Increase visibility for Governing Body on commissioning decision making
- Simplify governance and decision-making arrangements
- Increase clinical input to decision making

The proposed change is

- Establishment of a CCG Commissioning Committee which will have oversight of all commissioning decisions and provide assurance to Governing Body (through assurance committees where appropriate)

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 approve the establishment of the Commissioning Committee

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:

Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services	Yes – will ensure improve quality of decision making regarding commissioned services.	
Health Inequalities	Commissioning Committee will ensure that this is considered as part of any approved plans	
Equality (staff or public)	As above	
Resource and Finance	As above	
Legal	As above	
Engagement and Consultation	As above	
Risk	Reduced risk of challenge to decision making	

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.

Commissioning Committee
Draft Terms of Reference

1. Constitutional Obligations

1.1. The CCG's Governing Body hereby resolve to establish a Committee of the Governing Body known as the Commissioning Committee. The Committee is established in accordance with Devon CCG's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

1.2. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's Constitution and Standing Orders.

2. Purpose

2.1. The purpose of the Committee is to -

- Ensure the CCG fulfils the functions, duties and responsibilities as set out in the CCG's Constitution in relation to its commissioning function
- Co-ordinate operational aspects of the organisation to ensure that the CCG meets its strategic and operational objectives

3. Responsibilities

- Co-ordinate and direct the strategic commissioning operations of the CCG in accordance with the strategic direction set by the Governing Body.
- Oversee the operational commissioning of healthcare for the population of Devon in close liaison with other health and care commissioners in Devon.
- Develop the CCG's Commissioning Strategy response and Commissioning Intentions and recommend to the Governing Body. This will be achieved through partnership working across the Devon ICS.
- Develop the CCG's Operational Plan and recommend to the Governing Body
- Oversee arrangements for monitoring and delivery of the Operational Plan
- Approve proposals, businesses cases, service change, funding requests and scoping of procurements where they are in line with the CCGs strategic plan, financial scheme of delegation and approved budgets.
- Consider new contractual models to deliver the CCG's ambitions as set out in the Long Term Plan and make recommendations to the Governing Body.
- Ensure effective operational management of the CCG in accordance with organisational policies and procedures

- Oversee the development of the CCG as an effective strategic commissioner and local leader and build effective relationships with ICS partners.
- Take decisions and actions on any other appropriate matter within the delegated authority of its individual members.
- Develop and approve policies and procedures in line with Scheme of Delegation

4. Membership

- Clinical membership (1 GB Clinical Representative and 3 other clinicians employed in CCG commissioning roles)
- Director of Finance
- Director of Nursing
- Director of Commissioning x2
- Chief Operating Officer
- Independent Secondary Care Clinician

4.1. Members of the committee can send a nominated deputy to the meeting. These individuals must be able to operate with full authority over any issue arising at the meeting

4.2. Other Individuals may be invited to attend for all or part of any meeting as appropriate.

5. Quorum

5.1. A minimum of three clinical members and three executive members will constitute a quorum.

6. Voting

6.1. A decision put to a vote at the meeting shall be determined by a majority of voting Members present.

6.2. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

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

7. Chair

7.1. The meeting will be chaired by a clinician who is not a GB member.

7.2. If the Chair is absent then the Members of the Committee will select a chair for that meeting from the members present.

8. Register of Interests

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

9. Frequency of Meetings

9.1. The Commissioning Committee will meet at least ten times a year to discharge its duties with extraordinary meetings held as required and in line with the corporate calendar.

9.2. The Commissioning Committee has agreed that in the interest of expediency or when there are few items to be discussed that business of the committee can be conducted by e-mail and the actions/decision will be recorded by the Administrator for purposes of transparency and recording. Where a decision is required, sufficient Members must respond to ensure quoracy.

10. Reporting Arrangements

10.1. The Commissioning Committee Chair shall report formally to the Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the confidential meeting of the Governing Body.

10.2. The Commissioning Committee will provide reports and briefings as required by the Assurance Committees including Finance and Performance Committee, Quality Assurance Committee and Audit Committee

10.3. The Commissioning Committee shall make recommendations to the Governing Body on any area within its remit where action or improvement is needed.

10.4. Extracts from minutes will be made public as appropriate.

10.5. The Commissioning Committee will work closely with the Strategic Commissioning Forum to support joint working where appropriate.

11. Risk Reporting

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

12. Administration

12.1. Minutes of the committee will be recorded by a designated administrator.

12.2. Agendas and papers will normally be available five working days before the meeting is scheduled to take place. A formal attendance and action and decisions log will be held and reported to each meeting.

13. Review

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

13.2. These Terms of Reference will be reviewed on an annual basis or sooner if required with recommendations made to the Governing Body for approval by the Chair

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Ambulance Joint Commissioning Committee – Terms of Reference (ToRs)				
Date of committee: 18 June 2020 **Date report produced: 4 June 2020**				
Author (s) Name and Title: **Ginny Snaith, Board Secretary**		**Supporting Executive:** **Name and Title: Sonja Manton, Director of Commissioning, Northern, Eastern and Southern** **Contact Details: Sonja.manton@nhs.net**		
		Report Approved by: **Name and Title:** **Date**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

At the Governing Body meeting held in January 2020 the Ambulance Joint Commissioning Committee (AJCC) revised terms of reference (ToR's) were approved. Since this meeting there have been some changes to the terms of reference – appendix 1. These were highlighted and circulated to the voting members of the Governing Body for review, consideration and electronically outside of the formal Governing Body meeting.

12 out of 18 (66%) of the Governing Body voting members have responded and confirmed they accept and approve the changes made to these terms of reference.

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:

Revised ToRs for AJCC presented to Governing Body in January 2020.

Key recommendations and actions requested:
The Governing Body are asked to formally approve the revised ToRs for the AJCC as detailed in Appendix 1.
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:

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.

Ambulance Joint Commissioning Committee (AJCC)

Draft Terms of Reference

Introduction

1 Emergency ambulance services are currently commissioned on a collaborative basis across all nine South West clinical commissioning groups ("CCG"). Each CCG established by NHS England[1] under sections 14B,14C and 14D of the National Health Service Act 2006 (as amended) ("NHS Act") and listed in Appendix 1 to these Terms of Reference ("ToR") has agreed to:

1.1 jointly exercise their commissioning functions in relation to emergency ambulance services, pursuant to section 14Z3(2)(b) of the NHS Act; and

1.2 establish a joint committee, the Ambulance Joint Commissioning Committee ("AJCC"), pursuant to section 14Z3(2A) of the NHS Act. The AJCC will function as a corporate decision-making body for the management and exercise of the commissioning functions delegated to it.

2 The establishment of the AJCC reflects the need to coordinate the commissioning of emergency ambulance services across the region and to integrate 999 (emergency ambulance services) with wider urgent and emergency care. It is consistent with the statutory duties on CCGs under the NHS Act, including the duty to promote integration and the duty to act effectively, efficiently and economically.

3 The CCGs listed in Appendix 1 work as part of wider Integrated Care Systems and each CCG's representative on the AJCC brings to the work of the AJCC an understanding of the work of their ICS and its strategic priorities. Decisions taken on emergency ambulance commissioning by the AJCC will reflect national and local priority objectives, including the NHS Long Term Plan and local implementation plans across the South West region.

4 In particular, the intention is for the AJCC to fulfil a strategic commissioning function across the region, in order to ensure that the commissioning of emergency ambulance services is aligned and integrated with the wider urgent and emergency care sector, consistent with NHS England's Commissioning Framework for Ambulance Services (September 2018). Further information about this is set out below and in the related Collaborative Commissioning Agreement entered into between the CCGs.

Status of the AJCC

5 Arrangements made under section 14Z3 of the NHS Act may be made on such terms and conditions (including terms as to payment) as may be agreed between the parties. The terms that have been agreed are set out below.

6 Joint arrangements made under section 14Z3 of the NHS Act do not affect the liability of each individual CCG for the exercise of its functions.

[1] A full list of CCGs is included in Appendix 1. In the event that any merger takes place between some of the member CCGs, the list in Appendix 1 will be updated accordingly, with the guiding principle throughout being that each individual CCG will be entitled to nominate one appropriately senior individual member to the AJCC and that each representative shall have one vote.

7 The AJCC is established as a committee of each CCG, in accordance with Schedule 1A of the NHS Act and with the specific provisions contained within each CCG's Constitution.

8 The AJCC will commence its operation on TBC.

Role of the Committee

9 The AJCC has been established in order to enable the members to make collective decisions on the Delegated Functions[2]:

9.1 the commissioning of emergency ambulance services as an integral part of the urgent and emergency care system according to national requirements and standards;

9.2 developing and agreeing a shared vision and understanding of emergency ambulance commissioning, working with colleagues within the urgent and emergency care system to do so and ensuring that the vision supports alignment and integration of services;

9.3 negotiating and agreeing a contract that delivers national performance, clinical and quality standards, incorporating any known challenges and improvement plans into the contract;

9.4 performance managing the contract against agreed standards and key performance indicators, including agreed quality standards, observance of service specifications and monitoring of activity and finance;

9.5 ensuring that the ambulance service is clear on, and has plans to meet, their contractual, performance, quality, transformational and financial objectives and critical infrastructure resilience and interoperability. This includes but is not limited to all decision-making in relation to planned investments by the ambulance service;

9.6 managing the ambulance service's performance against the plans referred to above and being assured of performance;

9.7 supporting and challenging the ambulance service and holding it to account for planning guidance deliverables;

9.8 being assured of the ambulance service's level of emergency preparedness;

9.9 the award and entering into of contracts for the provision of emergency ambulance services and all decision-making in respect of variations to the contact, in accordance with national policy, service user needs and clinical developments;

9.10 all decision-making in respect of financial adjustments or sanctions resulting from provider breach of the contract;

[2] The Delegated Functions are set out in the Delegation, a copy of which is enclosed in the AJCC Governance Handbook.

9.11 all decision making relating to the termination of the contract, or any part of it, in accordance with the terms of that contract;

9.12 if necessary, responding to informal or formal legal challenges brought in connection with the commissioned services;

9.13 ensuring compliance with all relevant statutory duties as they apply to the CCGs including, but not limited to, those relating to equality (under the Equality Act 2010 and specifically including the public sector equality duty under s 149 of that Act); health inequality (section 14T of the NHS Act); patient and public involvement (section 14Z2 of the NHS Act); improvement in quality of services (section 14R of the NHS Act); and integration (section 14Z1 of the NHS Act); and

9.14 such other related commissioning functions as need to be exercised by the AJCC in order to lawfully complete the procurement and contracting process for emergency ambulance services and for managing the services in accordance with the terms of that contract.

10 In discharging its functions, the AJCC will:

10.1 ensure that patient outcomes are at the heart of everything it does;

10.2 provide system leadership and ensure the ambulance service is an integral part of system planning and collaboration;

10.3 work with colleagues to review and revise the agreed collaborative governance arrangements as the wider integrated care landscape develops.

11 In performing its role, the AJCC will exercise its functions in accordance with these ToR, the terms of the delegations made to it by the CCGs and the financial limit on its delegated authority which shall be the total budgeted resources that the CCGs have agreed to commit to the contract including any forecasted overspend. A copy of the delegation is attached at Appendix 2.

12 Where a decision needs to be taken in respect of any matter that may lead to the total budgeted resources being exceeded then the AJCC shall refer the matter back to the Governing Body of each constituent CCG for determination. The AJCC may decide to recommend a particular course of action to the constituent CCGs where appropriate.

Geographical Coverage

13 The AJCC will cover the entire region of South West England covered by the member CCGs as set out in their respective constitutions.

Membership

14 The AJCC shall consist of one representative from each CCG, as nominated by the respective CCG.

15 The CCGs have agreed that the representative should be the Chief Officer or Accountable Officer for each CCG or their nominated deputy, provided that such deputy must be of sufficient seniority (i.e. Executive Director level) to support the

functioning of the AJCC. Where deputies are nominated the Chair of the AJCC will approve such nominations before they take effect.

16 Each representative is expected to ensure that matters for consideration and agreement at a meeting of the AJCC have been appropriately discussed by their CCG prior to attending to AJCC meeting.

17 The Chair of the AJCC will be a shared responsibility amongst all CCGs. For the first six months of the AJCC's operation the Chair will be the representative for NHS Dorset CCG. In line with the review process for the AJCC, this will be reviewed after this initial period and Chairing responsibilities confirmed at that stage by the AJCC.

18 The Chair will have the following roles and responsibilities:

18.1 Be a visible, engaged and active leader, not a figurehead;

18.2 Have sufficient time, experience and the right skills to carry the full responsibilities of the role;

18.3 Ensure that the AJCC supports the delivery of a safe, risk assessed service;

18.4 Create an open, honest and positive culture;

18.5 Follow the specified procedures for decision-making, including in relation to managing actual and potential conflicts of interest;

18.6 Ensure problem resolution;

18.7 Ensure reporting requirements are complied with.

19 At its first meeting, the AJCC will appoint a Deputy Chair, drawn from its membership.

20 The following will be invited to attend the AJCC as non-voting attendees:

20.1 One or more representatives from NHS England and NHS Improvement.

21 The AJCC may call additional experts, such as clinicians, procurement experts and others, to attend meetings on an ad hoc basis to inform discussions and assist it with the exercise of its functions.

22 Secretariat support will be provided to the AJCC by the Commissioning Support arrangements in accordance with the terms of the Commissioning Support Arrangements Service Level Agreement.

23 In addition to managing meetings of the AJCC, the Secretariat shall be responsible for maintaining the AJCC Handbook, which shall include the following:

23.1 the AJCC Delegation;

23.2 the terms of reference for the AJCC and any sub-committees established by the AJCC;

23.3 the AJCC scheme of delegation and reservation;

23.4 the Collaborative Commissioning Agreement;

23.5 any other relevant documents, as determined by the AJCC.

Grounds for Removal from Office

24 Member representatives of the AJCC shall vacate their office if any of the following grounds apply:

24.1 The individual ceases to hold an appropriately senior role within their CCG and/or is otherwise disqualified from holding the role in question;

24.2 An alternative individual is nominated by the CCG member in question;

24.3 The individual fails to attend 3 or more AJCC meetings without prior agreement of the Chair, in which case the member CCG will be asked to nominate an alternative individual and/or the dispute resolution mechanisms set out below will be invoked;

24.4 The individual needs to step down from their role due to illness or other incapacity. In which case an alternative individual will be nominated by the CCG member in question;

24.5 The AJCC agree that continuation as a member representative is not in the interests of the AJCC, in which case the member CCG will be asked to nominate an alternative individual and/or the dispute resolution mechanisms set out below will be invoked.

Meetings and Voting

25 The AJCC will operate in accordance with the following provisions:

25.1 The AJCC shall adopt the standing orders of Dorset CCG insofar as they relate to the:

25.1.1 notice of meetings

25.1.2 handling of meetings

25.1.3 agendas

25.1.4 circulation of papers

25.1.5 conflicts of interest

25.2 The Secretariat will be responsible for giving notices of meetings, taking minutes and circulating these within one week after the meeting;

25.3 Any notice of a meeting will be accompanied by an agenda and supporting papers and will be circulated to each member no later than 7 days prior to the date of the meeting;

25.4 The Chair may agree that the members of the AJCC may participate in meetings by means of telephone, video or computer link or other live and

uninterrupted conferencing facilities. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting;

25.5 The Chair may determine that the AJCC needs to meet on an urgent basis, in which case the notice period shall be as specified by the Chair. Urgent meetings may be held virtually;

26 Each member of the AJCC shall have one vote. Attendees do not have voting rights. The aim will be for decisions of the AJCC to be achieved by consensus decision-making, with voting reserved as a decision-making step of last resort and/or where it is helpful to measure the level of support for a proposal. Where consensus cannot be reached, a decision shall be reached by 5 of the 7 members agreeing to approve the decision in question. Where agreement cannot be reached in this way, or where one or more CCG does not agree to abide by the decision of the AJCC, then the matter will be deferred for a period of 7 working days or for such period as agreed by the AJCC to be appropriate in the circumstances, in order to enable the dispute resolution procedure set out in paragraphs 40-42 below to be followed.

27 Quorum for decision-making shall be 5 out of the 7 representatives, including the Chair;

28 Conflicts of interest will be managed in accordance with the policies and procedures of each CCG Member and shall be consistent with the statutory duties contained in the NHS Act and the statutory guidance issued by NHS England (Managing conflicts of interest: revised statutory guidance for CCGs 2017 https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/).

29 Members of the AJCC have a collective responsibility for its operation. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

30 Where confidential information is presented to the AJCC, all members will ensure that they comply with any confidentiality requirements.

31 Decisions of the AJCC shall be binding on each CCG listed in Appendix 1.

Frequency of Meetings

32 For the initial period of its operation, the AJCC will meet bi-monthly, with the frequency being reviewed as part of the 6-month post commencement review.

33 At any stage, the frequency of meeting may be varied to meet operational need, with the Chair determining this as necessary and in accordance with the provisions for meetings as set out above.

Reporting

34 The AJCC will present its minutes to each CCG governing body for information and ensure that appropriate updates are provided to each AJCC sub-committee to enable them to carry out their role.

35 Individual member representatives are responsible for ensuring that they appropriately report-back on decisions made by taken by the AJCC and that the AJCC is informed of relevant local matters that impact on its operation and role.

AJCC sub-committees

36 In order to assist it with performing its role and responsibilities, the AJCC is authorised to establish sub-committees and to determine the membership, role and remit for each sub-committee. Any sub-committee established by the AJCC will report directly to it.

37 The AJCC may decide to delegate decision-making to any of its sub-committees duly established but, unless this is explicitly stated within the terms of reference for the relevant sub-committee, the default will be that no decision-making has been delegated. Where decision-making responsibilities are delegated to a sub-committee, these will be clearly recorded in the AJCC's scheme of reservation and delegation , which shall be maintained by the Secretariat to the AJCC.

38 Subject to paragraph 37, above, and as a guiding principle only, the AJCC will have overall responsibility for determining the strategy, vision and objectives for matters within its remit, with day-to-day operational matters being managed at sub-committee level or escalated to the AJCC as per the agreed escalation arrangements.

39 Details of any sub-committees established by the AJCC will be set out in the terms of reference for each sub-committee and the scheme of reservation and delegation for the AJCC, all of which shall form part of the AJCC Handbook.

Dispute Resolution

40 As far as possible any disputes relating to the AJCC and its operation will be resolved by the members, with reference to the guiding principles for its operation as set out above.

41 Where it is not possible for a dispute to be resolved in this way, mediation will be provided through the regional NHSE/I offices.

42 Where a matter is suspended pursuant to paragraph 26, above, the members will seek to resolve it themselves within the specified time period. Where this is not possible, the issue will be promptly referred to the regional NHSE/I office for review, with the objective being to enable a decision to be made and/or implemented, as appropriate in the circumstances. The members agree that this will be an option of last resort and that every reasonable effort will be made to resolve disputes between the AJCC members.

Withdrawal from the AJCC

43 Should this joint commissioning arrangement prove to be unsatisfactory, the governing body of any of the member CCGs can decide to withdraw from the arrangement, but has to give six months' written notice to the other CCG members, with new arrangements starting from the beginning of the next new financial year or as otherwise agreed by the remaining members of the AJCC.

Review

44 The arrangements for the AJCC, including its terms of reference and those of any sub-committee established by it, shall be reviewed after the first 6 months of its establishment and revised as necessary.

45 Thereafter, the ToR will be reviewed annually or more frequently as required.

Date of adoption: TBC

Appendix 1 List of CCG members

Bath and North East Somerset CCG

Bristol, North Somerset & South Gloucester CCG

Devon CCG

Dorset CCG

Gloucestershire CCG

Kernow CCG

Somerset CCG

Swindon CCG

Wiltshire CCG

NB: From the 1st April 2020 Bath and North East Somerset CCG, Swindon CCG and Wiltshire CCG are formally merging to become NHS BSW CCG.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 18th June 2020

Dates of Committees covered in this report: 23rd April and 4th June, plus ratified minutes from 6th February 2020 (Minutes of these committee meetings to be available as an addendum)

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Reports discussed and assurances received:

Members of the Committee discussed the following reports at 23rd April Committee:

Due to the Covid-19 pandemic, all regular reports were stood down from the Committee, only urgent matters were taken to the Committee for awareness and decision.

Members of the Committee discussed the following reports at 4th June Committee:

LMC Negotiations report – the committee noted the LMC report of topics and decisions from its May Committee meeting.

Restoration and Transformation Action Plan (Second Phase of NHS Response to Covid19): The Committee were presented with information about the early stages of the new Restoration and Transformation cell. There is a tremendous amount to do in the short term to bring all the services back online and learning from all areas of working will be taken forward for medium and long-term gains.

Primary Care Operational COVID-19 update report – Support for PC in COVID 19: The Committee was presented with a paper, for information, to give an indication of the work of the Primary Care Commissioning team during the COVID crisis. Mandy Seymour gave a verbal review to highlight the scope, breadth and pace of the work in Primary Care. Much of the necessary innovation in working practice will be captured and embedded in future working practices.

Care Homes - COVID-19 Care Home Support Model: A paper was presented which showcased the collaborative work undertaken, at pace, on Care Homes. This is a National imperative and there is much more work to follow on the wider implications.

Reports received and noted:

Members of the Committee received the following reports for noting at the 23rd April Meeting:

Managing the Primary Care Cell in Response to Covid-19 including Governance and Decisions Made:

The Cell has been up and running for around 8 weeks. Regular reviews take place on how the team are operating within with cell, which is also providing lessons learned. Decisions are made daily in order to be able to support Primary Care to deliver high quality, safe care.

Temporary Changes to LES/DES Arrangements:

The Committee were informed that the CCG have advised practices to temporarily suspend some LES and DES arrangements and work differently at this time.

Primary Care Hubs:

The Committee were provided with information around the work of the teams in setting up the Primary Care Hubs and how the hubs are being used.

Funding for Covid-19 Primary Care Hubs:

The Committee received information on the funding for Covid-19 Primary Care Hubs. The Committee acknowledged that as this is a fluid situation, it would be kept under regular review.

Members of the Committee received the following reports for noting at the 4th June Meeting:

A **highlight report** was presented for information on current projects – it was noted that the digital programme has far exceeded implementation expectations due to the COVID 19 necessary measures for patient consultations.

Finance: Primary Care Covid Spend Update. A verbal update with explanatory slides were provided to the committee. Covid spending and the effect on normal budgetary funding/planning were discussed. The first month's comparative spending per head data was presented, between and South Western CCGs. The Committee requested to see next month's data when available. Preventing budgetary over-spend, in the event of COVID funding ceasing, was discussed and a savings action-plan was requested.

GP Provision to the Matford Development, south west Exeter: the committee agreed to support the principle of a new facility, as per the process previously agreed by CCG and NHSE; subject to the financial affordability agreement being brought back to committee for sign off.

Risk Register Review (changes and areas of concern)

23rd April Meeting:

The Risk Register was reviewed by the Committee, there were no areas of change or concern.

4th June Meeting:

The Risk Register was reviewed by the Committee, there were no areas of change or concern.

Committee Decisions
23rd April Meeting: None **4th June Meeting:** None
Recommendations for Governing Body
23rd April Meeting: None **4th June Meeting:** None
Recommendations for other Committees
23rd April Meeting: None **4th June Meeting:** None
Terms of Reference or other committee effectiveness issues
23rd April Meeting: None **4th June Meeting:** **Governance Effectiveness Paper:** The survey findings were discussed by the Committee. There are several actions especially regarding the use of technology for improving efficiency of meetings. The options going forward will be discussed over the next few months.

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: Committee Chair Report – Audit Committee

Date of Governing Body: 18th June 2020

Dates of Committees covered in this report: 13th May 2020

(Minutes of these committee meetings are available as an addendum on request)

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

Contact Details: nick.ball1@nhs.net

Reports received and noted

- COVID Risk Assurance Report - discussed and provided assurance that all risks had been reviewed and updated where required. There have been risks suspended where work is not happening during the pandemic. The risk register is being reviewed and score weekly with robust discussion with incident cell leads. The risk register is available for detail
- Risk Assurance Report – discussed and provided assurance that all risk
- Draft Annual Report – the audit committee received and noted the report. Assurance provided this draft is on track for completion to a final version. This report forms part of good governance to assure the committee that the ARA 2019-20 for NHS Devon CCG is being developed within the nationally proposed deadlines and within Department of Health financial manual editorial guidance.
- Register of Gifts, Hospitality and Sponsorship Report – presented to the audit committee for review. Nothing to note.
- Proposal COVID19 report – presented to the audit committee which noted that changes of work going forwards due to the pandemic.
- Internal Audit Update Report – Data security protection toolkit report was shared which shows nothing to suggest that the CCG will not meet the submission deadline of 30th September. The report informed the committee of what work is going ahead and what has been stepped down due to the lockdown situation.
- Draft 2019/20 Head of Internal Audit Opinion – The internal audit service provides a service in accordance with the requirements set out in the mandatory Public Sector Internal Audit Standards, comprising the Definition of Internal Auditing, the Code of Ethics and the International Standards for the Professional Practice of Internal Auditing. Adopts a risk-based auditing approach and maintains an Internal Audit Manual to support compliance with Internal Audit Standards. The Audit Committee received and noted the report with the highest level of significant assurance opinion being provided.

- External Audit Progress report – the paper provides the Audit Committee with a report on progress in delivering Grant Thornton's responsibilities as the CCG's external auditors. The contents of the Progress Report were noted and there were no items for escalation to the GB.

- Counter Fraud Progress report - the report provided an update for the CCGs in respect of counter fraud activity.

Risk Register Review Updates

- Summary review of updates to corporate risk register and full COVID risk registers as at 5 May 2020 were reviewed at this meeting. Please see attached the latest version of the risk register for review.

Committee Decisions

The Audit Committee

- Noted the COVID Risk Assurance Report
- Noted the Risk Assurance Report
- Note the Draft Annual Risk Report
- Noted the Register of Gifts, Hospitality and Sponsorship Report
- Noted the Internal Audit update report
- Noted the Draft 2019/20 Head of Internal Audit Opinion
- Noted the External Audit progress report
- Noted the Counter Fraud Progress Report 2019/20

Items of concern to be escalated to the Governing Body

- N/A

Recommendations for Governing Body

- **N/A**

Recommendations for other Committees

- **N/A**

Terms of Reference or other committee effectiveness issues

- **N/A**

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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 CCG
Risk Report (High Risks Only)

Date produced: 10-06-2020 - 12:52

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners
108	We will make best use of resources [Reporting Committee] Primary Care Commissioning	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand and capacity) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system could be affected. This risk replaces risk 09 (SDT) and 68 (NEW Devon) (HISTORIC ID: Na)	GP Strategy STP Workforce Group & Strategy Locality Workforce Groups GP Provider Collaborative Groups Regional Workforce Board 100 day plan in design for Plymouth system Regular review at Primary Care Operational Group Regular review at Primary Care commissioning committee Feb 19 - The GP framework associated with the long term plan, having been released, is being reviewed for opportunities to further mitigate this risk Apr 19 - Work continues to support practices in working closer together and with wider parts of the system and also building on the skill mix development as outlined in the contract reform GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments 20 Jun 19 - risk reviewed at Primary care operational group. No further update Jul 19 - 100 day plan in design for Plymouth system 7 Aug 19 - Reworked as Plymouth Prospectus; financial implications being reviewed; on track for 1 Sept 19 launch. 2 Sept 19 - Plymouth Prospectus circulated to Plymouth practices. Others were sent to practices in South Hams, West Devon and the rest of Devon to inform them of the prospectus and encourage them to send expressions of interest for when CCG launch our longer term transformation plans 10 Oct 19 - BMJ Job Fayre in London on 4th & 5th October 19; stand promoting SW region - supported by CCG staff and Plymouth GP. 14 Nov 19 - Risk score has been reviewed in light of CQC contract suspension of one practice within Western system, given (material) impact on 3 practices covering circa 25,000 patients. Score has not been adjusted as this was felt to be a manifestation of the risk rather than an escalation of it. 16.12.19 risk score not adjusted due to current list dispersals (from 2 practice closures) [Control Gaps] Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support In part a lack of evidenced change to new models	20 [29/05/2019] 20 (L=5 x I=4)	Risk Opened: 29/05/2019 Reviewed: 10/06/2020	[10/06/2020] Feb 20 - Implementation of GP Strategy being drawn up. New PCN DES specification confirmed. Development teams to work with networks to support maximum use of funds available. BMJ subscription confirmed – all GP vacancies to be advertised nationally. Scheme beginning 1 April and in collaboration with LMC. Apr 20 - risk currently being managed as part of the COVID risk management process May 20 - work to support practices including implementation of digital applications, reduce admin burden by clarifying the expectations re reporting, claiming and payment methods for LES / DES and other activities during the period of COVID Jun 20 - there has been some early successful interest through BMJ subscription. work continues to support including the implementation of digital applications, reduce admin burden by clarifying the expectations re reporting, claiming and payment methods for LES / DES and other activities during the period of COVID,	Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. practice resilience toolkit Heat map devised to identify vulnerable GP practices Regular resilience meetings with Devon LMC Work continues to develop Primary Care Networks and fill roles [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Paul Baker

111	We will make best use of resources [Reporting Committee] Finance and Performance	There is a risk that the CCG will not be able to deliver its agreed control total for 2019-2020 as a result of the £80m savings target held by the CCG which includes £45m of system savings primarily directed at mitigating acute activity growth and cost savings as a result of transformation of existing services/practices. (HISTORIC ID: Na)	Contractual review mechanisms have been established to identify and agree activity variations as a result of reduced growth and or service change. A Risk Sharing agreement has been agreed with all local acute providers on how the £45m risk is managed in year. [Control Gaps] A formal PMO led Reporting/challenge mechanism is in the process of being established to capture the risk of the delivery of all savings programmes.	20 [10/10/2019] ▲ 20 (L=5 x I=4) [01/08/2019] ▲ 16 (L=4 x I=4) [31/07/2019] 14 (L=4 x I=4)	Risk Opened: 31/07/2019 Reviewed: 14/01/2020		Regular monthly reporting to the Finance Committee/Governing body on the inherent risk in the savings plan. Monthly finance working group meetings with system partners to discuss progress on delivery of the system savings target. [Assurance Gaps] None identified	Executive Lead: John Dowell Owner: Kevin Wheller
113	We will make best use of resources [Reporting Committee] Audit	There is a risk that there is a failure to deliver the CCGs key critical functions in an emergency which will impact on the CCGs statutory obligations This includes; fire, flood, loss of premise (partial or total) loss of electricity, loss of telecoms partial or total, loss of staff (pan flu/industrial/political action etc) (HISTORIC ID: Na)	An overarching Business Continuity Plan is in place and was reviewed and approved by the Executives in September 2019. Individual Business Continuity Plans are also in place for directorates and workstreams. [Control Gaps] Not all staff are aware of their directorate Business Continuity Plan, this is being addressed through communications briefings and intranet links following approval of the CCG Business Continuity Plan during October 2019. Currently the Head of Governance is covering for the vacant position of Emergency Preparedness Resilience Response Lead and European Union Exit Lead – new appointment anticipated to commence in Q4.	16 [24/04/2020] ▲ 16 (L=4 x I=4) [29/08/2019] 6 (L=2 x I=3)	Risk Opened: 03/09/2019 Reviewed: 21/04/2020	[11/09/2019] Executives have been signed up Strategic leadership in crisis training with NHSE 14 October 2019., [11/09/2019] Internal audit is being undertaken by ASW during the second week in October to review the CCGs business continuity plans. , [11/09/2019] Severe weather plans and communications plans are being reviewed by relevant service area (Urgent control leads and communications team) and feedback awaited in anticipation of NHSE assurance visit October 2019. , [11/09/2019] Cascade lists of staff have been developed and HR have recently published a staff structure by directorate/service provision, [11/09/2019] Overarching BCP has been drafted and is to be presented to Executive for consideration of approval 24 September 2019, [11/09/2019] The Head of Governance is meeting with BCP Leads across the CCG to test their BCPs,	Our Business continuity plan was graded as green, and our overall Emergency Preparedness Resilience Response rating was satisfactory for 18/19. Each directorate has a Business Continuity Plan in place and these have been reviewed during July/Aug 2019 The CCG was reviewed against the EPRR Core assurance standards by NHS England on 02 October 2019 - the outcome was fully compliant and will be presented to Governing Body end of October 2019. [Assurance Gaps] Capacity in the governance team to accommodate all requirements for Emergency Preparedness Resilience Response core assurance standards	Executive Lead: Sonja Manton Owner: Clare Doble
115	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that Transforming Care will not meet its "building the right support" trajectory and NHS LTP metric to reduce the number of children with LD and or Autism in a hospital place by 2023/24. The impact of this is Children will be place in out of area hospital placements a long way from home and their families, which will have a reputational risk for the CCG. (HISTORIC ID: Na)	Controls are the arrangements made or precautions taken, to reduce risk. (e.g. Governance processes / statutory frameworks, management structure & accountabilities, communications & patient / public feedback, policies & procedures / reviewed at team meetings etc). Please provide details of controls in place, below: Developing proposals to submit to Executive team Seeking additional resources from NHSE to implement proposals Considering existing resources which could be redirected Re-structure adults TCP team to support Children's TCP Recruitment process underway for Clinical lead post to March 2020 Additional co-ordination of CETR process UPDATE 27.04.20: •In line with national guidance, the Learning Disability and Autism Programme is continuing and performance monitoring is ongoing during COVID-19. •Good progress has been made with dedicated resource focused on reducing the number of Children and Young People in placement from 16 to 8 (21.04.2020). This is regularly reviewed and overseen by a fortnightly tracker meeting and reporting to the monthly Learning Disability and Autism Programme (LDAP) Group •Risk remains, as there is increasing activity in admission avoidance,(new admissions or re admissions) acerbated by COVID and risk to children with LD & Autism being restricted within their homes. [Control Gaps] Additional capacity needed to deliver Greater work needed to join up system approach to service Lack of project management to deliver CAMHS Capital Tier 4 admission avoidance project	16 [02/12/2019] 16 (L=4 x I=4)	Risk Opened: 23/01/2020 Reviewed: 05/05/2020	[23/01/2020] Draft proposal to be delivered at hot topics which details plans and resources required to address risk. This has now been approved. Ongoing conversations with NHSE re assurance. Reviewing existing resources to support Children's TCP plan. Meeting to be set up for Feb between CCG Director of Commissioning, and Directors of Children's in the Local Authorities. ,	For each of the risks and controls a source of assurance is set out ie. What provides evidence that the organisation has identified the risks and has controls in place. (e.g. Internal audit report, report to Board or Board Committees) Please provide details of assurances below: TCP Tracker meeting Care and Education Treatment reviews Performance data Escalation calls from NHSE TCP Steering Group LD and Autism Leadership group [Assurance Gaps] Joined up with NHSE Specialised Commissioning Linking in with Children's services, social, EHCP's	Executive Lead: Jo Turl Owner: Shona Charlton

109	We will continue to commission safe, effective and accessible services [Reporting Committee] Audit	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •Reduced quality of care with impact on patient safety leading to increased public and media attention and reputational damage •Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (HISTORIC ID: Na)	For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group on a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. 21/04/2020 - We are currently not monitoring performance on this standard in line with national guidance 27/02/2020 - The 2 weekly oversight by NHSIE has shown that we are on plan to meet the agreed trajectories for 52 week waits and diagnostics. There was a risk of losing 50% of the 52 week funding for RDE due to a gap in assurance however we have provided further info and the funds are now available 13/01/2020 - The system has maximised the opportunity to minimise the risk of delivery for 52w by obtaining and committing to revised trajectory as a result of 1.7 million of elective winter monies. This investment for UHP reduces the overall size of the waiting list as it does in South Devon and RD&E the investment in orthopaedics reduces the forecast to 38 these investments are monitored by detailed reporting template supplied by NHSE. The RD&E position improves to 38 while the other providers are still on trajectory to have zero 52ww breaches. The investment of winter elective monies will improve the overall STP position for diagnostics to 6.5% 19/11/2019- 52ww performance remains influx. The system wide PTL is fully operational and learning in Sept/Oct with regard to barriers patients accessing outsource activity is being used to refocus actions on gaining maximum benefit from outsourcing. Recent improvements in diagnostic have shown marginally improvement in 62 day standard. the system commitment to deliver diagnostic performance at 7% is dependant on a system wide plan to clear all endoscopy breaches by 31st March. A recent decision to9 stand down the mobile unit for East Devon and South patients and replace with trust wide insourcing and outsourcing plans will need careful monitoring during November /December to ensure no negative impact on this performance. 16/10/2019 - We have gained assurance that trusts are now compliant with the prostrate pathway which had been an significant barrier of the achievement of the 62 standard. Following agreement from NHSE medical director on the 24th October we were moved to procurement of the stand alone endoscopy unit to support RD&E and Torbay hospitals. Revised forecast for all 4 trusts at system level have now been quantified and delivered to NHSE these forecasts will be upgraded monthly in relation to all actions agreed at place or system. The 52 ww patient treatment list is now fully operational and sufficient independent sector capacity availability to impact significantly on 52ww performance early review of the process has identified the need for a more proactive approach to support patients choosing independent sector activity to support 52WW clearance. This approach has been agreed by the planned care programme board and will be operational from November 04th 13/09/2019 - In response to a request at the August System Performance Group a number of system wide plans to improve performance in diagnostics and 52ww were presented and agreed at September System Performance Group. It was recognised that the actions would contribute further to the improvement in 62 week pathways as well. The detail of these are as follows: a plan for North and East to clear endoscopy backlogs by outsourcing and insourcing at both RD&E and South Devon health Care Trust. This work is mirrored in similar plan at UHP to outsource to Care UK . An agreed protocol to enable and support increased capacity in contrast MRI and CT has been agreed at RD&E . 26/07/2019 - The CCG has a single point of focus and escalation via the head of performance in each locality these heads of performance are responsible foe collating information around referrals, contract performance against	16 [22/10/2019] = 16 (L=4 x I=4) [31/07/2019] ▲ 16 (L=4 x I=4) [06/06/2019] 9 (L=3 x I=3)	Risk Opened: 06/06/2019 Reviewed: 22/04/2020	[27/08/2019] System performance meeting monthly with providers,	Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. 13/01/2020 scrutiny at Dec SPG has provided assurance on these plans and elective board 19/11/2019 scrutiny at Nov SPG has provided assurance on these plans 16/10/2019 The quality of financial forecasting has been significantly improved with high degree of accuracy looking forward 3 months now achievable 13/09/2019 RAPS recovery action plans over the pervious 2 weeks have been quantified and outputs reflected in revised forecasts [Assurance Gaps] none identified	Executive Lead: Sonja Manton Owner: John Finn

			the plan and remedial actions to deal with referral growth deviation from contract activity levels and actions to improve performance at trust and system. Monthly reporting at place will now feed into System Performance Group. [Control Gaps] 13/01/2020 - Opel 4 esculation at the start of January puts some risk into this delivery 19/11/2019 RD&E ability to deliver the 5 endoscopy lists per week for 6 months within their organisation needs to be carefully understood and assurance gained. 16/10/2019 uncertainty around funding for endoscopy still an issue. Sufficient commissioning support to support recovery action plans at place. 13/09/2019 staffing at RD&E to provide increased endoscopy					

44	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that children and young people will experience significantly delayed waiting times for Autism (ASD) assessment. This risk is applicable to all under 18s across the STP footprint, although the numbers and wait times would be higher in NEW Devon so this could be seen as the higher area of risk. Historically demand has far outweighed capacity for ASD assessment and currently there are a number of services that Children and Young People and families cannot access without a formal diagnosis across the local area. Referral rates continue to rise despite significant work within health services and the wider system to make processes leaner, increase capacity for assessments and offer better needs led increase capacity for assessments and offer better needs led support for CYP and their families. UPDATE SEP 19: A new STP wide risk is with the Director of Commissioning for final sign off, while this risk has been updated it should not be considered in isolation to other ASD risks which were in place before the CCG merger. UPDATE OCT 19: Risk still awaiting sign off 31.10.19. (HISTORIC ID: 111)	Senior Managers have discussed a business case for allocating additional resource to ASD assessment, services, (although none were able to be allocated at this time) and waiting lists have been presented to senior managers as a cost pressure for 2019/20. Regular reporting between Torbay & South Devon Foundation Trust and children's commissioner. Waiting times and improvement work monitored through Contract Review Meetings with Virgin Care Limited. Action plans and trajectory work with both Virgin Care Limited and Torbay & South Devon Foundation Trust have been supported by commissioners and monitored through contractual routes, Contract Review Meetings and Joint Technical Working Group respectively. Multi provider, system wide ASD forum led by Virgin Care Limited to support continuous development. The re-procurement of children's community and wellbeing services have set out expectations for improved services as part of the NDITS specification and action plans will be required as part of mobilisation of the new provider. Sitrep reporting instigated for all providers following Devon SEND inspection highlighting long waits for ASD assessment. ASD strategic group is now meeting monthly and the neuro developmental Strategy Project Group has agreed to develop some of the operational aspects linked to the Written Statement of Action for Devon County Council. Update Oct 2019; Childrens Commissioners and providers are attending adults AIG for ASD funding to ensure there is focus on the14-18 cohort. UPDATE APRIL 2020: Monthly reporting by CFHD continues and shows continue monthly growth in referrals (March 200) impacting on waiting times (avg 291 weeks). The issues is being overseen through regular contact with the provider CFHD. Desk top assessments have been carried out where possible and capacity has shifted to offering telephone support and advice rather than assessments. Numbers of children waiting for assessment in March 2474 (Devon and Torbay). [Control Gaps] The re-procurement of children's community health and wellbeing services across the STP has not supported conditions conducive to enabling system wide performance improvement work and current providers are unlikely to make major changes/investments into the system when they are unclear what the new provider of Children's Community Health Wellbeing Services will want. Additional finances cannot be allocated due to the re-procurement of Children's Community Health Wellbeing Services. There is a pause on improvement planning work by Virgin Care Limited because of their contract ending. The multi agency ASD forum will postpone working until there is clarity on what the new provider for Children's Community Health Wellbeing Services wants to put in place from April 2019. The focus of the ASD Strategic Group is Devon and does not incorporate Plymouth or Torbay, although it is anticipated that service development will be shared through the wider system.	15 [31/10/2019] ▲ 15 (L=5 x I=3) [25/09/2019] ▼ 10 (L=2 x I=5) [25/09/2019] = 10 (L=5 x I=2) [19/09/2019] ▲ 15 (L=5 x I=3) [24/04/2018] 10 (L=5 x I=2)	Risk Opened: 01/04/2013 Reviewed: 22/04/2020	[22/01/2020] UPDATE JAN 2020: A new STP wide risk is with the Director of Commissioning for sign off, to combine risks 15, 44 and 75., [19/09/2019] Reason: Risk 44 (NEWD CCG)/ 15 (SDT CCG) is proposed for step down from the Corporate Risk Register to the Women's and Children's Team Risk Register as the scoring sits below 16. This risk will be reviewed and updated at monthly team meetings. Performance against waiting times will benefit from more structured monitoring as part of the new contract for Children's Community Health and Wellbeing Services from April 2019 and through situational reporting to commissioners following the Devon SEND inspection and Written Statement of Action. https://nww.newdevonccg.nhs.uk/riskregister/ UPDATE SEP 19: A new STP wide risk is with the Director of Commissioning for final sign off, while this risk has been updated it should not be considered in isolation to other ASD risks which were in place before the CCG merger. ,	Business cases have identified what additional resources could achieve across the STP. Priorities for ASD have not been challenged in the Children's Community Health Wellbeing Services reprocurement process. A significant amount of patient/ family engagement was undertaken as part of the reprocurement of children community health and wellbeing services, so commissioners understand what is important and length of wait for assessment was less so where families are communicated with effectively and feel supported. Virgin Care Limited also undertook an engagement exercise in 2017/18. Devon SEND inspection highlighted significantly high waiting times for ASD assessment and providers have responded to regular meetings to discuss ways to move forward jointly with commissioners. A bid to NHSE for funding to reduce ASD waiting times was partially successful. Providers are expected to use any additional resource in 2018/19. A business case has been developed alongside the Adults business case, requesting funding to the waiting list crisis and to support post and pre diagnosis. National picture is similar to ours. UPDATE SEPTEMBER 2019 £750K funding has been secured for a waiting list initiative across 2019/20 - 2020/21. This will enable over 1/3 of those waiting to be assessed. In addition a business case will be presented at Integrated Community Executive for post and pre diagnostic funding in January 2020. The adults business case to the Integrated Community Executive secured funding for pre diagnosis services from the age of 14 upwards. There are plans to pilot and roll out a schools focused set of behavioural workshops. Adult will mirror this with similar provision. [Assurance Gaps] Virgin Care Limited , who hold a significant majority of the waiting times have paused development work while the new provider of CCHWS confirms their long term plans and mobilisation starts. Due to the service's inclusion in the reprocurement of children's community health services no additional resource can be given from the CCG to address the waiting lists or develop new ways of working, at this time. There is a lack of understanding as to why parents are asking for an ASD assessment, to inform the wider system barriers to not having a diagnosis. There is a lack of clarity as to why referral rates are increasing generally. There is a lack of clarity as to which services are referring in for an ASD assessment. Funding from NHSE for waiting times is not enough to have a significant or sustained impact. Aspirations within the WSOA, including the reduction in waiting times will not be achieved if additional funding is not received for services. UPDATE SEP 2019 Waiting list initiative	Executive Lead: Sonja Manton Owner: Siobhan Grady

							funding will ensure a meaningful number of assessments are carried out but this will still leave a significant number of CYP waiting.	
102	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that the number of Devon Partnership Trusts overdue Root Cause Analysis Serious Incident (SI) reports might affect the embedding of learning and improvement. The impact of this to the CCG is a lack of assurance that patient safety improvements from incident learning are identified and actioned in a timely way (Previously linked to mirrored risk 103 which is now closed) (HISTORIC ID: Na)	May 2020 - Meeting arranged w/c 01/06/20 with Chris Burford, DPT & Phillip King, Devon CCG to include discussions around the increase in outstanding SI's & for an agenda item at the June QAC to be added on outstanding DPT RCA's. It was agreed this risk needs to be reviewed following the meeting with DPT (SD) May 2020 - Executive level decision has taken place during May 2020 between the organisations' Director of Nursing to address on-going late serious incidents (SW) April 2020 - The number of overdue SIs has increased. DPT remain committed to resolving but have lost staff to the COVID-19 frontline reducing their capacity to undertake RCAs. Safety systems team in regular contact with DPT (SZ) March 2020 - All overdue RCA's have been allocated to reviewers as of 5th March 2020. It was felt at Quality Assurance Committee on 12/03/20 whilst the number has not improved the quality and engagement is improved. The risk score will be reviewed as planned in April (IL) [Control Gaps] April 2020 - The number of overdue SIs has increased. DPT remain committed to resolving but have lost staff to the COVID-19 frontline reducing their capacity to undertake RCAs (SZ) March 2020 - DPT are not meeting trajectory, 31 remain overdue, this continues to be escalated to DPT Director of Nursing via DPT Head of Safety and Risk (IL) Assurance still lacking at Quality Committee in Common due to the written report on the management of Serious Incident's not being submitted – CCG chasing	15 [21/02/2019] ▼ 15 (L=5 x I=3) [25/01/2019] 20 (L=5 x I=4)	Risk Opened: 25/01/2019 Reviewed: 26/05/2020		March 2020 - The quality of investigations has greatly improved with less being returned for further information. The number of reported investigations has reduced to average 7 a month opposed to 12-13 a month, this is due to work with CCG / DPT/safeguarding and NHSE, reduced duplication and ensured only appropriate incidents reported. The number of overdue investigations has plateaued. There are now more clinical reviewers so more capacity in the team following training undertaken (IL) [Assurance Gaps] Action planning for overdue incidents is not visible whilst overdue. The quality of 'immediate' 72hr reporting is important in assuring that identified safety issues have been implemented.	Executive Lead: Darryn Allcorn Owner: Sara Wright
116	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that there will be a system impact from the COVID-19 outbreak (caused by a strain of coronavirus), affecting routine business among provider organisations and the CCG. The impact of this is; a) that both the CCG and provider organisations have a reduced capacity for routine business. b) that the CCG loses lines of assurance and accountability from provider organisations, reducing overall sight of, and assurance levels around, provider organisations. Potential mortality and morbidity impacts are included in this risk. Staff morbidity would exacerbate individual provider and system impact. (HISTORIC ID: Na)	May 2020 - The request to close this risk following discussion at QAC was declined due to the likelihood of command structures being stepped down & aspects of the risk that QAC need to be sighted on (SD) May 2020 - Covid response to global pandemic is well embedded within the formal incident management structure & actions across the CCG & wider Devon system. Liaising through regional LRF - command structure in place. All Covid-19 related risks are now captured in the Covid-19 risk register which is reviewed weekly & has Executive oversight. Recommendation to close this risk will be verbally communicated at the QAC on 28 May (LW) April 2020 - COVID risks are being sorted separately (SZ) CCG Incident Control room functions Care Cell: attached to Incident Control room Regional NHS England and Public Health England updates Provider & CCG business continuity plan implementation [Control Gaps] Resource required within the CCG in collaboration with provider organisations to support the COVID-19 response, coupled with anticipated staff sickness related to same, is resulting in cancellation of assurance meetings/work and de-prioritisation of other facets of organisational assurance.	15 [11/03/2020] 15 (L=5 x I=3)	Risk Opened: 11/03/2020 Reviewed: 26/05/2020	[10/04/2020] Incident control room functions as evidenced in action log,	The CCG Incident Control room functions on a continual basis and includes senior leadership. [Assurance Gaps] None identified	Executive Lead: Darryn Allcorn Owner: Jonathan Plumb

V1.10 updated 09 to 11 June 2020

Area of Risk	There is a risk that….....	Impact	Initial Likelihood	Initial Impact	Initial Risk Score	Current Likelihood	Current Impact	Current Risk score	Risk Score Movement	Mitigating Actions in Place	Exec Lead	Risk Owner	Further Action Required
CCG Business	The CCG does not have effective and efficient mechanisms for incident management	CCG is unable to co-ordinate the range of activities required for incident management. CCG play its part as a system leader during the COVID incident	2	4	8	2	4	8	⟺	Incident Control Room established with underpinning SOPs. Daily huddles and battle rhythm in place. Links to Regional ICC. System Gold Call three times a week LRF links in place and with local provider EPRR Leads. Business Continuity plans reviewed and refreshed;	Sonja Manton	Ginny Snaith/ Clare Doble	Weekly review with Incident Managers. Incident response review underway
CCG Business	The activity and performance requirements nationally mandated are not fulfilled due to local system capacity response to COVID 19, reducing critical care and elective capacity.	a)CCG and system do not meet agreed performance and activity targets b)CCG in contravention of its constitution c)patients are not seen within the mandated target times	2	4	8	2	4	8	⟺	Nationally mandated requirements have been revised. CCG is complying with these requirements Risk is recorded on the Regional Critical Care Cell Risk Register (SFT 23/04/2020) 10/06/2020 reviewed DB	John Dowell	Derek Blackford	
CCG Business	The CCG is unable to discharge its mandated and constitutional role due to the need to respond to the COVID outbreak and diverting its resource and expertise to lead this response at local level	a)CCG contravenes its constitution and role as system leader	2	4	8	2	4	8	⟺	CCG has reviewed and redeployed staff. Exec Team meets 3 times a week to review hot topics, and reviews list of deployed staff on a regular basis to ensure needs of the organisation are met. Exec Team also reviews incident management mechanism and cell structure to ensure fit for purpose to meet the needs of the organisation. NHSE/I aware of organisational need to redeploy staff as a result of Covid19. Daily CEO meeting with Devon providers in place.	Simon Tapley	Sarah Thompson/ Ginny Snaith	
CCG Business	Mandated quality and safety standards are compromised as resource is diverted to support COVID response, with less focus on normal quality reporting and intervention	The impact would be that: a)CCG quality team less sighted on quality or safety issues within provider settings b)CCG in contravention of its constitution and role as a system leader. C) Ability to understand themes related to quality across system diminished	4	4	16	4	4	16	⟺	CCG Safety Systems and Patient Experience Teams in place and monitoring serious incidents and complaints, thematically analysing available information, and cross referencing with other information sources where available. Nursing & Quality attendance at provider Governance Committees to continue.	Phillip King/Darryn Allcorn	Lorraine Webber	Some clinical cell staff returning to support review and restoratio/transformation of quality surveillance function LW 29/05/2020
CCG Business	Governance and accountability channels are compromised or not followed as required due to the constantly changing environment, speed at which tasks or guidance require enactment or lack of knowledge and understanding of governance requirements	The impact of this: a)compromising of the CCGs constitutional requirements b)unlawful and/or unsafe decisions being made c)no or limited audit trail of decision making processes	2	4	8	2	4	8	⟺	CCG has reviewed governance and accountability arrangements and proposed interim arrangements. Agreed at March GB. Paper on new arrangements approved at April GB	Ginny Snaith	Clare Doble	
Service Provision	There will be insufficient critical care capacity and capability to respond to the modelled surge/increase of COVID positive patients in Devon	This impact of this: a) COVID 19 patients may not have access to the level of critical care and equipment they need b) lack of required intervention will increase level of deaths	3	5	15	3	5	15	⟺	Modelling work underway Nightingale Hospital under construction Daily monitoring of critical capacity Staff re-training underway to support if required Programme to access increased number of ventilators Risk is recorded on the Regional Critical Care Cell Risk Register (SFT 23/04/2020)	Penny Harris/ Sarah Thompson	Sarah Thompson	Ongoing link to Regional cell as much work co-ordinated through this route
Service Provision	Decisions to make changes to services commissioned by the CCG through providers are done so without full cognoscente, clinical oversight and agreement whilst responding to the COVID 19 outbreak and management of capacity and resource	The impact: a)decisions made in isolation and impact on other services or capacity in system b)inequitable access for patients to services	3	5	15	3	5	15	⟺	Process in place for CCG AO sign-off of all proposed service changes - This includes risk assessment and clinical input. QEIA requested by CCG is assessed as required. QEIA has been streamlined/ adapted for COVID pandemic period service changes. Clinical Reference Group reviews Service Change log on a weekly basis. Service changes also reported to the CCG Governing Body on a monthly basis. 5.6.2020 update: Process remains in place and reported as above. Assessment of providers consideration to EDI included.	Simon Tapley	Sarah Wright	Review of QEIA to ensure robust process This risk has been escalated via the CCG SCG sitrep report. CCG working closely with Local Authorities to support provision of care in Care Homes - this risk has been escalated via SCG+G11 sitrep
Service Provision	That patients across the age spectrum, who require urgent or ongoing care will not access care in a timely way due to fears or uncertainty about attending or contacting hospital services	a)escalation requiring emergency admission and / or treatment b)early death or harm, including reduction of treatment options c)Future capacity unable to cope with backlog or sudden increase in referrals as lockdown is lifted.	5	5	25	2	5	10	↓	This risk has been escalated via SCG sitrep reporting to National partners. CCG Comms in line with national Comms to encourage the population to access services. Clear guidance has been received, communicated and implemented in both primary and secondary care in the management of cancer services. The CCG has joined with the Cancer Alliance, CRUK and Macmillan to agree a local communications message and campaign to encourage patients to present to their GP if they have concerning symptoms and to attend their appointments stressing the safetymeasures that have been put in place to enable these interactions to happen safely. LW 06/06/2020 I would update that 'adverse impacts' as a result of access to service or treatment delays are routinely monitored through our quality assurance routes which includes SI's, complaints, PALs enquiries and all core quality and safety intelligence that we review regularly. Themes from provider specific access or delay incidents are reviewed within their governance meetings attended by senior CCG nursing team and this adds to our overall surveillance programme. 08/06/2020 The Executive Team discussed and agreed to reduce the likelihood score to 2.	Simon Tapley	Lorraine Webber	
Service Provision	Care home and care at home could become compromised, due to outbreak risk, PPE, staffing and pathway issues. LW 05/06/2020	Unable to discharge patients from hospital in a timely manner to create required acute capacity Individuals safety & quality of care at risk due to: inadequate packages of care, staff capacity, equipment and training. LW 05/06/2020	5	4	20	5	4	20	⟺	CCG working closely with Local Authorities to support provision of care in Care Homes. 30.5.2020: SW: CCG led, multi partner Care Home & Care at Home Cell commenced 25.5.2020. CCG continue to support the LAs, care homes and home care through Care Home, PPE and Discharge Cells. Includes training and supply of PPE. 5.6.20 Support plan with programme of inputs in place and progressing - includes medicines, primary care, clinical nominated leads, training, digital and market support	Simon Tapley	Jo Shill	

Service Provision	The CCG will have insufficient plans in place to move the Devon system back into business as usual following COVID due to the capacity of staff to focus on recovery and re-establishment of elective and planned care.	a)Lose opportunity to implement system transformation b)delay in reestablishment of normal business and access to services c)deterioration in health of previously non-urgent diagnosed patients d)lack of clarity around service provision and return to BAU	4	4	16	4	4	16	⟷	Recovery cell developing the arrangements required to ensure transformational recovery of services post-incident. Restoration and Transformation cell and programme is well underway. The Restoration and Transformation Cell has weekly drop-in sessions with the CCG Executive Team on a Friday. This covers services standing back up, each workstream to respond to the Phase 2 NHSE/I requirements and updates from their programme.	Simon Tapley	John Finn	
Primary Care	COVID-19 outbreak could adversely affect the primary care teams ability to deliver current workplan and business as usual tasks.	The impact of this is that the delivery of general practice is compromised and could affect all areas of the healthcare system.	3	3	9	2	3	6	↓	**Apr 20 - COVID report due to monthly Primary Care Committee.** CCG Primary Care COVID lead identified Primary Care participation in CCG Daily COVID calls Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Regional NHS England and Public Health England updates Team reviewing daily COVID updates from comms team COVID report due to monthly Primary Care Committee Team business continuity plan Team what's app group enabled Working from home processes enabled 10/06/2020 - the Primary Care team has been divided into a COVID Team and a Business as Usual/operational team to ensure capacity to fulfil all requirements	Jo Turl	Mandy Seymour	Apr 20 - Team business continuity plan. Team what's app group enabled. Working from home processes enabled. COVID report due to monthly Primary Care Committee.
Primary Care	COVID-19 may result in GP practices being unable to return to business as usual in line with guidance if GPs are still actively dealing with COVID issues.	The impact of this is that the delivery of general practice is compromised and could affect all areas of the healthcare system.	5	5	25	2	4	8	↓	CCG team are keeping a log of any activity stood down PC team will work with recovery cell to reinstate Business as usual 10/06/2020 IT solutions have helped to support delivery of primary care by remote working	Jo Turl	Mandy Seymour	
Primary Care	Other primary care providers (other than GP or pharmacy) are not fully briefed or supported at a local level because NHSE commissioners and resource is redeployed to support COVID adding additional pressure on the Devon Primary Care commissioning team.	a) Increased workload for primary care team b) Potential reduction in services due to mixed or insufficient advice and guidance	3	3	9	3	2	6	↓	CCG Primary Care Team working with NHSE to coordinate messages 10/06/2020 Primary Care Team is supported by additional staff seconded to the team. Weekly calls with NHSE/I to mitigate and discuss any risks and escalate issues.	Jo Turl	Mandy Seymour	
Primary Care	There is insufficient access to digital solutions to support new ways of working in primary care	Patients may attend care facilities when care could more effectively and safely be delivered at home	4	4	16	2	3	6	↓	The CCG had deployed around 500 laptops to Devon GP practices as well as providing or funding several other remote working methods to allow GPs and other practice staff to work from home when required. A further batch of laptops (200) are about to be deployed at PCN level. Risk of resources (laptops etc) not being in right place if Track and Trace ends up in focussed isolation in small number of practices remains but will be localised JG	Andrew Millward	Jim Goodwin	Rollout of additional 200 laptops to PCNs. Hold stock of laptops in case of localised issues in practices (e.g. if track and trace ends up in high number of individuals having to isolate from one practice) JG
Ethical Framework	Decisions will not be made based on an ethical framework	Poor decision making will result in harm to patients. Significant risk of legal challenge	5	5	25	2	5	10	↓	Ethical Framework developed by NHSE/I. Ethical Reference Group established for Devon system 27/05/2020 Exec Team - Recommended the likelihood score can be reduced for this risk, as likelihood of not following the framework is reduced if it is approved by each organisation Board	Penny Harris /Paul Johnson	Penny Harris	Local implementation of framework. Ongoing review of decision making and support for frontline clinicians
CCG Staff	There are insufficient numbers and capable workforce to support the required response to the COVID outbreak	CCG unable to support local system as required or needed	2	3	6	2	3	6	⟷	All BAU functions reviewed and staff redeployed where appropriate. Regular reviews by Managers and Executives to ensure appropriate staffing in place.	Andrew Millward	Piers Tetley	
CCG Staff	Staff will suffer an increase in mental health issues due to social isolation, lone working and reduced direction driven by home working	a)reduction in staff available to work due to health b)reduction in staff available to work due to personal relationship breakdown c) increase in self harm/suicidal tendencies	4	3	12	3	3	9	↓	Managers contacting staff on regular basis Video briefings from Simon Tapley Regular written communications Staff made aware of access to support services Use of Teams to provide video contact 05/06/2020 likelihood score reduced AM	Andrew Millward	Piers Tetley	Weekly programme of activities to be co-ordinated by Staff Forum e.g. Virtual Coffee Roulette
CCG Staff	CCG staff are not fully utilised during COVID response if BAU not required in their area and redeployment not forthcoming	continued to be paid but no outputs recorded Reduced motivation Loss of skills	5	3	15	4	3	12	↓	Redeployment list held by HR. Managers and Execs reviewing with staff on regular basis. Liaison with providers (and other potential organisations for redeployment) 05/06/2020 likelihood score reduced AM	Andrew Millward	Piers Tetley	
PPE	There is an insufficient supply and access to appropriate PPE equipment to support the clinically safe management of COVID spread both to protect staff from already infected individuals and to contain further spread	The impact is: i) Potential scarcity of PPE as a result of volatility and uncertainty of supply due to changing policy landscape; ii) PPE may be a rate limiter in the recovery and restitution of non-elective and elective work in secondary care and primary care services; iii) Unable to meet the needs of care homes and increased infection rates if unable to complete fit testing given the size of the task and the differing designs available; iv) That there is inadequate supply of PPE to care homes as other COVID work steps down, such as LRF supply.	5	5	25	4	5	20	↓	This risk has been escalated via the CCG SCG sitrep report. PPE cell established and co-ordinating provision of PPE from local and national sources Processes developed by PPE Cell to compliment existing processes which include daily monitoring of all stock levels	Phillip King/Darryn Allcorn	Vanessa Crossey	Improved liaison with LRF. Improved reporting from providers on current stocks
Staff testing	Front line staff including community staff do not have ready and easy access to testing	The impact of this: a)unintentional increase in spread of COVID to individuals and patients as people continue to provide care or go about essential tasks b)Staff may self-isolate believing they have COVID due to symptoms and reducing clinical and care workforce	3	5	15	1	5	5	↓	Processes established for identifying staff for testing. Significant capacity available but uptake currently low (only using about a third of the capacity). All symptomatic staff have access to testing and currently working through process for testing asymptomatic staff. This includes support to the care sector as well as NHS staff through local coordination centres.	Sonja Manton	Fiona Peck	Further work with care sector on testing asymptomatic staff and residents. Develop home testing arrangements

Patient testing	Residents and staff in the Devon system will have inequitable access to testing and interpretation of guidance because there is no overarching single point of contact in Devon to co-ordinate this because responsibility lies with multiple stakeholders (three different local authorities serving the wider Devon population and regulatory bodies)	a)safety of staff and residents of care homes compromised b)inconsistent messaging to care homes across CCG footprint c)increased spread of Coronavirus in care home setting d)reduction in care home capacity if homes close to new admissions e)increased DTOCs in acute setting because of reduced capacity	3	5	15	2	5	10		CCG resource identified to support wider work on testing, linking with pathology network and LRF leadership on testing. Joint working arrangements with LAs through incident management arrangements. Maximising use of local acute testing capacity via locality coordination centres. Senior leadership also now working to join up work across all the testing pillars, including dedicated time with the LRF. Process in place to work as a network and arrange for testing across providers/ sites to ensure ease of access.	Sonja Manton	Fiona Peck	Ensure that access to rapid turnaround testing is arranged in such a way that patients awaiting results before moving on in their pathway are not disproportionately affected by availability of these tests locally.
Vulnerable groups	Patients who are on or will need to access an End of Life pathway are unable to access the support and care they need due to the focus on the COVID-19 outbreak	a)Inequitable access to care and treatment b)patients receive poor experience in EOL pathway c)clinicians and patients/families unclear on pathway d)uncertainty on where to get information	4	4	16	4	4	16		Multiagency end of life group established to develop pathway and communicate with relevant groups. Programme of work in place with key CCG staff to support arrangements for EoL CCG system leadership role, including support from Clinical and Meds Op Cells.	Phillip King/Darryn Allcorn	Lorraine Webber	EOL Task & Finish group undertaking surge capacity planning and a small expert group now reviewing treatment escalation plans (TEP) including DNAR process issues for out of hours clinical staff where printed or email version of TEP is used. Revised VOED guidance approved and in place. LW 01/06/2020
Vulnerable groups	Individuals across Devon system are falling through gaps in the nationally described process for identifying patients who should be shielding	a)patients who think they should be shielding isolate and are not eligible for support b)patients identified by secondary care may be taken off by primary care and not informed	4	4	16	2	4	8		CCG giving regular updates to primary care via daily bulletins and weekly webinar with guidance and advice Commissioning ADs co-ordinating response to shielded patients across localities and partners BI working to share data across all partners 10/06/2020 Project manager in place to coordinate system response	Jo Turl	Mandy Seymour	
Vulnerable groups	Safeguarding arrangements during the COVID-19 incident are continuing, but may not be as effective during this period due to the limitations all organisations are required to work to during the incident.	The impact to the CCG is that we may not be receiving assurance from providers that vulnerable people are being identified and responded to and could be experiencing abuse and neglect.	4	4	16	3	4	12		Guidance sent to providers to disseminate to front line staff regarding remote working practices that encourage disclosure. Practitioners still having face to face contact with vulnerable patients. Rise in education provision and attendance by vulnerable children, and rise in individuals re-engaging with health services gives greater opportunity for abuse to be identified and addressed. Calls continue with provider safeguarding leads, now moved to fortnightly and meeting scheduled to focus on non-covid issues. Ability to gain assurance from providers has increased as provider safeguarding committees are reinstated. Limited redeployment within safeguarding services currently. 05/06/2020 MT reduced likelihood score , the reason for this is the increase in education provision and attendance at school by vulnerable children, and rise in individuals re-engaging with health services giving greater opportunity for abuse to be identified and addressed. Ability to gain assurance from providers has increased as provider safeguarding committees are reinstated.	Phillip King/Darryn Allcorn	Michele Thornberry	

Risk Assessment Scoring Guidelines

Risk Assessment Scoring Guidelines - Using the management response guidance at the bottom of this page:

- If a risk falls into one of the boxes numbered **15-25** immediate action is required, so far as is reasonably practicable. (Risk score of 25 can only be approved by the Accountable Officer)
- If a risk falls into one of the boxes numbered **8-12** prompt action is required, so far as is reasonably practicable.
- If a risk falls into one of the boxes numbered 4-6, risk reduction is required, so far as is reasonably practicable.
- If a risk falls into one of the boxes numbered **1-3** further risk reduction may not be feasible or cost effective.

Assessing the likelihood/probability of risk

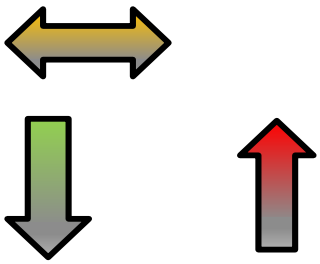
Score	Description	Definition
5	Almost Certain	Very likely. The event is expected to occur in most circumstances as there is a history of regular occurrence at the CCG or within the NHS.
4	Likely	There is a strong possibility the event will occur as there is a history of frequent occurrence at the CCG or within the NHS.
3	Possible	The event may occur at some time as there is a history of ad-hoc occurrence at the CCG or within the NHS
2	Unlikely	Not expected but there is a slight possibility it may occur at some time.
1	Rare	Highly unlikely, but it may occur in exceptional circumstances. It could happen but probably never will.

Risk scoring matrix (5x5 scores for impact & likelihood/probability)

		Likelihood/probability of Risk Occurring				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Impact	1 low	1	2	3	4	5
	2 Minimal	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 High	4	8	12	16	20
	5 Significant	5	10	15	20	25

Risk scoring categorisation	
1-3	Low risk
4-6	Medium risk
8-12	High risk
15-25	Significant risk

Overarching Risk Score and Management Response				
Risk Ranking	**Low**	**Moderate**	**High**	**Significant**
	1-3	**4-6**	**8-12**	**15-25**
Rectifying Action	**Business as usual. Acceptable but continue to monitor.**	**Management responsibility must be specified and actions set out over time**	**Senior Management attention needed. Actions set out within defined timescale to address control weaknesses**	**Immediate action required mitigate the risk and address in control or arrange continge**
Monitor	**At operational / departmental level**	**At operational / departmental level**	**Senior management**	**Executive level**
Escalation	**Risk Register**	**Risk Register**	**Risk Register**	**Governing Body Risk Assura Framework**
Acceptable Risk Score for Appetite	**5**	**8**	**12**	**15**



NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee (QAC)

Date of Governing Body: 18 June 2020

Dates of Committees covered in this report: 28 May 2020

Chair's Name and Title: Glynis Atherton, Non-executive lay member (Chair of Quality Committee)

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

The Committee received update reports as detailed below

Reports received and noted

Situational Updates (SBAR) received

Quality, Equality Impact Assessments of service changes

- Initial evidence suggests COVID-19 has potentially highlighted inequalities within the system and these will be considered as services are restored and transformed. A significant number of service changes were made in response to the COVID-19 pandemic. Many of these were nationally mandated.
- The QEIA panel was initially stood down during the Covid-19 response. A key development during this period has been the introduction of a short form QEIA that all providers were required to complete as part of the service change application process.

Patient Safety and Quality During COVID-19 in Acute and Community settings

- As a result of national guidance, many provider meetings where quality assurance information is routinely gained, have been stood down. However quality assurance has been sought through elements of the Quality Assurance Framework process (including serious incidents, complaints and concern), as well as from individual CCG cells and system partner incident management teams. Pre COVID-19 escalated quality issues will now be reviewed.

Patient Safety and Quality During COVID-19: Mental Health Services

- The Covid-19 pandemic is creating opportunity for creative and alternative ways of providing support to local populations which has the potential to improve access and delivery of mental health services for individuals in the longer term. The CCG 'Restoration and Transformation' work programme will focus on maintaining the positive service changes that can improve quality, including patient experience. Pre COVID-19 escalated quality issues are being reviewed and include delays in completing serious incident analysis reports.

Patient Safety and Quality During COVID-19 in Children & Young People Services

- Pre COVID-19 escalated quality issues are being reviewed. These include long waiting times for care including CAMHS, assurance processes by sharing of information in a timely manner with commissioners, and leadership.
- A Joint Management Incident Team for CYP has been established, chaired and led by the CCG and Local Authority colleagues.
- Devon system "Gold" calls ensure information is shared as well as issues escalated. This includes local authority colleagues who can offer additional community perspectives.
- The Devon Children & Families Partnership has been re-purposed to become the Joint Operational Incident Management Teams (JIMT). Note: For Plymouth City Council the Children's Services Bronze Response Room is working with the Children's Safeguarding Partnership and Children and Young People's Partnership, to help co-ordinate the local response to COVID 19.

COVID-19 Related Quality Updates (SBAR)

Monitoring of safeguarding response during the COVID-19 pandemic

- Isolation may increase the safeguarding risk to some individuals. Where services have been stood down or significantly adapted, the opportunity for patients to seek help or for signs of abuse to be identified by professionals is greatly reduced.

- As part of the statutory safeguarding responsibility held by the CCG, assurance from is being sought from providers on their processes for assessing potential adverse impacts on individuals through the implementation of national guidance during the pandemic and the system's ability to safeguard individuals.

Care Home Support Offer

- The committee received a paper detailing the multiple elements of the support being offered to care homes.

End of Life Care during the COVID-19 pandemic

- The committee was given a presentation and update on the end of life care work programme during the pandemic.

Risk Register Review Updates

Quality Risk Register Review (Corporate & COVID 19 Risk Registers)

- At 14 May 2020, NHS Devon CCG has 27 open risks on the corporate risk register. 16 of which reporting to the Committee. There are three risks pending closure as approved by the respective Executive.There are no new risks reported to the Committee during the period March 2020 to 14th May 2020. There has been no risk movement within the reporting period 26 February 2020 to 14 May 2020.
- The committee requested a potential new risk to be considered regarding the influenza vaccination programme this year.
- Risks held on the Covid 19 risk register that relate to the committee were also shared. The committee supported the report and assurance ratings as an accurate reflection of current patient safety and quality issues across the system. All ratings were assured.

Committee Decisions

No specific decisions required.

Items of concern to be escalated to the Governing Body
• The committee requested to understand if there is financial support for improving the position in relation to the autism improvement project beyond year end. • The committee acknowledged that whilst the Devon Partnership Trust (DPT) position in relation to outstanding serious incident reports has not increased and the quality of the reports has improved, the CCG is not seeing a reduction of outstanding serious incidents and this has been a longstanding issue.
Recommendations for Governing Body
To note the reports received and positions of assurance by the Quality Assurance Committee.
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
The Terms of Reference were discussed and following a review session in February 2020, a proposal for revisions to the Quality Assurance Committee will be presented to the June meeting. Further scoping and schematics are required to strengthen interdependencies between the Finance and Quality Committees, whilst ensuring clarity of role within the wider CCG and system Governance structures. There will also be consideration to strengthening engagement within the scope of this Committee.

Management of Conflict of interests:

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

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

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GOVERNING BODY

Report title: Locality Update Reports				
Date of committee: 18 June 2020 **Date report produced: 8 June 2020**				
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 08 June 2020**		
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, Southern and Western 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		

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Locality update report

Locality:	Northern.
Period covered by update:	March 2020 – May 2020
Locality clinical representative:	John Womersley
Locality executive lead:	Andrew Millward
Locality non-executive representative:	Charlotte Burrows

Key achievements/progress

- The new ways of working under the lockdown period have brought about an opportunity to make positive changes in the way the local health and social care system functions, both in the planning and delivery of care.
- Cross-organisational collaborative working, driven by strong supportive relationships, has taken centre stage. Not everything has gone well, but we intend to celebrate the successes and improve the deficiencies.

  In line with other hospitals in Devon outpatient and routine referrals were managed differently to aid capacity for dealing with Covid-19 Patients. NDHT has not seen a huge number of Covid-19 patients in the period March to June and capacity levels have been good. Nonetheless most system appointments have been able to move to 'virtual' offer and this has been viewed positively. As agreed with the CCG, NDHT was initially working to a 50% occupancy. This has now been increased to a 65% occupancy and NDHT have largely kept within this level except when wards are closed for deep cleaning. This will be monitored and reviewed.

- To aid system working, a series of Covid-19 cells have been set up. NDHT have an internal COVID-19 Cell. The CCG host two COVID-19 cells. The first is a Primary Care Cell composed of PCN Clinical Directors, GP Collaborative Board and CCG members. The second is the Northern System Covid-19 Cell which has GP Collaborative Board, NDHT acute and community members, DCC social care and SWAST colleagues as well as input from James Wright, Gill Munday and Becky Harty from the CCG. The cells have been very productive and there has been a good level of collaborative and joint working.

- A Primary Care Covid Site for the Northern Locality was sourced. The hospital worked closely with primary care and the CCG with regards to how the site would run and the interface with primary care and staffing.
- Collaborative working between Devon County Council, the CCG, NDHT, community services and primary care allowed for the opening of the Durrant Care Hotel. This is a hotel in Bideford that is being used as a temporary, short-term step-down facility for people who have not tested positive for COVID-19.
- The discharge of patients generally was discussed, and plans put in place to offer support from NDHT for these patients. This includes 12 days of senior clinical support being available by phone.
- Shielded Patients have been discussed and reviewed. Due to a good piece of collaborative working with the hospital clinical team and Primary Care, the lists for Northern Devon have been reviewed and verified. Plans are now being put in place for how these patients are identified on the system so that the appropriate levels of care and support can be put in place.
- Discharge planning has been a key part of our discussions. The impact on Social care services has been reviewed to ensure that no part of the system is overwhelmed.
- Support for Care Homes has been another key discussion area. Discussions held during our meeting has meant that there has been a link between the support being offered from the clinical team at NDHT, Community services support and Primary Care Support. This facilitated a quick response for the Care Homes Lead Work for the CCG.
- Community TEP Forms and the process for supporting Care Homes regarding decisions on admittance to hospital was discussed and process improved.
- Testing has been discussed. NDHT provided local support to Primary Care for testing Primary Care colleagues before a fuller testing regime was set up. NDHT has also been able to offer support to Community colleagues for Care Homes Testing whilst a fuller process was put in place
- As a result of discussions on the Northern Covid Call the Community Team are now sharing their 'Sit reps' with Primary Care.
- The NDHT Clinical Restoration Cell has been linked with the CCG Restoration Cell which will negate duplication or decisions being made in isolation.
- The weekly CCG/GP calls are developing into our Primary Care Restoration & Redesign cell.
- The Northern System COVID-19 Cell meeting calls have enabled Primary Care in northern Devon to be kept up to speed with what is happening within the Community Work and NDHT. This has enabled the planning of resources and areas of interdependent activity such as the Durrant Care Hotel.

Key priorities for the next three months

- The Restoration and Transformation Work needs to be embedded within the Northern Locality Structure. We have been fortunate to see new ways of working that have become embedded very quickly. We need to make sure we capitalise on this and look at how we can permanently transform our way

of working to ensure that there is collaboration between the various sectors. It is important that sectors do not work in isolation but see how the changes they make can impact on the system as a whole.

- We need to support our Primary Care, Hospital, Community and Mental Health colleagues in stepping back up their non-COVID offer, and ensure that there is a safe way of working as we continue to deal with an ongoing COVID threat in our community

- We need to strengthen our resource of **Locality Clinical Advisors.** We now only have three working for the Locality, totalling six of our 10 sessions, as the fourth has now moved more into a role supporting Medicines Optimisation.

- We need to make sure that plans for a **Northern Local Care Partnership** continue to be developed. Hopefully the joint system working we have seen over the past 3 months will enable us to set this up more quickly and with more support than was thought previously.

- We need to understand how the lockdown has affected the mental health of the Northern Devon population. This will not just be about isolation but also the economic effects on our community and the support available to people to make sure that there is financial and medical support available to help with mental health concerns and overall wellbeing.

- One Northern Devon will continue to work with local councils and the Voluntary Sector to provide support through OND's cascade system that links requests to the One Communities' and local parishes' volunteers.

Issues of concern or risk

- The planning for a second wave of Covid-19 for the Northern Locality need to be enhanced

- Workforce burnout is a real risk. The lockdown and extension of a new way of working has created fatigue in the system workforce and we need to look at how we can work differently but in a sustainable manner

- Funding for the additional work involved in coping with the Covid-19 Crisis needs to be understood and the longer-term implications for the locality and for the CCG need to be reviewed

- There is a growing concern in the system that we may see an increase in patients presenting late with conditions that need attention.

- There is a concern in the system that a further relaxation of lockdown and an unfettered influx of visitors to the county will put an increased strain on resources and may increase the R rate for our locality.

- We need to build on the good work that has come out of the new ways of working and avoid slipping back into the older system working.

- The **Northern Devon Suicide Prevention** initiative, which was going to link the STP Suicide Prevention programme with the One Northern Devon Suicide Prevention Action Plan, was hindered by the pressures of adjusting to the COVID-19 Challenge. We need to make sure that this stepped back up again as this will become more important than ever in the current situation which we are facing.

Discussions are needed regarding funding for the One Northern Devon initiative as part of ongoing work on its scope and development.

Support required from CCG/system or barriers to progress

There needs to be a greater recognition that paying attention to the wider determinants of health will significantly improve our populations quality of life. Increased resourcing in this area will improve peoples' wellbeing and most likely reduce longer term dependence on health services.

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Locality update report

Locality:	Eastern
Period covered by update:	March-May 20
Locality clinical representative:	Simon J Kerr
Locality executive lead:	John Dowell
Locality non-executive representative:	Glynis Atherton

Key achievements/progress

- Eastern locality tactical call established weekly bringing together partners from across the Eastern Health and Care System to develop locality strategic approach to commissioning and operational delivery amidst the covid-19 pandemic. The forum has presented an opportunity to test and reshape the longer-term Eastern locality architecture and build/ strengthen relationships between partners.

- Implementation of the covid-19 national discharge standards and the focus of the CCG Discharge and Out of Hospital Cell has enabled a close focus on the day to day management of discharges within the Eastern system and seen a significant improvement in DTOC and flow; “Green to Go” list moving from 130 to 35 and achieving discharge within 24-48 hour.

- Work has begun to produce an Eastern locality capacity and demand plan to describe out of hospital services, demand and capacity; this plan will support the locality with restoration and transformation as well as future pandemic surge planning.

- A care homes sub-group has been established to form an Eastern plan in response to NHS E requirements for care homes support and DCLG requirements for Care Home Resilience plans. Three pilots of multi-disciplinary working between RD & E and PCN’s are being established, we are working with DCC and the market management team to produce a simple support offer to homes communication which will be shared via the Provider Engagement Network which will identify which services to access according to need. The RD & E have made available their geriatrician

support line to care homes to support homes with the care of people post discharge.

- Support to the “recovery and restoration” cell to initiate services following a period of learning from the provision of covid services in the locality.

- Discussions initiated by the clinical team at the RD&E to understand how to provide a covid safe ED department and service by redesigning how the care is provided in partnership local PCN’s and the 111/CAS service.

- During covid service restriction the service provision from the community urgent care services at Tiverton, Exmouth, Honiton and Sidwell street Exeter have continued. Discussions have begun with the relevant providers to understand how to provide these services in the future.

Key priorities for the next three months

- Completing capacity and demand plan
- Establishing longer-term clinical leadership for each care home and continuing to shape the response to care home resilience plans.
- Continued development of the weekly East system tactical calls into a system demand and design partnership.
- Support the redesign of the ED at RD&E to improve the service for staff and patients and comply with social distancing requirements.
- Winter planning to include modelling of covid demand in addition to wider winter demand on services.

Issues of concern or risk

- The east system tactical call requires highly developed and trusted relationships between partners that will take time to develop and cement. This is unlikely to be in time to meet the requirements of the developing system work expected of the East.

Support required from CCG/system or barriers to progress

- Support from the CCG to further develop the emerging cross organisational relationships in the East to progress locality system into a partnership approach to care pathway planning and service delivery.
- Support to develop PCN specific locality hubs of same day primary care, shared nursing resource, community urgent care, social care and VSS services.
- Support to enable 111/CAS to have the capacity and skill set to act as the Devon central point of UEC signposting and triage to support the ED’s to

respond to the RCEM letter to ensure safe care and social distancing is maintained in the ED moving forwards.

- Project management resource to underpin the transformational plans within the East to identify and respond to the lessons learnt from covid19 service delivery and planning.

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Locality update report

Locality:	South
Period covered by update:	March – May 2020
Locality clinical representative:	David Greenwell
Locality executive lead:	Sonja Manton
Locality non-executive representative:	

Key achievements/progress

Service changes - response to COVID-19 and phase 2 recovery and restoration

The Trust and partners responded quickly to the NHS priority to create capacity to respond to the first C19 peak. An internal process was established to track service changes, including services stopped or reduced, to create capacity. The CCG had oversight of this process and the service changes made, of which there were approximately 110 service changes made, to release capacity, from March to April. The Trust's acute surge plan was shared with the CCG, which included ED streams for Covid and non-Covid patients and additional acute bed and ICU capacity. Community services also ran similar seperate service streams.

In particular, a second ED was created by utilising the existing day case surgery unit to accommodate a hot and cold ED site. Oncology was moved to Newton Abbot hospital to create additional capacity.

Following the publication of the service restart letter from NHSE/I on 29th April, the Trust have started a process of prioritising which services can start again and how, incorporating decisions about capacity, estates and PPE. Seven recovery programmes will oversee phase 2 and 3 of the restart process, and south system CCG leads have been identified for each workstream, which will also facilitate links with the 12 STP recovery priorities.

An overarching south recovery group consisting of all partners including SWAST, DDOC, primary care, local authority, CCG and TSDFT meet weekly to oversee this.

A joint meeting between the South devon locality primary care leads and the CCG primary care team has been established and an educational event being planned to share and review the learning from covid to inform the future way of working.

Urgent Care
The CCG are working with the Trust and the ambulance service to produce a mini-case study on the pre-hospital triage of potential ambulance conveyances that took place during phase 1 of the COVID-19 response. This was stood down following concerns on attendance at Derriford Hospital, but a clinical and managerial review of the scheme, involving SWASFT and TSD, is being led by Dr Dafydd Jones, UEC clinical lead and Christine Branson, Head of Urgent Care (South).

The Devon STP urgent and emergency care phase 2 recovery programme is focused on ED avoidance and achieving "socially distant" EDs, with a need to not return to pre-COVID ED crowding and waiting times. This includes working with 111 to strengthen capacity to support ED validation at higher levels to reduce attendance and working with SWASFT and other south west commissioners, and the AHSN, on initiatives which will continue to support higher hear and see and treat rates. There is learning that can also be taken from primary care's success with remote consultation.

Discharge Cell
The South Locality feeds into the Discharge Cell which is chaired by Penny Harris and Sarah Thompson on a daily basis.

The locality closely monitor all discharges in the 1-3 pathways (as described in the discharge guidance issued in March by NHSE). The locality team have daily huddles with the discharge hub in TSDFT to monitor discharge activity and pick up anything that can be done to expediate discharge or anything that needs escalating across the system.

This has worked well for the last 6-8 weeks with very few delayed transfers of care in the system and a steady flow of patients being discharged in a timely fashion to appropriate settings to continue their care.

Work with care homes

Torbay and South Devon have a well-established Care Home Visiting Service The CCG is currently looking into extending funding until the DES is published. Since the Covid-19 pandemic the Torbay Care Home Visiting Service (TCHVS) has transformed their way of working and now provides a predominantly remote support service, asking homes to take clinical observations, send clinical photos and undertake video consulting. They have been able to respond quickly to support three of their homes who have had confirmed Covid-19 cases. Working flexibly as a team has enabled them to continue their acute service to all of their homes, while one TCHVS GP conducted video assessments of every resident in the affected

homes, reviewed and updated every resident's treatment escalation plan (TEP) form. In addition they have also implemented a weekly well-being telephone call to support the staff in all of their homes. The TCHVS have been actively involved in the Covid-19 system wide approach too; have contributed to the End of Life task group, including developing video resources to support care homes with advanced care planning conversations and have helped develop the Covid19 Primary Care Home Action Card to support all practices responding to Covid-19 cases in Care Homes. The response from Care Homes regarding the Care Home Visiting Service has had a significantly positive impact on the Care Homes; health and wellbeing of all residents and to staff. The service is beginning to look at MDT working including medicines optimisation pharmacists, dieticans, geriatricians and Chadwell etc and is supportive of the RESTORE2 pilot which is underway. Note the service in South Devon is slightly different due to ways of working and the geographical footprint.

To note the three points outlined in the letter of 01 May are included and being driven forwards within the Covid-19 Restoration and Transformation and Integrated Care Model (ICM) and Social Care workstreams which are using much context of the services already being delivered.

Primary care

The Covid-19 primary care Covid hubs have been able to flex to meet demand:

- Cricketfield continues to be operational. The practice relocated back from Albany at the end of May. A portacabin will be in the Cricketfield car park for their PCN hub and escalation Covid hub for other South areas if needed. It is also the location for DDoc out of hours and the visiting vans are based there.
- Teignmouth continues to operate as a hub for Coastal PCN. They have a van to use for their visiting service.
- South Hams Hospital is equipped and ready to escalate to a Covid hub when required.
- Chelston Hall is equipped and ready to go should it be required.

Key priorities for the next three months

Service changes - response to COVID-19 and phase 2 recovery and restoration

The south CCG leads will be joining the Trust recovery programmes (clinical model, care at home, outpatient transformation, urgent care, electives and children and families) to deliver phase 2 and phase 3 changes.

The south system will have a recovery cell, co-ordinated by the CCG, which will meet weekly and bring together system partners to discuss response to C19 and short and long-term plans for service delivery, including overseeing all service changes in the locality.

Urgent Care
Review of admission avoidance schemes and consideration of establishment of a south Devon strategic urgent care group.

Discharge Cell
The locality is also working with the trust to focus on Length of stays over 7 and 14 days as these are slowly increasing. This will enable flow in the trust.

A review of the adherence to the Discharge Guidance is underway and this will help us identify where we need to focus efforts once we have located any gaps that might exist.

In order to support discharge, the Trust and CCG are working with Health Navigators to put in place health coaching support and follow up for those discharged from medical wards.

Primary care
The LES is still in LMC negotiations and not yet agreed. It is hoped it will enable local flexibility to complement existing services such as the care home visiting service.
In South the components already in place are the weekly check in call and care plans, however the pharmacy element needs addressing.

The South is supportive of using retired and returning GPs to support this work and Siobhan has connected with NHSE to discuss where returners can go.

An educational event is being planned with primary care to review the learning from covid with a view to understanding what has worked well for primary care and how to sustain that in the future.

Issues of concern or risk

Service changes - response to COVID-19 and phase 2 recovery and restoration

Ensuring alignment between STP work programmes, the south system and Trust recovery programmes is still being progressed.

A key challenge going forward will be to restart other essential services in the locality, whilst maintaining sufficient capacity for surge and social distancing.

Urgent Care
Increase in ED admissions and risks to delivery of A&E targets

Discharge Cell

The locality also monitor occupancy levels on a daily basis to ensure the trust is keeping to a sub 65% occupancy rate in their acute beds in order to be prepared for any future surge activity. The occupancy has remained below the target 65% apart from twice w/c 11th May. It is proving to be more difficult to maintain this level of occupancy as the demand for services starts to increase again. The number of ED attendances on 20th May was the highest it had been since 12th March and starting to look more like pre Covid rates.

Primary care
Query of how continued funding for Covid hubs will be managed.

Support required from CCG/system or barriers to progress

Discharge Cell

The provision of the wider support programme to care homes has made a difference to the relationship and willingness of care homes to accept patients being discharged from TSDFT. The continuation of this work will help to support the system.

Primary care
Concern about Flu vaccination this Autumn. NHSE/I has sent out invites to flu meetings (they are the commissioners). Jonathan Plumb leading from flu cell. All Collaborative Boards involved. A task and finish group being set up to include the LPC and determine how flu will be delivered this autumn. We will then work out what that looks like in south.

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Locality update report

Locality:	Western
Period covered by update:	To 5 June 2020
Locality clinical representative:	Dr Shelagh McCormick
Locality executive lead:	Jo Turl
Locality non-executive representative:	Nick Ball

Key achievements/progress

1.1 Continuing effective and positive engagement with partners including UHP, Livewell, local authorities, and Primary Care Network Clinical Directors through various channels including a weekly system video-conference – rapid raising of issues and risks, developing mitigations and enabling good communication in rapidly changing and complex environment.

1.2 All contracted organisations responded well to the national guidance and CCG's coordination of service changes early on and continuing through the COVID escalation.

1.3 Rapid transformation in response to COVID-19 escalation and national guidance through primary, community and acute services.

1.4 Members of the team are contributing to the various Devon-wide cells with a high proportion of staff seconded to other organisations to support the COVID response.

Key priorities for the next three months

1.1 Continued system escalation and response to COVID-19

1.2 Ensuring benefits reaped from escalation and rapid transformation are locked into local system through Restoration and Transformation work, Integrated Care Partnership procurement and other service improvements

1.3 Developments for use of Fair Shares funding, considering rapid transformation and change achieved recently and through COVID escalation.

1.4 Community wide capacity planning underway to understand the impact of any further peaks in COVID-19. The acute hospital capacity is better understood but the configuration of community hospital beds, hotel, intermediate care and independent sector capacity needs further work.

1.5 Progress PCN development in delivery the DES.

1.6 Bed occupancy remains higher than the refined target across the system and work continues to reduce this.

1.7 Concern at the availability of ICU capacity with the restoration of key surgical services, the continued need for access as a necessity of the Major Trauma Unit and any escalation of Covid cases.
1.8 Need to review ICP Specification and outcomes framework to take account of changes and learning during Covid.

Issues of concern or risk

1.1 COVID-19 – system-wide risks including to patients due to non-availability of services and healthcare and social care staff and wellbeing (various mitigations being actioned and will be considered and acted upon through Restoration and Transformation process)
1.2 Workforce capacity – nursing, domiciliary care, pharmacy, voluntary sector (being managed during COVID escalation, will require review and mitigation through Restoration and Transformation process)
1.3 Resilience of Plymstock GP practices as a result of Barton Surgery contract hand back (contract handed back 31 December 2019)
1.4 Community capacity for future COVID-19 peaks in activity needs to be understood as a priority.
1.5 Occupancy in UHP and Livewell SW being managed daily via the Discharge Cell.
1.6 Agreement on use of, and funding for Covid Hot Hubs for resolution within 2 weeks.

Support required from CCG/system or barriers to progress