NHS Devon Clinical Commissiong Group - Governing Body Meeting held in Public

Rooms 1a,b,c, Pomona House, Oak View Close, Torquay, Devon, TQ2 7FF

23 May 2019 14:00 - 23 May 2019 17:00

AGENDA

#	Description	Owner	Time
1	Welcome and Apologies Verbal	Chairman	14:00
2	Patient Experience - Charlotte's Story Film	Lay Member Championing Patient and Public Involvement	14:05
3	Register of Interests Paper Governing Body register 14.05.pdf 7	Chairman	14:15
4	Minutes and Action Log of the meeting held on 25 April 2019 Paper Drraft GB minutes held in Public 25.04.2019 v3 PJ... 11	Chairman	14:20
5	Chairs Report Paper Chairs Report V2.docx 21	Chairman	14:30
6	Interim Accountable Officers Report Paper Interim AO Report Governing Body PUBLIC NHS D... 25	Interim Accountable Office	14:40
7	FINANCE		
7.10	Finance and Performance Committee Report Paper Committee Chair Report - 18th April 16th May 201... 31	Chair Finance Committee	14:50
7.20	Monthly Finance and Activity Report Paper FPC_Report_GB_Month_12_FINAL_2018-19 (GB... 33	Director of Finance	15:00

#	Description	Owner	Time
8	GOVERNANCE AND ASSURANCE		
9	Risk Management Framework Paper Cover Sheet - Risk Management Framework.docx 55 Risk Management Framework V5.doc 59	Board Secretary	15:15
10	BREAK		15:30
11	Integrated Commissioning Executive (ICE) - ToRs Paper 1 Tors cover sheet.docx 93 2. Integrated Commissioning Exec ToR 16052019.d... 95	Interim Accountable Officer	15:45
12	Audit Committee Report Paper 1 Audit Committee Chair's Report -8.5.19.docx 101	Chair Audit Committee	15:55
13	FOR INFORMATION		
13.10	Quality and Performance Report Paper 01 Quality and Performance cover sheet.docx 105 02 Quality and Performance report.docx 109	Chief Nursing Officer/ Director of Commissioning	16:05
13.20	Locality Updates, Eastern, Northern, Southern and Western Paper 0. Locality Reports - front cover sheetcd.docx 139 1 Locality update report template Eastern Locality... 141 2 Locality update report template Northern May 201... 145 3 Locality update report template - Southern.docx 149 4. Locality update report template - Western.docx 151	Locality Clinical Lead Reprsentatives	16:15

#	Description	Owner	Time
13.30	Primary Care Committee Report Paper Committee Chair Report - Public PCC May 19.docx 153	Primary Care Committee Chair	16:40
14	Close of Meeting Verbal	Chairman	16:50

INDEX

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
	Ball	Nick	Vice Chair/Non Executive Director - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG	Member of Governing Body Member of Audit and Assurance Committee (Chair) Member of Finance and Performance Committee Member of Strategic Human Resources (HR) and Remuneration Committee	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
	Burrows	Charlotte	Lay Member - Patient and Public Involvement	Member of Governing Body Member of Quality and Assurance Committee Member of Strategic Human Resources (HR) and Remuneration Committee	I am chair of the Devon Maternity Voices Partnership (MVP) a collective of parents (and parents to be) and organisations who support maternity services (health professionals, charities, Healthwatch, non-health professionals) working together to review and contribute to the development of local maternity care across Devon. Devon CCG provide funding to the MVP		04/04/2019		09/04/2019	General Interest	Direct		NHS Devon CCG
	Collingwood-Burke	Lorna	Chief Nursing Officer and Caldicott Guardian - for NHS Devon CCG Interim Deputy Chief Officer NHS Devon CCG	Member of Governing Body Member of Quality Assurance Committee Member of Audit and Assurance Committee Member of Primary Care Commissioning Committee CCG Executive Team QEIA Panel Senior Leadership Team meeting (Strategic Risk Committee) Member Attendee Audit and Assurance Committee	Chief Nursing Officer for both NEW Devon and SD&T CCGs School Governor Ashleigh C 0f E School, Barnstaple and chair of the resources committee Member of and Nurse Lead for the national board for NHS Clinical Commissioners Chair of the Nurse Forum for NHS Clinical Commissioners Director role for DELT	Spouse is: GP Principal Wallingbrook Health Group - primary medical services (PMS) contract holder (ended 30/04/2018). Prescribed Specialised Advisory Group (PSSAG), Department of Health Member of Devon Health and Wellbeing Board GP Locum Devon Performers List from 01/05/2018	1 August 2017 - Joint post with NHS Devon CCG & New Devon CCG		17/04/2019	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015					Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Senior Leadership Team meeting (Strategic Risk Committee) Member Attendee Audit and Assurance Committee Member of Primary Care Commissioning Committee	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	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Member of Strategic Human Resources (HR) and Remuneration Committee (Non exec rem)	GP partner at Southover medical practice Member of an independant 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	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
Dr	Harrell	Ruth	Director of Public Health Plymouth City Council	Member of Governing Body Member of Primary Care Commissioning Committee	Member of NEW Devon CCG Governing Body		26/10/2016		26/10/2016	Non-Financial Personal Interest	Direct		NHS Devon CCG
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body Member of Strategic Human Resources (HR) and Remuneration Committee Transition Sub Committee Member of Primary Care Commissioning Committee	GP Partner, Cricketfield Surgery Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Clinical Chair NHS Devon CCG 1 March 2017 Church Warden Holy Trinity Church Spouse works in emergency department at RDE and for Exeter Medical School		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
	Kennedy	Nick	Secondary Care Consultant	Member of Governing Body Member of Quality Assurance Committee Member of Strategic Human Resources (HR) and Remuneration Committee Member of Primary Care Commissioning Committee QEIA Panel Member of Audit Committee	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer Partner, Staplegrove Anaesthetists LLP, Taunton Partner Blackdown Orthopaedic and Spinal Services, Taunton Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of Data safety monitoring committee (DSMC), The GAP study (safety of gabapentin) United Hospitals Bristol Member of national Independent Funding Request Panel NHS England		26/09/2017		06/10/2018	Financial / Personal	Direct		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) Eastern Locality Board NEWD Member of Audit and Assurance Committee Member of Strategic Human Resources (HR) and Remuneration Committee (Non exec rem)	Chair of East Devon GP Members Forum Partner Coleridge Medical Centre Undertakes DDOC shifts 5. Shareholder in Devon Doctors Ltd Shareholder in Devon Health Member of East Devon Health Practice part of the East Devon Federation (March 2018) chair of East Devon Members forum.	Spouse works for Social Services	14/02/2017	17/04/2019	Financial / Personal	Direct		NHS Devon CCG
	Mackness	Brian	Non Executive Director, Finance and Commerce	Member of Governing Body Member of Audit and Assurance Committee Member of Finance and Performance Committee (Chair) Member of Strategic Human Resources (HR) and Remuneration Committee Transition Sub Committee	Trustee and honorary secretary of ABBFEST, a community festival which makes grants to organisations which may include those providing health and social care. Member, County Organising Committee and County Publicity Officer, national gardens scheme which makes grants to inter alia, national charities working in the field of health and social care. Member, Parocial Church Council, St Mary' Abbotskerswell. The local Church may provide voluntary support and aid in the social care field. Chairman of patient group at Kingskerswell and Ipplepen Surgery,		July 2015	28/03/2019	Non-Financial Personal 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	Manton	Sonja	Director of Strategy NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Joint Staff Partnership Transition Sub Committee Senior Leadership Team meeting (Strategic Risk Committee) Member Member of Quality and Assurance Committee Attendee Audit and Assurance Committee	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit from 1st Nov 2018	03/04/2017	09/10/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Governing Body Clinical Lead – Western Locality	Member of Governing Body Member of Quality Assurance Committee Clinical Cabinet Western Locality Board NEWD QEIA Panel STP Collaborative Board Member of Strategic Human Resources (HR) and Remuneration Committee (Non exec rem) Member of Primary Care Committee	Elected member, South West Regional Council of BMA Sessional GP (self-employed) at Access Health Ltd , Plymouth. GP Appraiser (NHS England)	Partner is Medical Secretary and Board member of Devon LMC Partner is GP Partner, Church View Surgery, Plymstock	26/09/2017	18/12/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Director of Communications and HR functions NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Joint Staff Partnership Senior Leadership Team meeting (Strategic Risk Committee) Member Attendee Audit and Assurance Committee	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University.		19/06/2018	26/02/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Pearson	Virginia	Director of Public Health, Devon County Council Co-opted member of Governing Body	Member of Governing Body Member of Quality and Assurance Committee Member of Primary Care Commissioning Committee	Member, Devon Health and Wellbeing Board Member, Exeter Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Devon Safeguarding Children Board Attends Governing Body of NEW Devon CCG Council Member, Association of Director of Public Health Member, British Medical Association		02/02/2017	02/02/2017	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council
	Polak	Tracey	Public Health Consultant (Devon Council) Honorary Clinical Associate Professor – University of Exeter Medical School	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee Northern Locality Board NEWD Eastern Locality Board NEWD	Honorary contract with Exeter University	Spouse:Deputy Chief Nursing Officer, Eastern and Western Devon CCG (NEW Devon CCG)	24/10/2017	21/01/2019	Indirect interest	Indirect		NHS Devon CCG
	Snaith	Ginny	Board Secretary	Attendee of Governing Body Attendee Audit and Assurance Committee CCG Executive Team Senior Leadership Team Member	No interets declared		22/03/2019	09/04/2019				NHS Devon CCG
	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Senior Leadership Team meeting (Strategic Risk Committee) Member Attendee Audit and Assurance Committee	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	01/11/2016	20/12/2018	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

	Turl	Jo	Associate Director of Commissioning – Southern (Devon lead for – Mental health, Urgent care, Learning disabilities, Integrated care)	A & E Delivery Board Senior Leadership Team meeting (Strategic Risk Committee) Member Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) Member of Governing Body Member of Audit and Assurance Committee Member of Finance and Performance Committe Member of Primary Care Commissioning Committee		13/08/2015	16/10/2018	Non-Financial Interest Professional	Direct	NHS Devon CCG
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Member of Audit and Assurance Committee Member of Finance and Performance Committee Northern Locality Board NEWD Member of Primary Care Commissioning Committee Member of Strategic Human Resources (HR) and Remuneration Committee (Non exec rem)	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	NHS Devon CCG

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting held in Public – DRAFT Minutes

Date: 25 April 2019 Time: 12:45pm

Location: The Courtenay Centre, Kingsteington Road, Newton Abbot, TQ12 2QA

Item	Discussion	*Action**	*Decision taken by Organisation*
1	**Welcome and introductions** PJ, Chair welcomed everyone to the meeting and formally introduced the newly appointed lay members/ non-executives. PJ verbally detailed the biographies of Charlotte Burrows, Glynis Atherton and Judy Hargadon. PJ also welcomed Jo Turl, Director of Transformation and Ginny Snaith, Board Secretary who were also new members Devon CCG. The following apologies were noted: NK, RH, VP. TP represented Devon County Council Public Health in the absence of VP.		
2	**Register of Interest (ROI)** PJ asked if there were any new interests or amendments to the register to be declared. • CB declare her interest as chair of Maternity Voices Partnership (MVP) There were no other declarations made. A small number of formatting issues and minor amendments was raised, and GS gave assurance that these would be addressed.		
3	**Minutes of NHS NEW Devon and South Devon and Torbay CCG Committees in Common held on 28 March 2019** PJ led a page by page review of the minutes of the committees in common meeting which was held on the 28 March 2019 and were agreed as a true and accurate record of the meeting.		
4	**Merger Closedown Report and Legacy Arrangements** GS presented this report which provided a summary of the merger of NEW Devon and South Devon and Torbay CCGs and she described in detail the process followed in moving towards the formation of a single CCG.		

	GS highlighted the establishment of the merger transition sub-committee who provided oversight of the process and monitored progress on the project plans whilst moving through transition and closedown of the two CCGs. No issues to date have been raised, and it was anticipated that non-will occur, however the transition into the single CCG is still being monitored and supported by the Programme Management Office. The transition sub-committee met in March and a meeting has been schedule for May if needed. A legacy documentation process has been developed and put in place for collation of papers for safe storage for future reference. GS was pleased to report that best practice and collective learning around what we have achieved during the merger process has been captured which will be shared with our partner CCGs who are moving towards merging. PJ and the Governing Body formally thanked everyone who was involved in the merger process for their contribution. **The Governing Body:** • **Received and noted the contents of this report** • **Noted the closedown of the merger transition programme** • **Noted the arrangements for legacy documentation and handover**		
5	**Sign off Constitution, Governance Handbook and Terms of Reference** GS presented NHS Devon CCGs constitution which had been written and produced in line with the template legislation for merger. The constitution had been through a robust development process including NHS England approval process and approval by the merger transition sub-committee. The purpose of the constitution being presented at this meeting was for official sign off and approval as this was the first governing body meeting of NHS Devon CCG. GS drew attention to the Governance Handbook, although not a legal document but developed for guidance which contained governance information in parallel with guidance from NHS England whilst meeting our statutory requirements. GS referred to the statutory committees Terms of Reference (ToRs) included in the handbook and assured the Governing Body that these had been through a robust process including scrutiny at the relevant committees for checks. Following discussion, the Governing Body: • Approved the constitution for NHS Devon Clinical Commissioning Group • Approved the Governance Handbook and noted the plans for ongoing development • Specifically approved the ToRs included in the handbook subject to a minor amendment to the wording on page 79 of 89 of the Quality Committee's ToRs		

6	**Risk and Assurance Report** GS referred to the report included in the pack and explained that the report had been refreshed, however noted that more was required. There were duplication of risks and risks were not being regularly reviewed and updated, but it was important to bring this report to the first meeting of the single CCG. GS also reported that the risk and assurance framework was being reviewed and feedback from internal audit was awaited around the recommendations on the management of risks. GS described the format of the report and referred to the scoring risk matrix and risk appetite. GS directed the members to page 235 the current risks and drew attention to the high risks. Concern was raised around risk 97 Mayflower procurement – Primary Care and Health and Social Care Community Services in Plymouth. SMC gave background information on how Mayflower became a risk which was due to several GP practices who gave notice to terminate their contracts. Some practices have merged to manage patients and remains a risk. A further practice has triggered a termination period and the practice is currently being assisted and supported by the CCG under delegated commissioning. CD asked how risks find their way on to the register as some risks relate to the local authorities. GS responded that anyone can report a risk and bring it to the attention of the risk manager and informed the Governing Body that work is underway to streamline the reporting process for risks. Comments and feedback on the future format of the risk reports were requested to be sent directly to GS. **The Governing Body:** • **Noted the Risk Register in line with its constitutional obligations, considering the adequacy and effectiveness of the controls and assurances identified in the management of risk including measures to address gaps in controls and assurances, and identify any further action that should be taken to manage key risks** • **Note the very high/significant risks on the risk register** • **Were asked to provide feedback on the format and content of future risk reports**		
7	**Chairman's Report** PJ confirmed the CCGs Governing Body Membership including the minimum requirements and additional membership support of non-executive lay membership. PJ was pleased with the skills and mix of members and personally thanked BM for continuing in his role as non-executive for an extended period until a long-term solution to appoint has been secured. PJ thanked everyone who had been involved in the leadership review and that two feedback workshops have been planned with PA Consulting in		

	early May. PJ was confident that we have the right leadership and support in place to function as a CCG and across the wider system. PJ is working with our provider boards to continue building upon relationships. System chairs are regularly meeting and there are plans for a chair and non-executive provider and commissioner development day for system thinking which will be facilitated by NHS Clinical Commissioners. Relationships with our local authority partners are developing and combined Heath and Wellbeing Boards is being considered which will include CCG representation to support our population needs as an integral part of our STP. **The Governing Body received and noted the chairs report update.**		
8	**Interim Accountable Officers Report** **Merger to NHS Devon CCG** JD presented this report and touched on the merger and the work underway in delivery of both sets of financial accounts for NEW Devon and SDT CCG. JD provided assurance that this was on track and was expecting a smooth conclusion to the process. **Delegated Commissioning** As of the 1 April 2019 NHS Devon CCG took on the delegated responsibility for the commissioning of general practice from NHS England. This will mean that the CCG will be responsible for £165m of added investment which will be governed through the primary care committee and reported through the finance and performance report. **360ºstakeholder survey** JD highlighted the 360ºstakeholder survey and that the operating pan 2019/20 was still in negotiation and will be brought back to the Governing Body in due course. **Key meetings and visits** There had been several key meetings over the past month and JD was pleased to report the annual assurance meeting with NHS England had been positive. **EU Exit Preparedness** In recent months NHS organisations nationwide and Devon have been working together to prepare business continuity arrangements in the event of a no deal exit from the European Union. Situation Reports (SitReps) have been requested by NHS England daily to aid our preparations. An imminent no deal has been stood down, but preparations are continuing whilst further guidance is awaited. SM described the process and pilot that was used to support the 1,200 people from other parts of the EU who are part of our team in NHS Devon who are affected by this, and the Governing Body were assured around the support that is available for the non-EU families.		

	NHS Long Term Plan The local response to the NHS Long Term Plan is continuing to be developed and we are now looking to plan for 20/21. This workstream will regularly feature in reporting and involvement of the Governing Body. Concern was raised in whether we have resources to manage commissioning properly. JD responded that this was being reviewed by function. **The Governing Body received and noted the contents of the Interim Accountable Officers Report.**		
9	**Feedback from Devon CCG Launch Event** AM presented this report and formally thanked his colleagues in the communications team for their contribution in making the launch of the CCG on 1 April a success. AM detailed the format of the event and noted that all attendees were invited to complete a short survey to share their feedback and AM drew attention to the results detailed on page 268 to 270. The afternoon session was aimed at local organisations and groups from councils, NHS provider, local Healthwatch Patient and Participant Groups, local Optical and Pharmaceuticals who all were represented. Work is underway to continue to promote the new organisation following on from the launch and this will include the unveiling of the new website and marketing with our stakeholders. Events will be planned in collaboration with our locality colleagues and wider engagement with our membership. NB remarked that the launch was an excellent day and now we must put things into action. We will be focusing on our values which will form a key part of our appraisal and recruitment process. **The Governing Body received and noted the contents of the feedback from the Devon CCG launch event.**		
10	**Locality Updates** **Northern** JWo was pleased to report the input and support that Northern Devon Healthcare Trust has received from the clinicians at the RDE has been positive. The Local Care Partnership (LCP) is being developed collaboratively to de-medicalise the cycle of illnesses, and excellent 'doing' groups have been formed to work together around the value of one Northern Devon. JWo felt there is a need to nourish and support our communities to be more self-resilient to enable Northern Devon to become a better place to live in. The well being agenda is a focus and vision for Northern Devon and how it fits into the wider system. **Eastern** SK reported that the locality is settling in following the co-location to County Hall from Newcourt House and felt the team had re-connected.		

	A recent GP event was a success which included the introduction of the new children's services provider. Engagement with the GPs is being structured and a workplan has been developed. A digital event is being organised for September which will include primary care. A good news story was that the Community Care Services model was working well and that we have had supportive links with our partners in Dorset. Primary Care Networks (PCNs) have been formed but have not established a legal agreement at this time. Thoughts are being considered about the role of the CCG and the Local Medical Committee (LMC) to support the clinical directors. **Southern** Sub structure within the Southern locality has a desire to remain strong and there has been a good opportunity to gather intelligence and provision of communication with the practices. In line with Southern Devon Healthcare Foundation Trust specialties are linked to the sub localities to encourage thinking differently and the clinical meetings in the locality has been split into three different functions: 1. Primary Care Networks 2. Intelligence and communications 3. Joint working with Southern Devon Healthcare Foundation Trust on the new care model DG reported that PCNs are progressing well and directors have been nominated. DG highlighted the risk of GPs potentially leaving practices within the Southern locality that are struggling. Plans are in place for these practices to be supported by well-staffed practices as an interim measure. **Western** SMc informed the members that the procurement for the Mayflower Integrated Care Partnership is progressing including good engagement. Mannamead practice has seen a redistribution of resource following a trigger to give notice on their contract notice period this remains an ongoing concern. There has been a positive response to a digital pilot in the Western locality supported by the Chief Information Officer. PCNs are continuing to be developed, however there are some practices that need to identify a network. SMc noted that it has been acknowledged we need to ensure that all patients within the Western locality are covered and no areas of concerns have been identified. It however remains likely that not all posts will be recruited to and alternative plans are being considered. SMc was pleased to report that the well-being hubs are emerging with another three more expected this year.		

	Time has been spent in University Hospitals Plymouth (UHP) Emergency Department (ED) to understand the reasons for attendances, the results will be analysed address the issues. It was also noted the UHP now provide sick notes for patients which is a positive supported by the Patient and Liaison Service (PALS), **The Governing Body received and noted the locality updates, for the Northern, Eastern, Southern and Western Locality.**		
11	**Quality and Performance Report** SMa referred to the quality and performance report included in the pack and updated the Governing Body on the following areas: **A&E** Challenges were experienced over the winter period, however an improvement in performance was seen for February and March and it was noted that we are moving towards achieving the national target. A good level of assurance has been given however the Easter bank holiday period did prove challenging. LCB reported that pressure in the system is experienced in A&E departments when the Care Quality Commissioning (CQC) are undertaking inspections. UHP has seen challenging times over the last two or three months with 12 patients identified as breaching 12 hours. This has resulted in regulatory oversight including meetings with NHS Improvement, the CCG and provider organisations around improving performance issues. 52 week waits are also under scrutiny. LCB assured the Governing Body that there was no evidence of any harm to patients for those that breached the performance target and observational audits around the timeliness of care showed no areas of concerns around the standard of care, however maintaining privacy and dignity had proved challenging. Northern Devon Healthcare Trust had also seen similar pressure when the CQC were inspecting and Torbay and Southern Devon Healthcare Trust had also been under similar pressure. The RDE had seen 13 breaches which included a higher number of people with mental health crisis. SK noted that the RDE does have exemplary performance in urgent care and wondered if we were sharing best practice with other trusts. SMa replied that we were sharing best practice but to note that our provider organisations do have different issues and are seeing unprecedent activity in the system. **Delayed Transfers of Care (DTOC)** The acute trusts are coping well, and performance is improving. **South Western Ambulance Service Trust (SWAST) cat 1 main response time** Category 1 response times are generally good and are improving. A deep dive is underway to focus on handover delays and results will be reported through the A&E delivery board.		

	NHS 111 answering calls within 60 seconds Call answering delays work is underway and we are working closely with Dorset as a partner organisation. No cause of harm has been identified for those calls not answered within 60 seconds. **Planned Care** Standards are still struggling to be met however the referral to treat targets has remained static for this year. A firm focus continues around 52-week waiters. The target is challenging but improvements are being seen through a collective system response. **Cancer Standards** Two week waits, and 62 day waits performance has been an outlier nationally for some time, but performance is improving. **Diagnostic Testing** The CCG is continuing to monitor this performance target closing which remains below the national target. On aggregate we are improving slowly and measures such as purchasing more capacity has been put in place. **Mental Health** We are currently performing well in particular around access rates and psychiatric therapy. We are meeting waiting times standards which has not been included in the performance report. Out of area placements in Devon high due to the lower inpatient beds for Devon.. At the moment Devon are not performing well for dementia diagnosis rates however a set of communications with our GP membership has been circulated and we are expecting to see an improvement in this area. LCB acknowledged the Children's services procurement and transition which has gone extremely well with very few hiccups especially as this was a complicated piece of work and that the Local Maternity System (LMS) is now in the top ten of plans nationally and LCB formally thanked everyone for their hard work.		
12	**Close of meeting** The chair thanked everyone for their contribution into the first meeting of NHS Devon CCG. The meeting closed at 17.05pm.		

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*
Andrew Millward (AM)**	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Brian Mackness (BM) **	Non-Executive Director/ Lay Member – Devon CCG
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG

Ginny Snaith (GS) **	Board Secretary, Devon CCG
Glynnis Atherton (GA) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Womersley – Dr (JWo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Transformation, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Lorna Collingwood-Burke (LCB) **	Chief Nursing Officer, Devon CCG
Nick Ball (NB) **Vice Chair** **	Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) A	Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) **Chair** **	Clinical Chair, Devon CCG
Ruth Harrell – Dr (RH) Apologies	Director of Public Health, Plymouth City Council
Shelagh McCormick- Dr (SMc) **	Clinical Lead Representative, Western Locality, Devon CCG
Tracey Polak (TP)	Assistant Director Public Health, Devon County Council
Simon Kerr – Dr (SK) **	Clinical Lead Representative, Eastern Locality, Devon CCG
Simon Tapley (ST) Apologies	Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **	Director of Commissioning, Devon CCG
Virginia Pearson – Dr (VP) Apologies	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) **	Executive Assistant, NEW Devon CCG
James Peskett (JP) **	PA Consulting
David Mehaffy (DM) **	PA Consulting
Kathryn O'Halloran (KO) **	PA Consulting

Minutes approved	Date:	Signed by chair:

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: CHAIRS REPORT					
Date of committee: 23 May 2019 **Date report produced:** 13 April 2019					
Author (s) Name and Title: Dr Paul Johnson, Chair, paul.johnson4@nhs.net		**Supporting Executive: N/A** **Report Approved by: N/A**			
Public or Private (Governing Body only):			**Public**	☞	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**		**Information** ☞
Does this report place individuals at the centre?			**Yes**	☞	**No**

Executive Summary:

This report contains updates on:

- Progress since the last Governing Body held in April 2019
- Highlights and Activities
  - Place based non executive lay members
  - Governing Body
  - Leadership Review
  - GP Engagement
  - Agreed Meetings
  - External Meetings and Events

Management of Conflict of interests:

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

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

N/A

Key recommendations and actions requested:

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

Chairs report.
Reference to other documents or accompanying papers:
N/A
Have the legal implications been considered?
N/A
Equality Impact Assessment:

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

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

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

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

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

GOVERNING BODY – CHAIRS REPORT

1. Introduction

Much has happened since the last Governing Body and I would like to thank all the members of the Governing Body who have contributed to these last few weeks. Our new non-executive members – Charlotte, Glynis and Judith – have embraced the steep learning curve of getting up to speed with the NHS in Devon and have contributed and chaired to great effect in our various committees. Our clinical representatives have helped us understand what we need to do to ensure we have the right clinical leadership both at the pan-Devon level and particularly in our local places. And our executive team have continued to work with NHS England and our providers to tackle the challenges we face around ensuring our services are safe and high performing and that we are able to provide these services within the finances available.

We will hear more about this work during this meeting as well as recognise the ongoing priorities we face, particularly around agreeing a 19/20 Operating Plan with NHSE, developing our response as an STP to the NHS Long Term Plan, and establishing the roles of our local places and supporting the clinicians and managers in their place-based roles.

2. Other highlights and activities I have been involved in over the last 4 weeks include:

Place Based Non-Executive Lay Members

I can now confirm that Nick Ball has worked with the other non-executives and they have agreed which locality each will be assigned to.

Western – Nick Ball
Southern – Judy Hargadon
Eastern – Glynis Atherton
Northern – Charlotte Burrows

3. Governing Body

Thank you to all who provided feedback on the last Governing Body. There were some very useful points around ensuring adequate time for discussion, clarity around decision making and appropriate length and content of papers. I will continue to work on this with Ginny Snaith, Board Secretary, to improve our papers and processes and welcome your ongoing feedback.

4. Leadership Review

The leadership review co-commissioned by the CCG and NHSE has been completed and we have had the opportunities for both CCG leaders and STP leaders to work with PA Consulting on their findings and agree some priority areas to ensure we are fully equipped to function as both a strategic commissioner and an integrated care system. Further work will be led by Simon Tapley for the executive teams and Suzi Leather for the STP leadership.

5. GP Membership Engagement

As a membership organisation, particularly as we now hold delegated commissioning of Primary Care, effective engagement with our GP members is essential. The communications team have developed proposals which I have discussed with the governing body representatives. One of the key recommendations is to ensure our membership have the opportunity to meet with senior leaders of the CCG. As part of this I will be attending a number of local GP meetings over the next couple of months including:

GP agreed engagement meetings:

- Southern Collaborative Board – 21 May
- Northern GP Forum – 21 May
- Exeter GP Forum – 4 July
- East GP Forum – 16 July
- Mid Devon GP Forum – 19 July

6. External Meetings

Anne-Marie Morris, MP for Newton Abbot
With Anne-Marie's ongoing interest in the proposed consultation for Teignmouth this was an opportunity to discuss some of the detail and provide assurance around the process. Ongoing engagement with Anne-Marie leading up to and during the consultation will be hugely valuable in helping us ensure the right outcome for this population.

Tracey Lee, Chief Executive Plymouth City Council
It was refreshing to hear the positive stories of really progressive and innovative work that is happening in Plymouth as well as share our awareness of the challenges that Primary Care face and joint determination to address these challenges and move to a stable and thriving Primary Care in the city. I will be working closely with the City Council, our executive team and the locality clinical representative, Shelagh McCormick to make this a priority for us as the delegated commissioners.

Jasmine Lodge Launch
Devon Partnership Trust launched their new Mother and Baby Unit, Jasmine Lodge, on 9 May. A really well designed space for up to eight mothers. A huge thank you to the inspiring staff who showed me round.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: INTERIM ACCOUNTABLE OFFICER REPORT					
Date of committee: 23 May 2019 **Date report produced:** 9 May 2019					
Author (s) Name and Title: Simon Tapley, Interim Accountable Officer Sonja Manton, Interim Director of Commissioning Jo Turl, Director of Transformation Paul O'Sullivan, Deputy Director of Strategy Molly Bishop, Business Manager		**Supporting Executive:** Simon Tapley **Name and Title:** Interim Accountable Officer **Contact Details:** simon.tapley@nhs.net **Report Approved by:** Simon Tapley **Name and Title:** Interim Accountable Officer **Contact Details:** simon.tapley@nhs.net **Date:** 9 May 2019			
Public or Private (Governing Body only):		**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**		**Information** ✓
Does this report place individuals at the centre?		**Yes**	✓	**No**	

Executive Summary:
This report contains updates on:

- Operating Plan for 2019/20
- Review of Devon Health and Social Care System by PA Consulting
- Primary Care Networks
- Key meetings and visits
- NHS Long Term Plan

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

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

N/A

Key recommendations and actions requested:

This report is for information only.

Reference to other documents or accompanying papers:

N/A

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

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

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

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

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

GOVERNING BODY – INTERIM ACCOUNTABLE OFFICER REPORT

1. Operating Plan 2019/20

The CCG submitted its Operating Plan to NHS England on 4 April 2019, setting out the CCG's commissioning priorities and objectives, its delivery plans, and approach to transformative change as part of the Devon System Plan for 19/20.

In April, all NHS partners of the Devon system received formal feedback from regulators on the submitted plans, highlighting the requirement to work together to focus further on meeting the control total set for the system.

Regulators have been working closely with us over recent weeks to help identify further opportunities for making best use of our collective resources this year. The CCG and system partners are expected to submit refreshed plans on 23 May 2019.

2. Review of Devon Health and Social Care System by PA Consulting

PA Consulting have been engaged by Devon CCG, Devon Sustainability and Transformation Partnership (STP) and NHS England to carry out a review of the Devon Health and Social Care System, with a focus on:

- Behaviours and ways of working that support the sustainable development of an integrated care system in Devon;
- CCG leadership capacity and capability that supports effective commissioning across the Devon system;
- The right senior system leadership roles to support effective collaboration and partnership working;
- Building towards Devon becoming a fully-authorised and sustainable integrated care system; and
- Defining the Devon health and care system at system-, place-, and locality-levels, and in relation to its external partners/neighbouring systems.

The review has involved observing key meetings across Devon and interviews with a number of key stakeholders. The emerging findings from this review will be available soon.

3. Primary Care Networks

On 31 January 2019 document entitled 'Investment and evolution: A five-year framework for GP contract reform to implement *The NHS Long Term Plan'* was jointly issued by NHS England and the British Medical Association. Subsequently additional guidance has been issued, including in April 2019 (jointly by NHSE and BMA) 'Network Contract Directed Enhanced Service – Guidance for 2019/20 in England. Taken together these documents describe the most significant contractual changes for General Practice since 2004, and arguably for a considerably longer period than that.

The timeline for configuration and authorisation of Primary Care Networks (PCNs) is comparatively compressed:

By 15 May 2019 - Primary Care Networks submit registration information to their CCG

By 31 May 2019 - CCGs confirm PCNs and approve variation to medical services contracts

Early June 2019 - NHS England and GPC work with CCGs and LMCs to resolve any issues

The local PCN configurations will look rather different to the groups, federations and networks we are currently familiar with. There are two principle reasons for this. The first is the guidance issued setting (soft) parameters as to size of PCN to ensure that the balance between being of sufficient size to be viable and ensuring that effective relationships can be maintained is achieved. The second is that PCNs as providers with formal commissioning responsibilities is understandably making individual Practices review current arrangements to ensure they are content that these are suitable for the future.

The parameters suggest PCNs will typically serve populations of between 30 and 50 thousand people. The principle exception to the lower threshold would be where commissioner recognises that low population density means a lower population value is appropriate, though the PCN must still be viable and to that end guidance suggests this would only permit 'slightly smaller' populations. The upper threshold is a little more flexible as it is possible for example to form a single large network, perhaps for a sizeable rural area, provided there are clearly identified 'neighbourhood' structures that would sit comfortable with the 30 to 50 thousand parameters.

It should also be noted that it is entirely possible for a GP Practice to elect not to be part of a PCN. Locally we expect the vast majority, and quite possibly all, Practices to be a member of a PCN with 34 PCNs expected to cover Devon. In the event that is not the case, commissioners would need to engage with PCNs in the area of that Practice to ensure services to be provided through PCNs are available to our full CCG population.

4. Key meetings and visits

It has been an extremely productive and busy month, with key meetings and visits as follows:

- Dr Paul Johnson and I have been meeting with key stakeholders across Devon as part of an introduction to Devon CCG
- A range of meetings with system Chief Executives and the regional NHS England team relating to the system Operating Plan for 2019/20.
- A range of meetings with NHS England regarding a review of our planning activity assumptions for 2019/20.
- Meetings with PA Consulting, who are undertaking the system capability and capacity review.

5. NHS Long Term Plan

April's report set out the requirement for the Sustainability and Transformation Partnership (STP) to develop a local plan to take forward the NHS long term plan for the population of Devon. The NHSE / I regional planning update at the beginning of May has confirmed that the 5 year plan implementation framework will be released with the initial 20/21 Planning Guidance in May 2019 and the initial submission date for the 5-year plan will be in Autumn 2019.

Work is now progressing to review and refresh our evidence base and case for change as a system including:

- Assessment and gap analysis of our plans, including 19/20 operating plan, against the national NHS Long Term Plan deliverables.
- Update of current and future population health need including key health issues, variation within the STP and inequalities.
- Projection of demand for health and care services and key areas for attention within our plans.
- Review the medium-term financial plan and resource allocation (pending national financial planning guidance).
- Review of workforce plans and key challenges.
- Refresh of the evidence base to identify opportunities for improvement and adoption of best practice.

- Review the recurrent themes and key messages from recent engagement activity across a wide range of groups in order to inform further focused engagement over the forthcoming months.

The plan will be developed through the existing STP system groups, for example via a dedicated clinical cabinet meeting in June, as well as the STP programmes to build on the current work and enable engagement of all partners. The work to develop Devon's long term plan is being undertaken in close co-ordination with the refresh of the Devon Joint Health and Well Being Strategy in order to optimise the opportunities for prevention and engagement with relevant partners and stakeholders. Once all local authority Health and Well Being Boards chairs are confirmed, following local elections in Plymouth and Torbay, further engagement and meetings will take place to facilitate a collaborative approach across the STP and provide for a shared understanding of our system priorities for population well-being and outcomes.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 23rd May 2018

Dates of Committees covered in this report 18th April 2019 & 16th May 2019

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

Chair's Name and Title: Brian Mackness, Non-Executive Director (April meeting) & Nick Ball, Non-Executive Director (May meeting)

Contact Details:

Reports discussed and assurances received

- **Risk Register report – April & May 2019 meeting**
- **Monthly finance verbal report – April 2019 meeting**
- **Monthly finance report – May 2019 meeting**
- **Governing Body Quality & Performance report – April & May meeting 2019**
- **STP Finance report – April & May meeting 2019**
- **19/20 Operational Planning – April & May meeting 2019**
- **The clinical effectiveness review was approved by the committee – April 2019 meeting**
- **Delegated Primary Care – April 2019 meeting**

Reports received and noted

- **Contract Status updates – Novation inclusive of section 75 & Annual Procurement report – April 2019 meeting**

Risk Register Review (changes and areas of concern)

- **Two risks were approved for closure by the committee – April 2019 meeting**
- **The Board Secretary declared that the risk report does need reviewing and it needs to be more robust with updates – April 2019 meeting.**
- **Two risks were approved for closure by the committee – May 2019 meeting**

Committee Decisions

- **The clinical effectiveness review was approved by the committee – April 2019 meeting**

Recommendations for Governing Body
• **Governing Body is asked to receive and note the contents of this report.**
Recommendations for other Committees
• **None**
Terms of Reference or other committee effectiveness issues
• **The terms of reference were acknowledged by this committee – April 2019 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.

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

GOVERNING BODY MEETING

Report title:	**FINANCIAL PERFORMANCE REPORT**				
Date of committee: 23rd May 2019 **Date report produced**: 9th May 2019					
Author (s) Name and Title: **Finance, Business Intelligence and Contracting Directorate** **Contact Details:** Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting)			**Supporting Executive:** John Dowell **Name and Title:** Director of Finance **Contact Details:** **Report Approved by:** **Name and Title:** John Dowell, Director of Finance **Date:** 9th May 2019		
Public or Private (Governing Body only):			**Public**	✓	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**		**Information** ✓
Does this report place individuals at the centre?			**Yes**	✓	**No**

Executive Summary:

The CCG's financial plans for 2018/19, before qualifying for any sustainability funding, set out forecast deficits to 31st March 2019 of £20.0m and £5.0m for NEW Devon CCG and South Devon & Torbay CCG respectively.

The Commissioner Sustainability Fund (CSF) was introduced by NHS England to incentivise the CCGs financial performance. To be eligible for access to the CSF CCGs must formally meet all of the following conditions:-

- **Demonstrate commitment to delivery of financial control total**
- **Agreement of a milestone-based recovery plan of cumulative debt**
- **Delivery of the financial plan for the year by meeting the year to date financial control total for each quarter across 2018/19 and provide a credible and well-evidenced forecast in line with the plan at the end of quarters 1, 2 and 3.**

Both CCG's have met the conditions linked to receive the sustainability funding in full (£20.0m for NEW Devon and £5m for South Devon & Torbay), therefore the CCG's revised positions to the 31st March 2019 are now

balanced and we have confirmed to NHSE that we will deliver our control totals as anticipated. **The draft accounts for the 18/19 financial year have been submitted to our Auditors on 23rd April 2019 and we are currently in the process of being audited.**

Strategic risk: Achievement of 2018/19 control totals	**Mitigating Actions:** 18/19 control totals achieved

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 your own organisation via either d-ccg.corporateservices@nhs.net or corporate.sdtccg@nhs.net to update the central register.
Committees that have previously discussed/agreed the report and outcomes:
Key recommendations and actions requested:
The committee is asked to note the month 12 position as at 31st March 2019 and the level of risk to deliver of the CCG's control totals.
Reference to other documents or accompanying papers:
n/a
Have the legal implications been considered?
n/a

Equality Impact Assessment:						
Who does the proposed piece of work affect?	**Patients**	✓	**Carers**	✓		
	Staff	✓	**Public**	✓		
					Yes	**No**

1. Will the proposal increase discrimination for people in protected groups?		✓
2. Will the proposal reduce discrimination for people in protected groups?		✓
3. Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		✓
4. Will the patients or workforce be disadvantaged as a result of the proposed work?		✓
5. Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?		✓

If the answer to any of the above questions is yes (other than questions 2 and 3) or you are unsure of your answers to any of the above, you should provide further information using **Quality and Equality Impact Assessment**.

If an equality assessment is not required briefly explain why and provide evidence for the decision.

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

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

Northern, Eastern and Western Devon and South Devon & Torbay Clinical Commissioning Groups

Finance Report

Month 12 – 2018/19

Contents

Appendices

1. Executive Summary

We have aligned much of the work of the two Clinical Commissioning Groups (CCGs), merged the executive teams into one, and established a governing body in common and committees in common. Executive directors now fulfil Devon-wide roles and most teams work across the CCGs. With this in mind this report brings together the finance performance of both CCGs and seeks to provide the necessary assurance to the Governing Body.

Financial Position

This report sets out the financial performance of the CCG's to the end of March 2019 (month 12 management accounts).

The CCG's plans for 2018/19 have been produced in conjunction with our main acute providers within a wider System Transformation Plan (STP) footprint.

The CCG's combined 2018/19 position, including the 12 months sustainability funding (£25m) is £0m. The CCG's position is balanced due to the conditions required for the final quarters sustainability funding being met in M12 (£7.0m for NEW Devon and £1.75m for South Devon & Torbay). See Appendix 4 regarding the Commissioning Sustainability Funding process.

Financial Position as at 31st March 2019	NEW Devon CCG			S Devon & Torbay CCG		
	Planned Deficit £'000	Actual Deficit £'000	Variance to plan £'000	Planned Deficit £'000	Actual Deficit £'000	Variance to plan £'000
Year to date position before CSF	20,000	20,000	0	5,000	5,000	0
Q1, Q2, Q3 & Q4 CSF received	-20,000	-20,000	0	-5,000	-5,000	0
Year to date position after CSF	**0**	**0**	0	**0**	**0**	0
Forecast deficit before CSF	20,000	20,000	0	5,000	5,000	0
If Q1 to Q4 CSF fully received	-20,000	-20,000	0	-5,000	-5,000	0
Forecast deficit after receiving full CSF	**0**	**0**	**0**	**0**	**0**	**0**

Final Outturn

Overall both CCG's are reporting achievement of the control totals as set out above.

NEW Devon CCG's outturn position includes overspends in acute activity within non-NHS /NHS providers, out of area placements and GP prescribing. These variances have been offset by anticipated underspends in complex care and use of contingency.

South Devon and Torbay CCG is forecasting an outturn position which includes an increased acute activity within non-NHS /NHS providers, as well as, cost pressures in prescribing, continuing healthcare and out of area placements. These variances have been offset by the underspend in running costs, contract reserves and the use of the contingency.

Savings Plan

Both CCG's are reporting an underachievement of the savings plan with total savings at 95% of plan.

STP Plan

The CCG's plans sit within an overall plan for the STP which has a deficit of £61m (excluding anticipated Transformation Funding) with a savings plan of £151m. The plan is based on an agreed set of block contracts with the main providers which de-risks the majority of this element of the CCG's commissioning budget and delivers savings within those contracts of £19m.

As at month 12, both CCGs have achieved their financial positions and have received their transformation funding in full. The last reported position for the providers forecast an overspend of £21.5m and a subsequent shortfall of Provider Sustainability Fund (PSF) of £13.5m. There also remained a £5.1m unmitigated risk. We are expecting final month 12 positions for all providers to be presented at the system finance working group in April.

2. Financial Assurance Dashboard

The NHS England CCG Improvement and Assessment Framework cover 4 domains and 6 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.

The two specific areas the framework assesses in terms of financial sustainability are

- Financial plan
- In Year Financial performance

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

NO.	INDICATOR	NEW D CCG	SD & T CCG
Financial Plan Ratings detail		RAG	RAG
1	Minimum cumulative 1% planned surplus	RED	RED

NO.	INDICATOR	NEW Devon CCG		%	RAG	SD & Torbay CCG		%	RAG
		Plan/Target	Actual/Forecast			Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m			£'m	£'m		
2	Year to Date in year surplus including the receipt of the Commissioner Sustainability Fund for full 12 months	0.0	0.0	0.0%	RED	0.0	0.0	0.0%	RED
3	Forecast Outturn in year surplus assuming full receipt of the Commissioner Sustainability Fund (default red if in deficit)	0.0	0.0	0.0%	RED	0.0	0.0	0.0%	RED
4	QIPP - Year To Date Delivery (% achieved)	-70.8	-68.2	96.3%	GREEN	-7.8	-6.9	89.2%	AMBER/ GREEN
5	QIPP - Forecast Outturn Delivery	-70.8	-68.2	96.3%	AMBER/ GREEN	-7.8	-6.9	89.2%	AMBER/ GREEN
6	Running Costs	19.4	15.5	80.0%	GREEN	6.1	5.2	85.2%	GREEN
7	Risk adjustment to surplus (% of allocation)	0.0	0.0	0.0%	GREEN	0.0	0.0	0.0%	GREEN
8	Cash Position (% drawn down)	100.0		0.0%	GREEN	100.0		0.0%	GREEN
9	BPPC (% paid - value)	95%	99.7%	104.9%	GREEN	95.0%	99.2%	104.4%	GREEN

NO.	INDICATOR	NEW D CCG	SD & T CCG
CCG Additional Indicator			
10	Delivery of plan Ytd	GREEN	GREEN
11	Delivery of Plan FOT	GREEN	GREEN

3. Detailed Financial Performance

NEW Devon CCG

FOR THE PERIOD FROM 01 APRIL 2018 TO 31 MARCH 2019

Month 12 March	NHS NEW Devon Clinical Commissioning Group					
	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES						
Acute Services	618,137	621,401	3,264	618,137	621,401	3,264
Mental Health Services	124,356	125,540	1,184	124,356	125,540	1,184
Community Health Services	171,905	171,913	8	171,905	171,913	8
Complex Care	105,121	103,773	-1,348	105,121	103,773	-1,348
All Other Healthcare	46,162	42,082	-4,080	46,162	42,082	-4,080
Primary Care Services						
Prescribing	140,370	141,759	1,389	140,370	141,759	1,389
Other Primary Care	22,180	21,227	-953	22,180	21,227	-953
Primary Care Subtotal	162,550	162,986	436	162,550	162,986	436
Subtotal	1,228,231	1,227,695	-536	1,228,231	1,227,695	-536
CORPORATE						
Running Costs	14,963	15,499	536	14,963	15,499	536
TOTAL COMMISSIONED SERVICES	1,243,194	1,243,194	-0	1,243,194	1,243,194	-0
Allocation excl b/fwd position	1,243,194	1,243,194	-	1,243,194	1,243,194	-
2018/19 Surplus/Deficit	0		-0	0		-0

Final Outturn

NEW Devon CCG's outturn position includes an overspend on acute activity within non-NHS /NHS providers. The position also includes a cost pressure of £1.3m on the DPT contract, relating to out of area beds, and an overspend of £1.4m on prescribing.

These variances have been offset by underspends in complex care primary care and use of the contingency fund resulting in a balanced position after receipt of the CSF.

South Devon & Torbay CCG

FOR THE PERIOD FROM 01 APRIL 2018 TO 31 MARCH 2019

Month 12 March	NHS South Devon and Torbay Clinical Commissioning Group					
	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES						
Acute Services	230,473	235,311	4,838	230,473	235,311	4,838
Mental Health Services	33,265	36,518	3,253	33,265	36,518	3,253
Community Health Services	62,930	60,880	-2,050	62,930	60,880	-2,050
Complex Care	34,799	35,661	863	34,799	35,661	863
All Other Healthcare	13,682	6,619	-7,063	13,682	6,619	-7,063
Primary Care Services						
Prescribing	46,627	47,770	1,143	46,627	47,770	1,143
Other Primary Care	10,543	10,463	-81	10,543	10,463	-81
Primary Care Subtotal	57,171	58,232	1,062	57,171	58,232	1,062
Subtotal	432,319	433,221	902	432,319	433,221	902
CORPORATE						
Running Costs	6,094	5,192	-902	6,094	5,192	-902
TOTAL COMMISSIONED SERVICES	438,413	438,413	0	438,413	438,413	0
Allocation excl b/fwd position	438,413	438,413	-	438,413	438,413	-
2018/19 Surplus/Deficit	-0		0	-0		0

Final Outturn

South Devon and Torbay CCG's outturn position includes and overspend on acute activity within non-NHS /NHS providers as cost pressures within prescribing and complex care. The position includes a cost pressure of £1.5m on the DPT contract relating to out of area beds. These variances have been offset by the running costs underspend and use of the contingency fund resulting in a balanced position after receipt of the CSF

3.1 Acute Services

A substantial proportion of both CCG's expenditure relates to commissioning services from Acute Providers. The majority of the contract agreements are based on block payment arrangements reducing uncertainty to the financial position of the CCGs.

The position with Torbay and Southern Devon FT is underpinned by a risk sharing arrangement. Increased activity overall for the year has resulted in a significant overspend against the contract.

Activity information from non-NHS providers of acute care shows a marked increase and in a large part driven by the need to address referral to treatment targets.

What follows is a summary of the CCG referrals for NEW Devon CCG and SD & Torbay CCG and details of Acute Activity and Performance for the main provider contracts.

3.2 Mental Health Services

NEW Devon CCG

The 2018/19 Mental Health budget provides services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and Livewell Southwest.

At month 12 the outturn is £1.3m overspent and relates entirely to out of area mental health placement costs.

South Devon & Torbay CCG

The 2018/19 core Mental Health budget includes all adult contracts and some Children and Young Peoples expenditure, with the majority of contracts appearing under Community Services. The main contract for adult services is with DPT totalling £29.798m which is a block contract.

The month 12 position is reporting a year end overspend of £1.5m and includes the cost of out of area mental health placements.

3.3 Community Health Services

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

NEW Devon CCG

There is a pressure relating to activity being experienced within the community hospitals based in Cornwall including Stratton, Launceston and Liskeard. This is largely relating to a shift in discharge practices at Derriford in order to alleviate pressures on patient flow and bed availability. This pressure is offset by a small number of underspends within other budgets for community services.

South Devon and Torbay CCG

There are a number of overspends including £20k for palliative care GP facilitators and an overspend of £66k relating to community equipment in Torbay. However, benefits from 2017/18 results in an overall forecast underspend position.

3.4 Complex Care

NEW Devon CCG

The final overall position for Placements shows an underspend of £1.3m. This positive outcome builds on the successful financial management of this area in recent years. Within this position CHC and FNC have both achieved underspends which have helped to offset pressure on joint funded clients. CHC has also been successful in delivering QIPP savings once again and has achieved £10.1m savings against its £8.0m stretched target.

South Devon & Torbay CCG

The 2018/19 Placed People budget includes Continuing Healthcare (CHC), Funded Nursing Care, Individual Patient Placements (IPPs) and Retrospective Continuing Healthcare costs.

The majority of this budget is managed and monitored for the CCG by Torbay and South Devon Foundation NHS Trust. It includes CHC, Funded Nursing Care, Intermediate Care and IPPs. This expenditure forms part of the Risk Share Agreement in place with the trust and will therefore be subject to the overall contract position at the year end.

For the CCG managed budgets, the outturn position is overspent by £0.863m and is due mainly to IPPs (section 117).

It should be noted that other placement budgets are not managed through Torbay and South Devon Foundation NHS Trust. These other budgets include Joint Agency Children's Placements (South Devon) and Section 117 placements (South Devon).

3.5 All Other Healthcare

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

The variances shown against NEW Devon and South Devon & Torbay CCG's position relates, in the main, to the use of the contingency fund to mitigate the impacts of the Acute and Mental Health Services pressures that have been accounted for.

3.6 Primary Care Services

Prescribing

Based on January's prescribing data NEW Devon's outturn position has been reported at £1.4m overspent, while South Devon & Torbay's position is overspent by £1.1m. This position reflects a deterioration of £0.1m for NEW Devon and an improvement of £0.3m for SD&T CCG. Having previously reviewed the accuracy of both CCG's and the national forecasting models, it has been agreed to reflect the national model forecast going forward.

Significant steps forward have taken place with the Meds Optimisation team, finance and BI to improve the forecasting models. This means that both CCGs are included in the same process for reporting. SDT have handed over the Management Accounting functions to NEW Devon as part of the new structure.

Other Primary Care Services

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

NEW Devon CCG

The final position includes underspends in Home Oxygen, enhanced services and GP IT.

South Devon and Torbay CCG

There is a small underspend within GP enhanced services and an underspend in Medicines Optimization due to staff vacancies. There are overspends on GP IT and other primary care investments.

3.7 Running Costs

CCGs are required to manage the running costs (administration costs) of the organisation within an allowance. This allowance amounts to £19.523m for NEW Devon CCG and £6.094m for SD & Torbay CCG (including £208k and £65k non-recurrent funding respectively). Running costs are deemed to be those which are not for or related to the purchase of healthcare services (programme costs).

The CCGs have been sharing resources with the aim of making efficiencies and reducing the administration costs of running the organisations as a result. The outturn at M12 was £15.499m for NEW Devon and £5,192m for South Devon.

3.8 Resource Allocation

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

	NEW Devon CCG	SD & Torbay CCG
Planned revenue resources	£'000	£'000
Recurrent revenue baseline	1,184,674	407,738
Recurrent allocated growth	9,624	3,153
Recurrent resources for the purchase of healthcare	**1,194,298**	**410,891**
Running costs allowance (recurrent)	19,315	6,029
Total recurrent revenue resources	**1,213,613**	**416,920**
Recurrent adjustments	-787	-340
Non-recurrent adjustments	30,160	21,768
Running costs allowance (non-recurrent)	208	65
Total revenue resources	**1,243,194**	**438,413**
Total forecast expenditure	1,243,194	438,413
Total revised planned overspend	0	0

4 QIPP/Systems Savings Plan

In order to support the priorities and contractual commitments within both CCG's financial plans for 2018-19, it requires delivery of a series of efficiency improvements and service changes in relation to its existing expenditure.

Overall against the total savings plan the CCG's are reporting an outturn that delivered 95% of the savings plan as per the analysis below.

QIPP ACHIEVEMENT REPORT

FOR THE PERIOD FROM 01 APRIL 2018 TO 31 MARCH 2019

NORTHERN EASTERN AND WESTERN DEVON CCG

Month 12 March	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
Independent Sector	-395	-856	-461	-395	-856	-461
Prescribing	-7,929	-8,295	-366	-7,929	-8,295	-366
Continuing Healthcare	-8,008	-10,101	-2,093	-8,008	-10,101	-2,093
IPP	-1,454	-1,906	-452	-1,454	-1,906	-452
Running Costs	-2,550	-2,550	-	-2,550	-2,550	-
Social Care	-7,000	-7,000	-	-7,000	-7,000	-
System Gap	-5,000	-5,000	-	-5,000	-5,000	-
Mental Health	-69	-69	-	-69	-69	-
Other	-2,482	-2,482	-	-2,506	-2,506	-
RTT	-6,000		6,000	-6,000	-	6,000
Subtotal	**-40,887**	**-38,259**	**2,628**	**-40,911**	**-38,283**	**2,628**
Total CCG Savings	**-40,887**	**-38,259**	**2,628**	**-40,911**	**-38,283**	**2,628**

QIPP Reported to NHSE

Contractualised 17/18 FYE	-17,989	-17,989	-	-17,989	-17,989	-
Headroom	-11,943	-11,943	-	-11,943	-11,943	-
Subtotal	**-29,932**	**-29,932**	**-**	**-29,932**	**-29,932**	**-**
TOTAL SAVINGS REPORTED TO NHSE	**-70,819**	**-68,191**	**2,628**	**-70,843**	**-68,215**	**2,628**

SOUTH DEVON & TORBAY CLINICAL COMMISSIONING GROUP

Month 12 March	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
NHS South Devon & Torbay CCG						
Acute	-250	-	250	-250	-	250
Independent Sector	-500	-	500	-500		500
Prescribing	-4,000	-3,915	85	-4,000	-3,915	85
Running Costs	-1,000	-1,000	-	-1,000	-1,000	-
Other	-1,250	-1,250	-	-1,250	-1,250	-
Subtotal	-7,000	-6,165	835	-7,000	-6,165	835
Total CCG Savings	-7,000	-6,165	835	-7,000	-6,165	835
QIPP Reported to NHSE						
Contractualised FYE	-750	-750	-	-750	-750	-
TOTAL SAVINGS REPORTED TO NHSE	-7,750	-6,915	835	-7,750	-6,915	835

5 Other Financial Information

5.1 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 positions at the 31st March 2018 and 31st March 2019 are shown in appendix 2.

5.2 Capital

NEW Devon CCG has received a total of £0.285m capital funding in M8, £0.212m towards the shared infrastructure and £0.073m for IT equipment. South Devon and Torbay CCG has received £0.04m of capital funding for business as usual projects.

5.3 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:

	NEW Devon CCG		SD & Torbay CCG	
	Number	£'000's	Number	£'000's
Non NHS Creditors - % of bills paid within target	99.38%	99.44%	97.64%	96.02%
NHS Creditors - % of bills paid within target	98.70%	99.86%	98.61%	99.67%

5.4 Cash

There are a number of key cash performance targets that the CCGs' are measured against; these are set out in appendix 3.

6 Recommendations

The Governing Body is requested to:

Note and review the month 12 draft year end positions which deliver each CCG's control total for 18/19.

Appendices

Appendix 1 Monthly Financial Position

The intention is to provide a consistent level of detail to allow further scrutiny of the main areas of spend which we will develop for the newly merged CCG in the next financial year.

Appendix 2: Statement of Financial Position

NEW Devon CCG

AS AT 31 MARCH 2019	NHS NEW Devon CCG		
STATEMENT OF FINANCIAL POSITION	**OPENING**	**ACTUAL**	**MOVEMENT**
	£000's	£000's	£000's
NON CURRENT ASSETS			
Property Plant Equipment	4,355	3,006	-1,349
Intangible Assets	48	10	-38
Investment Properties	0	-	-
Trade & Other Receivables	162	0	-162
Other Financial Assets	0	-	-
Total Non Current Assets	4,565	3,016	-1,549
CURRENT ASSETS			
Inventories	328	328	-
Trade & Other Receivables - NHS	7,890	7,170	-719
Trade & Other Receivables - Non NHS	6,009	6,424	415
Other Current Assets	0	-	-
Cash & Cash Equivalents	127	1,315	1,189
Non-current Assets held for Sale	0	-	-
Total Current Assets	14,353	15,237	884
Total Assets	18,918	18,253	-665
CURRENT LIABILITIES			
Trade & Other Payables - NHS	-14,960	-16,340	-1,379
Trade & Other Payables - Non NHS	-79,922	-80,096	-173
Other Liabilities	-754	709	45
Borrowings / Cash in Transit	-3	-1,555	-1,552
Provisions	0	-	-
Total Current Liabilities	-95,640	-98,700	-3,060
Total Assets less Current Liabilities	-76,722	-80,446	-3,725
NON-CURRENT LIABILITIES			
Trade & Other Payables	0	-	-
Other Financial Liabilities	0	-	-
Total Non Current Liaibilities	0	-	-
Total Assets Employed	-76,722	-80,446	-3,725
FINANCED BY TAXPAYERS EQUITY			
General Fund	76,722	80,446	3,725
Total Taxpayers' Equity	76,722	80,446	3,725

Continued

South Devon & Torbay CCG

AS AT 31 MARCH 2019	NHS South Devon and Torbay CCG		
STATEMENT OF FINANCIAL POSITION	**OPENING**	**ACTUAL**	**MOVEMENT**
	£000's	£000's	£000's
NON CURRENT ASSETS			
Property Plant Equipment	121	114	- 8
Intangible Assets	0	-	-
Investment Properties	0	-	-
Trade & Other Receivables	0	-	-
Other Financial Assets	0	-	-
Total Non Current Assets	121	114	- 8
CURRENT ASSETS			
Inventories	72	72	-
Trade & Other Receivables - NHS	2,296	1,356	- 940
Trade & Other Receivables - Non NHS	395	160	- 235
Other Current Assets	0	-	-
Cash & Cash Equivalents	60	369	309
Non-current Assets held for Sale	0	-	-
Total Current Assets	2,823	1,957	- 866
Total Assets	2,944	2,070	- 874
CURRENT LIABILITIES			
Trade & Other Payables - NHS	-3,795	- 5,690	- 1,895
Trade & Other Payables - Non NHS	-15,254	- 13,502	1,752
Other Liabilities	-215	- 221	- 6
Borrowings / Cash in Transit	-2	- 335	- 334
Provisions	-275	- 231	44
Total Current Liabilities	-19,540	- 19,979	- 439
Total Assets less Current Liabilities	-16,596	- 17,909	- 1,313
NON-CURRENT LIABILITIES			
Trade & Other Payables	0	-	-
Other Financial Liabilities	-107	- 95	12
Total Non Current Liaibilities	0	-	-
Total Assets Employed	-16,596	- 18,004	- 1,301
FINANCED BY TAXPAYERS EQUITY			
General Fund	16,703	18,004	1,301
Total Taxpayers' Equity	16,703	18,004	1,301

Appendix 3: Cash

There are a number of key cash performance targets that the CCG is measured against:

	Month 12	
Measure	**NEW Devon CCG**	**SD&T CCG**
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 £438.348m for SD&T CCG and £1,242.156m for NEW Devon CCG the year.*	99.8% of the MCD has been utilised as at month 12 (100% is expected based on a straight line trajectory at month 12).	99.7% of the MCD has been utilised as at month 12 (100% is expected based on a straight line trajectory at month 12).
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £7,477 for March.	Notional charges amount to £605 for March.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has maintained 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.	The CCG has maintained 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 4: Commissioning Sustainability Funding

The Commissioner Sustainability Fund (CSF) was introduced by NHS England to incentivise the CCGs financial performance.

To be eligible for access to the CSF, CCGs must formally meet all of the following conditions:-

- Demonstrate commitment to delivery of financial control total
- Agreement of a milestone-based recovery plan of cumulative debt
- Delivery of the financial plan for the year by meeting the year to date financial control total for each quarter across 2018/19 and provide a credible and well-evidenced forecast in line with the plan at the end of quarters 1, 2 and 3.

Monitoring delivery of financial control totals
CCG's achievement of its year-to-date control total in each quarter and maintaining a forecast in line with plan throughout is a prerequisite to secure its allocation of CSF for that quarter. The CCG's actual financial performance will be compared to its financial control total for that quarter and the forecast outturn for the year compared with the plan. Having achieved (or exceeded) the control total, the organisation becomes eligible for funding. If a CCG fails on its financial performance target it will not be eligible for any CSF funding in that quarter (even if it meets other eligibility criteria). If a CCG achieves its control total in subsequent quarters it will become entitled to previous missed quarters of CSF.

CCGs must have evidenced a commitment to deliver their control totals by quarter 1 2018/19 through submission of a compliant financial plan submission. CCGs that have not signed up to the control total and associated conditions by Quarter 1 2018/19 but do so at a later date will forfeit eligibility to receive earlier quarters of the CSF in 2018/19 even if the other conditions have been achieved.

Quarterly review and payment process
Release of the CSF will be subject to a quarterly review process in arrears based on an assessment against the CSF conditions only – no other factors will be taken into account. Access to funding will be determined through the NHS England monitoring process in consultation with NHS Improvement.

To encourage sensible phasing of plans and to discourage in particular phasing of savings plans towards the latter part of the year, the payment of CSF monies will be weighted towards the latter part of the year. Thus CCGs will be eligible for 10% of the total CSF allocation for quarter 1, 25% for quarter 2, 30% for quarter 3 and the balance of 35% for the final quarter.

If NEW Devon CCG and South Devon CCG meet the payment criteria the resulting year to date reporting impact is as follows:

NEW Devon CCG	Quarter 1 £'000	Quarter 2 £'000	Quarter 3 £'000	Quarter 4 £'000
Cumulative control total before allocation of CSF funding	5,000	10,000	15,000	20,000
Cumulative CSF Financial performance bonus	-2,000	-7,000	-13,000	-20,000
Cumulative control total after allocation of CSF funding	3,000	3,000	2,000	0

`

South Devon & Torbay CCG	Quarter 1 £'000	Quarter 2 £'000	Quarter 3 £'000	Quarter 4 £'000
Cumulative control total before allocation of CSF funding	1,250	2,500	3,750	5,000
Cumulative CSF Financial performance bonus	-500	-1,750	-3,250	-5,000
Cumulative control total after allocation of CSF funding	750	750	500	0

Above extracts taken from NHS England's guidance - The Commissioner Sustainability Fund and financial control totals for 2018/19

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Risk Management Framework					
Date of committee: 23rd May 2019 **Date report produced: 14th May 2019**					
Author (s) Name and Title: **Ginny Snaith, Board Secretary** **Contact Details:** **g.snaith@nhs.net**			**Supporting Executive: Simon Tapley, Interim Accountable Officer** **Contact Details:** **Simon.tapley@nhs.net** **Report Approved by: Simon Tapley**		
Public or Private (Governing Body only):			**Public**	**X**	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**	**X**	**Information**
Does this report place individuals at the centre?			**Yes**	X	**No**

Executive Summary:

Following the appointment of the Board Secretary in April 2019 the arrangements for Risk Management in the CCG have been reviewed. Although good progress has been made there are still a number of areas in which arrangements need to be either changed or strengthened. Many of these issues were picked up in the Internal Audit of Corporate Governance carried out in March 2019. Although the audit gave an overall satisfactory rating there were a number of recommendations made as follows:

- The Policy will need to be updated in preparation for the merger and to reflect the proposed changes to the CCG's Risk Management arrangements and governance structure, including the establishment of the new Strategic Risk Committee

- In order to maintain robust and consistent risk management controls, new risk management processes and arrangements should be clearly defined and documented, and the Risk Management Framework Policy should be updated accordingly in readiness for the merger and the formation of Devon CCG

- Following merger, the newly formed CCG would benefit from a formal risk management training plan being in place and being delivered, so that all staff and members are fully aware of their risk management responsibilities

- In order to strengthen risk registers further the quality and completeness of information recorded for each risk should be scrutinised by risk owners, with support from risk co-ordinators and the information made more robust where necessary

- Training should be provided to risk owners where necessary to facilitate the review of risk register information

- Risk information reported to Committees and the GB should include details of the corporate objective that the risk relates to /impacts achievement of

- A top down review of strategic level risks against each corporate objective is needed. This was recommended in our 2017/18 review of Risk Management but has not been formally undertaken in year.

- The merger and creation of Devon CCG presents an ideal opportunity for a review of corporate objectives, and identification and alignment of strategic level risks which may impact on those objectives. We recommend that such a review should be undertaken

- The effectiveness of the Assurance framework as a risk management tool would be improved if it set out the CCGs corporate objectives and clearly linked strategic level risks to each objective.

- The CCGs need to ensure that the Assurance Framework is considered by the Governing Body at least four times a year, in accordance with the CCG's policy and constitutional requirements.

In response to these recommendations, a revised Risk Management Framework and supporting handbook have been developed and is being presented to the Governing Body for approval.

The key changes to the framework can be summarised as follows:

- All risks to be reviewed and updated (merged where required) and ensure that all information is complete
- All risks to be recorded through central process to ensure oversight. Reports will be produced which contain subsets of the risks for different purposes.
- Assurance Framework to be developed and maintained
- Risk Register and Assurance Framework to be discussed a Governing body as well as Audit Committee
- Assurance scoring to be used for Assurance Framework but not for all risks on register
- Risk Report to be presented to Senior Leadership Team (rather than Strategic Risk Committee) and used to shape agenda
- Executives to take responsibility for adding and removing risks (except those with a risk score of 15 and above)
- Risk Management Training programme to be established for all staff and Governing Body members.

- The role of Committees should focus assurance the risk management processes are operating appropriately rather than on active management of risk

To note: The Internal Audit also recommended that work needs to be undertaken on System wide management of risk as part of the STP governance arrangements – This work still needs to be done and this recommendation has not been addressed.

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:

This framework has been discussed at Exec Team, Senior Leadership Team and Audit Committee and is recommended for approval by the Governing Body.

Key recommendations and actions requested:

Governing Body is asked to approve the Risk Management Framework.

Reference to other documents or accompanying papers:

None

Have the legal implications been considered?

Yes

Equality Impact Assessment:

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

	Yes	No
1. Will the proposal increase discrimination for people in protected groups?		✓
2. Will the proposal reduce discrimination for people in protected groups?	✓	
3. Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		✓
4. Will there be a positive benefit to the patients or workforce as a result of the proposed	✓	

5. Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?		✓

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

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

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

NHS Devon Clinical Commissioning Group

Risk Management Framework

NHS Devon Clinical Commissioning Group

Author (s): Theresa Farris, risk and governance manager NHS Devon CCG Ginny Snaith; Board Secretary	Contact Details: theresa.farris@nhs.net clare.doble@nhs.net	
Approved by:	Date of formal approval	Review Date:
Date Issued:		
All policies are held centrally by Governance: d-ccg.governance@nhs.net		

Document Change History: Risk Management Framework Policy		
Version	**Date**	**Comments (i.e. reviewed/amended/approved)**
V1	August 2017	Review and produce a joint policy for Northern, Eastern and Western Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group. To reflect the risk appetite of both organisations as they align systems.
V 1.4	November 2017	Staff Forum & Staff Council – NEW Devon 7 November 2017 and SDT CCG 20 November 2017
V1.5	July 2018	Risk Appetite approved by Chief Officers Team Meeting
V1.5	July 2018	Risk Appetite discussed at Audit Committee – committees in common
V1.6	12 September 2018	Audit Committee – committees in common - **APPROVED**
V1.6	27 September 2018	Governing Body – meeting in common APPROVED
V2	April 2019	Review to reflect merger of the organisations and recommendations of Internal Audit March 2019
V3	April 2019	Reviewed by Board Secretary
V4	April 2019	Following feedback from Exec Team 30th April 2019
		Reviewed at Audit Committee and Senior Leadership Team
V5		Governing Body July 2019

Equality, diversity and inclusion statement

NHS Devon CCG is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of

staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672
Email: pals.devon@nhs.net
Post: Patient Advice and Complaints Team
FREEPOST EX184
County Hall
Topsham Road
Exeter
EX2 4QL

Risk Management Framework Contents		
Section	**Title**	**Page**

Risk Management Framework

1. Statement of Intent

1.1 The objective of this risk management framework is to ensure that the organisation is best placed to deliver its strategic objectives set out in its operational plan. At the forefront of this framework is the knowledge of protecting members of the public and staff, and best utilising the assets of the organisation and identifying any risk that may affect NHS Devon Clinical Commissioning Group hereafter known as the CCG in the achievement of its objectives, for example, risks in relation to commissioning comprising clinical, quality, safety, financial, patient experience, performance, reputation and business conduct must be assessed and appropriate actions taken.

1.2 In the CCG risk management is not the responsibility of one role or one individual, it is the responsibility of everyone.

1.3 The CCG is committed to ensuring that risk management is a key part of the CCG's role of improving the health of the local population and ensuring an outstanding level of patient safety through commissioning of high-quality services that meet the needs of local people. The CCG also has a statutory and regulatory obligation to ensure that systems of control are in place to minimise the impact of all types of risk which could affect the function of the CCG. This includes both the risk to the organisation and the risk to those individuals to whom the CCG has a duty of care.

To this end:

- risks within the organisations are identified, assessed, treated and monitored and are integral to the governance of the CCG
- all elements of the commissioning process, including needs assessment, tendering, contract management and evaluation, include robust risk assessment and monitoring mechanisms

1.4 Risk management is a continuously evolving process and engagement of all staff and partners is essential for its successful implementation. Therefore, the CCG will work with its partners to promote robust risk management across its whole health and social care economy, to improve patient safety and learning from all incidents.

1.5 It is not the intention of the CCG to use risk management to stifle risk taking and/or innovation. Risk is inherent in all activity. The risk management systems ensure that risk is identified in line with the CCG risk appetite, the level of risk will be deemed acceptable as part of the overall impact of the project or process.

1.6 All managers and staff need to acknowledge risks in line with the Nolan Principles of openness and transparency. With this approach the overall level of risk within the CCG will be reduced, actively mitigated and have a clear action plan and trajectory for closure. The overall approach within the CCG will be one of help and support of each other, rather than recrimination and blame. The CCG Governing Body are committed to this approach.

1.7 This framework is designed to coordinate risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register and its supporting documents across the CCG, namely: assurance framework (AF) and corporate risk register (CRR). This will enable the CCG to facilitate improvements in patient safety, quality of care, CCG reputation and financial governance and provide reports that will contribute to the monitoring and auditing of all risks inherent within the organisation through the appropriate forums.

2. Introduction

2.1 This document is the risk management framework for NHS Devon Clinical Commissioning Group (The CCG). The CCG is committed to a framework that identifies and takes appropriate action to minimise risk to patients, stakeholders and the CCG through a comprehensive system of internal assurances and controls whilst providing maximum potential for flexibility, innovation and best practice in delivery of its vision, mission and objectives.

The CCG has adopted corporate objectives, as approved by the Governing Body and will actively identify and report any risks, threats and opportunities to achieving the organisation's objectives.

2.2 The CCG approach to risk management, in line with being a clinically led member practice organisation, is supported by its committees and working groups who manage and have oversight of risk at both a strategic and operational level. The CCG culture is of devolved accountability, empowered decision making and corporate responsibility. In line with their operating models, all delegated functions by the Governing Body are managed through the committee governance arrangements, therefore, this framework is based on proportionate governance structures, policies, procedures which report and identify and manage risk in the place or by the person(s) where the most value is added.

2.3 Key success factors for embedding risk:

- Risk management is everybody's business
- Our risks are understood and managed effectively
- Leadership behaviours and accountability drives a risk aware culture
- Risk aware behaviours are underpinned through performance management
- Compliance with legal and statutory requirements
- Assist compliance with national guidance
- Encourage proactive risk management
- Meet the CCG commissioning responsibilities for risk management through the contracting process

2.4 Risk management is viewed by the CCG as an integral part of good management practice which underpins the organisations objectives and enables the prioritisation of its resources in line with risks. An integrated approach to risk management is embedded so that lessons learned can be understood and applied across the all populations of the CCG.

3. Purpose and Scope

3.1 This framework is intended for use by all members and employees (clinical, managerial, specialist and administrative) of NHS Devon Clinical Commissioning Group. The Governing Body will continuously strive to ensure that there are effective governance and risk management systems and arrangements in place and that these are monitored on an on-going basis.

3.2 Work is underway to develop system-wide arrangements for risk management. This framework will be revised if required to accommodate these new arrangements whilst ensuring that the principles of good governance and accountability and maintained

3.3 All staff must be familiar with the contents of this document – and more importantly – what it means in terms of implementation and applicability to their role

3.4 The purpose of this framework is to provide a consistent defined systematic approach to identifying, reporting and managing risk in both organisations. This policy provides a framework for the embedding of risk management in all activities within the organisations.

3.5 The framework provides a method by which organisational understanding of risks in all its constituent parts, control measures, importance of actions, review and ownership is robustly assured through the CCG governance structure.

3.6 Risk management is the responsibility of everyone either directly or indirectly working with the CCG to achieve its objectives. The CCG key strategic risk management aims as a commissioner of health services are as follows:

- To adopt an integrated approach to the management of risk and to integrate risk into the overall arrangements for clinical and corporate governance;
- To support the achievement of the CCG objectives
- To comply with national standards
- To have clearly defined roles and responsibilities for the management of risk
- To commission a high-quality service for patients and continuously strive to improve patient safety
- To ensure that risks are continuously identified and assessed, and that they are treated, either by avoidance (by discontinuing a specific activity), taking or increasing the risk in order to pursue an opportunity, removing the risk source, changing either the likelihood/probability or consequence, sharing or transferring the risk, or retaining the risk by informed decision
- To use risk assessments in informing the overall business planning/investment process in the CCG
- To encourage open and honest reporting of incidents through the use of a single incident reporting system
- To establish clear and effective communication that enables information sharing;
- To foster an open culture that allows organisation wide learning

4. Definitions

4.1 **Risk** - the chance of something happening that will have an impact upon objectives. It is measured in terms of likelihood/probability and impact. Refer to appendix 1 for examples of likelihood/probability and impact of risk, along with the 5x5 risk scoring matrix.

4.2 **Clinical risks**: defined as “those risks which have a cause or effect which is primarily clinical or medical” examples include clinical care activities, consent issues and medicines management.

4.3 **Corporate or organisational and business risks**: defined as “those risks which primarily relate to the way in which the CCG is organised, managed and governed”. Examples include human resource issues and corporate governance risks concerning the establishment of an effective organisational structure with clear lines of authorities and accountabilities. The risk events can include inappropriate decision making and delegation of authorities; all can result in sub optimal performance and losses for the CCG.

4.4 **Specific risk areas**: Behind the comprehensive areas of risk above there are more clearly identified risk areas that the CCG may encounter and need to manage:

Change	These concern risks that programmes and projects do not deliver agreed benefits within an agreed budget, and/or introduce new or changed risks that are not effectively identified and managed.
Legal and Compliance	These include Health & Safety; Data Protection, Employment practices; employment legislation; the NHS constitution; freedom of information; civil contingencies; deprivation of liberty and regulatory issues.
Operations	These concern the day to day concerns that the CCG is confronted with

	as it strives to deliver its strategic objectives. They can be anything from loss of key staff to process failure. It covers risk events such as failure by a third party to deliver a service for the operational, breakdown in partnership with third party, failure to manage internal change etc. Operational risks are largely short or medium term where impact is high/medium and likelihood/probability is low to high
Information & Technology	These concern the day to day issues the CCG is confronted with as it drives to deliver its strategic objectives. They can be anything from loss of data to failure of a key IT system. It covers risk events such as cyber security a technological breakdown, loss of hard or soft copy data, failure by a third party to deliver a service breakdown in partnership with third party, failure to manage internal change etc
People	These concern insufficient staff resources (capacity and capability). These risks can have a significant impact on the performance and reputation of the CCG.
Strategic	These concern the long-term strategic objectives of the CCG. They can be affected by external factors such as the economy, changes in the political environment, technological changes, and in legal and regulatory changes. The strategic risks are mainly significant risks that can potentially impact the whole of the CCG.
Clinical	These concern risks that arise directly from the commissioning of healthcare to patients. This includes safeguarding, clinical errors and negligence, healthcare associated infection and failure to obtain consent.
Reputational	It is important that the reputation of the CCG is protected through robust systems of communication with stakeholders. Systems of communication with external stakeholders that contribute to minimise risk need to be in place, including regular meetings, patient surveys, publications and public meetings. The CCG has a large and diverse range of stakeholders with whom it needs to develop and maintain engagement

4.5 **Risk Management** – Includes all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate, monitoring and reviewing progress.

4.6 **Risk Management Process** - the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk.

The risk management process is a continual cycle and is the responsibility of everyone in the organisation. Please refer to the risk handbook for further definitions and glossary of terms used with regard risk.

5. Accountabilities and Responsibilities

5.1 The management of risk is a key organisational responsibility. The Governing Body holds overall responsibility for the CCG's risk management framework and is supported by the Chief Officer and Executives. The Audit Committee will provide assurance on risk management to the Governing Body.

5.2 For risk management to be part of operational activity throughout the CCG, it is important that individual accountability is clearly defined. All staff must accept the management of risks as one of their fundamental duties and must have a sense of ownership and

commitment to identifying and minimising risks. Risk issues are present in the CCG at all times and the day to day management of those risks is the responsibility of all staff employed by the CCG.

5.3. As a commissioner of healthcare, the CCG is committed to ensuring that services are provided to high standards, and that any risk to patients, staff or the organisation are treated by a process of identification, assessment, management, and, any mitigations to risk applied. To facilitate understanding and ownership of responsibility for risk management the CCG encourages a culture of openness and honesty in relation to reporting adverse incidents and near misses. Adverse incident reporting will be used in a positive way as learning opportunities to eliminate or reduce risks in the future.

5.4. Key responsibilities for risk management are:

Accountable officer / Chief officer	The Accountable officer/Chief Officer has the responsibility for having an effective risk management system in place within the CCG. This is to ensure that the CCG is meeting statutory requirements and adhering to guidance issued by the Department of Health in respect of governance.
Directors of Strategy, Commissioning and Transformation	The Director of Commissioning is required to have an ability to understand the CCG risk environment, including knowledge and understanding of the strategies that have been adopted by the CCG and the risks inherent in any transformation strategies.
Chair of the Governing Body	The Chair of the Governing Body is expected to have the skills, knowledge and experience to assess and confirm that appropriate systems of internal control are in place for all aspects of governance, including financial and risk management, including any risks to the delivery of the QIPP programme.
Lay member / Audit Chair with lead role for governance	The Lay member (Audit Chair) on the governing body with a lead role in overseeing key elements of governance and systems of internal control, is expected to have the skills, knowledge and experience to assess and confirm that appropriate systems of internal control and assurance are in place for all aspects of governance, including financial and risk management.
Chief Nursing Officer/ Caldicott Guardian	The Chief Nursing Officer within the CCG has a lead role for the safeguarding of children and of vulnerable adults and consideration of nursing and patient safety at all times. The chief nursing officer also oversees clinical audit and clinical best practice development and benchmarking. The Chief Nursing Officer who is also the Caldicott Guardian has a direct route to escalate risk to the SIRO.
Chief Finance Officer	The Chief Finance Officer has overall responsibility for the integrity of the system of internal financial controls, financial risk and for specific responsibilities as set out in the standing financial instructions. The chief finance officer: • Holds executive responsibility for financial risk management, financial performance management and is accountable to the Chief Officer. • Has professional responsibility for internal audit • Ensures the effectiveness of the organisations financial control systems, including counter fraud measures • Ensures that the significant financial risks faced by the CCG are identified and managed effectively

Senior Information Risk Owner	The SIRO is an executive who is familiar with and takes ownership of the organisation's information risk management policy and acts as an advocate for information risk on the Governing Body. The SIRO in turn provides assurances to the organisation's Chief Officer.
Board Secretary	The Board secretary will advise the Governing Body (and managers) on matters of good governance within statutory and regulatory frameworks and being accountability for a range of corporate issues. They are accountable to the Chief Officer, Executives and lay member for governance, for the management of the corporate risk register and assurance framework. As a key member of the Senior Leadership Team(s) working closely with the Governing Body, the Board Secretary will share responsibility for ensuring functions are exercised effectively, efficiently, economically, with robust governance and in accordance with the terms of the CCG Constitution as agreed by their members.
Operational Senior Managers	Each senior manager is operationally responsible for ensuring effective structures and systems for managing risks, reflecting this framework, exist within their team/department. • Ensuring risk management is incorporated into all processes • Ensuring that the risk management strategy and other information is disseminated to all staff within the CCG • Identifying staff within the CCG who are responsible for taking risk management forward and making their roles, responsibilities and accountabilities clear both to them and to other staff • Ensuring that all staff have received corporate induction and specific local induction regarding risk management processes and are aware of their personal responsibility for risk management • Undertaking regular and thorough self-assessment for risk and demonstrating outcomes from the assessment process, including action plans and evidence of implementation • Ensuring appropriate risks are entered onto the risk register • Ensuring that a robust process of self-audit and review exists for all risk related objectives and activity. • Ensuring that documentary evidence exists for all risk management activity and to demonstrate that CCG standards and legal and statutory requirements are being met • Ensuring that risk related governance objectives are achieved.
Managers	Managers have specific operational responsibilities in relation to their area of work. Managers are also responsible for ensuring that risks within their area are identified, assessed, monitored and captured on the organisational risk register in accordance with this framework.
All Staff	All members of staff are accountable for their own working practice and behaviour and this is implicit in contracts of employment and reflected in individual job descriptions. It is the duty of all members of staff to ensure that all actions taken are in the best interest of the organisation and that they do not expose the organisation to unnecessary levels of risk. All staff are required to follow the processes set out within this framework with regard to the identification of risk within their sphere of work. Individual accountability must be clearly defined and reflected in objective setting and performance reviews through line management accountabilities. • Be alert to risks and recognise their duty to report them through their line management arrangements so that appropriate action can be taken.

	• Be aware of existing risk assessments related to their area of work and relevant procedures or control measures to be adopted to reduce identified risks • Contribute to minimising risks wherever possible • Be familiar with the CCGs risk management framework (this document) and associated standard operating procedures • Recognise their duty under legislation to take reasonable care for their own safety and of others that may be affected by the CCGs business • Report incidents and serious incidents requiring investigation (SIRI) as per the respective policies, which should be read in conjunction with this policy • Attend all relevant risk management training as required by this framework and job description.
Information Asset Owners (IAOs)	The CCG's Information Asset Owners (IAOs) shall ensure that information risk assessments are performed at least annually. IAOs will submit the risk assessment results to the SIRO via the IG Forum for review. IAOs are senior individuals involved in running the relevant business areas. Their role is to understand and address risks to the information assets they 'own'. IAOs are likely to be supported by Information Asset Administrators (IAAs) e.g. User Administrators who are operational staff with day to day responsibility for managing risks to their information Assets. The CCG's Information Asset Register holds a list of all the current IAOs and IAAs.
Partnership working groups	The CCG is committed to the continuing development of partnership working with other health and social care organisations. In commissioning quality services, the CCG needs to be acutely aware of accountability arrangements and the management of risks in partnership working arrangements. There is an understanding that in addition to internal risks, there are also external risks that the CCG shares with partner organisations such as NHS England, Local Acute Trusts), Local Authority, social care and other partner stakeholders. These risks need to be assessed and where necessary appropriate 'risk sharing' management arrangements set in place. When partnership agreements are being developed risk management will be specifically addressed. This will need to incorporate clear lines of accountability and responsibility for staff working across partner organisations. Within the agreement there will be an explicit statement that sets out how the risk management structures and systems of the organisations will link and how decisions will be made, and which organisations will lead on the management of a specific identified risk. The CCG will work closely with partner organisations to achieve a shared ownership of risks facing the health economy and the solutions that are implemented. The CCG expects risk management to be a priority for those from whom it commissions services.
Contractors	Contractors and temporary staff are required to follow CCG policies and procedures as well as being aware of risk assessments within their area of work.
Commissioning services	The CCG commissions health services on behalf of the registered population of Devon. The CCG Governing Body must be informed of, and where necessary, consulted on all significant risks that arise from the service level agreements with other healthcare providers. The failure of a commissioned service to deliver services as agreed would be a significant threat to the achievement of one or more objectives of the CCG. Therefore, risks must be systematically identified, assessed and

	analysed in the same way as other risks to the CCG with clear accountabilities defined. Risk associated with commissioned services will feature in the CCGs corporate risk register to enable the Governing Body to be fully informed on the risk profile of the CCG.

6. Risk Appetite

6.1 The Good Governance Institute states:

"*The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks. Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite*".

Risk appetite is therefore 'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.' (HMT Orange Book definition 2005)

The CCG has articulated their risk appetite by creating the following statements:

'The Governing Body of NHS Devon CCG recognise that risk is a natural part of health and social care provision. The CCG will manage and mitigate risk whenever possible, to optimise patient safety. Whenever possible, we will look to take calculated risks where the potential results outweigh the costs.

Management should implement specific limits or tolerance levels that are aligned with those overall limits set by the Governing Body at departmental or functional, activity and operational risk levels'

Our risk appetite statement helps our staff and our stakeholders to understand the level of risk the Governing Body are prepared to accept across the Clinical Commissioning Group. It describes the levels of risk we are prepared to tolerate and how they will be treated and by whom.

Management should implement specific limits or tolerance levels that are aligned with those overall limits set by the Governing Body at departmental or functional, activity and operational risk levels (Appendix 1).

Appetite Level	Described as
None	**Avoid:** the avoidance of risk and uncertainty is a Key Organisational objective
Low	**Minimal** (as little as reasonably possible): the preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious:** the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open:** willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM).
Significant	**Seek:** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk. **Mature**: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Appendix 1 indicates the overarching risk score and management response expected to review and agree actions to address risks identified and held on the joint risk register. The risk scoring matrix also considers likelihood/probability and impact to produce an agreed risk score.

6.2 The Governing Body will on an annual basis set specific limits for the levels of risk the CCG is comfortable to tolerate in the pursuit of its objectives.

7. Risk Capture

7.1 Risk will be captured by all parts of the organisation via the reporting system. A Risk Template should wherever possible be completed by the risk owner with the support of the directorate risk coordinator. Risks must then be approved by the responsible Executive before being added to the risk register.

Expert advice and guidance from the Governance Team will assist to provide as accurate an assessment as possible.

Risk information should be captured using the following fields using template Appendix 4.

Risk description	An identity by which the risk is known throughout the life of the risk in the organisation e.g. There is a risk that……
CCG Objective	The risk must be linked to one of the CCGs objectives
Executive Lead	Is the identified Director who is lead for the risk and who is corporately responsible for ensuring that the mitigating action plans are put in place and that risk scores are reduced. The Executive Lead must have approved the risk prior to adding to the corporate risk register for committee approval.
Risk Owner	Will be the senior officer leading on the area of work in which the risk has been identified.
Risk Coordinator	Maintaining consistency in reporting, ensuring use of language is appropriate and the content of the risk register is kept up.
Risk Rating	Is the assessment of likelihood/probability and impact of the risk before controls are considered? (Appendix 1 risk scoring matrix)
Controls	Are identified and put into place to mitigate the causes identified. Gaps in the controls are identified and remedied.
Assurances	Provide the CCG with confidence that the risk is being fully managed and reported. Gaps in these assurances are identified and remedied.
Actions	These are the activities in place to drive the risk down to a more acceptable risk rating level. Updates are made to the risk register to confirm actions completed.
Reporting	Risk is reported via a named committee, which includes Governing Body and Governing Body Committees.
Residual Risk Rating	This is the risk level that remains (likelihood/probable and impact) after controls have been put into place.
Adequacy of Controls and Assurances	This will provide reassurance that the risk is being managed and impact has been mitigated.

8. Risk Monitoring and Review

8.1 Risk will be scrutinised in the following way:

- **Team/Department Level** – Team/department risks shall be reviewed at team/department meetings to ensure that risks are continually monitored, accurately reflecting current position and that the head of department is satisfied that the current position of risks within their department is a true and accurate reflection of the

department risk profile. Executive Directors will have responsibility for agreeing the addition of risks to the register or removal of risks if they are scored up 15.

- **Senior Leadership Team–** will act as the CCG's senior risk committee. All risks and the assurance framework (AF) will be brought before the group monthly as a specific agenda item for review and recommendation of any additions and changes. Additionally, the group will ensure that the Risk Register is used to develop the agendas for meeting to ensure that all high-risk areas are reviewed on a regular basis.
- **Governing Body Committees** – As appropriate, committees will provide assurance of the risk process following formal accountability of the risk process from heads of department at department level and locality clinical leads at locality level. The Committees will provide assurance that collectively the risk register, and AF form a true reflection of the risk profile of the organisation, that evidence of robust risk management is in place on captured risks and that those risks are accurately assessed prior to Governing Body reporting.
- **Governing Body** – The Governing Body is ultimately accountable for risk management in the CCG and assure themselves through the risk register and the Assurance Framework that assurance over risks identified to achieving the vision, priorities and aims/objectives in the CCG are being managed effectively.

The Governing Body is ultimately responsible for:

- approving the risk management framework
- the system of internal control and risk management
- insuring that national and CCG clinical governance issues are addressed

The Governing Body will agree appropriate courses of action where it appears that risks are not being effectively managed.

- **Audit Committee** – The finance and governance non-executive lay member chairs the Audit Committee which reports directly to the Governing Bodies. The committee's primary role is to conclude upon the adequacy and effective operation of the CCG's internal control system. The committees work will focus on the framework of risks, controls and related assurances that underpin the delivery of the CCGs objectives in the Assurance Framework. Members of the Audit Committee are presented with the assurance framework for the CCG as specified in the CCG's constitution.

- The Audit Chair will provide a summary to the Governing Body of its assurances and where necessary request deep dives to be undertaken in areas of risk where further assurances are required. The Audit Committee provides assurance to the Governing Bodies that the risk management process that is in place is designed effectively to provide a robust risk management framework.

8.2 Risks should be reviewed by each risk owner as a matter of good practice in accordance with the timescales indicated in the table below or following a review of actions assigned to the risk to understand if the profile of each risk has altered across its constituent parts.

Risk Level;	Frequency of review by risk owners	Management of risks
Low Risk	No less than Quarterly	Managed by teams
Medium Risk	Monthly	Managed by directors

High Risk		Report to Senior Leadership Team
Significant Risk		Report to Audit Committee / Governing Body

A monthly review of each Risk by the Risk Owner is considered to be best practice, with the risk coordinator supporting the risk manager to maintain an accurate risk register for the CCG.

The Board Secretary is responsible for the CCG risk register as a whole, and requires the support of all directors, risk manager, risk owners and risk coordinators to add and review all risks.

Risk will be reviewed

Governance Level	Frequency	Reported	Risk Register Owner
Team/Directorate	At least Quarterly	All risks relating to relevant Team/ Directorates	Risk Co-ordinator with Risk Owners
Senior Leadership Team	Monthly	Risk Register and Assurance Framework	Board Secretary
Audit Committee	As specified in the CCG constitution	Risk Register and Assurance Framework	Board Secretary
Quality Assurance Committee	At every meeting	Safety and Quality Risks	Chief Nursing Officer/ Caldicott Guardian
Primary Care Joint Commissioning Committee	At every meeting	Primary Care Risks	Director of Primary Care
Finance and Performance	At every meeting	Finance and Performance Risks	Chief Finance Officer Director of Commissioning
Governing Body	In accordance with the constitution	Assurance Framework (AF)	Board Secretary

9. Risk Reporting

9.1 Risk reporting will be facilitated by the Head of Governance on behalf of the Governing Body, Senior Leadership Team and Audit Committee and will provide the appropriate risk register report for each of the areas listed above.

10. Risk Register

10.1 The CCG will capture all corporate risks on a single database.

The risk assessment process provides a systematic examination of the CCG's work processes and enables the reporting of a CCG wide risk profile to the appropriate level as described above. Appendix 1 contains the matrix that is to be used when scoring the identified risks.

10.2 On identification of a new risk to be added to the corporate register, the risk register template Appendix 4 must be completed as fully as possible and submitted to the executive director whose area of responsibility the risk impacts for approval. A new risk must not be added to the corporate risk register without the approval of the responsible executive.

10.3 Requests for new risks to be added to the risk register will be reviewed by the Governance Team to ensure that:

- All required information fields are completed
- They do not duplicate an existing risk
- That they do not contradict an existing risk

10.4 Each team, directorate and committee will capture their risks in the corporate risk register for their area of responsibility. This is typically done by the nominated risk coordinator for the directorate, following instructions from the director, head of department or risk owner. The risk coordinator is not responsible for the risk, they will act as a resource to ensure that the risk is regularly reviewed and updated. Risk coordinators collectively form the risk coordinators group, where learning and best practice can be shared to add value and consistency to the CCG's risk register entries.

- Separate risk registers will not be held for programmes/projects or teams but a generic or bespoke risk register report will be available for each team, department, locality group or CCG committee meeting. Risk Register reports may also be produced for Programme meetings if appropriate

- Risks exceeding a rating of 15 (very high) will be reported on the Corporate Risk Register and presented to the Senior Leadership Team, Audit Committee and Governing Body
- The Senior Leadership Team will discuss the potential escalation of other corporate risks to the assurance framework depending on the perceived impact to corporate priorities and objectives

10.5 **Controls**

The controls are the systems, measures and management actions that are in place to manage or mitigate the effects of the key risks. In some instances, they may be tried and tested systems that have been audited and are proven to control risks. At a high level, for example, a management structure is an organisational control as are the governance arrangements themselves. In other instances, they are more likely to be management actions that are required to manage a specific risk that has been identified.

As the Department of Health's guidance recognises "The relationship between a risk and control is not necessarily straightforward. One specific risk may be mitigated by a number of controls. Some of those controls may only be effective when operating in conjunction with other controls and one control may relate to more than one risk."

Examples of key controls include:

- Governance processes; statutory frameworks, e.g. governance frameworks (standing orders, standing financial instructions and scheme of delegation)
- Management structure and accountabilities
- Risk management processes
- Communications and patient and public feedback
- Compliance with regulatory standards
- Management processes
- Policies and procedures

10.6 **Assurances**

For each of the risks and controls a source of assurance is set out, i.e. what provides evidence that the organisation has identified the risks and has controls in place. Assurances may be internal or external e.g. internal audit reports, a report to Governing Body or Governing Body Committees. The process for gaining assurance about the effectiveness of the key controls is to triangulate the relevant evidence.

10.7 **Gaps in Controls and Assurances:**

The effectiveness of the controls and supporting assurance will be evaluated for any gaps. Further action needs to be identified to address the gaps in controls and assurances that have been identified.

11. Assurance Framework

11.1 All principal objectives and their associated risks are set out in the Governing Body Assurance Frame Work (AF). The AF serves as the key document to assure the Governing Body that risk management is in place to address risks to the organisation's principal objectives. The AF (template shown at Appendix 5) is also a source for identifying links to CCG's Corporate Risk Register and risk management plans.

The AF identifies where there are risks to the CCG's principal objectives, the controls in place to mitigate those risks and the assurance available to the Governing Body that the risks are being managed. The AF also indicates where there are potential gaps in controls and assurances and provides a summary of the actions in place to resolve these gaps. Our risk appetite in relation to the risks associated with each principal objective is given in the AF. Assurance scoring will be used to evaluate the level of assurance given.

The Audit Committee will review the AF quarterly. The Governing Body will review the AF quarterly.

Governing Body Assurance Framework		Timescale
Maintenance Coordination	Governance Team	Ongoing and at least monthly
Updating		Ongoing and at least monthly
Review and sign off	Directors	Ongoing and at least monthly
Monitoring	Directors Audit Committee Governing Body	Monthly Quarterly Quarterly

12. Mitigating Action

12.1 Mitigating action describes the part of the risk assessment process when decisions are made about how to treat risks that have been identified. The options for mitigating action are:

- **Reduce Risk:** For risks with high likelihood/probability and impact, risk reduction

measures are absolutely essential. Take direct action to reduce the level of risk to an acceptable level. Current 'ongoing' controls and actions to be continually monitored and actions planned to be implemented. Actions recorded must be 'SMART' (specific, measurable, agreed, realistic and time bound). This will require defined actions to be allocated to individuals, implementation dates agreed and implementation status to be monitored.

- **Transfer Risk:** It may be that the risk can be transferred to another organisation by way of a contractual agreement (for instance the private sector) or shared with partner organisations. In some instances, a risk may be insurable either totally or in part (e.g. legal liability, property, motor vehicle). However, it must be remembered that responsibility for statutory functions cannot be fully transferred and the reputational implications of risks need to be managed.
- **Manage Risk**: For risks with a higher likelihood/probability but a low impact the approach should be to manage and control the risk, i.e. by improving and documenting processes, providing adequate training and education or by implementing controls and procedures to regularly monitor and review the situation.
- **Contingency Plan**: If the likelihood/probability is low but the impact high contingency plans (or business continuity plans) should be developed. The purpose of contingency plans is to ensure the organisation's critical business functions or processes can continue at an acceptable level.
- **Accept Risk:** If the likelihood/probability is low and the impact is low, it is reasonable to do nothing and to accept certain risks. The ultimate aim of the risk management system is to reduce all risks to a level that the organisation is willing to accept. A decision taken not to implement any additional controls or actions indicates that the cost of control will exceed the benefits of risk reduction. When deciding on this management strategy, care will need to be taken to ensure consequences of the defined risk are fully considered, e.g. potential breach of legislation, reputational loss. Current 'ongoing' controls and actions (established 'routine' controls) will need to be monitored.
- **Terminate Risk**: The risk may be so serious that adding controls or modifications do not reduce the risk to an acceptable level. At this stage withdrawal from the activity may be considered.

13. Incident Reporting

13.1 The routine reporting of adverse events, incidents and 'near misses', is an essential requirement of the CCG's risk management framework policy.

All staff are required to report non-clinical incidents and near misses using the processes agreed within each of the CCGs.

Detailed guidance regarding incident reporting and investigation is contained within the NHS Devon CCG policy for the management of incidents (including serious incidents) https://www.newdevonccg.nhs.uk/information-for-patients/serious-incidents-100161

All staff should be encouraged to report incidents. This will be achieved through awareness training and by on-going support from the quality directorate for serious incidents.

The CCGs will comply fully with the commitment to identify record, investigate and report incidents and serious untoward incidents to the appropriate agencies including the appropriate NHS reporting bodies.

14. Risk Training

14.1 As described in section 5, accountabilities and responsibilities, directors, deputies, associate directors and key managers are responsible for the compliance with the risk management framework policy. This will ensure that all identified remedial actions are taken for risks identified within their area of responsibility.

14.2 Annual risk awareness training for Governing Body members, Directors, deputy Directors and associate directors to be facilitated by the Board Secretary.

a. Staff new to the organisation will receive risk management training via induction.

b. Training for Directors, Deputy Directors, Associate Directors and key managers is ongoing throughout the year via the risk updating process.

c. Ensure that staff have the knowledge, skills, support and access to expert advice necessary to implement the strategies, policies and procedures associated with this Policy

d. Details of the risk management framework will be available to all employees of the CCG and communicated to stakeholders and the public. Via the following:

- Induction programme
- Local induction via team risk co-ordinator
- Risk assessment
- CCG staff bulletin
- Risk reports to CCG Governing body and sub committees
- Risk reports to identified committees/groups to review and support programme risk. Escalating to corporate risk register as necessary

15. Monitoring Effectiveness and Compliance

15.1 The government financial reporting manual requires CCGs to prepare a governance statement as part of the annual report and accounts. This is referred to as the annual governance statement (AGS) and is part of the CCGs annual report. This also includes the Head of Internal Audit Opinion.

15.2 Each year the CCG is required to carry out an internal audit of its risk management processes and report this within the AGS. This includes any recommendations for improvement.

a. The AGS is reviewed and approved annually by the Audit Committee before being submitted to the Governing body as part of the annual report and accounts.

b. The Audit Committee also review risk though papers submitted throughout the year. In addition to risk reports being submitted to:

- Quality Assurance Committee
- Finance and Performance Committee
- Primary Care commissioning Committee
- Senior Leadership Team

The committees listed can also request information on specific risks to seek further assurance and details of actions being taken to address the risk.

16. Document review and Version Control

16.1 The risk management framework policy will be reviewed every two years, or sooner should any changes be made to national guidance.

16.2 Changes will be issued as amendments to the policy and be clearly entered on page 2 of this document.

Appendix 1

Summary of Risk Appetite and Acceptable Risk Score

Risk Category	Definition	Appetite/ tolerance	Residual / Acceptable Risk Score	Rationale
Public, Patient and staff Safety (people)	These concern insufficient staff resources (capacity and capability). These risks can have a significant impact on the performance and reputation of the CCG.	Low	4	Patient and staff safety is of the highest importance and the CCGs will not accept any risks that threaten this. The CCG will aim to commission quality services for our patients.
Provider Performance (quality / patient experience)	Risk events such as failure by a third party to deliver a service, breakdown in partnership with a third party, or failure to manage internal change etc.	Moderate	8	The CCG challenges provider performance so as to help improve the service to patients and the public,
Statutory and mandatory compliance and governance. National policy	These include health and safety, data protection, employment practices, employment legislation, the NHS Constitution, Freedom of Information Act, Civil Contingencies Act, Deprivation of Liberty and regulatory issues.	Low	4	The CCG complies with all applicable legislation and will not accept any risk which (if realised) would result in non-compliance.
Financial Statutory Duties	In line with Constitutional requirements and standing financial instructions.	Low	4	Achieving financial balance both within the CCGs and in the wider local health economy is both a strategic priority and a statutory duty. Therefore the CCG will not accept any risk that (if realised) will threaten this.
Fraud and negligent financial loss	This is in line with Anti-Fraud and bribery act and NHS Protect requirements.	Low	4	The CCG will not tolerate financial losses from fraud and negligent conduct as this represents corporate failure to safeguard public resources.
Commissioning	These relate to the day to day concerns the CCGs are confronted with when striving to deliver strategic objectives. They can be anything from loss of key staff to process failure.	Moderate	8	Innovative approaches for commissioning incorporate inherent risk, which can impact on the delivery of outcomes. These concern risks that programmes and projects do not deliver agreed benefits within agreed budget and/or introduce new or changed risks that are not effectively identified and managed.
Reputation	It is important that the reputations of both CCGs are protected through robust systems of communication with stakeholders. .	Low	4	The CCG will maintain high standards of conduct, to safeguard both the organisation and public and stakeholder confidence.
Strategic	Strategic risks can be defined as the uncertainties and untapped opportunities embedded in strategic intent and how well they are executed. As such, they can impinge on the whole organisation, rather than just an isolated department or locality.	High	12	Were the CCG to fail to deliver its strategic priorities, the reputation of the CCG would be compromised, jeopardising its ability to carry out its core purpose and/or meet its strategic objectives
Engagement	The processes of engaging with and involving stakeholders in commissioning decisions	Moderate	8	The CCG will work with its member practices and other organisations (including but not restricted to other CCGs and local authorities) to ensure the best outcome for patients and communities. We are willing to accept the risks associated with a collaborative approach.
Information and technology	These can be anything from loss of data to failure of a key IT system	Moderate	8	We manage our systems to minimise the threat of risk events such as a technological breakdown, loss of hard or soft copy data, failure by a third party to deliver a service, failure to manage internal change etc.
Innovation	Commissioning intentions and operating plan	High	12	We encourage a culture of innovation and are willing to accept risks associated with this approach where they do not threaten risk areas that the CCG are not prepared to accept (as defined above e.g. quality patient care / safety).

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 to mitigate the risk and address gaps in control or arrange contingencies**
Monitor	**At operational / departmental level**	**At operational / departmental level**	**Senior management**	**Executive level**
Escalation	**Risk Register**	**Risk Register**	**Risk Register**	**Governing Body Risk Assurance Framework**
Acceptable Risk Score for Appetite	**5**	**8**	**12**	**15**

Assessing the impact of risk

Appendix 2

Score	Public staff and patient safety (physical or psychological harm)	Quality/complaints/ audit	Finance	Staff	Service delivery	Environment estate and IT
Catastrophic	• Incident leading to avoidable death or serious permanent harm due to a failure of process, breach of policies or protocols/procedures or safe working practices. • An event which adversely impacts on a large number of patients or multiple permanent injuries or irreversible health effects, or serious safeguarding issues • Increased mortality rates or serious incidents/never events indicating failure of the services to deliver patient safety, requiring immediate intervention such as suspension of service or escalation.	• Totally unacceptable level or quality of treatment/services. • Gross failure of patient safety if findings not acted upon. • Inquest/Ombudsman's enquiry with identification of gross failure to meet national standards of care or treatment. • Totally unsatisfactory patient outcome or experience	Serious impact on financial position of CCG	Non delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff	Sustained failure to meet standards and / or national requirements. Serious impact on overall performance and possible intervention Serious long term impact (nationally and locally) on reputation, prolonged interest and DoH / Select Committee overview Serious breach with potential for ID theft or over 1000 people affected	Permanent loss of service or facility Catastrophic impact on environment, multiple breach and prosecution Damage will spread beyond one item of equipment and take over 1 week to repair
Major	• Major injury leading to long term incapacity or disability (not irreversible) • Requiring time off work for >14 days • Increased length of hospital stay by >14 days • Mismanagement of patient care with long term effects, including • Safeguarding • Increased mortality rates or serious incidents/never events indicating urgent interventions e.g risk summit, improvement plan or contractual action	• Non -compliance with national standards with significant risk to patients if unresolved • Multiple complaints or an independent review • Low performance rating • Critical report (internal or external) • Mismanagement of patient care – long term effects	Significant impact on financial position of CCG	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing levels or competence (>5 Days) Loss of key staff	Major impact on overall performance which puts achievement of standards and / or national requirements at risk. National and local interest and impact on reputation specific to an issue – prolonged interest Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected	Loss / interruption of service or facility > 1 week Major impact on environment, multiple breach and prosecution notice issued Equipment will be out of action less than 1 week to repair

Moderate	• Moderate injury requiring professional intervention and leading to long term incapacity or disability • Requiring time off work 4-14 days • RIDDOR reportable incident • An event which impacts on a small number of patients including safeguarding • Increased length of hospital stay by 4-15 days • An increasing mortality rate or serious incidents/never events trend requiring monitoring with action plan to mitigate risk	• Treatment or service has significantly reduced its effectiveness • Formal complaint with potential to go to independent review • Repeated failure to meet internal standards • Major patient safety implications if findings are not acted upon • Mismanagement of patient care – short term effects	Significant impact on financial position of CCG	Late delivery of key objective / service due to lack of staff Unsafe staffing levels or competence (>1 Day)	Failure to meet internal standards with some impact on overall performance of the CCG. Local interest and impact on reputation specific to an issue Serious breach of confidentiality e.g. up to 100 people affected	Loss / interruption of service or facility > 1 day Moderate impact on environment, improvement notice issued Equipment shut down immediately and restarted in less than half a day.
Minor	• Minor injury or illness requiring minor intervention • Requiring time off work >3 days • Increased length of hospital stay by 1-3 days • Mortality rates within normal limits or individual serious incidents that require monitoring	• Overall treatment or service suboptimal • Formal complaint – local resolution • Single failure to meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved • Unsatisfactory patient experience – easily resolvable	Minor impact on financial position of CCG	Low staffing levels that reduces the service quality	Failure to meet internal standards with some impact on overall performance Short term local interest and impact on reputation specific to an issue Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected	Loss / interruption of service or facility > 1 day Minor impact on environment, single breach of legal requirement Moderate damage to equipment easily repairable.
Insignificant	• Minimal injury requiring no/minimal intervention or treatment • No time off work • Mortality rates or serious incidents require routine monitoring.	• Peripheral element of treatment or services suboptimal. • Informal complaint / enquiry • Unsatisfactory patient experience not directly related to patient care	Minor impact on financial position of CCG	Nil	Failure to meet individual employee objectives Minimal impact Potentially serious breach. Less than 5 people affected or risk assessed as low, e.g. files were encrypted	Loss / interruption of service or facility > 1 hour Minimal or no impact on environment Little damage to equipment

Appendix 3

Definitions/Glossary

Definitions	Risk Management
Acceptable Risk	The maximum score associated with a specific risk that the CCG is willing to tolerate.
Accident	An unintended event or series of events that result in death, injury, loss or environmental damage.
Adverse Event	An undesired outcome that may or may not be the result of error.
Assurance	Confirmation that the control environment that is in place is robust and that the controls are working so as to ensure that they will have the desired impact on the risk identified.
Assurance Framework	Links organisational objectives with identified risk to achieving those objectives, via the risk register. It identifies gaps in the control and assurance environment, along with the actions required in order to mitigate risks and control them as far as reasonably practicable.
Board Assurance Framework	A method for the effective and focused management of the principal risks that arise in meeting the CCG objectives.
CCG Risk Register	A scored list of clinical, organisational, financial and strategic risks to the organisation, identified by the Executive Directors, by sub-committees of the Board or by processes of assurance. Controls and assurances in relation to these risks are also set out in the CCG Risk Register.
Consequence	Is the most likely impact on the organisation should the risk materialise
Control	Is something that helps minimise the likelihood/probability of a risk occurring, or if it does occur reduces the consequence of that risk.
Executive Lead	Is an identified Director who is the lead for the risk and who is corporately responsible for ensuring that the mitigating action plans are put in place and that the risk scores are reduced.
Hazard	A source of potential harm.
Incident	An incident is any occurrence which gives rise to, (or, in the case of a near miss narrowly avoids giving rise to), unexpected or unwanted effects involving the safety or well-being of any person on CCG premises or employed by the CCG. It also refers to the loss of or damage to property, records or equipment that are on CCG premises or belong to the CCG. The term therefore includes accidents, clinical incidents, security and confidentiality breaches, violence, and any other category of event, which does or could result in harm. It also includes failures of medical or other equipment.
Likelihood	Is a measure of the frequency of the specific risk being realised.
Probability	The likelihood of a specified event or outcome occurring. This is measured by the ratio of specific events or outcomes to the total number of possible events or outcomes. Probability is expressed along a scale ranging from ‘rare’ to ‘almost certain’ By definition, a risk is a probability of a loss or an opportunity. As such, risks are modelled with probability and impact and Appendix 2 should be used to determine this, alongside a clear trajectory to be agreed between the Risk Owner and Executive Lead
Residual Risk	A risk that remains after all efforts have been made to mitigate or eliminate, risks associated with a business process or investment. After a risk assessment, a residual, risk may be known but not completely controllable.

Risk	The chance of something happening that will have an impact upon objectives. It is measured in terms of consequences and likelihood/probability.
Risk Analysis	A systematic process to understand the nature of, and deduce the level of, risk.
Risk Appetite	The amount and type of risk that an organisation is prepared to seek, accept or tolerate
Risk Assessment	The overall process of risk identification, risk analysis and risk evaluation.
Risk Avoidance	A decision not to become involved in, or to withdraw from, a risk situation. 26
Risk Co-ordinator	Is the identified individual who ensures that all relevant risks for their locality, directorate, team or department are visible on the risk register, and who will liaise with the senior member of the governance team to ensure risks are reported effectively and escalated as necessary to the assurance framework.
Risk Criteria	Terms of reference by which the significance of risk is assessed.
Risk Evaluation	Process of comparing the level of risk against risk criteria.
Risk Exposure	The level of risk that an organisation or process or project is exposed to.
Risk Identification	This is the process of determining what, where, when, why and how something could happen.
Risk Level	Is calculated using the Risk Matrix to multiply the selected consequence and likelihood/probability to determine a risk grade.
Risk Management	Includes all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.
Risk Management	The culture, processes and structures that an organisation applies in order to realise potential opportunities, whilst managing adverse effects.
Risk Management Process	The systematic application of communicating, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk.
Risk Owner	Is named on the risk register as the individual responsible for ensuring that the action plan in place to mitigate the impact is delivered.
Risk Reduction	Actions taken to lessen the likelihood/probability, negative consequences or both associated with risk.
Risk Reduction	Actions taken to lessen the likelihood/probability, negative consequences or both associated with risk.
Risk Register	Is a log of risks faced by an organisation and is used to ensure that appropriate action is being taken to control and reduce each risk as far as reasonably practicable. Each register comprises an assessment of each risk including a description, analysis and a summary of action to be taken in respect of each identified risk.
Risk Tolerance	Is the level of risk that the organisation is prepared to accept and be exposed to at any point in time. This will vary dependant on the conditions facing the organisation at any point in time.
Risk Treatment	Process of selection and implementation of measures to modify risk (avoiding, modifying, sharing and retaining).
Service User	A person who is using services provided by the CCG.
Stakeholders	Those people and organisations who may affect, be affected by, or perceive themselves to be affected by a decision, activity or risk.
The CCGs	South Devon and Torbay Clinical Commissioning Group (SDTCCG) and Northern, Eastern and Western Devon CCG (NEWD)

Appendix 4

Risk Register Template

Date risk opened:					
Risk Description:	*There is a risk that ……..* *The impact of this is (.the impact statement should clearly state the effect of the risk to the CCG)*				
Is the risk evidenced on a provider risk register	*Yes or No please comment in the assurance box*				
Executive Lead:					
Programme lead/senior manager					
Risk Owner:					
Risk Name*:* *(2-4 word title to describe risk eg: Fracture liaison service)*					
Risk Score *(likelihood score x impact score) – please refer to risk matrix scoring section of risk policy*					
Likelihood:	*Rare (1)*	*Unlikely (2)*	*Possible (3)*	*Likely (4)*	*Almost Certain (5)*
Impact:	*None (1)*	*Minor (2)*	*Moderate (3)*	*Severe (4)*	*Catastrophic (5)*
Risk Coordinator:					
Date risk reviewed:					
Committee Reported to:					
Other reporting areas:*(if appropriate) (evolving list)*					
CCG Objectives *(please indicate the objective the risk links to)*	**CCGs Corporate Objectives 2018/2019** 1. To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon 2. To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome 3. To ensure that the organisation contributes to system financial balance and maintains improvements in efficiency, productivity and sustainability for the wider benefit of the NHS 4. To improve collaborative working arrangements with communities promoting self-care, prevention and make continuous improvements in health and wellbeing for the population of Devon 5. To make continued improvements in performance against core standards to deliver measurable results 6. To deliver integrated care closer to home 7. To support research, develop integrated commissioning alongside innovation and growth to benefit the population of Devon *8.* To empower, motivate and maximise staff expertise and knowledge by harnessing our most important asset – our staff				

Controls:	*Controls are the arrangements made or precautions taken, to reduce risk. (eg. 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:*
Control Gaps: *(Detail gaps or state 'none identified')*	
Assurances:	*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:*
Assurance Gaps: *(Detail gaps or state 'none identified')*	
Actions	
Controls:	*Controls are the arrangements made or precautions taken, to reduce risk. (eg. 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:*
Control Gaps: *(Detail gaps or state 'none identified')*	
Assurances:	*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. (eg. Internal audit report, report to Board or Board Committees) Please provide details of assurances below:*
Assurance Gaps: *(Detail gaps or state 'none identified')*	
Actions	
Executive Lead Approval	*Name & date*
Added to Risk Register	*Date*

Governing Body Assurance Framework

Governing Body Assurance Framework Risk Tracker

The Governing Body Assurance Framework identifies the CCG's principal, strategic objectives and the principal risks to their delivery. The controls in place to manage those identified risks are summarised. The internal and external assurances that controls are in place and have the impact intended are set. Where there are gaps in controls or assurances these are described, and the actions planned to mitigate these are also explained. The table below gives an overall summary of the Governing Body Assurance Framework. The detailed framework is on page 3.

Risk Tracker	Lead Director	Initial Risk Score	Current Risk Score	Risk Appetite	Trend	Gaps in Controls Assurance
Principle Objective 1: To commission services to reduce health inequalities and match resources explicitly to improve the local health and wellbeing needs of the population of Devon.						
Description of risk		Eg 12	Eg 12	Eg Reduce		**No**
Description of risk		Eg 9	Eg 9	Eg Remove		**Yes**
Principle Objectives 2: To focus on safe and effective service delivery, improving positive experiences of patient health and care to achieve the best clinical outcome.						
Description of risk						**No**
Description of risk						**Yes**
Principle Objectives 3: To ensure that the organisation contributes to system financial balance and maintains improvements in efficiency, productivity and sustainability						

for the wider benefit of the NHS.						
Description of risk						**No**
Description of risk						**Yes**
Principle Objectives 4: To improve collaborative working arrangements with communities promoting self-care, prevention and make continuous improvements in health and wellbeing for the population of Devon.						
Description of risk						**No**
Description of risk						**Yes**
Principle Objectives 5: To make continued improvements in performance against core standards to deliver measurable results.						
Description of risk						**No**
Description of risk						**Yes**
Principle Objectives 6: To deliver integrated care closer to home						
Description of risk						**No**
Description of risk						**Yes**
Principle Objectives 7: To support research, develop integrated commissioning alongside innovation and growth to benefit the population of Devon						
Description of risk						**No**
Description of risk						**Yes**

Principle Objectives 8: To empower, motivate and maximise staff expertise and knowledge by harnessing our most important asset – our staff						
Description of risk						**No**
Description of risk						**Yes**

<table>
<tr><td colspan="2">Objective:</td><td>Director Lead:</td></tr>
<tr><td colspan="2">Risk:</td><td>Date Last Reviewed:</td></tr>
<tr><td>Risk Rating
(Likelihood x consequence)
Initial:
Current:
Appetite:</td><td></td><td>Reason for current score:

Rationale for risk appetite:</td></tr>
<tr><td colspan="2">Controls: (What are we currently doing about this?)
Mitigating Actions: (What have we done and what should we do?)</td><td>Assurances:

Assurance Score:

Gaps in Assurance: (What additional assurances should we seek?)</td></tr>
<tr><td colspan="2">Current Performance: (With these actions taken, how serious is the problem?)</td><td>Additional Comments:</td></tr>
</table>

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: NHS Devon CCG Integrated Commissioning Executive (ToR)					
Date of committee: 23 May 2019 **Date report produced: 16 May 2019**					
Author (s) Name and Title: **Ginny Snaith, Board Secretary**		**Supporting Executive: Simon Tapley, Interim Accountable Officer** **Report Approved by: Ginny Snaith** **Name and Title: Board Secretary** **Date:** 16 May 2019			
Public or Private (Governing Body only):		**Public**	**X**	**Private**	
For approval.					
Purpose and scope of report:	**Consultation**		**Approval**	**X**	**Information**
Does this report place individuals at the centre?		**Yes**	**X**	**No**	

Executive Summary:

The Integrated Commissioning Executive meeting will provide a mechanism for joint planning and shared decision making by the relevant responsible senior officers who have the authority to act in accordance with the decision making framework of each partner organisation.

The Governing Body is asked to receive and approve these ToR's

Strategic risk: (include risk number if on register)	**Mitigating Actions:**

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 your own organisation via either d-ccg.corporateservices@nhs.net or corporate.sdtccg@nhs.net to update the central register.

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

Integrated Commissioning Executive – 15 May 2019

Key recommendations and actions requested:

The Governing Body is asked to receive and approve the ToRs for the Integrated Commissioning Executive

Reference to other documents or accompanying papers:

N/A

Have the legal implications been considered?

Yes

Equality Impact Assessment:

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

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

If the answer to any of the above questions is yes (other than questions 2 and 3) or you are unsure of your answers to any of the above, you should provide further information using **Quality and Equality Impact Assessment**.

If an equality assessment is not required briefly explain why and provide evidence for the decision.

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

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

NHS
Devon
Clinical Commissioning Group

Integrated Commissioning Executive
Terms of Reference
Draft V4.1

1. Introduction

1.1 Over the last 2 years Local Authorities and NHS organisations across Devon, Plymouth and Torbay have been working to develop more effective ways of delivering integrated health, care and well-being services whilst also making best use of public resources. Collaborative arrangements are continuing to develop between partner organisations, both commissioning organisations and providers of services, to improve population health and enable access to modern, safe and sustainable services. Effective collaboration between organisations will also enable progress toward working as a self-improving system with increased maturity and delegated regulatory functions.

1.2 The proposed arrangements for integration consist of:

- An Integrated Commissioning Executive who will lead strategic planning, resource allocation and incentivising the system to make progress on joint priorities, development of joint funding arrangements between the NHS and each local authority to support integrated commissioning and review progress against planned outcomes, service quality and cost effectiveness

- Joint leadership of integrated commissioning teams with responsibility for commissioning health, care and well-being services for the local population of different communities in the geographical areas across Devon, Plymouth and Torbay as well as supporting commissioning programmes across wider Devon for services or care groups where this will be more effective and efficient

This document sets out the Terms of Reference of the Integrated Commissioning Executive (ICE).

2. Purpose

2.1 The Integrated Commissioning Executive meeting will provide a mechanism for joint planning and shared decision making by the relevant responsible senior officers who have the authority to act in accordance with the decision-making framework of each partner organisation. It will be a meeting of executives rather than a joint committee of the statutory organisations or a new additional organisation. Each partner organisation will continue its own internal executive functions & meetings to manage the business of that organisation.

2.2 The Integrated Commissioning Executive, through leadership of the commissioning process, will have a role in contributing to policy formulation or development of long-term plans.

2.3 The integrated commissioning executive will agree joint strategies or actions to implement agreed policies or long-term plans, prioritising and deploying resources in accordance with the decision-making frameworks of individual organisations, and reviewing impact and progress.

2.4 A planning & policy framework and system governance framework will be developed during 2019/20 to support partner organisations to work effectively together as an integrated care system.

2.5 An integrated strategic planning cycle will be developed to facilitate early planning and policy direction which in turn will speed decision making and delivery.

Principles for working

- Manage ambiguity
- Be agile and take opportunities as continue to develop
- Shared aim of becoming a self-improving system with increased maturity and delegated regulatory functions. This will require both:
  - Supporting providers in the most effective way
  - Purposeful relationship management with regulator
- Add value in working at system level rather than duplicate local system planning and
- commissioning functions

3. Responsibilities

3.1 The responsibilities of the Integrated Commissioning Executive can be categorised as follows:

Outputs

- Forming a joint view of the future state and communicating the vision
- Delivery of the Operating plan for 2019/20 and supporting development of a Long-Term Plan for wider Devon
- Ensure Commissioning Plans and Strategies take into account and addresses the needs of the population of Devon
- Agreeing a commissioning finance plan including allocation against priorities, resource distribution and incentives
- Determine future approach with relevant providers to integrated or delegated Commissioning arrangements, e.g. commissioning individual care and support packages to service level commissioning and delivery
- Oversight of delivery of commissioning plans and resultant transformation plans including reviewing the impact of these. including maintaining oversight of the outcome's framework
- Creating the conditions to enable local partnership development including finance, performance, delivery of Integrated Care Model, local and system transformation
- Oversight of joint commissioning risk register

Process

- Establish a well organised planning cycle and forward work plan for the executive to

manage the agenda and balance strategic planning with delivery

- Establish and support business processes to perform function effectively and efficiently including e.g appropriate feeds/reporting from quality, finance and BI
- Establish and maintain rigorous commissioning processes with plans informed by evidence, e.g. of population need, variation in outcomes, access, cost-effectiveness
- Continue developing commissioning capabilities, including planning cycle, outcomes framework, intelligence, change capability
- Test and refine role in year with live examples – e.g. the role of the ICE in relation to Peninsula Clinical Services review and strategy

4. Attendance

Core membership will include as a minimum those senior officers with responsibility for commissioning services and managing resources on behalf of their organisations including those jointly deployed through pooled fund arrangements:

- Devon CCG Accountable Officer
- Local Authority Directors from Devon, Plymouth and Torbay with DASS responsibility
- NHS Devon CCG Directors with commissioning responsibility

It is expected that these individuals will attend at least 75% of meetings and will arrange for a deputy with an appropriate level of delegated authority to attend when they are unable to do so.

Other relevant Devon CCG Executives, CCG clinical membership representative, Local Authority Officers and System Leadership roles will attend and inform decision making according to the agenda. In terms of the latter, it is proposed that an additional system role is created to provide dedicated leadership capacity for Population Health and Well Being with the role to be undertaken by a Director of Public Health on rotational basis in a part time capacity.

Directors of Children's Services* will be invited to attend as needed to enable whole population planning and alignment of the priorities of local children and young people's plans with the wider Devon whole system plan or where improvement in service delivery requires action at executive level across services for adults and children.

Full list of attendees:

Accountable Officer (Chair)**	NHS Devon CCG
Chief Officer for Adult Care and Health **	Devon County Council
Strategic Director for People**	Plymouth City Council
Director of Adults Services and Housing**	Torbay Council
Director of Commissioning	NHS Devon CCG

Director of Transformation	NHS Devon CCG
Director for Population Health and Wellbeing	Devon STP
Director of Children's Services*	Devon County Council
Director of Children's Services*	Plymouth City Council & Torbay Council
Director of Finance	NHS Devon CCG / STP
Director of Comms & HR	NHS Devon CCG / STP
Chief Nursing Officer	NHS Devon CCG
Locality Clinical Representative	NHS Devon CCG
Primary Care Medical Director	Devon STP
Professional / Clinical Director	Chair of Devon STP Clinical Cabinet
Director with responsibility for long term plan	NHS Devon CCG

**The Chair and Vice Chair roles will alternate between CCG Accountable Officer and Director of Adult Social Services on a bi-annual basis. When the Chair is the Accountable Officer of the CCG the Vice-chair will be Local Authority and vice-versa.

5. Decision Making

5.1 The Integrated Commissioning Executive meeting will be a meeting of 'decision makers', with authority held by individual executives. It will therefore be a meeting rather than a joint committee of the statutory partners.

This does not preclude moving to a joint committee of the NHS and Local Authorities at a future date if deemed to be required and with agreement of all partners.

5.2 During the first 6 months of operation, the meeting will review how decisions can be made when there are significant differences of opinion and how wider system working can be developed to support this.

5.3 The schemes of delegation should provide for appropriate delegation of responsibility to enable expediency of decision making, whilst senior officers remain accountable through the governance mechanisms of their individual organisations.

5.4 The responsibility for decision making of policies or long-term plans rests with the appropriate bodies of respective organisations i.e. the Cabinets or Health & Well Being Boards of Local Authorities, CCG Governing Body and with collective system governance mechanisms where statutory organisations are represented by leaders and chief executives i.e. STP Collaborative Board.

6. Register of Interests

6.1 All members of the ICE will be required to make a declaration of interests. This register of interests will be reviewed at the beginning of each meeting and appropriate arrangements for any potential conflicts agreed.

7. Frequency of Meetings

7.1 Monthly in the first instance.

8. Reporting Arrangements

8.1 The mechanism for reporting decisions made at ICE will be through the officer members to their relevant organisations. These governance arrangements will vary and it will be the responsibility of each individual officer to ensure that the decisions made are reported in the appropriate way.

9. Administration

9.1 Administration and business support to be provided by NHS Devon CCG Accountable officer's office in the first year.

Review

The planned integrated commissioning arrangements are deliberately flexible, maintaining the agility to adapt and take opportunities for further development as required for future years.

The Integrated Commissioning Executive will review the effectiveness of the arrangements operating during 2019/20 and draw learning to inform how these should be further developed. The TOR's will be reviewed after 6 months. It is recognised that some facilitation may be required to support the development process and challenge thinking.

In addition, adaptation of the planning processes will also take account of the ongoing work to develop a system governance framework that supports effective collaboration and democratic accountability including collaboration between the three Local Authority Health & Well Being Boards and Scrutiny Committees.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: Thursday, 23rd May 2019

Dates of Committees covered in this report – Audit Committee held on Wednesday, 8th May 2019

(Minutes of these committee meetings to be available as an addendum). Approved March 2019 minutes attached.

Chair's Name and Title: Nick Ball, Non-Executive Director Financial Management, Probity and Audit

Contact Details: 07794 337509

Reports discussed and assurances received

- **Annual Report and Governance Statement –** the report was provided for assurance and is in the final stages for sign off.

- **Governance:**

Risk Management Framework

A revised framework and supporting handbook have been developed and the Exec Team is asked to recommend the documents for approval to the Audit Committee. Exec Team support is also sought for implementation of the new processes.

The Audit Committee agreed to support all the recommendations in the report.

Joint Risk and Assurance Report

All risks are linked to one of the CCG corporate objectives which will be used to support the development of the Assurance Framework by identifying where there are risks to NHS Devon CCG principal objectives.

The Audit Committee agreed to support all the recommendations in the report and approved the closure of risks 55, 22, 98 & 99.

DOI Gifts, Hospitality and Sponsorship Audit Report

The report was presented to the Audit Committee and the Committee were happy to support this and approved the recommendations.

Terms of Reference

The ToR was presented to the Audit Committee and there were a number of suggested changes to be made as follows:-

- Membership – The Chief Nurse should be moved to the section for attendees do not have voting rights.
- Membership – The Accountable Officer to attend only as an observer, the Board Secretary will re-word the paragraph.
- Frequency of meetings - An Auditor Panel will be reconvened at the July Audit Committee.
- Frequency of meetings – under 7.3 – paragraph should read "The Auditor Panel will **usually** meet on the same day as the Audit Committee". The word usually needs to be added.

The Board Secretary noted the comments and will ask the Governing Body to note the changes.

Reports received and noted

Legal Spend Report 2018/19

The report was presented to provide information and assurance to the Audit Committee regarding the current legal framework and legal spend.

- **External Audit:**

Review external audit progress reports

The paper included a summary of national issues and developments that may be relevant to NHS Devon as a Clinical Commissioning Group.

- **Internal Audit**

Internal Audit Update Report

The report summarised the work of ASW Assurance since March 2019 and included final audit and assurance reports.

2018/19 Draft Head of Audit Opinions Statement

This report was presented to the Audit Committee for information and assurance. Final Opinions will be issued ahead of the 23rd May 2019 Extraordinary Audit Committee Meeting.

It is with great pleasure that I can report that the HOIA is issuing an opinion of Significant Assurance" for both CCGs. This is a considerable achievement given the highly transitional year in question.

Audit Strategy and Audit and Assurance Plan 2019/20 – 2021/22

The first draft of Devon CCG's Audit Strategy and Audit and Assurance Plans, covering the period 2019/20 to 2021/22, was presented to the former Audit Committee in Common for review and comment at the March 2019 meeting.

The draft Audit and Assurance Plan has been reviewed by the Executive and updated and is now presented to the Audit Committee for approval.

Internal Audit Charter

A copy of ASW Assurance's Internal Audit Charter was provided for consideration by the Audit Committee and sets out the purpose, authority and responsibilities of internal audit in accordance with Public Sector Internal Audit Standards.

- **Counter Fraud and Security:**

Receive counter fraud annual report

This report summarised the work undertaken by the Local Counter Fraud Specialist (LCFS) during 2018/19.

Receive draft counter fraud plan 2019/20

The draft Counter Fraud Plan for 2019/20 has been designed to help manage fraud, bribery and corruption risks across the CCG.

Local Security Management Specialist (LSMS)

The draft Security Management Plan for 2019/20 has been designed to help manage security arrangements across the CCG.

Risk Register Review (changes and areas of concern)

- An additional risk 104 *(relates to the CCG not having the required resource to effectively administer Datix)* has been added to the risk register and the Audit Committee were asked to approve this.
- Risk 55 (*relates to the potential loss of access to some or all ICT services to the CCG*) and Risk 22 (*the CCG will see direct intervention if directions not implemented*) have been resubmitted as the minutes of the previous meeting did not confirm the committee's approval to close.
- Risk 98 (*lack of workforce capacity to the CCGs following the restructure in 2018*) and Risk 99 (*the impact of this is that the CCGs are unable to deliver on all aspects of their corporate objectives*) (mirrored risks on the risk registers of NHS SDT CCG and NHS NEW Devon CCG) have been reviewed by the risk owner and recommended for closure at this committee.

The Audit Committee agreed to support all the recommendations in the report and approved the closure of risks 55, 22, 98 & 99.

Committee Decisions

- **Approved changes to the Risk Register as listed above.**

Recommendations for Governing Body

- Minor changes to ToR
- BCF discussion – a future development agenda

Recommendations for other Committees
Nothing to report.
Terms of Reference or other committee effectiveness issues
Nothing to report.

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Quality and Performance report					
Date of committee: 23 May 2019 **Date report produced: 08/05/2019**					
Author (s) Name and Title: **Lorraine Webber – Associate Chief Nursing Officer (South & West) South** **Kelvin Grabham: Associate Director of Business Intelligence** **Karen Helliwell: Senior Information Specialist** **Contact Details: karen.helliwell@nhs.net**			**Supporting Executive:** **Name and Title:** **Kelvin Grabham – Associate Director of Business Intelligence** **Lorna Collingwood-Burke– Interim Deputy Chief Officer**		
			Report Approved by: **Name and Title: as above** **Date:** 08/05/2019		
Public or Private (Governing Body only):			**Public**	√	**Private**
For information and assurance					
Purpose and scope of report:	**Consultation**		**Approval**		**Information** √
Does this report place individuals at the centre?			**Yes**	√	**No**
Executive Summary: This report provides the latest information on key quality and performance indicators including those contained in the NHS Constitution. The report includes as an appendix the Improvement and Assessment Framework (IAF) indicators for the latest quarter.					
Strategic risk: (include risk number if on register)			**Mitigating Actions:**		

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 your own organisation via either
d-ccg.corporateservices@nhs.net or corporate.sdtccg@nhs.net to update the central register.

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

None

Key recommendations and actions requested:

For information and assurance

Reference to other documents or accompanying papers:

PDEG/SPG reports

Have the legal implications been considered?

Yes

Equality Impact Assessment:

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

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

If the answer to any of the above questions is yes (other than questions 2 and 3) or you are unsure of your answers to any of the above, you should provide further information using **Quality and Equality Impact Assessment**.

If an equality assessment is not required briefly explain why and provide evidence for the decision.

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

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

sexual orientation, marital status, religious belief or disability.

Governing Body – Quality & Performance Report

May 2019

Summary

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

Performance against the main constitutional standards is summarised below:

- A&E 4hr wait: March showed an improvement in performance at STP level, rising from 82.9% to 85.4% (compared to the national position of 86.6%). However, provisional April data shows a more challenging month with growth in attendances and a decrease in performance to 81.5%.
- The RTT position was relatively static in March at 80.5% with the waiting list increasing by around 1,250 patients. There was good progress in reducing over 52-week waits, falling at all providers and moving from 339 to 188 at STP level.
- Diagnostics performance improved again in March with the breach rate falling from 11.9% to 10.5%, the lowest rate seen in 2018/19. The majority of the improvement was related to reduced imaging breaches although there has also been progress in endoscopy.
- The acute delayed transfers of care (DTOC) position improved in March from 3.9% to 3.2% and is now achieving the national target for the first time, with NDHT, UHP and TSD all remaining under the 3.5% target and improvement at RD&E from 6.2% to 5.0%.
- Cancer: March saw a slight improvement in performance at STP level against the 62 day target from 71.5% to 72.4% with a small reduction in the backlog and long wait position. STP level performance improved again against the main 2ww measure at 89.5% although this remains under the 93% target. Breast symptomatic performance fell further to 70% with TSD at 38.8%.

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

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

Children and Young People Services
The smooth transition of services from the incumbent provider to the new provider, NHS Alliance, from 1 April 2019, has been positive and effective due to the on-going collaborative work between the CCG and both provider organisations. Formal reporting and review of assurance information from the quality outcomes framework is due to commence in May.

Delegated Commissioning Primary Care
From 1 April the CCG has been receiving significant events reported by all GP practices across Devon. The process for logging, triaging and reviewing these incidents and for any subsequent serious incident management is now the responsibility of the CCG nursing and quality directorate. The quality assurance process will enable the CCG to establish any themes and learning from incidents occurring within primary care. A second planning workshop with NHS England will take place in May to plan the transition of other quality functions to the CCG.

NHS Quality Checkers
The CCG were awarded funding from the Devon County Council Better Care Fund to support work employing 'Quality Checkers' who have first-hand experience of using NHS services as individuals with a learning disability. Four teams of NHS Quality Checkers have been tasked to identify and help improve the way in which care and support is delivered to people with a learning disability across Devon. Leading the work is Devon Link Up, an independent charity based in Honiton run by and for people with learning disabilities and/or Autism.
NHS Quality Checkers are people who:

- Are paid to check NHS services
- Have a learning disability, dual diagnosis of learning disability with autism or have an additional mental health need
- Have experience of using services themselves so know about the importance of good quality support
- Know what to ask and where to look to find answers

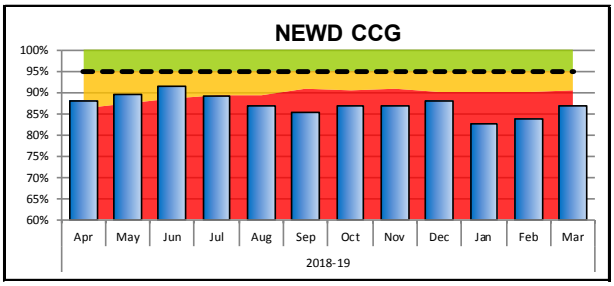
Quality Checkers play a unique role in monitoring services as they are experts by experience. Feedback and outcome reports from the teams will be used to strengthen the CCG quality assurance framework.

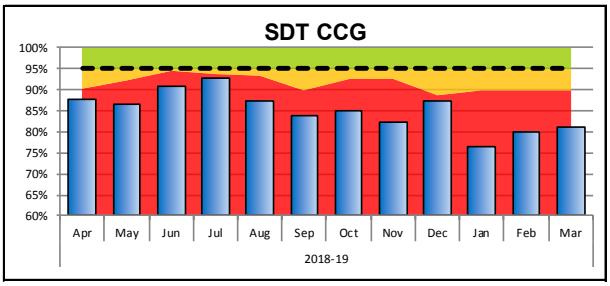
A&E Performance - Percentage of patients waiting less than 4 hours.

All types (including MIU and WiC)

Trust	Trajectory	March	2018/19
RDEFT	91%	93.2%	93.2%
NDHT	90%	83.5%	84.8%
UHP	90%	79.9%	81.1%
TSDFT	90%	81.0%	85.4%

CCG	Trajectory	March	2018/19
NEWD CCG	90%	86.6%	87.1%
SDT CCG	90%	81.0%	85.4%
DEVON STP	95%	85.4%	86.7%
ENGLAND	95%	86.6%	88.0%

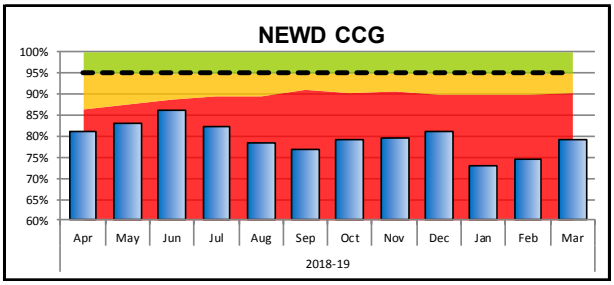


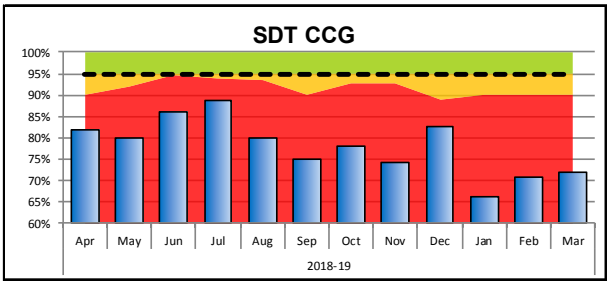


Type 1 A&E only

Trust	Target	March	2018/19
RDEFT	95%	87.5%	87.0%
NDHT	95%	79.5%	80.9%
UHP	95%	70.9%	72.2%
TSDFT	95%	71.9%	78.1%

CCG	Target	March	2018/19
NEWD CCG	95%	79.1%	79.5%
SDT CCG	95%	71.9%	78.1%
DEVON STP	95%	77.4%	79.2%
ENGLAND	95%	79.5%	81.5%





Performance Commentary

In March the STP position was 85.4%, up from 82.9% in February. This compares to the national position of 86.6%.
RD&E maintained good performance at 93.2%, TSD moved above 79.8% at 81.0%, NDHT rose slightly to 83.5% and UHP improved from 74.0% to 79.9%.
However, provisional April performance shows a decrease to 81.5% at STP level with RD&E continuing to perform well at 92% but TSD falling slightly to 80%, NDHT dropping to 80% and UHP falling to 73%.

Quality Commentary and Improvement Actions

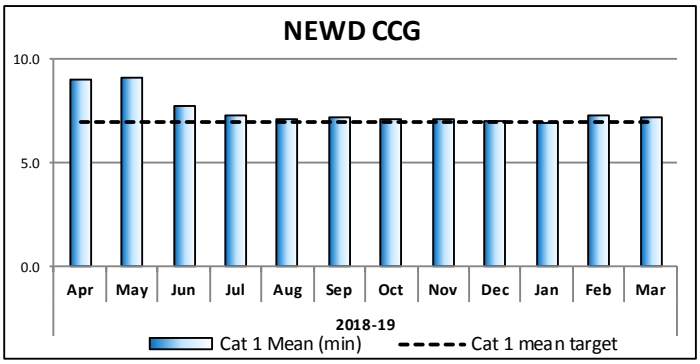
The CCG is maintaining increased levels of quality surveillance during the current period and has undertaken additional review work within the localities experiencing significant pressure. The South and West localities continue to experience increased demand impacts within their urgent and emergency care pathways and the CCG is undertaking observational audits, end to end reviews of patients experiencing lengthy periods within emergency departments during days of escalation and front door reviews. Information around patient experience, safety and effectiveness of care from this additional surveillance is shared with the providers and informs the local system escalation calls that are in place in these localities. This also enables providers to develop their internal assurance mechanisms for checking care quality during periods of escalation which will provide further assurance.

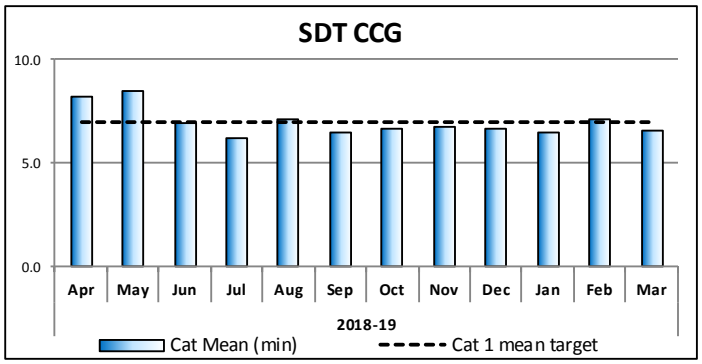
Safety metrics continue to be reviewed on daily ED dashboards and escalation calls between the providers and the CCG include checks on the length of time that patients are waiting in the department, length of time to first assessment, clinical observations, patient risk assessments and staffing levels.

SWAST Cat 1 Mean response time

Trust	Target	March	2018/19
NEWD CCG	7.00	7.20	7.9
STP	7.00	7.00	7.7

Trust	Target	March	2018/19
SDT CCG	7%	6.60	7.2





Performance Commentary

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

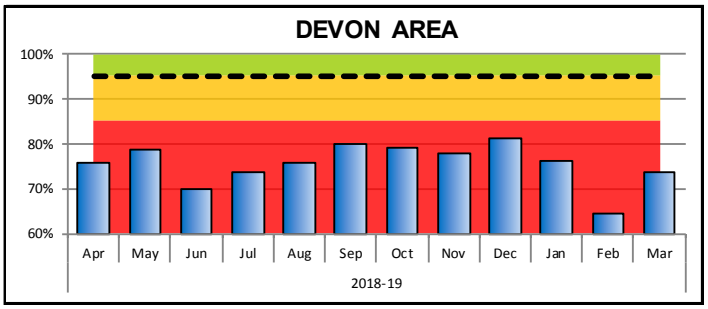
Quality Commentary and Improvement Actions

SWASFT continue to report a significant risk across their footprint in respect to the number of patients waiting for an ambulance following triage (call stacking) and this has not reduced. There is no reported impact on the most seriously ill patients who need immediate help (with category 1 incident response times within the required target). SWASFT continue to monitor for harm caused by delays in getting to patients. Patient experience is indicated as poor where wait times are lengthy, but generally feedback to SWASFT is positive. This risk is monitored weekly by SWASFT executive and is reported through the SWASFT Quality Assurance Group chaired by Dorset CCG as Lead commissioner where it is considered as part of a package of quality indicators.

To support SWASFT in mitigating this risk the CCG is working with emergency department providers in focusing on handover delays (to enable earlier release of ambulances). Each organisation agreed to undertake an end to end review into a 60 min+ handover delay and findings from these will be reported to May's Devon A&E Delivery Board.

NHS 111 answering calls within 60 Seconds

Trust	Target	March	2018/19
DEVON	95%	73.8%	80.8%
ENGLAND	95%	80.8%	75.7%



Performance Commentary

The proportion of calls answered within 60 seconds improved in March at 73.8% following a significant drop in February. However, performance remains well below the target of 95%.

Quality Commentary and Improvement Actions

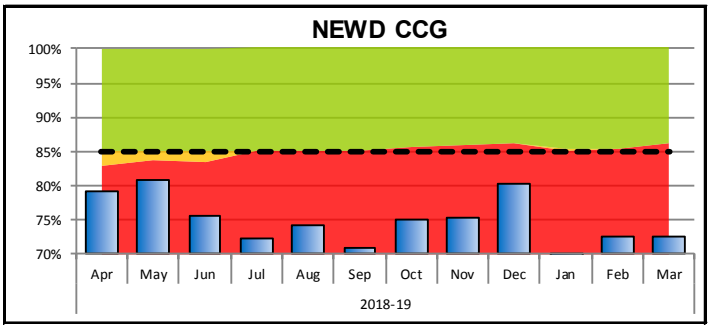
A number of calls are abandoned by patients before answering: it is not clear if this is due to length of wait to be answered or some other reason. Collating information and experiences from these patients is challenging as it is not clear if these patients then access alternative services such as ED or primary care. The incident reviews and additional end to end reviews enable us to look at contacts with health services that some of these patients may have made however, this will only provide information for a small number of patients. The CCG quality assurance process continues to check quality intelligence sources for any adverse impact on patient care or experience as a result of delays in call answering.

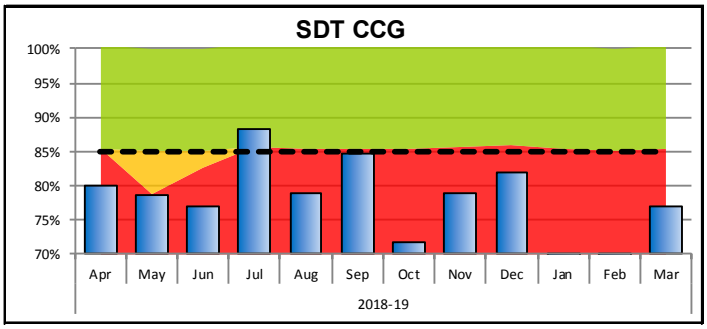
Devon Doctors Ltd continue to report challenges with staffing and the impact on waiting times and experience for patients as well as on the health and wellbeing of staff. They have participated in local escalation calls and system planning. The CCG is meeting with Devon Doctors Ltd this month to fully explore the workforce and staffing issue and resulting impact on the urgent and emergency care system and to consider actions to mitigate.

Cancer 62 day Urgent Referral

Trust	Trajectory	March	2018/19
RDEFT	85%	70.8%	72.9%
NDHT	85%	74.1%	78.1%
UHP	85%	68.0%	73.8%
TSDFT	82%	77.0%	79.0%

CCG	Trajectory	March	2018/19
NEWD CCG	86%	72.5%	74.6%
SDT CCG	85%	77.0%	77.7%
DEVON STP	86%	72.4%	75.3%
ENGLAND	85%	76.1%	76.1%





Performance Commentary

March saw a slight improvement in performance at STP level with RD&E and TSD both seeing an improved position of 71% and 77% respectively. NDHT decreased from 82.7% to 74.1% and UHP decreased from 74.3% to 68.0%

The backlog of over 62 day waits fell slightly with a reduction at TSD, UHP and NDHT, but a slight increase at RD&E, whilst TSDHT saw a large reduction of the open 104 day waits from 53 to 35.

Quality Commentary and Improvement Actions

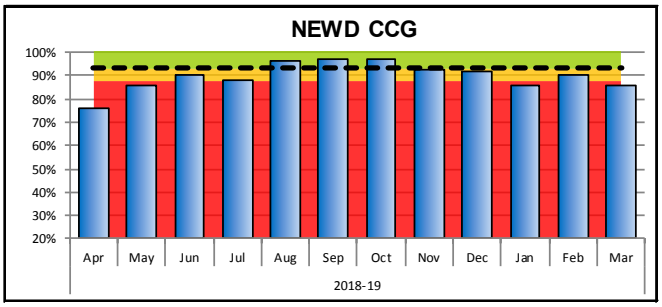
The CCG is engaged in focused work with Devon providers to improve diagnostic pathways and has already implemented best practice pathways across Devon for Prostate and Lung cancers. Devon CCG has a strategic plan in place that clearly sets out key areas of work that will enable sustainable achievement of the 62 day standard. We will be specifically focusing on leading and facilitating system level redesign to create capacity and optimise use of available resources. It is envisaged that this will not only ensure patients are seen safely within the given time frames, but also have a positive experience of services at this potentially difficult time.

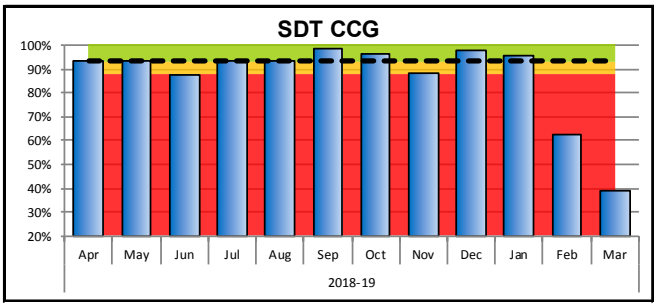
Provider organisations have given assurance on the mechanisms by which they maintain patient safety through clinical triage processes, ensuring long waiting patients on cancer pathways remain safe.

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

Cancer Targets (March-2018)

Target	Measure	NEWD	SDT CCG	STP	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	89.5%	79.9%	89.5%	84.1%	95.2%	94.1%	80.0%
93%	2 week breast	86.0%	38.8%	69.6%	95.1%	96.3%	72.6%	38.8%
90%	62 day screening	91.4%	100.0%	91.4%	100.0%	N/A	84.2%	70.0%
85%	62 day consultant	85.1%	100.0%	85.4%	82.7%	89.9%	64.3%	100.0%
96%	31 day first	92.9%	95.7%	92.3%	88.6%	97.2%	91.7%	95.7%
94%	31 day surgery	90.4%	68.4%	87.7%	87.4%	91.7%	85.4%	96.0%
98%	31 day drugs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.5%
94%	31 day radiotherapy	86.4%	100.0%	87.1%	98.1%	100.0%	64.2%	100.0%





Performance Commentary

Due to a data issue at TSD March STP performance has been estimated.

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

Breast symptomatic performance fell in March to 69.6% due to an estimated drop in TSD position from 62% to 39%. UHP also saw a large decrease from 94% to 73%. NDHT remained static at 96% with RD&E seeing an improved position from 85% to 95%.

For the main two week wait target the STP showed an improved position at 89.5% from 87.7% with NDHT seeing a rise from 89.7% to 95.2% (meeting the 93% target), UHP continuing to perform well at 94.1%, RD&E remaining static at 84.1% but TSD seeing a decrease to 80.0%.

Quality Commentary and Improvement Actions

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

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

The CCG clinical leadership within the South Devon locality have ensured a focus on cancer targets during their May preparatory meeting. This aims to ensure system wide understanding of challenges or blocks to improvements in access to and waiting times for patients within these cancer standard groups.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

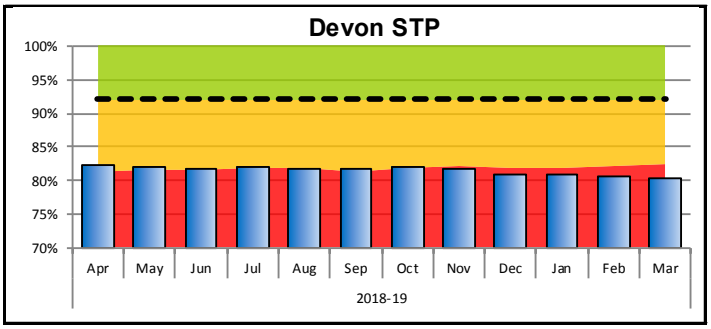
Trust	Trajectory	March	2018/19
RDEFT	85.4%	84.5%	83.1%
NDHT	76.9%	79.2%	78.4%
UHP	80.1%	77.3%	79.1%
TSDFT	82.5%	81.3%	81.8%

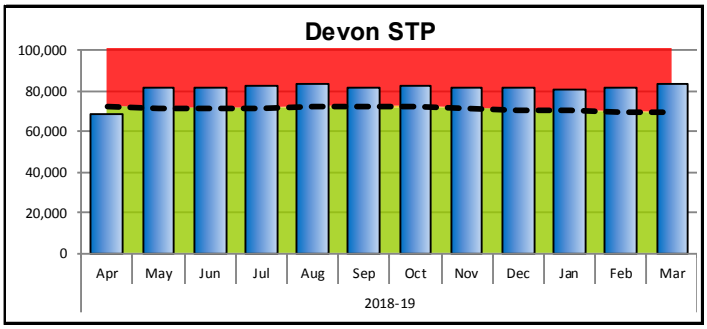
CCG	Trajectory	March	2018/19
NEWD CCG	82.4%	80.3%	81.4%
SDT CCG	82.9%	80.9%	82.0%
DEVON STP	82.5%	80.5%	81.6%
ENGLAND	92.0%	88.2%	89.5%

RTT incomplete waits volume

Trust	Trajectory	March
RDEFT	30,170	34,278
NDHT	12,215	11,524
UHP	25,551	27,922
TSDFT	18,332	19,408

CCG	Trajectory	March
NEWD CCG	50,655	60,510
SDT CCG	18,280	22,403
DEVON STP	68,935	82,913





Performance Commentary

The STP level RTT position was relatively static in March at 80.5% against the national position of 88.2%. RD&E performance fell from 82.0% to 81.6%, UHP saw a slight reduction from 78.4% to 77.3%, NDHT improved by 0.3% to 79.2% and TSD remained at 81.3%.

The number of incomplete pathways increased by around 1,250 patients at STP level and are around 4,500 higher than March 2018, with increases at all providers except NDHT in March.

Quality Commentary and Improvement Actions

The CCG continues to apply the principle that where performance is reduced we seek assurance that patient harm has not occurred. As detailed above, there is on-going communication across the system in sharing good practice and willingness to develop a more consistent approach to mitigating the risk of harm when patients experience long waits.

The CCG has received evidence from providers that quality measures alongside performance are now used routinely within their monitoring processes. Included within this is the on-going work to ensure patients remain safe whilst waiting and are effectively communicated with by providers and also through DRSS.

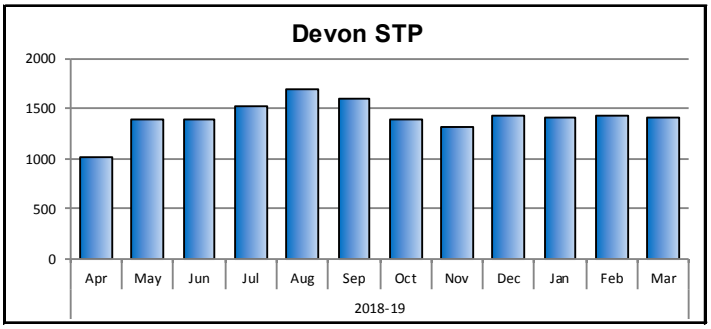
There has been significant improvement in waiting times for several elective care pathways. In turn, improvement in patient experience and reduction in potential risk has been evident across the system. In light of this improvement, providers have now also demonstrated a commitment to sustaining this work by continuing to work closely together in the best interest of the population of Devon.

RTT Incomplete Pathways long waiters

40-52 week waits

Trust	Target	March	2018/19
RDEFT		569	6438
NDHT		129	3018
UHP		610	6693
TSDFT		312	3713

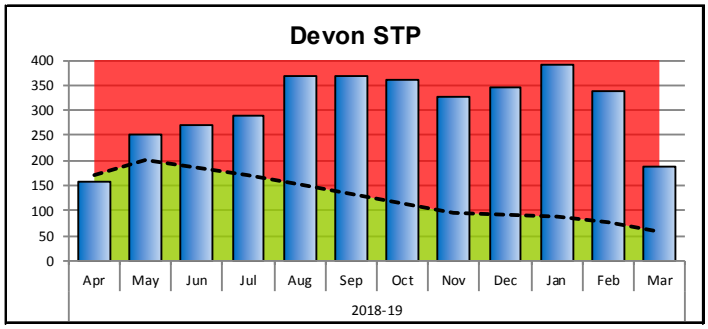
CCG	Target	March	2017/18
NEWD CCG		1013	12690
SDT CCG		390	4285
DEVON STP		1403	16975



Over 52 week waits

Trust	Trajectory	March	2018/19
RDEFT	8	67	1095
NDHT	24	16	933
UHP	54	48	1444
TSDFT	0	79	838

CCG	Trajectory	March	2018/19
NEWD CCG	57	104	2728
SDT CCG	2	84	932
DEVON STP	59	188	3660



Performance Commentary

Over 52 week waits fell in March moving from 339 to 188 at STP level. All providers saw reductions with UHP decreasing from 104 to 48 breaches, RD&E falling from 153 to 67, NDHT breaches moving from 50 to 16 and TSD falling from 92 to 79.

Quality Commentary and Improvement Actions

Across the STP providers have given assurance on how they check for harm, as well as ensuring as positive an experience as possible for patients, through clinical reviews and communicating with patients.

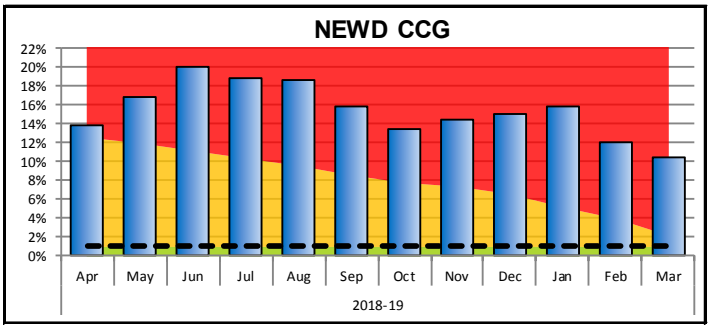
Elements of planned care work continue to be outsourced to the independent sector, with the aim of improving choice and experience and reducing potential risk from a long wait. The CCG's continue to seek assurance that provider Trusts are undertaking surveillance to ensure quality is maintained when outsourcing service provision.

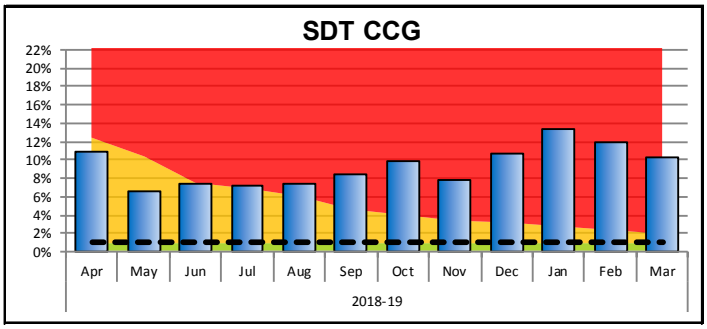
Further assurance has been gained through collaborative work with DRSS on the improvement in communication when choice is offered to patients on appointment locations and waiting times. Patient experience of using the DRSS service is reviewed from the online questionnaire made available.

Diagnostic 6 week wait

Trust	Trajectory	March	2018/19
RDEFT	1.0%	16.1%	13.1%
NDHT	1.0%	14.6%	26.2%
UHP	3.4%	5.9%	16.5%
TSDFT	1.9%	10.1%	8.3%

CCG	Trajectory	March	2018/19
NEWD CCG	2.1%	10.5%	15.5%
SDT CCG	1.9%	10.3%	9.3%
DEVON STP	2.1%	10.5%	14.2%
ENGLAND	1.0%	2.2%	1.9%





Performance Commentary

STP level performance improved again in March from 11.9% to 10.5%, the lowest rate seen in 2018/19.

There was improvement at all providers with NDHT falling from 17.9% to 14.6%, TSD moving from 10.7% to 10.1%, RD&E improving slightly from 16.4% to 16.1% and UHP falling from 6.8% to 5.9%. The majority of the improvement was related to reduced imaging breaches although there has also been progress in endoscopy.

Quality Commentary and Improvement Actions

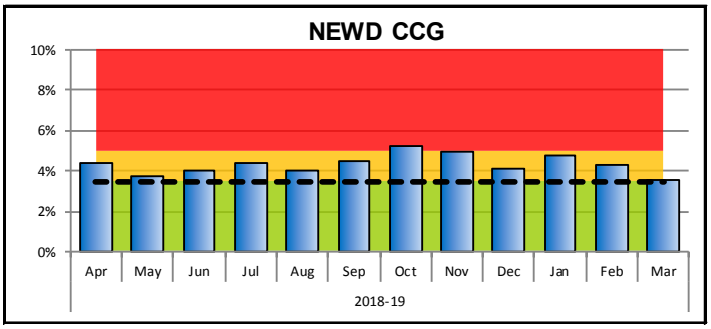
There remain challenges across Devon in relation to patient experience when waiting for diagnostic testing. Delays continue, despite areas of improvement, but providers have evidenced efforts to reduce potential risk and improve experience by implementing measures to see patients within time frames, but also remain in close contact with them whilst they wait. Providers continue to demonstrate a Devon wide approach to quality, by liaising and planning improvements together, supported closely by DRSS.

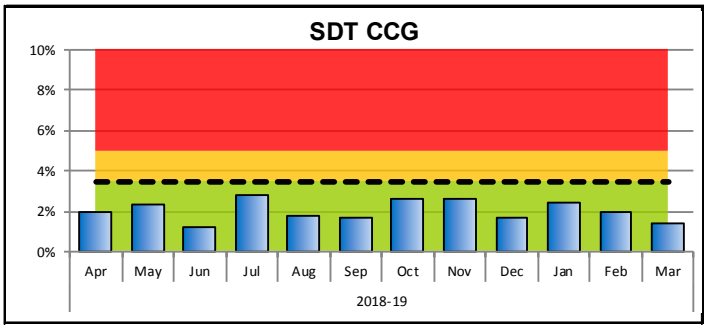
The CCG continues to review clinical and non-clinical information, monitor incidents, complaints and feedback about diagnostic delays and diagnostic reporting delays. Where delays in tests or reporting occur, all providers conduct a review.

Acute Delayed Transfers of care

Trust	Target	March	2018/19
RDEFT	3.50%	5.0%	6.3%
NDHT	3.50%	1.7%	1.9%
UHP	3.50%	2.9%	3.3%
TSDFT	3.50%	1.4%	2.0%

CCG	Target	March	2018/19
NEWD CCG	3.50%	3.6%	4.3%
SDT CCG	3.50%	1.4%	2.0%
DEVON STP	3.50%	3.2%	4.0%





Performance Commentary

The acute delayed transfers of care (DTOC) position improved in March from 3.9% to 3.2% and is now achieving the national target for the first time, with NDHT, UHP and TSD all remaining under the 3.5% target and improvement at RD&E from 6.2% to 5.0%.

Quality Commentary and Improvement Actions

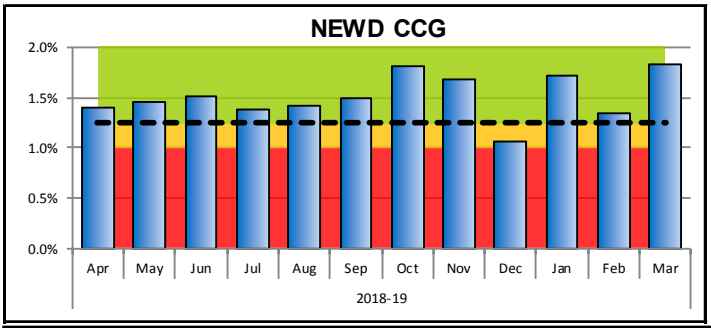
Improvement plans in each locality include both performance and quality actions. Progress continues to be reviewed through the locality A&E Delivery Boards, with reporting and oversight through the Devon A&E Delivery Board. Impact of delayed transfers of care can be seen across the urgent care pathways and the CCG has sight of the position and impact on a daily basis through receipt of the daily situation reports from providers.

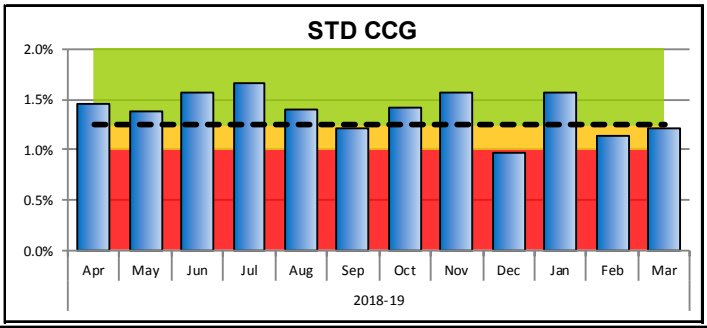
Each locality monitors and manages delayed transfers of care for individual patients and they consider their local system capacity to ensure patients are transferred in a timely way. In the Eastern locality there has been significant challenges however a consistent reduction in the number of patients experiencing delayed transfers of care has now been seen over several months. There is continued evidence that quality is improving following the increased focus on improving the timeliness of transfers, allowing patients to be discharged safely and for that discharge experience to be effective and positive.

IAPT Monthly Access rate

Trust	Target	March	2018/19
DPT	1.25%	1.4%	16.9%
LIVEWELL	1.25%	2.4%	18.9%

CCG	Target	March	2018/19
NEWD CCG	1.25%	1.8%	30.5%
SDT CCG	1.25%	1.2%	27.0%





Performance Commentary

Performance continued to be strong against the IAPT indicators with both achieved at STP level. with DPT and Livewell achieving the access and recovery measures in March

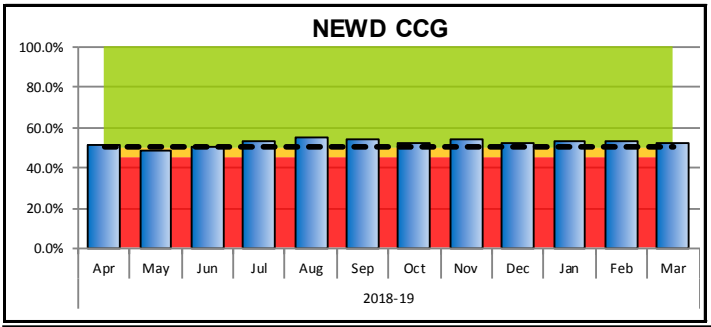
Quality Commentary and Improvement Actions

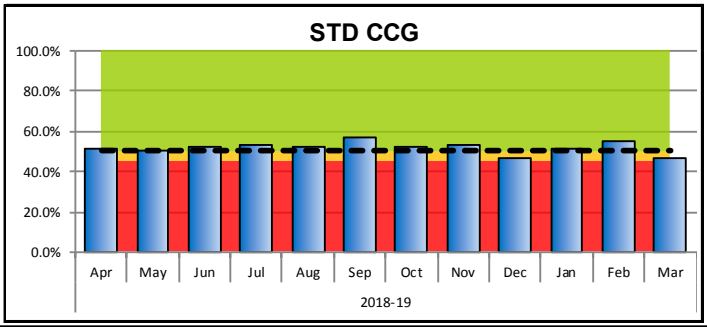
Quality assurance continues through a range of sources and the CCG also receives feedback via the yellow card system from professionals working within the system and these are shared with the providers for review and response. This enables any concerns around crisis response timeliness to be identified.

IAPT Recovery rate

Trust	Target	March	2018/19
DPT	50%	50.4%	53.3%
LIVEWELL	50%	53.9%	49.1%

CCG	Target	March	2018/19
NEWD CCG	50%	52.6%	53.0%
SDT CCG	50%	47.1%	51.9%





Performance Commentary

Both DPT and Livewell continue to perform well against the 50% recovery target with both meeting the standard in March.

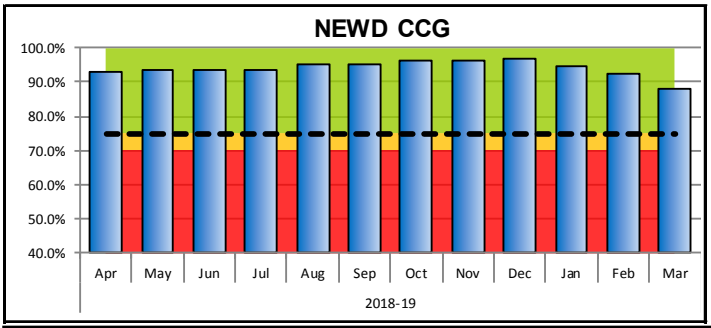
Quality Commentary and Improvement Actions

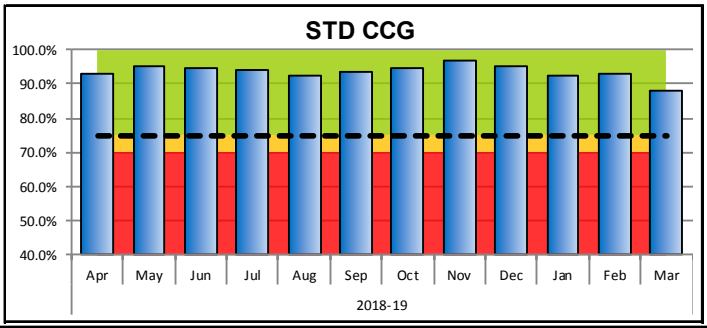
The CCG continues to review all information from provider meetings and other sources to inform the range of indicators within the quality assurance process.

IAPT waiting 6 weeks

Trust	Target	March	2018/19
DPT	75%	89.5%	93.8%
LIVEWELL	75%	84.8%	93.8%

CCG	Target	March	2018/19
NEWD CCG	75%	88.1%	93.9%
SDT CCG	75%	88.1%	93.2%





Performance Commentary

Both providers consistently achieve the 75% target with consistently very good performance.

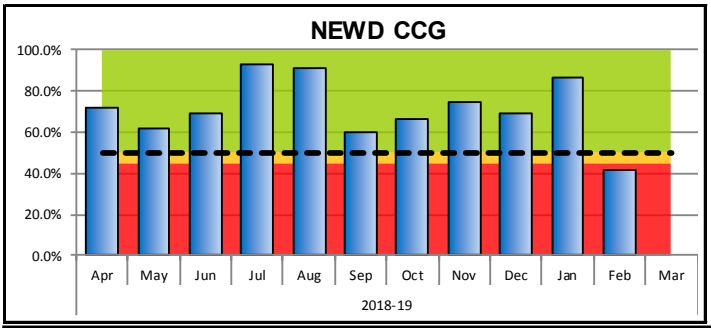
Quality Commentary and Improvement Actions

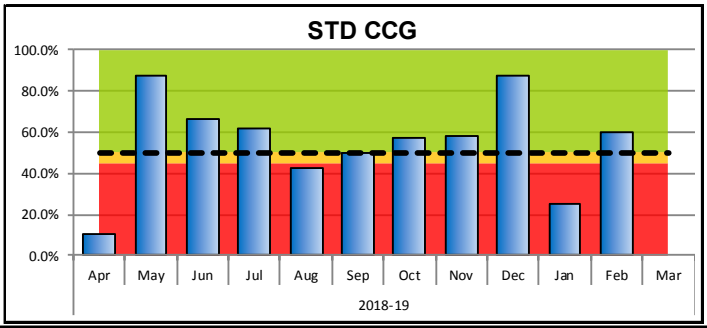
Provider quality assurance continues through the quality assurance framework process.

Mental Health Early Intervention

Trust	Target	February	2018/19
DPT	50%	52.2%	72.7%
THE ZONE	50%	25.0%	25.6%

CCG	Target	February	2018/19
NEWD CCG	50%	41.2%	71.9%
SDT CCG	50%	60.0%	54.1%
ENGLAND	50%	73.2%	75.4%





Performance Commentary

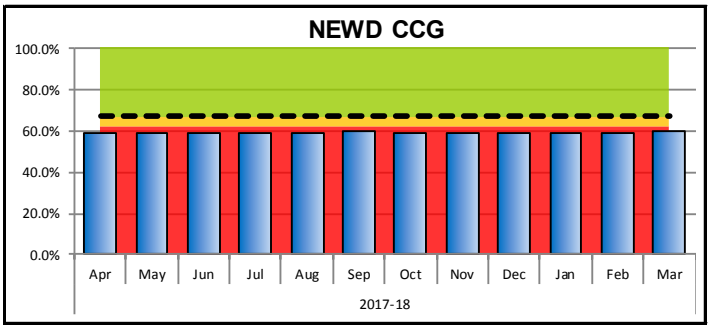
This is a two part indicator for patients with suspected first episode psychosis or at risk mental state on a completed pathway receiving NICE-recommended care package and allocated to and engaged with an EIP care co-ordinator. Very small numbers at The Zone (Plymouth) result in large variances in monthly performance. Performance has fallen below the national target in February following a drop in performance at DPT from 65.2% to 52.2%. The Youth Enquiry service sees very small numbers of patients and so performance is variable.

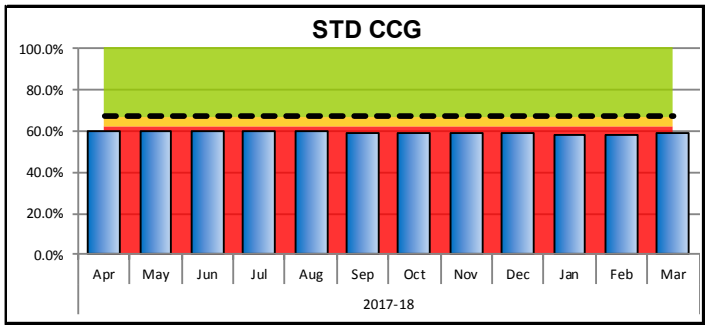
Quality Commentary and Improvement Actions

The CCG assurance process has continued to demonstrate the positive impact of early intervention services. This, along with a lack of complaints and other negative feedback, indicates that patients are receiving a safe and positive experience.

Dementia Diagnosis Rate

CCG	Target	March	2018/19
NEWD CCG	67%	59.9%	59.2%
SDT CCG	67%	58.8%	59.3%
ENGLAND	67%	68.3%	68.7%





Performance Commentary

STP level performance remained static and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (42%), Mid Devon (49%) and Plymouth (56.3%). Conversely Exeter is at 71.4%, Torbay 62.8% and East Devon at 64.4%.

Quality Commentary and Improvement Actions

Improving dementia care including the early diagnosis of dementia will remain a focus of the STP mental health programme for 2019/20. The improvement plan developed with system partners will continue and the established STP Dementia steering group with representation from LA, CCG, third sector and providers have agreed three main priorities.

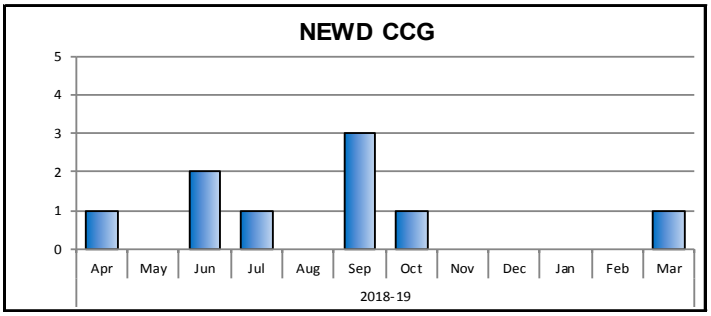
1. Ensure consistent and formal diagnosis will be available for all those who are presenting with dementia related symptoms.
2. A clear diagnosis pathway across the STP and personalised care plan for all those with a diagnosis.
3. Proactive liaison and support for care homes.

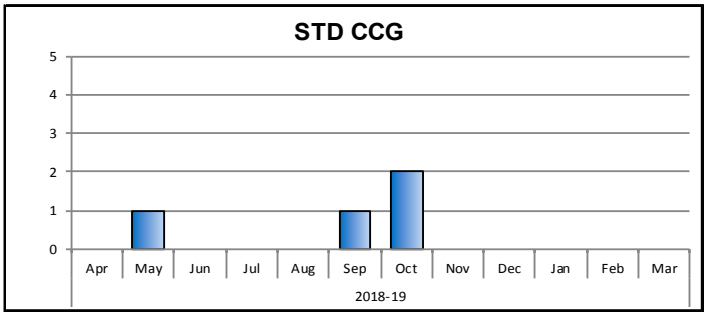
The dementia diagnosis dashboard is in place and gives information on diagnosis rates by locality and individual GP practice.

MRSA breaches

Trust	Target	March	2018/19
RDEFT	0	0	2
NDHT	0	0	0
UHP	0	1	6
TSDFT	0	0	1

CCG	Target	March	2018/19
NEWD CCG	0	1	9
SDT CCG	0	0	4
DEVON STP	0	1	13





Performance Commentary

There was one reported MRSA case in April which was in the RD&E. Note that the single case reported in May from UHP was in a Cornwall patient, so is included in Kernow CCG's figures and not those of NEW Devon CCG or Devon STP. There were two cases reported in June, one at UHP and one out of area and one reported MRSA case in July which was in the RD&E. There were three reported breaches in September for Devon STP and a further two seen in October, one at UHP and one out of area. March saw one breach for Devon although this occurred out of area.

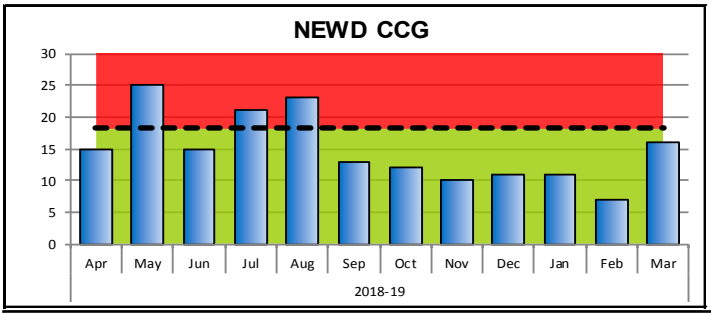
Quality Commentary and Improvement Actions

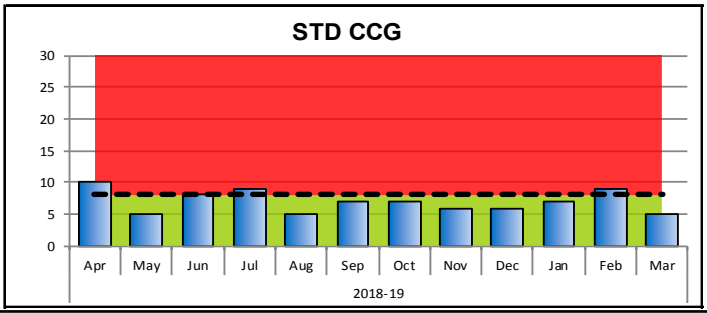
Local reviews of any MRSA case that occurs continues.

C-Diff breaches

Trust	Target	March	2018/19
RDEFT	<31	2	16
NDHT	<7	1	5
UHP	<35	6	30
TSDFT	<18	1	13

CCG	Target	March	2018/19
NEWD CCG	<219	16	179
SDT CCG	<97	5	84
DEVON STP	<316	21	263





Performance Commentary

There were 10 C-Diff cases acquired within the acute providers and 21 across the STP in March. Year-to-date performance remains within target for both NEWD CCG and SDT CCG.

Quality Commentary and Improvement Actions

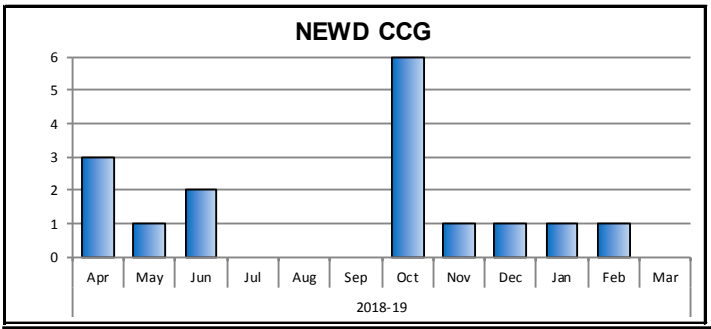
Case numbers for acute Trusts and the CCGs were all under the nationally set trajectory at the end of 2018/19, which demonstrated a positive commitment to reduction across the system.

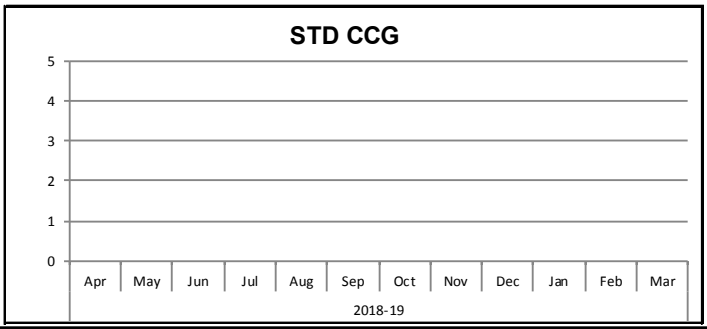
There has been a period of Increased Incidence of C difficile at RDEFT in April, involving ten cases. These have been fully reviewed and ribotyped, and there is no evidence of an outbreak. Provider annual infection prevention & control reports (IPC) are now being shared with the CCG and we use this information within our assurance framework. These reports provide information on all health care associated infections (HCAI) and the management and improvement work undertaken throughout the previous year.

Mixed Sex accomodation breaches

Trust	Target	February	2018/19
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	0	6
TSDFT	0	0	0

CCG	Target	February	2018/19
NEWD CCG	0	1	16
SDT CCG	0	0	0
DEVON STP	0	1	16





Performance Commentary

UHP have seen six breaches in 2018/19 whilst NEW Devon CCG has seen 16 in total, with one in February for a patient treated out of area. SD&T CCG have seen no breaches in 2018/19.

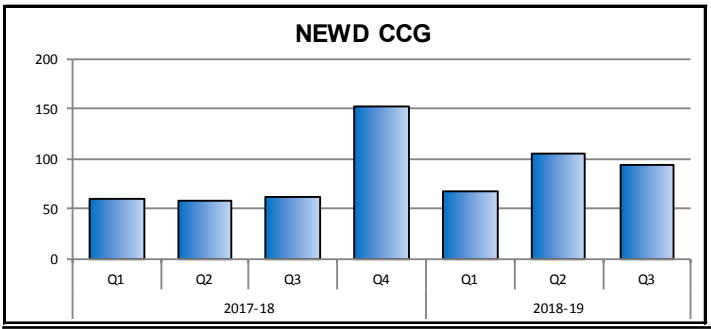
Quality Commentary and Improvement Actions

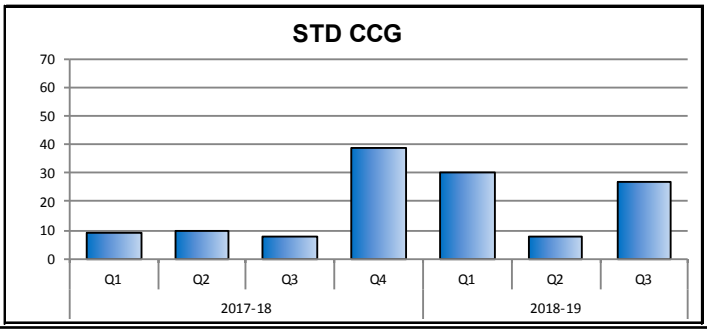
EMSA data continues to be provided on a monthly basis and only where there is a clear clinically justifiable need to do so, will the guidelines be breached. If a breach has occurred the providers EMSA local decision matrix is submitted for the CCG to review.
There have been no breaches reported in the previous month

Cancelled operations not treated with 28 days of cancellation

Trust	Target	Q3	2018/19
RDEFT	0	11	30
NDHT	0	5	14
UHP	0	78	223
TSDFT	0	27	65

CCG	Target	Q3	2018/19
NEWD CCG	0	94	267
SDT CCG	0	27	65
DEVON STP	0	121	332





Performance Commentary

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

Quality Commentary and Improvement Actions

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

NHS Northern Eastern Western Devon

Summary

	Area	Indicator	Period	England ..	Target	99P: NHS Northern, Eastern and Western Devon CCG Rate	Rank	Change
Better Health	Annual assessment	999a: Annual assessment	2017-18			GD		
	Child obesity	102a: Percentage of children aged 10-11 classified as overweight or obese	2014-15 to 2016-17	33.9%		29.5%	(26/195)	↓
	Diabetes	103a: Diabetes patients that have achieved all the NICE recommended treatment targets: three (Hb..	2017-18	38.7%		36.1%	(158/195)	↓
		103b: People with diabetes diagnosed less than a year who attend a structured education course	2017-18 (2016 cohort)	8.54%		7.44%	(104/195)	↑
	Falls	104a: Injuries from falls in people aged 65 and over	17-18 Q3	1994		1675	(58/189)	↑
	Personalisation and choice	105b: Personal health budgets	18-19 Q2	50		354	(3/195)	↑
	Health inequalities	106a: Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care s..	18-19 Q1	2074		2259	(105/195)	↓
	Antimicrobial resistance	107a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	2018 09	0.995	0.965	0.984	(77/195)	↓
		107b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	2018 09	8.67%	10%	9.57%	(131/195)	↓
	Carers	108a: The proportion of carers with a long term condition who feel supported to manage their conditi..	2018	0.59		0.60	(90/195)	✕
Better Care	Provision of high quality care	121a: Provision of high quality care: hospital	18-19 Q1			64	(24/195)	↓
		121b: Provision of high quality care: primary medical services	18-19 Q1			70	(7/195)	+
		121c: Provision of high quality care: adult social care	18-19 Q1			64	(14/195)	+
	Cancer	122a: Cancers diagnosed at early stage	2016	52.6%	53.52%	56.4%	(22/195)	↓
		122b: People with urgent GP referral having first definitive treatment for cancer within 62 days of ref..	18-19 Q2	78.6%	85%	72.7%	(166/195)	↓
		122c: One-year survival from all cancers	2015	72.3%		73.6%	(35/189)	↑
		122d: Cancer patient experience	2017			8.9	(35/195)	↑
	Mental health	123a: Improving Access to Psychological Therapies – recovery	18-19 Q2	51.3%	50%	53.5%	(63/195)	↑
		123b: Improving Access to Psychological Therapies – access	18-19 Q2	4.24%		4.29%	(90/195)	↑
		123c: People with first episode of psychosis starting treatment with a NICE-recommended package ..	2018 11	75.3%		66.1%	(156/195)	↑
		123f: Mental health out of area placements	18-19 Q2	121		478	(188/195)	↓
		123i: Delivery of the mental health investment standard	18-19 Q2			Green		+
	Learning disability	124a: Reliance on specialist inpatient care for people with a learning disability and/or autism	18-19 Q2			40	(38/195)	↑
		124b: Proportion of people with a learning disability on the GP register receiving an annual health ch..	2017-18	51.4%		53.8%	(81/195)	↑
		124c: Completeness of the GP learning disability register	2017-18	0.49%		0.54%	(65/195)	↑
	Maternity	125a: Neonatal mortality and stillbirths	2016	Null		3.92	(69/194)	↑
		125b: Women's experience of maternity services	2017	83.0		83.9	(77/195)	✕
		125c: Choices in maternity services	2017	60.8		60.5	(106/195)	✕
		125d: Maternal smoking at delivery	18-19 Q2	10.5%		11.6%	(103/195)	↓
	Dementia	126a: Estimated diagnosis rate for people with dementia	2018 11	68.2%		59.3%	(184/195)	↑
		126b: Dementia care planning and post-diagnostic support	2017-18	77.5%		77.2%	(123/194)	↓
	Urgent and emergency care	127b: Emergency admissions for urgent care sensitive conditions	18-19 Q1	2371		2187	(75/195)	↑
		127c: Percentage of patients admitted, transferred or discharged from A&E within 4 hours	2018 12	86.4%	95%	87.1%	(78/195)	↑
		127e: Delayed transfers of care per 100,000 population	2018 11	10.4		13.7	(159/195)	↓
		127f: Population use of hospital beds following emergency admission	18-19 Q1	500		426	(30/195)	↓
	End of life care	105c: Percentage of deaths with three or more emergency admissions in last three months of life	2017	5.37%		4.15%	(31/194)	↑
	Primary care	128b: Patient experience of GP services	2018	83.8%		89.0%	(13/195)	✕
		128c: Primary care access – proportion of population benefitting from extended access services	2018 10	98.4%		100.0%	(1/193)	↑
		128d: Primary care workforce	2018 03	1.04		1.09	(34/195)	↓
		128e: Count of the total investment in primary care transformation made by CCGs compared with th..	18-19 Q2			Red		+
	Elective access	129a: Patients waiting 18 weeks or less from referral to hospital treatment	2018 10	87.1%	92%	81.8%	(179/195)	↑
	7 day services	130a: Achievement of clinical standards in the delivery of 7 day services	2016-17			2	(56/195)	✕
	NHS Continuing Healthcare	131a: Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital ..	18-19 Q2	12.3%		0.00%	(1/195)	+
	Patient safety	132a: Evidence that sepsis awareness raising amongst healthcare professionals has been prioritise..	2017			Amber		✕
	Diagnostics	133a: Percentage of patients waiting 6 weeks or more for a diagnostic test	2018 11	2.41%		14.4%	(195/195)	↑
Sustainability	Financial sustainability	141b: In-year financial performance	18-19 Q2			Amber		+
	Paper-free at the point of care	144a: Utilisation of the NHS e-referral service to enable choice at first routine elective referral	2018 10	92.4%		114.2%	(10/195)	↓
	Demand management	145a: Expenditure in areas with identified scope for improvement	18-19 Q2			Red		+
Leadership	Probity and corporate govern..	162a: Probity and corporate governance	18-19 Q2					✕
	Workforce engagement	163a: Staff engagement index	2017	3.78		3.83	(31/189)	↑
		163b: Progress against the Workforce Race Equality Standard	2017	0.13		0.14	(140/189)	↑
	Quality of leadership	165a: Quality of CCG leadership	18-19 Q2			Amber		+
	Patient and community enga..	166a: Compliance with statutory guidance on patient and public participation in commissioning healt..	2017			Amber		✕
	CCGs local relationships	164a: Effectiveness of working relationships in the local system	2017-18			55.8	(180/189)	↑

Direction of change arrows
↑ Increase
↓ Decrease
+ Equal
✕ No data

Null
Green
Amber
Red
Good

Colour of change arrows
Improvement
Deterioration
No change
n/app

Null
0
0.0
0.4%
0.5%
0.00
0.00%
0.01
0.01%
0.07
0.14%
0.90%
0.94%
1
1.03%
1.20%
2.60%
3
3.8
3.01%
4
6.50%
8
55.0%
62
-0.06%
-0.07%
-0.27%
-0.41%
-0.005
-1
-1.8
-1.21%
-1.44%
-5.77%
-6
-8.5%
-28
-55

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

Indicators with a target
Pass
Fail
n/app

Summary

	Area	Indicator	Period	England ..	Target		Rate	99Q: NHS South Devon and Torbay CCG Rank	Change
Better Health	Annual assessment	999a: Annual assessment	2017-18				RI		
	Child obesity	102a: Percentage of children aged 10-11 classified as overweight or obese	2014-15 to 2016-17	33.9%			30.9%	(46/195)	
	Diabetes	103a: Diabetes patients that have achieved all the NICE recommended treatment targets: three (Hb..	2017-18	38.7%			35.5%	(164/195)	
		103b: People with diabetes diagnosed less than a year who attend a structured education course	2017-18 (2016 cohort)	8.54%			9.30%	(82/195)	
	Falls	104a: Injuries from falls in people aged 65 and over	17-18 Q3	1994			1904	(89/189)	
	Personalisation and choice	105b: Personal health budgets	18-19 Q2	50			204	(8/195)	
	Health inequalities	106a: Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care s..	18-19 Q1	2074			1836	(57/195)	
	Antimicrobial resistance	107a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	2018 09	0.995	0.965		0.990	(81/195)	
		107b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	2018 09	8.67%	10%		17.0%	(194/195)	
	Carers	108a: The proportion of carers with a long term condition who feel supported to manage their conditi..	2018	0.59			0.59	(106/195)	
Better Care	Provision of high quality care	121a: Provision of high quality care: hospital	18-19 Q1				63	(39/195)	
		121b: Provision of high quality care: primary medical services	18-19 Q1				72	(2/195)	
		121c: Provision of high quality care: adult social care	18-19 Q1				64	(14/195)	
	Cancer	122a: Cancers diagnosed at early stage	2016	52.6%	53.52%		56.2%	(25/195)	
		122b: People with urgent GP referral having first definitive treatment for cancer within 62 days of ref..	18-19 Q2	78.6%	85%		84.1%	(43/195)	
		122c: One-year survival from all cancers	2015	72.3%			74.3%	(22/189)	
		122d: Cancer patient experience	2017				9.0	(13/195)	
	Mental health	123a: Improving Access to Psychological Therapies – recovery	18-19 Q2	51.3%	50%		53.8%	(55/195)	
		123b: Improving Access to Psychological Therapies – access	18-19 Q2	4.24%			4.23%	(97/195)	
		123c: People with first episode of psychosis starting treatment with a NICE-recommended package ..	2018 11	75.3%			55.9%	(178/195)	
		123f: Mental health out of area placements	18-19 Q2	121			998	(195/195)	
		123i: Delivery of the mental health investment standard	18-19 Q2				Green		
	Learning disability	124a: Reliance on specialist inpatient care for people with a learning disability and/or autism	18-19 Q2				40	(38/195)	
		124b: Proportion of people with a learning disability on the GP register receiving an annual health ch..	2017-18	51.4%			58.9%	(42/195)	
		124c: Completeness of the GP learning disability register	2017-18	0.49%			0.67%	(20/195)	
	Maternity	125a: Neonatal mortality and stillbirths	2016	Null			3.56	(53/194)	
		125b: Women's experience of maternity services	2017	83.0			86.4	(30/195)	
		125c: Choices in maternity services	2017	60.8			66.8	(19/195)	
		125d: Maternal smoking at delivery	18-19 Q2	10.5%			12.5%	(114/195)	
	Dementia	126a: Estimated diagnosis rate for people with dementia	2018 11	68.2%			59.4%	(183/195)	
		126b: Dementia care planning and post-diagnostic support	2017-18	77.5%			76.8%	(134/194)	
	Urgent and emergency care	127b: Emergency admissions for urgent care sensitive conditions	18-19 Q1	2371			2038	(52/195)	
		127c: Percentage of patients admitted, transferred or discharged from A&E within 4 hours	2018 12	86.4%	95%		87.6%	(69/195)	
		127e: Delayed transfers of care per 100,000 population	2018 11	10.4			11.7	(132/195)	
		127f: Population use of hospital beds following emergency admission	18-19 Q1	500			362	(5/195)	
	End of life care	105c: Percentage of deaths with three or more emergency admissions in last three months of life	2017	5.37%			5.61%	(105/194)	
	Primary care	128b: Patient experience of GP services	2018	83.8%			87.4%	(31/195)	
		128c: Primary care access – proportion of population benefitting from extended access services	2018 10	98.4%			100.0%	(1/193)	
		128d: Primary care workforce	2018 03	1.04			1.11	(30/195)	
		128e: Count of the total investment in primary care transformation made by CCGs compared with th..	18-19 Q2				Green		
	Elective access	129a: Patients waiting 18 weeks or less from referral to hospital treatment	2018 10	87.1%	92%		82.3%	(177/195)	
	7 day services	130a: Achievement of clinical standards in the delivery of 7 day services	2016-17				2	(56/195)	
	NHS Continuing Healthcare	131a: Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital ..	18-19 Q2	12.3%			0.00%	(1/195)	
	Patient safety	132a: Evidence that sepsis awareness raising amongst healthcare professionals has been prioritise..	2017				Amber		
	Diagnostics	133a: Percentage of patients waiting 6 weeks or more for a diagnostic test	2018 11	2.41%			7.71%	(184/195)	
Sustainability	Financial sustainability	141b: In-year financial performance	18-19 Q2				Amber		
	Paper-free at the point of care	144a: Utilisation of the NHS e-referral service to enable choice at first routine elective referral	2018 10	92.4%			80.6%	(111/195)	
	Demand management	145a: Expenditure in areas with identified scope for improvement	18-19 Q2				Amber		
	Probity and corporate govern..	162a: Probity and corporate governance	18-19 Q2						
Leadership	Workforce engagement	163a: Staff engagement index	2017	3.78			3.78	(87/189)	
		163b: Progress against the Workforce Race Equality Standard	2017	0.13			0.12	(98/189)	
	Quality of leadership	165a: Quality of CCG leadership	18-19 Q2				Amber		
	Patient and community enga..	166a: Compliance with statutory guidance on patient and public participation in commissioning healt..	2017				Amber		
	CCGs local relationships	164a: Effectiveness of working relationships in the local system	2017-18				68.1	(94/189)	

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

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

Null
Green
Amber
Requires improvement

Null
0
0.1
0.2%
0.3%
0.6%
0.00%
0.02%
0.03
0.09
0.68%
0.82%
1
1.6
2.01%
2.81%
4
4.0
4.96%
5.57%
6.56%
8.46%
11
32
100.0%
212
-0.06
-0.15%
-0.58%
-0.92%
-0.009
-1
-1.21%
-1.47%
-1.85%
-2.11%
-6
-28
-55
Red

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

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

NORTHERN EASTERN WESTERN DEVON CLINICAL COMMISSIONING GROUP (NEW DEVON CCG)																		
PERFORMANCE MEASURES																		
INDICATOR	**TARGET**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
Referral to treatment - percentage seen within 18 weeks - Admitted pathways	>=90%	76.4%	74.3%	72.2%	73.2%	75.4%	71.7%	71.7%	69.8%	73.6%	70.7%	68.9%	69.8%	74%	73%	72%	70%	72.2%
Referral to treatment - percentage seen within 18 weeks - Non-admitted pathways	>=95%	90.5%	91.9%	90.4%	90.4%	89.8%	88.1%	88.1%	87.9%	88.7%	87.8%	88.2%	88.5%	91%	89%	88%	88%	89.1%
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	>=92%	82.5%	81.9%	81.6%	82.0%	81.5%	81.6%	81.8%	81.7%	80.8%	80.7%	80.5%	80.3%	82%	82%	81%	81%	81.4%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	108	195	222	218	290	276	281	250	259	289	236	104	525	784	790	629	2728
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	<=1%	13.8%	16.8%	20.0%	18.9%	18.6%	15.9%	13.5%	14.4%	15.0%	15.8%	12.0%	10.5%	16.9%	18%	14%	13%	15.5%
Cancer - percentage seen within 2 weeks - urgent referral to first seen	>=93%	88.1%	87.1%	86.8%	86.4%	86.8%	84.5%	83.6%	85.4%	86.8%	86.1%	89.8%	89.5%	87.3%	86%	85%	88%	86.7%
Breast symptomatic- percentage seen within 2 weeks	>=93%	75.7%	86.1%	90.3%	88.2%	96.2%	96.9%	96.9%	92.5%	91.9%	85.8%	90.4%	86.0%	84.3%	94%	94%	87%	89.7%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	>=85%	79.2%	80.7%	75.5%	72.2%	74.3%	71.1%	75.1%	75.2%	80.2%	68.3%	72.5%	72.5%	78.4%	73%	77%	71%	74.6%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.3%	75.0%	87.5%	95.1%	95.2%	87.5%	88.6%	100.0%	100.0%	90.2%	88.0%	91.4%	85.0%	94%	95%	90%	90.8%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	84.2%	90.0%	76.9%	89.3%	78.3%	87.5%	74.0%	82.7%	85.3%	86.0%	83.1%	85.1%	84.0%	85%	81%	85%	83.7%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	96.0%	98.3%	95.9%	97.1%	97.7%	95.3%	96.3%	96.5%	97.3%	94.1%	92.0%	92.9%	96.7%	97%	97%	93%	95.9%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	96.2%	96.3%	94.8%	95.9%	93.1%	88.1%	92.9%	89.7%	91.4%	87.1%	86.3%	90.4%	95.7%	93%	91%	88%	91.8%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	100.0%	99.6%	99.6%	99.5%	98.8%	99.4%	99.6%	100.0%	99.3%	100.0%	100.0%	100.0%	99.6%	99.3%	100%	100%	99.7%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	98.6%	92.6%	94.6%	98.8%	99.0%	95.8%	98.1%	92.2%	92.0%	93.5%	92.2%	86.4%	94.4%	98%	94%	91%	94.4%
Accident and Emergency - percentage attendances seen within 4 hours (Acute only)	>=95%	80.9%	82.8%	86.0%	82.4%	78.4%	76.9%	79.1%	79.4%	81.3%	72.9%	74.5%	79.1%	83.3%	79.3%	79.9%	75.6%	79.5%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & MIU)	>=95%	87.8%	89.4%	91.4%	89.1%	86.9%	85.4%	86.8%	86.8%	87.8%	82.6%	83.8%	86.6%	89.6%	87.2%	87.1%	84.4%	87.1%
Cancelled Operations - Number of patients not treated within 28 days of cancellation	0			68			105			94				68	105	94		267
IAPT Percentage of people entering treatment against the level of need in the general	1.25%	1.4%	1.5%	1.5%	1.4%	1.4%	1.5%	1.8%	1.7%	1.1%	1.7%	1.3%	1.8%	4.4%	1.4%	1.5%	2%	4.4%
IAPT recovery rate - percentage of people who are moving to recovery	50%	51.0%	48.7%	50.4%	53.5%	54.8%	54.3%	52.1%	54.5%	52.7%	53.5%	53.7%	52.6%	51.0%	48.7%	50.4%	53.5%	51.0%
IAPT - started treatment with 6 weeks of referral	75%	93.2%	93.6%	93.7%	93.8%	95.0%	95.3%	96.5%	96.4%	96.7%	94.6%	92.2%	88.1%	93.2%	93.6%	93.7%	93.8%	93.2%
IAPT - started treatment with 18 weeks of referral	95%	99.8%	100.1%	99.9%	99.8%	100.0%	100.9%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	99.8%	100.1%	99.9%	99.8%	99.8%
Mental Health - Percentage of people on CPA who were followed up with in 7 days of discharge	95%	88.2%	98.1%	100.0%	100.0%	97.3%	100.0%	100.0%	97.4%	97.7%	97.6%	92.8%	100.0%	88.2%	98.1%	100.0%	100.0%	88.2%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	92.9%	93.8%	94.9%	92.7%	91.6%	91.1%	91.9%	91.2%	91.4%	94.0%	93.7%	93.7%	92.9%	93.8%	94.9%	92.7%	92.9%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	72.2%	61.5%	69.2%	93.3%	90.9%	60.0%	66.7%	75.0%	69.2%	86.7%	41.2%						62.5%
Dementia	62%	58.9%	58.9%	58.9%	59.3%	58.8%	59.7%	58.9%	59.3%	59.0%	59.3%	59.2%	59.9%	58.9%	59.3%	58.8%	59.7%	58.9%
QUALITY MEASURES																		
INDICATOR	**TARGET**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
MRSA bacteraemia - number of hospital infections	0	1	0	2	1	0	3	1	0	0	0	0	1	3	4	1	1	8
Clostridium difficile - number of hospital infections	<=219	15	25	15	21	23	13	12	10	11	11	7	16	55	57	22	34	134
Mixed sex accommodation (MSA) - number of hospital breaches	0	3	1	2	0	0	0	6	1	1	1	1		16	0	6	2	6
Delayed transfers of care (acute) - Percentage of delays per available bed	3.50%	4.4%	3.8%	4.0%	4.4%	4.0%	4.5%	5.3%	5.0%	4.1%	4.8%	4.3%	3.6%	4.1%	4.3%	5.3%	6.3%	4.3%
Delayed transfers of care (all) - Percentage of delays per available bed	3.50%	4.7%	4.3%	4.3%	4.8%	4.6%	5.1%	5.8%	5.5%	4.4%	5.1%	4.9%	3.9%	4.5%	4.5%	5.5%	15.1%	4.5%

Appendix C. Key performance indicators – SD&T Devon CCG

NHS SOUTH DEVON AND TORBAY CLINICAL COMMISSIONING GROUP (SDT CCG)																				
PERFORMANCE MEASURES																				
INDICATOR	**TARGET**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**Q1**	**Q2**	**Q3**	**Q4**	**17/18**
Referral to treatment - percentage seen within 18 weeks - Admitted pathways	>=90%	75.3%	74.5%	72.6%	70.0%	69.7%	69.9%	73.3%	69.8%	69.0%	67.1%	68.9%	70.7%	67.8%	64.9%	64.1%	69.9%	71%	69%	66%	68.8%
Referral to treatment - percentage seen within 18 weeks - Non-admitted pathways	>=95%	87.0%	87.6%	87.7%	88.3%	88.3%	87.6%	87.1%	85.8%	86.1%	85.6%	84.9%	87.5%	86.7%	87.9%	88.3%	88.1%	86%	86%	88%	87.0%
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	>=92%	83.1%	82.8%	82.1%	82.2%	82.9%	82.0%	82.2%	82.8%	81.7%	82.4%	82.4%	81.8%	81.5%	80.8%	80.9%	82.4%	82%	82%	81%	82.0%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	31	37	43	50	58	48	71	80	92	79	78	87	102	103	84	156	243	244	289	156
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	<=1%	5.9%	3.6%	8.9%	10.9%	6.6%	7.4%	7.1%	7.4%	8.4%	9.9%	7.7%	10.7%	13.3%	11.9%	10.3%	8.3%	8%	9%	12%	9.3%
Cancer - percentage seen within 2 weeks - urgent referral to first seen	>=93%	78.8%	69.7%	73.6%	62.1%	58.5%	76.8%	64.8%	77.9%	79.8%	82.0%	81.7%	80.8%	78.7%	81.4%	79.9%	65.8%	74%	82%	80%	74.8%
Breast symptomatic- percentage seen within 2 weeks	>=93%	93.2%	97.7%	94.6%	93.5%	93.6%	87.3%	93.5%	93.2%	98.8%	96.0%	88.5%	97.8%	95.6%	62.6%	38.8%	91.7%	95%	94%	79%	90.8%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	>=85%	85.8%	83.0%	81.2%	80.0%	78.5%	77.0%	88.3%	78.9%	84.8%	71.7%	78.8%	81.8%	68.8%	68.8%	77.0%	78.5%	84%	77%	69%	77.7%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	66.7%	94.4%	100.0%	88.9%	100.0%	75.0%	100.0%	100.0%	92.9%	91.7%	90.9%	92.9%	90.9%	100.0%	70.0%	88%	98%	92%	96%	93.7%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	90.0%	71.4%	100.0%	87.5%	92.9%	90.9%	100.0%	78.6%	100.0%	92.9%	85.7%	72.7%	87.5%	71.4%	100.0%	91%	91%	85%	83%	87.5%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	90.9%	96.4%	98.3%	97.1%	97.3%	95.5%	97.4%	97.7%	96.6%	94.7%	97.3%	96.4%	95.7%	95.4%	95.7%	97%	97%	96%	95%	96.3%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	94.0%	98.1%	96.6%	98.2%	100.0%	95.7%	93.3%	94.4%	91.1%	92.6%	90.9%	100.0%	91.7%	93.5%	96.0%	98%	93%	94%	89%	94.0%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	98.9%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	98.6%	97.5%	100%	100%	100%	99%	99.7%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	96.7%	95.7%	98.4%	89.8%	97.2%	98.2%	97.3%	98.4%	96.3%	95.3%	100.0%	100.0%	92.6%	96.3%	100.0%	93%	97%	98%	95%	95.6%
Accident and Emergency - percentage attendances seen within 4 hours (Acute only)	>=95%	77.2%	72.8%	72.3%	81.7%	79.9%	86.0%	88.6%	80.1%	75.0%	77.9%	74.3%	82.5%	66.1%	70.8%	71.9%	82.6%	81.5%	78.2%	69.6%	78.1%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & MIU)	>=95%	83.8%	81.1%	80.6%	87.6%	86.7%	90.9%	92.7%	87.2%	83.8%	85.1%	82.2%	87.5%	76.4%	79.8%	81.0%	88.5%	88.1%	84.9%	79.1%	85.4%
Cancelled Operations - Number of patients not treated within 28 days of cancellation	0			39																	
IAPT Percentage of people entering treatment against the level of need in the general population	>=15%	1.5%	1.4%	1.2%	1.5%	1.4%	1.6%	1.7%	1.4%	1.2%	1.4%	1.6%	1.0%	1.6%	1.1%	1.2%	4.4%	1.4%	1.3%	1.3%	27.0%
IAPT recovery rate - percentage of people who are moving to recovery	>=50%	53%	48%	53%	51%	50%	53%	53%	53%	57%	53%	53%	47%	51%	55%	47%	51.3%	54%	51%	51%	52%
IAPT - started treatment with 6 weeks of referral	75%	92%	94%	96%	93%	95%	94%	94%	92%	94%	95%	97%	95%	92%	93%	88%	94.3%	93%	96%	91%	93%
IAPT - started treatment with 18 weeks of referral	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mental Health - Percentage of people on CPA who were followed up with in 7 days of discharge	>=95%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%	75.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	40.0%	66.7%	66.7%	85.7%	100.0%	71.4%	85.2%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	>=95%	93.0%	93.1%	88.8%	85.0%	91.6%	91.0%	89.9%	87.3%	86.1%	81.7%	83.9%	85.4%	91.0%	92.4%	93.1%	89.2%	87.8%	83.7%	92.2%	87.9%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	>=50%	16.7%	100.0%	100.0%	10.0%	87.5%	66.7%	61.5%	42.9%	50.0%	57.1%	58.3%	87.5%	25.0%	60.0%			51.9%	51.4%	66.7%	44.4%
Dementia	>=62%	61.1%	61.0%	60.3%	59.8%	60.1%	59.9%	59.7%	59.7%	59.3%	59.2%	59.4%	58.6%	58.3%	58.3%	58.8%	59.8%	59.6%	59.1%		59.3%

QUALITY MEASURES																					
INDICATOR	**TARGET**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**Q1**	**Q2**	**Q3**	**Q4**	**17/18**
MRSA bacteraemia - number of hospital infections	0	2	0	0	0	1	0	0	0	1	2	0	0	0	0	0	1	1	2	0	4
Clostridium difficile - number of hospital infections	<=97	7	10	9	10	5	8	9	5	7	7	6	6	7	9	5	23	21	19	21	84
Mixed sex accommodation (MSA) - number of hospital breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
Delayed transfers of care (acute) - Percentage of delays per available bed	<=3.5%	2.1%	1.5%	1.2%	1.9%	2.3%	1.2%	2.8%	1.8%	1.7%	2.6%	2.7%	1.7%	2.5%	2.0%	1.4%	1.8%	2.1%	2.3%	2.9%	2.0%
Delayed transfers of care (all) - Percentage of delays per available bed	<=3.5%	4.6%	4.3%	3.2%	4.9%	4.5%	4.0%	5.8%	4.2%	4.5%	4.9%	5.2%	5.5%	5.9%	4.9%	4.2%	4.9%	4.8%	15.6%	16.6%	4.9%

Appendix D: Sustainability Transformation Plan (STP) Summary

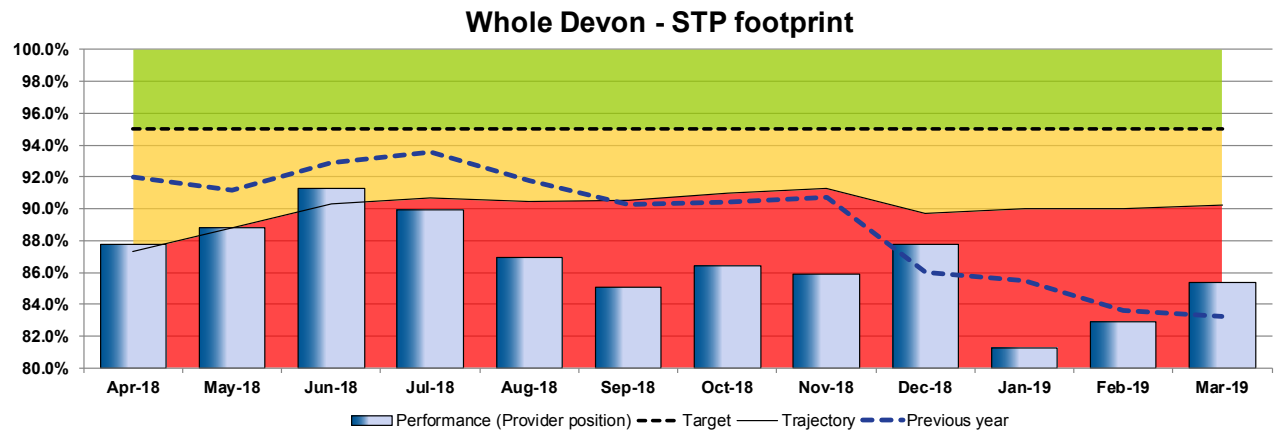
STP KPI Summary

INDICATOR	TARGET	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	ENGLAND January Position	STP Rank January Position	Q1	Q 2	Q 3	Q 4	2018/19 YTD
Referrl to treatment - Incomplete waits	78364	80,395	81,178	81,526	82,273	82,971	81,428	82,049	81,429	81,483	80,089	81,661	82,913	N/A	N/A	81,526	82,049	81,483	81,661	82,913
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	STP Trajectory	82.4%	82.2%	81.7%	82.0%	81.9%	81.7%	81.9%	81.9%	81.0%	80.9%	80.6%	80.5%	87.0%	43 / 44	82.1%	81.9%	81.6%	80.7%	81.6%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	158	253	270	289	370	368	360	328	346	391	339	188	N/A	N/A	270	368	346	339	188
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	STP Trajectory	13.2%	14.6%	17.6%	16.8%	16.5%	14.2%	12.7%	13.0%	14.0%	15.3%	11.9%	10.5%	2.3%	43 / 44	15.1%	15.9%	13.2%	12.5%	14.2%
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	81.1%	82.2%	86.0%	83.9%	78.8%	76.5%	78.8%	78.2%	81.6%	71.3%	73.7%	77.4%	79.5%	33 / 44	83.1%	79.8%	79.5%	74.2%	79.2%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	STP Trajectory	87.8%	88.8%	91.3%	89.9%	86.9%	85.0%	86.4%	85.9%	87.8%	81.3%	82.9%	85.4%	86.6%	30 / 44	89.3%	87.4%	86.7%	83.3%	86.7%
Accident and Emergency over 12 hour trolley waits	0	1	4	4	5	4	13	6	6	8	26	7	8	1 Average	5 / 44	9	22	20	41	92
Cancer - percentage seen within 2 weeks - urgent referral to first seen	STP Trajectory	81.3%	80.0%	84.2%	81.1%	84.4%	83.2%	83.2%	84.6%	85.3%	84.3%	87.7%	89.5%	93.4%	42 / 44	81.8%	82.8%	84.3%	87.0%	83.9%
Breast Symptomatic - percentage seen within 2 weeks	>=93%	81.3%	89.0%	89.4%	90.4%	95.3%	97.6%	96.6%	91.0%	94.2%	89.1%	80.0%	69.6%	82.6%	21 / 44	86.8%	94.3%	93.8%	85.1%	90.0%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	STP Trajectory	79.4%	80.1%	75.9%	75.7%	75.3%	74.3%	74.2%	76.1%	80.6%	68.4%	71.5%	72.4%	76.1%	39 / 44	78.4%	76.1%	76.7%	70.6%	75.3%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.0%	80.0%	85.7%	96.5%	97.0%	90.0%	89.3%	97.4%	97.9%	90.4%	91.9%	91.4%	84.2%	14 / 44	85.5%	95.0%	94.4%	91.1%	91.5%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	84.5%	90.4%	78.7%	90.1%	78.4%	89.0%	76.4%	83.2%	84.0%	86.1%	82.2%	85.4%	82.7%	20 / 44	84.8%	86.0%	81.2%	84.7%	84.1%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	96.3%	98.0%	95.8%	97.2%	97.7%	95.6%	95.8%	96.7%	97.1%	94.5%	92.9%	92.3%	96.7%	29 / 44	96.7%	96.9%	96.5%	93.4%	96.0%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	97.5%	97.2%	95.1%	95.2%	93.5%	89.0%	92.8%	90.0%	93.4%	88.6%	88.3%	87.7%	92.8%	29 / 44	96.6%	92.7%	92.0%	88.2%	92.4%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.6%	99.7%	99.7%	99.7%	99.2%	99.6%	99.7%	100.0%	99.5%	99.7%	99.7%	100.0%	99.4%	11 / 44	99.7%	99.5%	99.8%	99.8%	99.7%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	92.3%	93.9%	95.6%	98.3%	98.8%	95.9%	97.3%	94.5%	94.6%	93.2%	93.5%	87.1%	97.3%	35 / 44	93.8%	97.7%	95.6%	91.9%	94.8%
Cancelled Operations - Number of patients not treated within 28 days of cancellation (Acute only)	0			98			113			121				N/A	N/A	98	113	121		332
Cancelled Operations - Urgent Operations cancelled for a 2nd or more time	0	2	0	0	0	1	1	1	2	2	1			N/A	N/A	0	2	2	5	9
Delayed transfers of care - days delays as a percentage of occupied beds (Acute only)	3.5%	4.0%	3.5%	3.6%	4.1%	3.7%	4.0%	4.8%	4.6%	3.7%	4.4%	3.9%	3.2%	N/A	N/A	3.7%	4.0%	4.4%	5.8%	4.0%
Delayed transfers of care - days delays as a percentage of occupied beds (Acute &community)	3.5%	4.7%	4.3%	4.2%	4.9%	4.6%	5.0%	5.7%	5.5%	4.6%	5.3%	4.9%	3.9%	N/A	N/A	4.5%	4.8%	5.2%	5.0%	4.8%
Delayed transfers of care - days delays as a percentage of occupied beds (MH only)	7.5%	5.9%	5.2%	5.0%	3.3%	2.4%	3.9%	3.8%	3.4%	3.7%	4.5%	4.6%	5.2%	N/A	N/A	5.4%	3.2%	3.6%	4.8%	4.1%
Category 1 Mean response Duration (min)	7	8.8	8.9	7.6	7.0	7.1	7.0	7.0	7.0	6.9	6.8	7.3	7.0	18	N/A	8.4	7.0	7.0	7.0	7.7
Category 1 90th response Duration (min)	15	16.8	17.2	15.0	12.7	13.3	12.8	12.6	12.8	12.3	12.0	13.1	12.3	31	N/A	16.3	12.9	12.6	12.5	14.6
Category 2 Mean response Duration (min)	18	22.6	23.1	25.4	26.7	25.5	25.9	24.8	26.0	26.6	28.5	28.3	27.3	22	N/A	23.7	26.0	25.8	28.0	24.8
Category 2 90th response Duration (min)	40	46.6	47.3	53.1	56.4	53.2	53.8	51.0	53.6	55.7	58.7	59.5	56.0	45	N/A	49.0	54.5	53.4	58.1	51.8
Category 3 90th response Duration (min)	120	114.3	169.9	175.5	177.0	157.1	152.9	139.4	163.0	160.2	169.7	161.3	156.5	148.50	N/A	153.2	162.3	154.2	162.5	155.6
Category 4 90th response Duration (min)	180	275.8	366.5	363.2	355.5	376.6	321.0	306.4	258.5	210.2	220.2	214.4	200.1	197.13	N/A	335.2	351.0	258.4	211.6	335.0
Hear & Treat	11%	8.9%	11.4%	11.7%	12.1%	11.3%	11.9%	11.7%	12.1%	11.8%	12.5%	12.4%	11.4%	N/A	N/A	11%	12%	12%	12%	12%
Ambulance Incidents Resolved Without Conveyance to an Emergency Department	54.6%	51.9%	53.4%	52.9%	54.1%	53.4%	51.5%	52.2%	52.3%	52.8%	52.1%	52.9%	52.0%	N/A	N/A	53%	53%	52%	52%	53%
Ambulance Handovers Taking Between 30 and 60 minutes	0	277	302	296	339	328	381	369	329	274	444	324	648	N/A	N/A	875	1048	972		4311
Ambulance Handovers Taking over 60 Min	0	9	24	22	12	23	25	28	20	15	32	19	17	N/A	N/A	55	60	63		246
Care Programme Approach (CPA) proportion of people under adult MH specialties on CPA followed up within 7 days of discharge from psychiatric in-patient care	95%	86.1%	96.4%	100.0%	97.7%	97.5%	97.9%	100.0%	97.8%	97.9%	97.9%	86.4%	98.0%	N/A	N/A	95.4%	97.7%	98.7%	94.5%	96.7%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	91.8%	93.5%	94.1%	92.2%	90.8%	90.1%	89.9%	89.7%	90.2%	93.4%	93.5%	93.6%	N/A	N/A	93.1%	91.1%	89.9%	93.5%	91.7%
IAPT Percentage of people entering treatment against the level of need in the general population (Monthly Access rate)	1.25%	1.4%	1.4%	1.5%	1.4%	1.4%	1.4%	1.7%	1.7%	1.0%	1.7%	1.3%	1.7%	N/A	N/A	4.4%	4.3%	4.4%	1.6%	29.6%
IAPT recovery rate - percentage of people who are moving to recovery	50%	51.0%	49.2%	51.0%	53.3%	54.3%	55.0%	52.3%	54.1%	51.1%	52.9%	54.1%	51.0%	N/A	N/A	50.4%	54.1%	52.7%	52.6%	52.7%
IAPT - started treatment with 6 weeks of referral	75%	93.2%	93.9%	93.9%	93.9%	94.4%	95.0%	96.1%	96.5%	96.4%	94.1%	92.3%	88.1%	N/A	N/A	93.7%	94.4%	96.3%	91.6%	93.8%
IAPT - started treatment with 18 weeks of referral	95%	99.9%	100.0%	99.9%	99.9%	99.9%	100.6%	100.0%	99.9%	100.0%	100.0%	100.0%	99.8%	N/A	N/A	99.9%	100.1%	100.0%	99.9%	100.0%
Dementia diagnosis rate	67%	59.2%	59.2%	59.2%	59.4%	59.1%	59.6%	59.0%	59.4%	58.9%	59.1%	58.9%	59.6%	68.7%	40 / 44	59.2%	59.4%	59.1%		59.2%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	50.0%	71.4%	68.2%	78.6%	64.0%	53.3%	61.5%	68.8%	76.2%	65.2%	48.1%		77.9%	39 / 44		62.0%	67.6%	69.7%	56.0%
MRSA bacteraemia - number of hospital & community infections	0	1	1	2	1	0	4	3	0	0	0	0	1	N/A	N/A	4	5	3		13
Clostridium difficile - number of hospital & community infections	<=316	25	30	23	30	28	20	19	16	17	18	16	21	N/A	N/A	78	78	52		263
Mixed sex accommodation (MSA) - number of hospital breaches	0	3	1	2	0	0	0	6	1	1	1	1		N/A	N/A	6	0	8		16

4 hour waits A&E &MIU

STP footprint

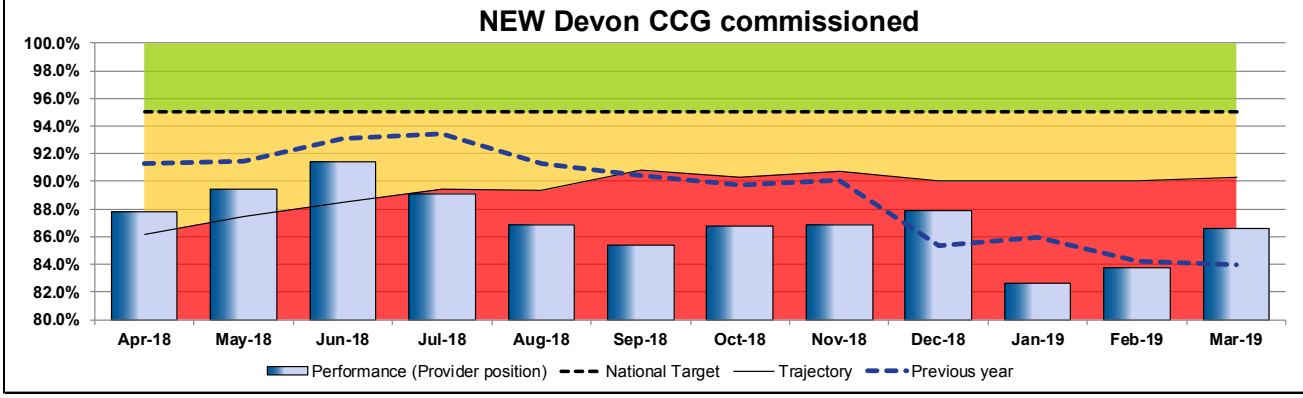
STP footprint	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (Provider position)	>95%	87.8%	88.8%	91.3%	89.9%	86.9%	85.0%	86.4%	85.9%	87.8%	81.3%	82.9%	85.4%
Trajectory		87.3%	88.8%	90.3%	90.7%	90.4%	90.6%	90.9%	91.3%	89.7%	90.0%	90.0%	90.2%
NHS England		88.5%	90.4%	90.7%	89.3%	89.7%	88.9%	89.1%	87.6%	86.4%	84.4%	84.2%	86.6%



Comment:
In March the STP position was 85.4%, up from 82.9% in February. This compares to the national position of 86.6%.
RD&E maintained good performance at 93.2%, TSD moved above 79.8% at 81.0%, NDHT rose slightly to 83.5% and UHP improved from 74% to 79.9%.
Provisional April performance shows a decrease in performance to 81.5% at STP level with RD&E continuing to perform well at 92% but TSD falling slightly to 80%, NDHT dropping to 80% and UHP falling to 73%.

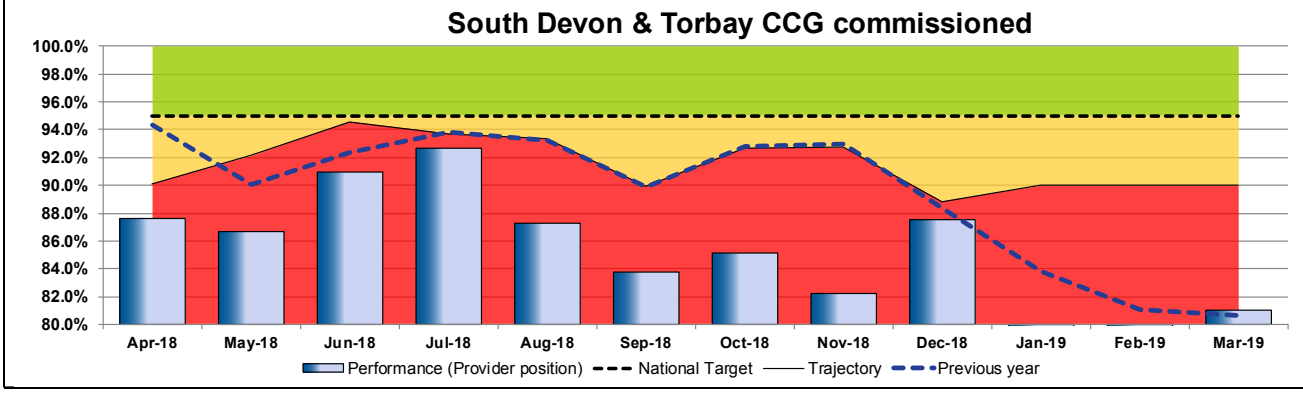
NEW Devon CCG

CCG (NEW Devon)	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (Provider position)	>95%	87.8%	89.4%	91.4%	89.1%	86.9%	85.4%	86.8%	86.8%	87.8%	82.6%	83.8%	86.6%
Trajectory		86.2%	87.5%	88.5%	89.5%	89.3%	90.8%	90.3%	90.7%	90.0%	90.0%	90.0%	90.3%



South Devon & Torbay CCG

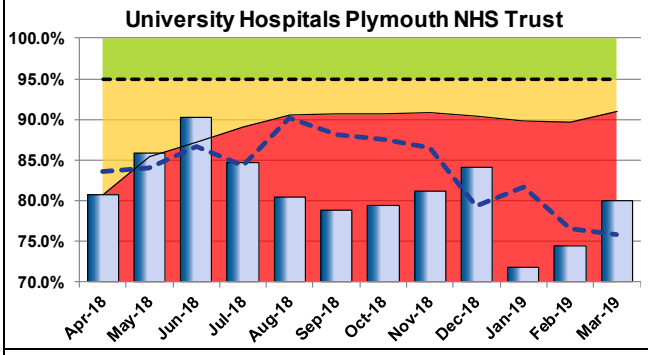
CCG (STD Devon)	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (Provider position)	>95%	87.6%	86.7%	90.9%	92.7%	87.2%	83.8%	85.1%	82.2%	87.5%	76.4%	79.8%	81.0%
Trajectory		90.1%	92.1%	94.6%	93.7%	93.3%	90.0%	92.7%	92.7%	88.8%	90.0%	90.0%	90.0%

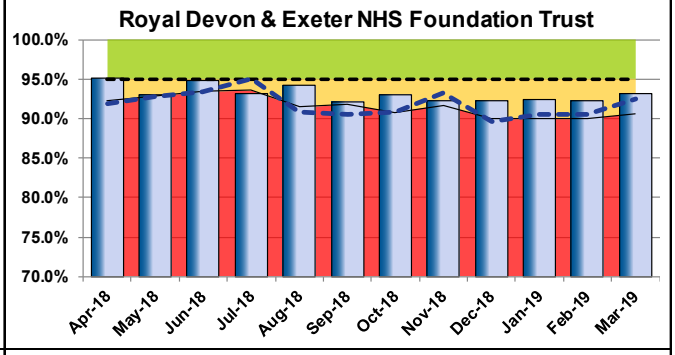


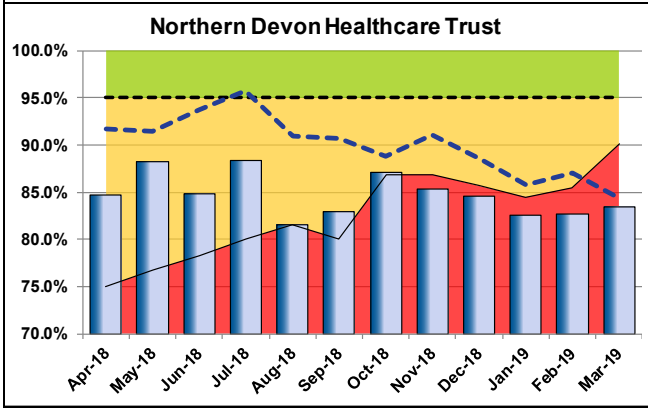
4 hour waits A&E &MIU……continued

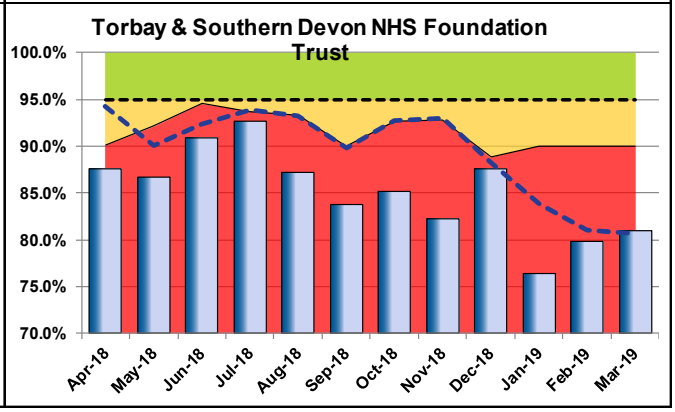
Provider level

Provider		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
UHP (trust total)	Actual	80.8%	85.8%	90.2%	84.7%	80.4%	78.9%	79.5%	81.2%	84.1%	71.8%	74.5%	79.9%
	Trajectory	80.8%	85.4%	87.1%	89.1%	90.5%	90.6%	90.7%	90.8%	90.3%	89.8%	89.7%	91.0%
RDE (trust total)	Actual	95.2%	93.0%	94.8%	93.2%	94.2%	92.1%	93.1%	92.2%	92.2%	92.5%	92.2%	93.2%
	Trajectory	92.3%	92.8%	93.5%	93.6%	91.5%	91.8%	90.8%	91.7%	90.0%	90.0%	90.0%	90.7%
NDHT (trust total)	Actual	84.7%	88.3%	84.8%	88.4%	81.6%	82.9%	87.1%	85.4%	84.5%	82.5%	82.7%	83.5%
	Trajectory	75.0%	76.7%	78.3%	80.0%	81.6%	80.0%	86.9%	86.9%	85.7%	84.5%	85.5%	90.1%
TSDHFT (trust total)	Actual	87.6%	86.7%	90.9%	92.7%	87.2%	83.8%	85.1%	82.2%	87.5%	76.4%	79.8%	81.0%
	Trajectory	90.1%	92.1%	94.6%	93.7%	93.3%	90.0%	92.7%	92.7%	88.8%	90.0%	90.0%	90.0%





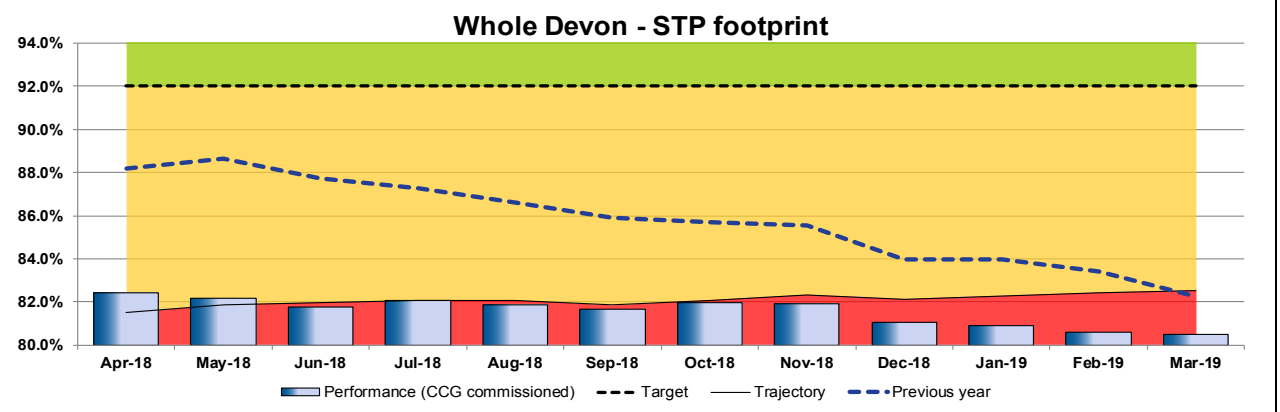




18-week RTT (incomplete pathway)

STP footprint

STP footprint	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>92%	82.4%	82.2%	81.7%	82.0%	81.9%	81.7%	81.9%	81.9%	81.0%	80.9%	80.6%	80.5%
Trajectory		81.5%	81.9%	82.0%	82.0%	82.1%	81.8%	82.1%	82.3%	82.1%	82.3%	82.4%	82.5%
NHS England		87.5%	88.1%	87.8%	87.8%	87.2%	86.7%	87.1%	87.3%	86.6%	86.7%	87.0%	
RTT total waiting list	78,364	80,395	81,178	81,526	82,273	82,971	81,428	82,049	81,429	81,483	80,089	81,661	82,913
Trajectory		77,749	78,454	78,845	78,578	79,363	78,528	78,603	77,324	76,200	75,616	75,353	74,733

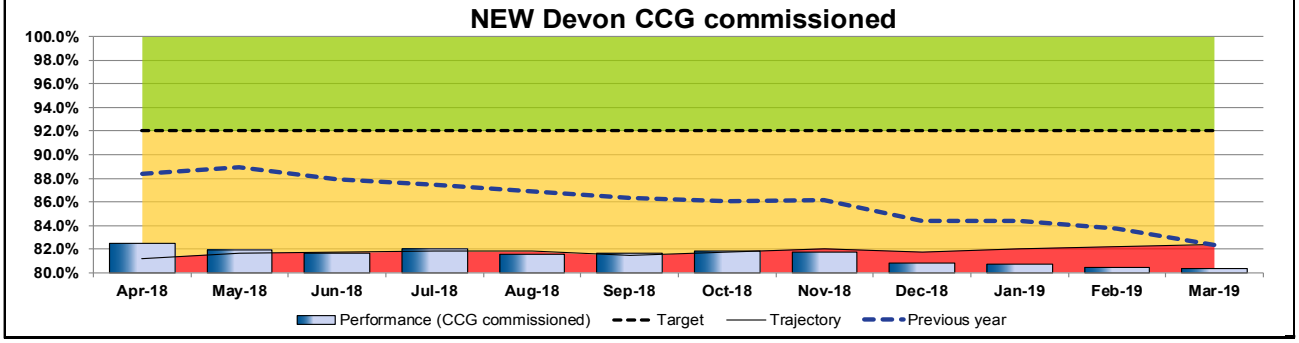


The STP level RTT position was relatively static in March at 80.5% with all providers seeing a reduction in performance. RD&E performance improved from 82.0% to 84.5%, UHP saw a slight reduction from 78.4% to 77.3%, NDHT improved by 0.3% to 79.2% and TSD remained static at 81.3%.

The number of incomplete pathways increased by around 1,250 patients at STP level and are around 4,500 higher than March 2018, with increases at all providers except NDHT in March. Over 52 week waits fell in March moving from 339 to 188 at STP level. All providers saw large reductions with UHP decreasing from 104 to 48 breaches, RD&E falling from 153 to 67, NDHT breaches moving from 50 to 16 and TSD falling from 92 to 79.

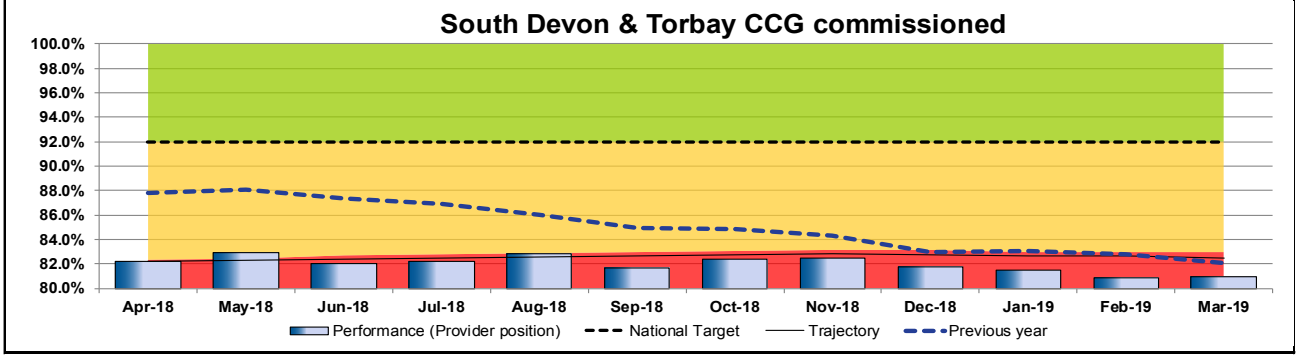
NEW Devon CCG

CCG (NEW Devon)	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>92%	82.5%	81.9%	81.6%	82.0%	81.5%	81.6%	81.8%	81.7%	80.8%	80.7%	80.5%	80.3%
Trajectory		81.2%	81.7%	81.7%	81.8%	81.8%	81.5%	81.8%	82.1%	81.8%	82.0%	82.3%	82.4%
RTT total waiting list	57,746	59,248	59,395	59,684	60,992	61,517	59,967	60,381	59,936	60,245	58,990	60,163	60,510
Trajectory		58,061	58,754	58,968	58,817	59,477	58,584	58,726	57,640	56,522	56,047	55,818	55,310



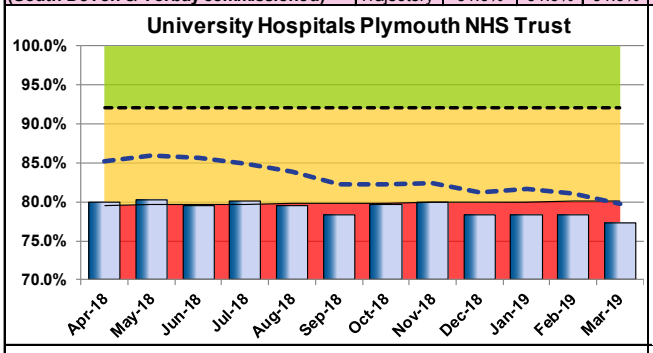
South Devon & Torbay CCG

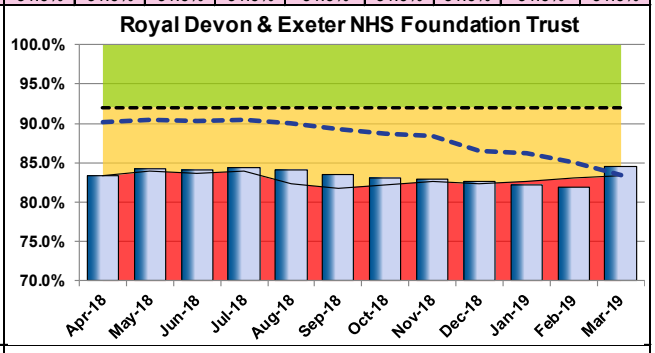
CCG (STD Devon)	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>92%	82.2%	82.9%	82.0%	82.2%	82.8%	81.7%	82.4%	82.4%	81.8%	81.5%	80.8%	80.9%
Trajectory		82.2%	82.3%	82.4%	82.5%	82.6%	82.7%	82.7%	82.8%	82.8%	82.7%	82.6%	82.5%
RTT total waiting list	20,618	21,147	21,783	21,842	21,281	21,454	21,461	21,668	21,493	21,238	21,099	21,498	22,403
Trajectory		19,688	19,700	19,877	19,761	19,886	19,944	19,877	19,684	19,678	19,569	19,535	19,423

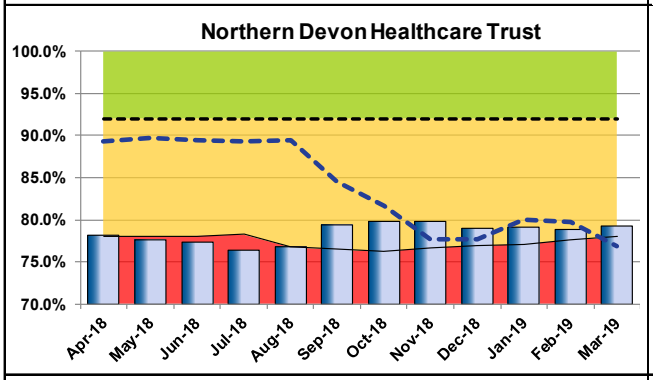


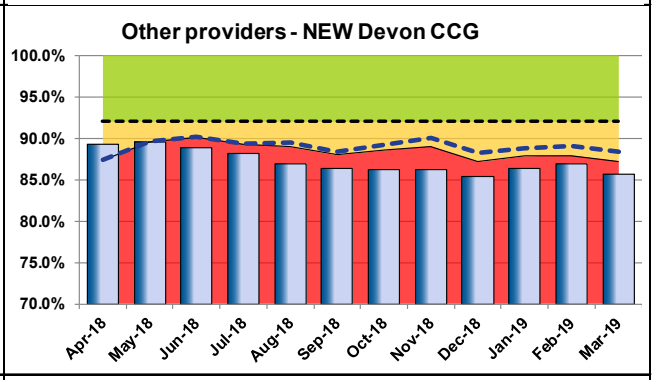
Provider level

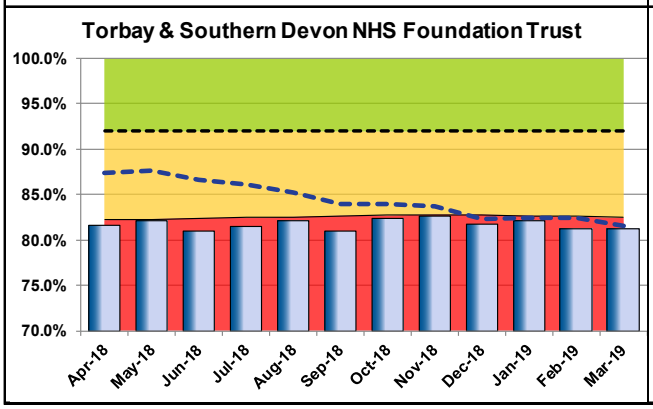
Provider		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
UHP (trust total)	Actual	79.9%	80.3%	79.5%	80.1%	79.5%	78.4%	79.6%	79.9%	78.4%	78.4%	78.4%	77.3%
	Trajectory	79.6%	79.6%	79.7%	79.7%	79.8%	79.8%	79.9%	79.9%	79.9%	80.0%	80.0%	80.1%
	Waiting list	26,115	25,836	25,802	25,682	26,205	25,906	26,399	26,758	26,798	27,356	27,872	27,922
	Trajectory	26,199	25,966	26,154	25,920	26,099	25,572	25,536	25,543	25,228	25,772	25,725	26,347
RDE (trust total)	Actual	83.4%	84.2%	84.0%	84.5%	84.0%	83.6%	83.1%	83.0%	82.6%	82.2%	82.0%	84.5%
	Trajectory	83.4%	83.9%	83.7%	83.9%	82.3%	81.8%	82.2%	82.6%	82.3%	82.7%	83.0%	83.3%
	Waiting list	31,372	31,581	32,252	33,164	33,457	33,399	33,875	33,899	34,261	33,386	33,770	34,278
	Trajectory	31,485	31,806	32,220	32,471	32,662	32,512	32,838	32,274	31,241	30,783	30,496	30,178
NDHT (trust total)	Actual	78.2%	77.7%	77.3%	76.4%	76.8%	79.4%	79.8%	79.8%	79.0%	79.2%	78.9%	79.2%
	Trajectory	78.0%	78.0%	78.1%	78.3%	76.8%	76.5%	76.2%	76.7%	76.9%	77.1%	77.6%	78.0%
	Waiting list	13,473	13,823	14,176	14,399	14,197	12,915	12,647	12,668	12,520	11,790	11,633	11,524
	Trajectory	13,314	13,314	13,314	13,314	14,197	13,989	13,785	13,641	13,575	13,439	13,299	13,101
TSDHFT (trust total)	Actual	81.7%	82.2%	81.0%	81.5%	82.2%	81.0%	82.4%	82.7%	81.8%	82.2%	81.3%	81.3%
	Trajectory	82.2%	82.3%	82.4%	82.5%	82.6%	82.7%	82.7%	82.8%	82.8%	82.7%	82.6%	82.5%
	Waiting list	19,214	19,543	19,380	18,908	18,720	18,760	19,014	18,773	18,463	18,430	18,564	19,408
	Trajectory	18,363	18,316	18,359	18,317	18,361	18,336	18,346	18,279	18,303	18,282	18,332	18,332
Other providers (NEW Devon commissioned)	Actual	89.3%	89.6%	88.9%	88.1%	86.9%	86.4%	86.2%	86.1%	85.3%	86.4%	86.9%	85.7%
	Trajectory	87.3%	89.6%	90.1%	89.3%	88.9%	87.9%	88.5%	89.0%	87.1%	87.8%	87.9%	87.2%
Other providers (South Devon & Torbay commissioned)	Actual	82.4%	83.0%	82.1%	82.4%	83.2%	82.2%	82.8%	82.8%	81.9%	81.9%	81.2%	81.4%
	Trajectory	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%

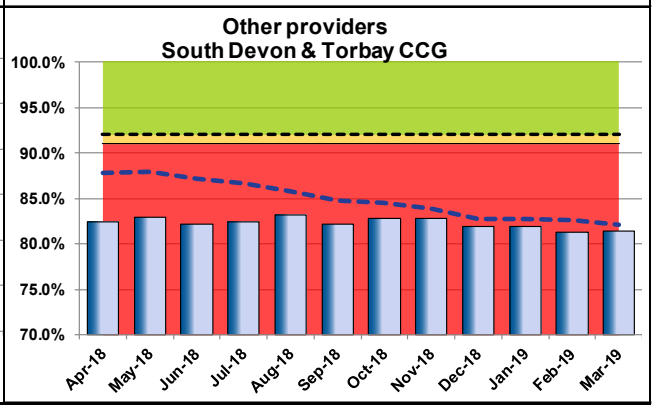








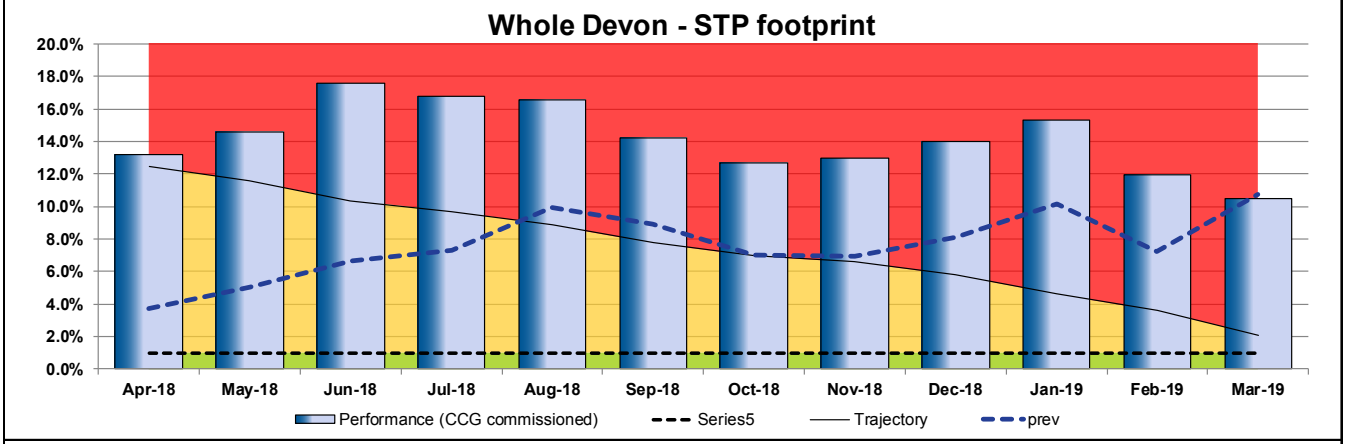




6 Week Diagnostics

STP footprint

STP footprint	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>1%	13.2%	14.6%	17.6%	16.8%	16.5%	14.2%	12.7%	13.0%	14.0%	15.3%	11.9%	10.5%
Trajectory		12.5%	11.6%	10.4%	9.7%	8.9%	7.8%	7.0%	6.6%	5.8%	4.6%	3.6%	2.1%
NHS England		2.5%	2.7%	2.9%	2.8%	3.1%	2.7%	2.3%	2.4%	3.3%	3.6%	2.3%	

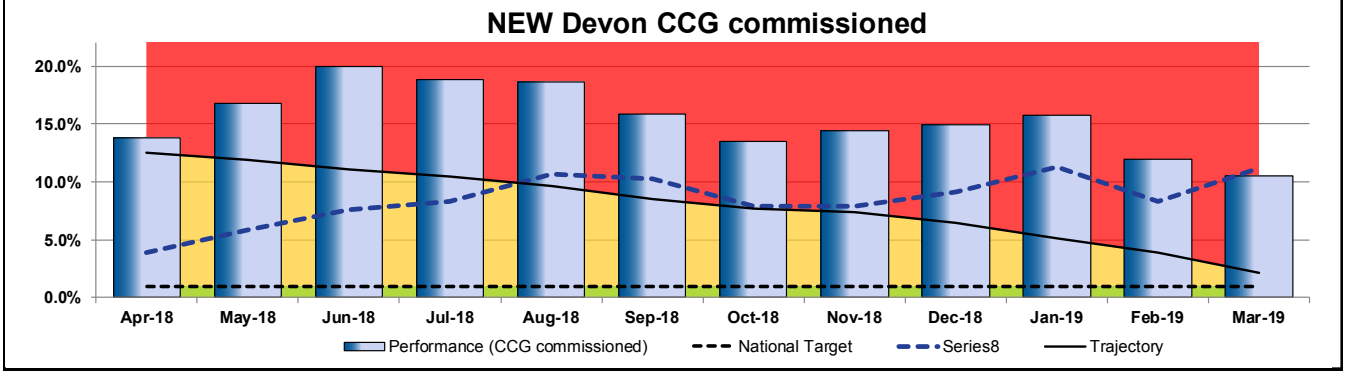


STP level performance improved again in March from 11.9% to 10.5%, the lowest rate seen in 2018/19.

There was improvement at all providers with NDHT falling from 17.9% to 14.6%, TSD moving from 10.7% to 10.1%, RD&E improving slightly from 16.4% to 16.1% and UHP falling from 6.8% to 5.9%. The majority of the improvement was related to reduced imaging breaches although there has also been progress in endoscopy.

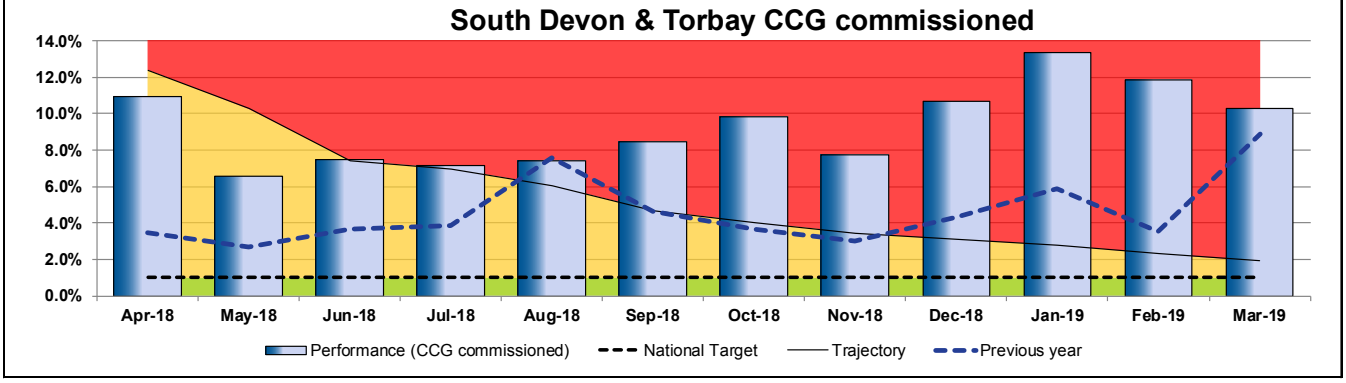
NEW Devon CCG

CCG (NEW Devon)	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>1%	13.8%	16.8%	20.0%	18.9%	18.6%	15.9%	13.5%	14.4%	15.0%	15.8%	12.0%	10.5%
Trajectory		12.5%	11.9%	11.1%	10.4%	9.6%	8.6%	7.7%	7.4%	6.5%	5.1%	3.9%	2.1%



South Devon & Torbay CCG

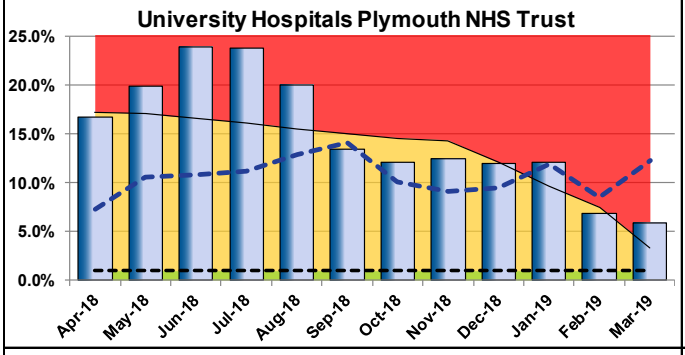
CCG (STD Devon)	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>1%	10.9%	6.6%	7.4%	7.1%	7.4%	8.4%	9.9%	7.7%	10.7%	13.3%	11.9%	10.3%
Trajectory		12.4%	10.3%	7.4%	7.0%	6.1%	4.7%	4.0%	3.4%	3.1%	2.8%	2.3%	1.9%

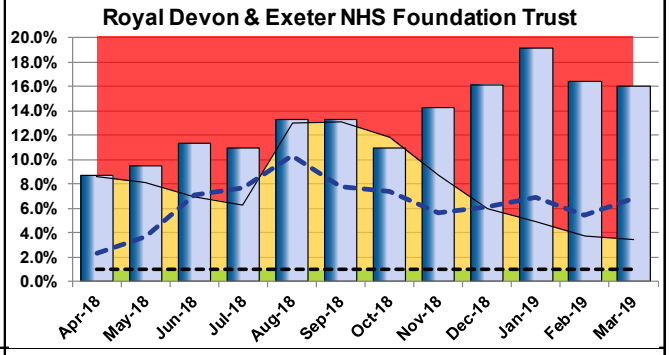


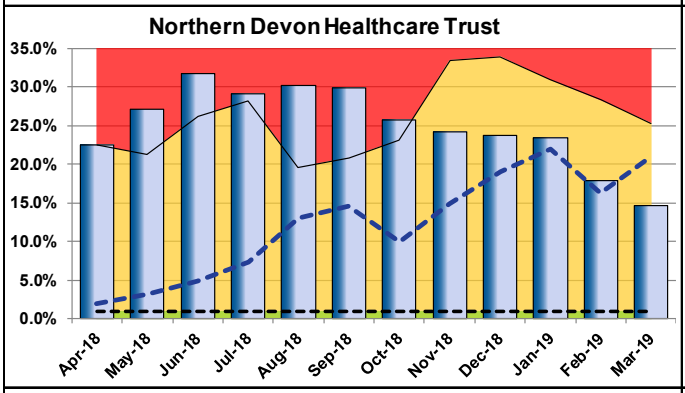
6 Week Diagnostics……continued

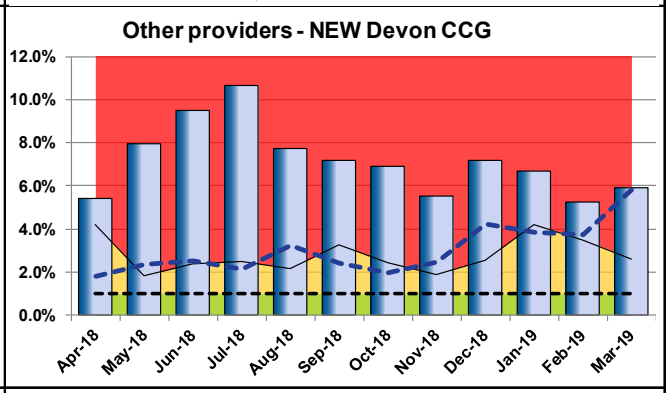
Provider level

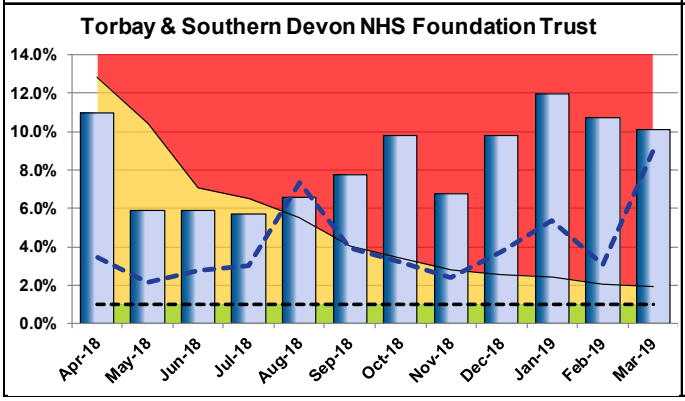
Provider		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
UHP (trust total)	Actual	16.7%	20.0%	24.0%	23.9%	20.1%	13.5%	12.1%	12.5%	12.0%	12.1%	6.8%	5.9%
	Trajectory	17.3%	17.1%	16.6%	16.2%	15.6%	15.0%	14.6%	14.3%	12.1%	9.6%	7.5%	3.4%
RDE (trust total)	Actual	8.7%	9.5%	11.3%	10.9%	13.3%	13.3%	11.0%	14.3%	16.1%	19.1%	16.4%	16.1%
	Trajectory	8.6%	8.1%	7.0%	6.3%	13.0%	13.1%	11.8%	8.7%	6.0%	4.9%	3.7%	3.5%
NDHT (trust total)	Actual	22.4%	27.1%	31.7%	29.0%	30.2%	29.9%	25.8%	24.2%	23.8%	23.3%	17.9%	14.6%
	Trajectory	22.4%	21.3%	26.2%	28.1%	19.6%	20.8%	23.1%	33.4%	33.9%	30.9%	28.3%	25.3%
TSDHFT (trust total)	Actual	11.0%	5.9%	5.9%	5.7%	6.6%	7.7%	9.8%	6.7%	9.8%	12.0%	10.7%	10.1%
	Trajectory	12.8%	10.4%	7.0%	6.5%	5.5%	4.0%	3.4%	2.8%	2.6%	2.4%	2.1%	1.9%
Other providers (NEW Devon commissioned)	Actual	5.4%	7.9%	9.5%	10.6%	7.7%	7.2%	6.9%	5.6%	7.2%	6.7%	5.3%	5.9%
	Trajectory	4.2%	1.8%	2.4%	2.5%	2.2%	3.3%	2.4%	1.9%	2.5%	4.2%	3.5%	2.6%
Other providers (South Devon & Torbay commissioned)	Actual	10.8%	5.7%	5.9%	5.7%	6.4%	7.7%	9.7%	6.6%	9.7%	11.8%	10.7%	9.8%
	Trajectory	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

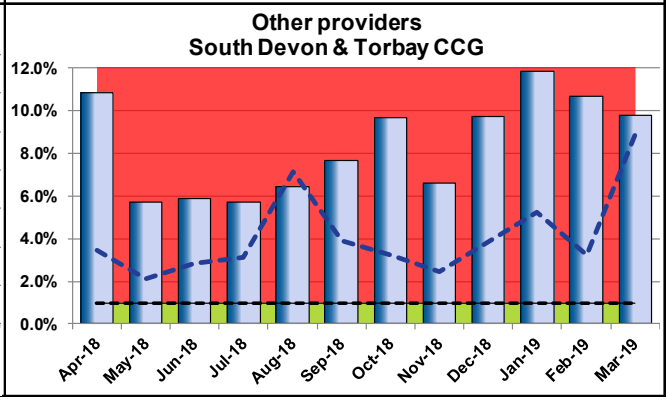








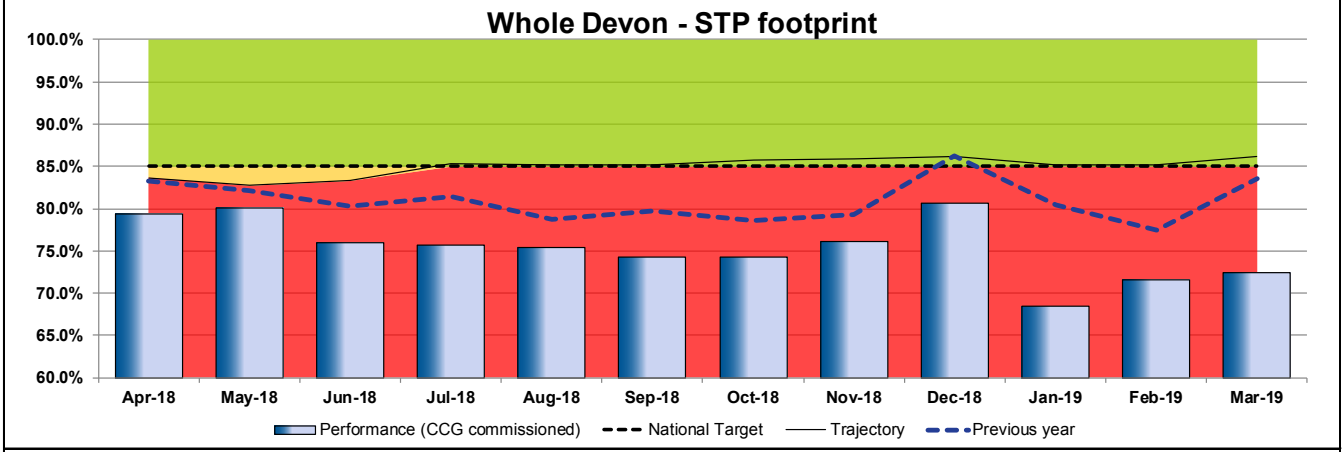




62 day standard Cancer waits

STP footprint

STP footprint	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>85%	79.4%	80.1%	75.9%	75.7%	75.3%	74.3%	74.2%	76.1%	80.6%	68.4%	71.5%	72.4%
Trajectory		83.6%	82.7%	83.3%	85.3%	85.2%	85.1%	85.7%	85.9%	86.1%	85.2%	85.2%	86.1%
NHS England		82.3%	81.1%	79.2%	78.2%	79.3%	78.2%	78.4%	79.2%	81.1%	76.2%	76.1%	

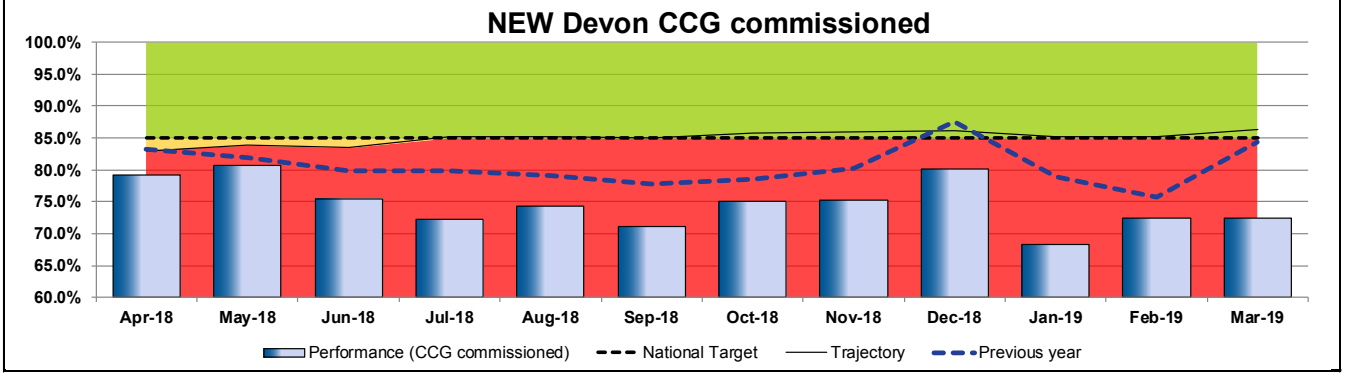


March saw a slight improvement in performance at STP level with RD&E and TSD both seeing an improved position of 71% and 77% respectively. NDHT decreased from 82.7% to 74% and UHP decreased from 74.3% to 68%

The backlog of over 62 day waits fell slightly with a reduction at TSD, UHP and NDHT, but a slight increase at RD&E, whilst TSDHT saw a large reduction of the open 104 day waits from 53 to 35.

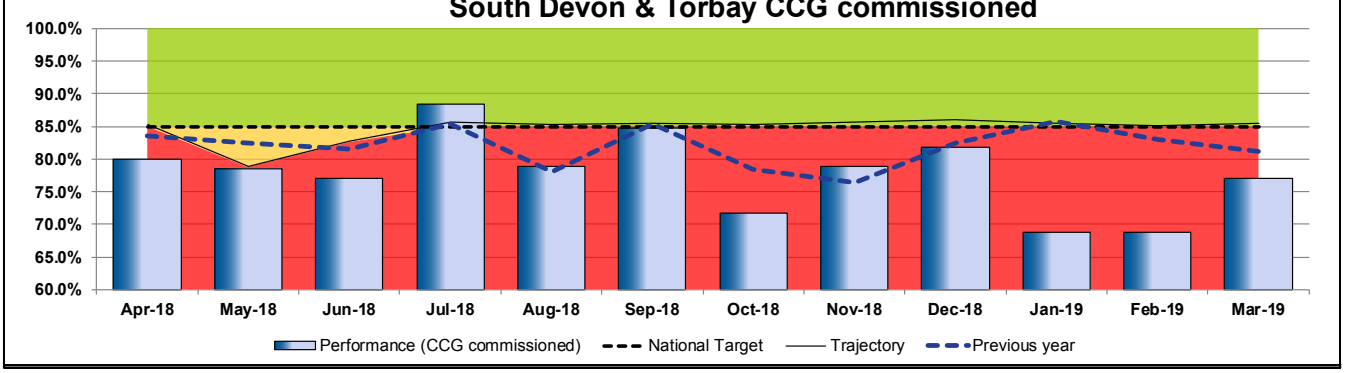
NEW Devon CCG

CCG (NEW Devon)	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>85%	79.2%	80.7%	75.5%	72.2%	74.3%	71.1%	75.1%	75.2%	80.2%	68.3%	72.5%	72.5%
Trajectory		83.0%	83.8%	83.5%	85.2%	85.2%	85.1%	85.7%	86.0%	86.1%	85.2%	85.3%	86.3%



South Devon & Torbay CCG

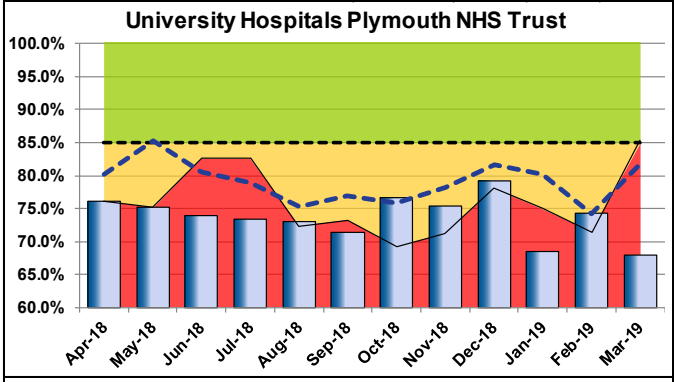
CCG (STD Devon)	National target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Performance (CCG commissioned)	>85%	80.0%	78.5%	77.0%	88.3%	78.9%	84.8%	71.7%	78.8%	81.8%	68.8%	68.8%	77.0%
Trajectory		85.4%	78.8%	82.7%	85.7%	85.3%	85.4%	85.4%	85.7%	86.0%	85.4%	85.1%	85.4%

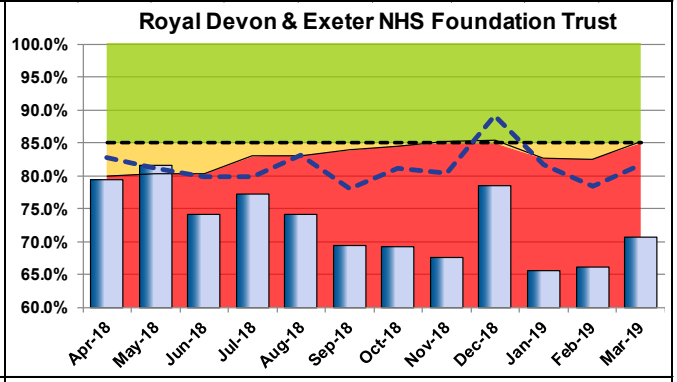


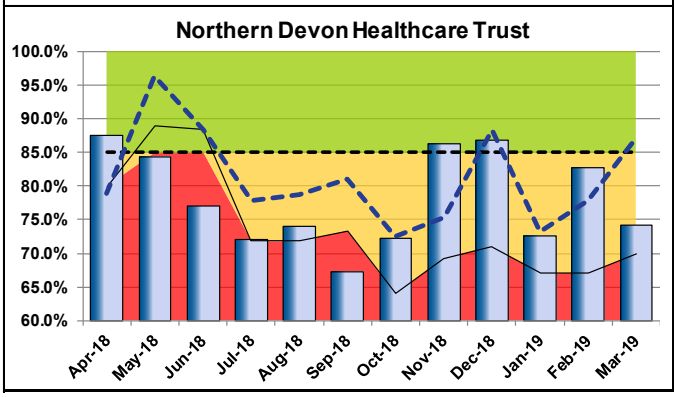
62 day standard Cancer waits……continued

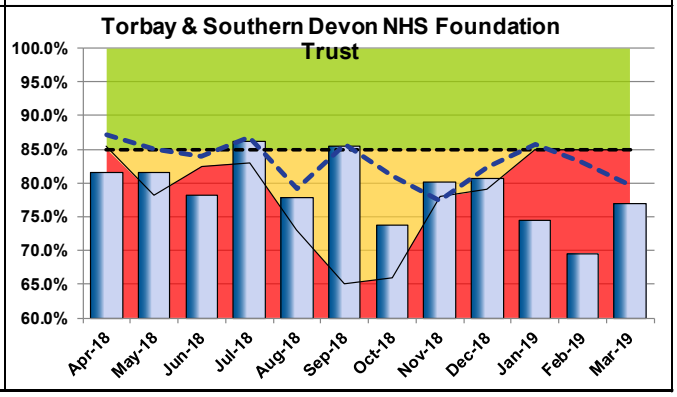
Provider level

Provider		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
UHP (trust total)	Actual	76.1%	75.2%	74.0%	73.5%	73.0%	71.4%	76.7%	75.5%	79.2%	68.5%	74.3%	68.0%
	Trajectory	76.2%	75.2%	82.6%	82.6%	72.4%	73.2%	69.2%	71.3%	78.1%	75.0%	71.4%	85.4%
RDE (trust total)	Actual	79.4%	81.6%	74.1%	77.2%	74.2%	69.4%	69.3%	67.6%	78.6%	65.7%	66.1%	70.8%
	Trajectory	80.0%	80.4%	80.3%	83.0%	83.1%	83.9%	84.6%	85.2%	85.5%	82.7%	82.6%	85.2%
NDHT (trust total)	Actual	87.5%	84.3%	77.0%	72.0%	74.0%	67.3%	72.3%	86.2%	86.8%	72.6%	82.7%	74.1%
	Trajectory	79.9%	89.0%	88.4%	71.8%	71.8%	73.3%	64.0%	69.3%	71.0%	67.0%	67.1%	69.9%
TSDHFT (trust total)	Actual	81.7%	81.7%	78.1%	86.2%	77.9%	85.5%	73.8%	80.1%	80.6%	74.5%	69.4%	77.0%
	Trajectory	85.4%	78.1%	82.5%	83.0%	73.0%	65.0%	66.0%	78.0%	79.0%	85.0%	85.0%	85.0%









NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Locality Reports					
Date of committee: 23 May 2019 **Date report produced: 14 May 2019**					
Author (s) Name and Title: **Dr John Womersley, Northern Locality Representative** **Dr Simon Kerr, Eastern Locality Representative** **Dr David Greenwell and Dr Matthew Fox, Southern Locality Representatives** **Dr Shelagh McCormick, Western Locality Representatives**			**Supporting Executive:** Simon Tapley **Name and Title:** Simon Tapley, Chief Operating Officer **Contact Details:** 01803 652 508 or simon.tapley@nhs.net **Reports Approved by:** **Clinical, Lead Executive and Non-executive Lay Member Representatives** **Date:** 14 May 2019		
Public or Private (Governing Body only):			**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):						
Purpose and scope of report:	**Consultation**		**Approval**		**Information**	**X**
Does this report place individuals at the centre?			**Yes**	X	**No**	

Executive Summary:

The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Western and Southern Devon Localities.

Strategic risk: (include risk number if on register)	**Mitigating Actions:**

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 your own organisation via either d-ccg.corporateservices@nhs.net or corporate.sdtccg@nhs.net to update the central register.

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

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

N/A
Key recommendations and actions requested:
The Governing Body should consider each briefing item and seek assurance, or approve action, where it feels appropriate.
Reference to other documents or accompanying papers:
N/A
Have the legal implications been considered?
N/A
Equality Impact Assessment:

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

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

If the answer to any of the above questions is yes (other than questions 2 and 3) or you are unsure of your answers to any of the above, you should provide further information using **Quality and Equality Impact Assessment**.

If an equality assessment is not required briefly explain why and provide evidence for the decision.

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

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

NHS
Devon
Clinical Commissioning Group

Locality update report

Locality:	Eastern Locality
Period covered by update:	April 19/May 19
Locality clinical representative:	Simon Kerr
Locality executive lead:	John Dowell
Locality non-executive representative:	Glynis Atherton

Key achievements/progress

3 district based members forums considering integrated care, carers services, end of life care, wellbeing Exeter, social prescribing. Working with RD+E COE clinicians, yellow card updates

Eastern locality delivery group partnership working, linkage with 4 federation leads, evolving PCN clinical directors. Community conversations, enhanced care in care homes and comprehensive model of care discussions.
Engagement with STP Meds ops leads

Preparatory group working with Northern locality. Quality, finance and primary care updates. Long-term conditions, integrated care, planned care and mental health commissioning programmes.

Identification of clinical sessions being used for locality working and planning for future engagement & liaison with members GP's in each district.

Working with **eastern A+E delivery board,** local urgent care performance and partnership working with acute trust, SWAST and local authority colleagues

Key priorities for the next three months

Further development of local care partnership engagement forum with work planner, TOR, identification of remit and role regarding development of PCN clinical leads and their roles within Eastern integrated locality working. Engagement with all key stakeholders and consensus re way forwards with clarity of system expectations of this local working

Establishment of next 3 members' forums for July to consider further STP priorities notably mental health. Also incorporating SWAST and alternate urgent care transport services

Identification and agreement of current clinical sessional roles within locality and agreement and recruitment of additional possible 10 further sessions per week of locality clinical support.

Establishment of programme of primary care networks visits to incorporate, referral management, planned care commissioning, primary care commissioning, prescribing planning and communications.

Further joint working with Eastern GP collaborative board and understanding re respective roles regarding primary care networks development and working with other eastern locality providers

Issues of concern or risk

Concerns from Exeter GP's re gap in provision for patients requiring mental health support more complex than DAS and perhaps "unsuitable" for CMHT.

Cardiology waiting times.

Delays in discharge summaries reaching primary care

RD+E EPR Epic IT software implementation and engagement with primary care

Support required from CCG/system or barriers to progress
Further “deep dive” analysis of demand and capacity for managing cardiology services and alternative community based service options. Comms support with primary care and other community based stakeholders. HR support with clinical sessions engagements and further induction of new clinicians within the locality

NHS
Devon
Clinical Commissioning Group

Locality update report

Locality:	Northern Locality
Period covered by update:	April 2019/May 2019
Locality clinical representative:	John Womersley
Locality executive lead:	Andrew Millward
Locality non-executive representative:	Charlotte Burrows

Key achievements/progress

- North is operating a Pro-Active Care Home Practice scheme where dedicated time (multi-disciplinary) is allocated to care Homes to perform Ward rounds to pro-actively reduce resident decline and urgent contact with services.
- Working with RD&E and NDHT to streamline access to Cardiac Catheter Lab, by creating a daily pathway for two patients to transfer from NDHT to RD&E into 2 dedicated slots with 2 beds waiting (from yesterday's patients), with the previous day's patient's being discharged and taken back to North Devon. Will reduce delays in patients waiting for an escalation of care and Length of Stay.
- Specialist Homeless intervention with multi-agency shared funding to reduce chaotic lifestyle and chaotic access to healthcare/discharge issues.
- GP Practices have well advanced plans to declare the constitution of Primary Care networks and the appointment of Clinical Directors
- Establishment of a small Local Care Partnership Delivery Group to oversee the co-ordinated integration of our A&E, ICM and planned care groups. Chaired by CCG
- In Diabetes Care the Northern model of practice support visits including a combined peer to peer/virtual clinic model and has been rolled out successfully across GP practices and has been very well received.
- One year of STP diabetes sustainability funding confirmed
- Resolution of contracting disputes around Leg Ulcer Service and Ambulatory Catheter Care.
- Strengthening local relationships between NDHT consultants Medical Advisory Committee and GP Practices. Through GP Forum meetings
- Strong sustained engagement with Holsworthy Community Involvement Group and developing cross border collaborative opportunities.

- One Northern Devon has used funding to develop community infrastructures around social prescribing.
- Development of STP social prescribing programme

Key priorities for the next three months

- Deep-Dive into Care Home data cross-referencing Acute and 999 to identify causes for Northern outlying Care Home data.
- Develop deflection/alternate solutions to Care Home acute admission particularly Ambulatory Care sensitive conditions.
- Roll-out of Right Care High Intensity User (HIU) programme building on good work in ED but expanding to include 111, 999 and Primary care.
- Co-working with NDHT on the "sustainable-model" of acute care.
- Continue to support the development of Community's social prescription offer through One Northern Devon 'One's'.
- Re-instate Clinician-to-Clinician Groups by specialty to promote/deliver service change.
- Engage with emerging PCNs and Clinical Directors
- Continued work to improve the dementia diagnosis action plan. Ensure people in care homes who are diagnosed with dementia are recorded as such in primary care. Ensure diagnosis is recorded on GP systems when dementia is diagnosed by providers such as Devon Partnership NHS Trust
- Establish commissioning intensions for the Holsworthy area.
- Continued focus on the local implementation ICM and the wider System 19/20 plan.
- Contracting monitoring and developing clear specification and KPIs for leg ulcer service
- Progressing the STP diabetes transformation programme
- Long Term Conditions :- focus on diabetes as well as respiratory and COPD redesign opportunities. Review specifications for Hospice at Home and Marie Curie services.
- Establishing GP Dermatology Champions and shared learning opportunities –include Childhood Eczema (and nurse champions). Agenda for next GP Forum.
- Clarify and strengthen the role of Patient Participation Groups linked to GP practices.
- Go out to local GP practices and recruit a full complement of GP clinical system advisers (Locality Clinical Representatives)
- To move One Northern Devon from its development phase on to the required delivery phase with the implementation of several 'One' town specific pilots
- Working with PCN's to support the implementation of link workers as part of a wider social prescribing offer
-

Issues of concern or risk

- NDHT's sensitivity to small changes in demand destabilising ED performance and flow through the hospital. Need to look at more flexible model to promote resilience to relatively small peaks of demand.
- Time taken for Community Urgent Care Strategy to resolve Locality configuration is delaying a robust good quality local solution to national guidance.
- Appointment of Pharmacists, Physios, Paramedics etc. by Primary Care Networks risks denuding and destabilising other parts of our Northern Health and Wellbeing System. Perhaps, over time, PCNs will develop mutual support agreements as seen in the acute sector
- Difficulty establishing a full complement of local clinical representatives to fully populate C2C meetings as well as support and advice service delivery changes needed to successfully deliver 19/20 plan
- Sustainability of North Devon Hospice 'Hospice to Home' service, need for rapid review of integrated end of life care offer.
- Sustainability of North Devon integrated diabetes service, issues with consultant capacity/ workforce

Support required from CCG/system or barriers to progress

- Early resolution to Community Urgent Care Strategy outcome

- Continued support required from primary care team around PCN development and wider integration opportunities.

NHS
Devon
Clinical Commissioning Group

Locality update report

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

Key achievements/progress

- Local Care Partnership (LCP) delivery group meeting
- Development of a new operational delivery structure at TSDFT to support new model of care and patient-flow through the system
- Opening of the new Friends Centre in Brixham
- Programme in place for roll out of HOPE self-care courses
- Shared data agreements in place in Coastal between primary care, health and wellbeing team and intermediate care.
- 18/19 – 65 small grants (£20,000) delivered to voluntary organisations in Torbay to support health and wellbeing objectives
- Collaborative work with home care providers, staff and service users defined shape of new Living Well @ Home contract in Torbay
- Expressions of Interest circulated for Self-Optimising Team for home care in Torbay
- Torbay Proud to Care launched and care ambassadors recruited.
- First meeting of ICM Project Board

Key priorities for the next three months

- Evolve and support Local Care Partnership arrangements
- Liaise with and support development of PCNs ensuring alignment with integrated community teams and evolving community mental health offer to support communities in a joined up and holistic way
- Confirming local clinical commissioning expertise to support key pieces of work
- Roll out of social prescribing framework in alignment with PCNs
- ICM project board agree system priorities and workplan.
- Enhanced Health in Care Homes framework gap analysis completed
- Development of local Quality Surveillance Group (QSG) - workshop planned for end May

Issues of concern or risk

- T&SD Performance and Financial Position
- PCN Networks potential for unplanned and uncoordinated working
- IT and data issues that delayed provision of key Emergency Department (ED) safety metrics to support the escalation periods.

Support required from CCG/system or barriers to progress

- Continued support for LCP development and sub-locality CCG structure to maintain GP engagement
- Progress on risk stratification model at STP level to support pro-active multi-agency management of patients.

NHS
Devon
Clinical Commissioning Group

Locality update report

Locality:	Western
Period covered by update:	Up to 10 May 2019
Locality clinical representative:	Dr Shelagh McCormick
Locality executive lead:	Jo Turl
Locality non-executive representative:	Nick Ball

Key achievements/progress

- Primary Care Network Development
- Integrated Care Model (e.g. diabetes, respiratory, enhanced health in care homes, LTC health coach pilot, strength and balance to reduce frailty/falls) with refresh of priority programmes
- Children's Procurement – Implementation
- Improved Access
- Podiatry review complete and agreed
- Preparation for Procurement of an Integrated Care Partnership

Key priorities for the next three months

- Primary Care Networks including early development of enhanced primary care teams and alignment of existing social prescribing programme and resources with Devon-wide approach and PCN engagement
- Integrated Care Partnership Procurement
- Integrated Care Model (5 priority programmes: Primary and community integration; multi-morbidity including LTC, frailty and dementia; population health management; wellbeing hubs; enhanced health in care homes)
- Emergency Department Performance
- Population health management (Devon-wide and local projects)

Issues of concern or risk

- Emergency Department
- Operational Plan
- Diagnostics
- Primary Care Provision
- Improved Access
- Pharmacy Workforce
- Population health management

Support required from CCG/system or barriers to progress

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Primary Care Committee

Date of Governing Body: 23rd May 2019

Dates of Committees covered in this report: 4th April (ratified minutes) 2nd May 2019

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

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

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

Reports discussed and assurances received

- Members of the Committee discussed the following reports:

Finance Report

Miles Earl reported CCG finance report, highlighting minimal variations and no specific issues to raise.

Miles outlined the main changes since last month, including an additional allocation of £1.2 million non-recurrent, in respect of GP indemnity inflation, QOF forecast deterioration of £300K and locum claims increase by £150K

An overspend of £5.3 million was outlined in the paper for 2018/19 which falls to NHS England as the commissioner.

GP Contract Summery

Paul Baker updated the Committee on the GP Contract Summary. Paul gave an overview of the new contract and highlighted areas which may give rise t issues for the committee in the future.

Primary Care Networks

Paul Baker brought a paper to the group asking for Committee's agreement for Executive authorisation of Primary Care Networks. The members discussed how networks would align to community services and Collaborative Boards, with the need to flexible. Members also discussed how we would support Clinical Directors and governance arrangements within networks.

Estates Update

Members of the Committee were presented with a paper on Cranbrook GP Premises and interim premises arrangements. Members agreed that funding should be granted for this project with colleagues from Finance to make decision outside of the meeting on whether this should be in the form of direct funding from the CCG or as a loan from East Devon District Council.

Primary Care Operational Group

Members of the Committee approved revised Terms of Reference of the Primary Care Operational Group.

Primary Care Highlight Delivery Status

Paul Baker reported a drift from green to amber, reflecting higher targets and aspirations. The Committee were asked to approve the format of the report and the measures recorded within it. The Committee members agreed that more quality indicators should be included and quality information from the last 3 months could be included.

Options Appraisal for Mannamead Surgery

Mark Procter presented an options appraisal to the group outlining options for Mannamead Surgery. The Committee approved the way ahead, agreeing contractor, staff and patients should be advised of outcome at an appropriate time prior to any other stakeholders being communicated with.

Reports received and noted

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

Dentistry Contract – Tess Fielding attended the meeting to update members on the current position with the dentistry contract. Tess reported low access to an NHS dentist in Plymouth at 47.4% (compared to an average of 50-55%). The Committee members discussed access for frail and elderly patients, patients living in deprived areas and patients with learning and mental illness. Tess Fielding asked members of the Committee to highlight any issues to her so that she can develop appropriate services.

LMC Negotiation Meeting Outcome Report – Paul Baker reviewed the paper with the group with no actions.

Locality Flash Reports – Members noted the locality flash reports

CEPN Report – Feedback from training better than expected. Members noted the report

Contracting Report – Mark Procter presented the contracting report, which now only reports on contracting changes and new CQC reports. Members noted the temporary closure information and three new CQC reports, which were all reported as 'good' and congratulated the practices on achieve this rating.

Forward Planner – Members reviewed and noted the Committee forward planner

Risk Register Review (changes and areas of concern)

- The Risk Register was reviewed by members with one elevation on risk this month. The group agreed to elevate the risk of the Mayflower procurement from 12 to 16.

Committee Decisions

- The Committee supported the proposal for Executive authorisation outlined in the Primary Care Network paper
- The Committee agreed to fund alterations at Cranbrook GP Practice with decision to be made by Finance colleagues on the technicalities.
- The Committee approved Terms of Reference of the Primary Care Operational Group.
- The Committee asked for additional quality indicators to be included in the Primary Care Highlight Delivery Status.

• The Committee approved option 4 on the Mannamead options appraisal paper, which is to enact the Emergency Framework and include in the existing Mayflower procurement process.
Recommendations for Governing Body
• **None**
Recommendations for other Committees
• **None**
Terms of Reference or other committee effectiveness issues
• **N/A**

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.

Public Addendum Pack - Approved Committee Minutes

Governing Body Public

23 May 2019 14:00 - 23 May 2019 17:00

INDEX

NHS
Devon
Clinical Commissioning Group

Primary Care Committee
PUBLIC MINUTES

Date: Thursday 4th April 2019 Time: 0900-1130

Location: MR1A/B/C, Pomona House and via teleconference

Item	Discussion	*Action**	*Decision taken by Organisation*
1.	**Welcome and Apologies** Dr Nick Kennedy welcomed all attendees to the Primary Care Committee, the first of the new Devon CCG and the first since the CCG began delegated commissioning. Apologies were noted and Dr Kennedy confirmed that the Committee was quorate. Dr Kennedy confirmed that his role in Committee was now Interim Chair. The Committee will need to be chaired by a lay member in the future and he will step down once a new chair has been appointed. Introductions were made around the table.		
2.	**Declaration of Interests** No amendments were required to the current declaration of interest register. No declarations of interest were received from members today. **Action: To ensure any new members of the Committee has completed DoI**	**All Members**	
3	**Approve previous minutes, update on action** The minutes from the last public meeting held Thursday 7th March 2019 were approved as an accurate reflection of the meeting. The action log was updated as follows: **Action 91** – Mark Procter confirmed that he had liaised with Paul Johnson and agreed to use Lynton as an example in the future.	**Closed**	

	Action 100 - Good news stories – Communications Team have suggested that good news stories be released at end of each quarter. Action to remain open until end of Q1. Good news story to be embedded in GP Update (or replacement) **Action 102** – Deep dive into practice locum claims – Ben Chilcott to update this meeting or Mark to follow up with Ben after the meeting. Ben Chilcott updated that due diligence work is ongoing. **Action103** – Tracker – paper today. Decision made to discontinue tracker activity **Action104** – Property voids – Mark Procter updated that this work is ongoing but has been delayed due delegations transfer and due diligence. Ben Chilcott reported that he was committed to bringing a list of property voids. Budget/allocation for 19/20 to come to May meeting to give overall context of wider CCG position. Overall system still being negotiated. CCG position not expected to move but not yet finalised. Outturn position for CCG elements are stable and NHSE also stable. Paper to go through Finance Committee **Action 107** – Mark Procter confirmed that he was in discussion with localities. - Sub-group to be set up to focus on broader workforce strategy. - Work ongoing and events taking place across the country to attract new nurses and pharmacists. - Recruitment locally an issue - Lorraine Webber highlighted that career pathways were not currently in place and the sub-group group will pick up this work. **Action: Workforce item on the agenda for PCC in May** **Action 110** – on today's agenda **Action 111** – Cranbrook premises discussions – Mark Procter confirmed that ongoing conversations were taking place with an urgent need for solutions. NHS England keen for rapid conclusion. Paper will be available later today. Mark Procter asked the Committee for agreement that Paul Baker could be delegated to make decisions on his behalf. The group agreed that Ben Chilcott and Paul Baker could be delegated. Dr Kennedy offered to be available for advice if required. **Action 112** – STP estates report – **Action: Paper to come to May/June meeting** **Action 113** – Pathfield Medical Group merger application – Paul Baker confirmed that this is now complete. Action closed **Action 114** – Services to Brixham Hospital – Mark confirmed possible option with Mayfield and TSDFT to fund changes. Action closed. **Action 115** – Operational Group ToR on today's agenda. Action closed	**Closed** **AP** **Closed** **AP** **Closed** **Closed**	

	Action 116 – Training uptake. Action to remain open		
4	**Risk Register** Paul Baker presented the recently updated risk register to the Committee. Paul confirmed Executive review to ensure a robust risk register. No risks were recommended for closure and no additional risks added. Paul confirmed that workforce risks had been aligned across the CCG		
	Finance		
5	**PCC Finance Report** Ben Chilcott reported on Finance paper with no expected variance. No specific issues to raise. Ben Chilcott reported that there had been an NHSE adjustment to allocation and impact has been reviewed. Budgets have a level of contingency built in to them, but still fairly tight. Changes to allocations that are still being worked through for a number of areas. Additional allocations in June. Ben Chilcott assured the group that first payments to GPs for PMS practices are expected on 7th April. Everything in hand and all payments have gone off.		
6	**Strategy**		
6.1	**Delegation MoU** Mark updated that the final draft of MoU is ready to sign and supports final staff transfer over next 3-6 months. Quality section to be added in as an appendix. Mark Procter asked the group for approval to sign once the quality appendix has been added. The group agreed that Lorraine Webber would review the quality section and Operational Group to be delegated to sign of quality section. **Action: Final delegation document to be shared with members virtually for agreement.** Fortnightly delegated commissioning meeting still taking place and the group agreed that work can be continued within this meeting. LW raised concerns regarding safeguarding and highlighted that nursing and quality would be in a separate MoU.	**MP**	
6.2	**Delegated Commissioning Highlight Report and Transition Plan** Mark Procter reported that delegated commissioning is now live. Mark reported that he is working on requests for additional capacity (minimal requests now being received). Paper going to Execs on Tuesday and Jo Turl will follow-up. Requests for posts in Primary Care Team and Quality Team were submitted.		

	Jo Turl highlighted that at the recent annual CCG Performance Meeting, NHSE congratulated the CCGs on their work on delegated commissioning. Nick Ball asked whether priorities in the report are on track. Mark Procter reported that estates work is ongoing and in hand but not complete.		
6.3	**Primary Care Operation Group ToR** Dr Kennedy reported that an external GP should be a voting member and Jenny Early had decided not to renew her contract with the new CCG, so recruitment would take place for a new external GP. Dr Kennedy asked members whether a GP from Cornwall would be appropriate for recruitment to this role. Members said that this would still be appropriate, but recruitment should have a wider scope. Dr Kennedy felt that this would not be an easy post to recruit to. Committee confirmed they were happy with the proposed ToR for the Operational Group, which will be a sub-group of this Committee. Group to meet every month 2 weeks before PCC with review in 6 months. Nick Ball asked whether it would be useful to include definitions in section 10. Mark Procter agreed that this should be added into the ToR. **Actions:** **Amended ToR to be distributed to the Group.** **Meeting to be reviewed by PCC in October meeting**	**MP** **AP**	
7	**Contracting**		
7.1	**Chilcote Boundary Change** Paul Baker reported on the Chilcote boundary change proposal and the intention of the CCG to approve area 2 and 3 to be removed but reject removal of area 1. Paul highlighted some key points to the group: • Section 1.4 – Key map showing boundary changes. Paul highlighted that the vast majority of patients would still be within revised area. • Section 3 – Sladnor Park development • Section 4 – Patient engagement. Paul confirmed that this proposal has been through PGG. Response rate lower than expected but has been supportive • Section 5 – Practice feedback. Sladnor Park an area of concern. • Section 6 – Recommendations. Area 2 and 3 being approved to be removed. Area 1 not removed from boundary area. Dr Kennedy asked the group for questions: - Dr Kennedy – why did ten practices not respond and give feedback to proposals? *Paul Baker said that he felt that impact for some practices is quite small. Ones that expected to respond have responded.* - Jo Turl – Is Sladnor Park development is still live, as it has been through planning several times*? Paul Baker responded to say that*		

	development is not imminent but expected to go ahead. 160 units, some with multiple occupancy. Some expected complex patients. Potential that they may still end up servicing this area as part of network. - Nick Ball – In the patient engagement data, have we checked whether any of the 54 responses are from patients who would be directly affected by the change of boundary? *Paul Baker said that some responses were from patients who would become outside the area and assurance was requested that they would not be deregistered from the Practice.* - Nick Ball – Can we seek assurance that home visits would be maintained? *Paul B responded to say that there is no way of monitoring this, but it would be flagged through the complaints process.* - Dr Kennedy – are the practice aware that their proposal has been broken down into three areas for consideration? *Paul B responded to say that the Practice will probably be disappointed in the decision to break down into the three areas. The Practice may want to have a conversation about the decision and how it was reached.* - Dr Kennedy – some boundary changes can have impact on population. Should there be a QEIA process? *Lorraine Webber agreed that QEIA process should be followed. Mark Procter confirmed that QEIA questions had been asked during consultation but not in a formal way LW to work with PB on QEIA process and decide whether this change needs to go through the QEIA panel formally.* **Decision: Dr Kennedy asked the Committee for approval and members agreed** **Action: LW and PB to look into whether QEIA process needs to be followed**	**LW/PB**	**Agreed**
8	**Commissioning**		
8.1	**Extended Access** Paul Baker reported to the group on the improved access for weekend and evening offer Key points - Section 3 – March output above 75% national requirement. Many areas above 90% of national requirement - Section 6.3 – three headline messages. • Patient survey had just under 2000 responses, which is a good response rate with two thirds aware of the service offer. • Comms planned to increase further patient awareness with some steer from patients around how we might achieve this. • Patient travel time. Majority of patients happy to travel around 30 minutes to access extended access services, which can be taken into consideration when planning services within hubs and networks. Dr Kennedy asked the group for questions:		

	Lorraine Webber – Are providers collecting patient experience data? P*roviders have a 6 monthly cycle of collecting patient experience data. Lorraine confirmed that she will be collecting patient experience data through the normal routes and will feed into the operational group.* Jo Turl – Utilisation of EA appointments in Western area is variable? why should utilisation be less in Plymouth compared to elsewhere? *Paul agreed that we need to improve utilisation in this area. Paul explained that in most of Devon the network model allows data sharing. In Plymouth DDocs are responsible for most extended access services and do not have access to patient records meaning that they do not have the same capability and utilisation is therefore very low. Where practices have introduced the practice network model utilisation has improved significantly.* Ruth Harrell – Who are the people who want extended access to services and how are we getting the message to them? *Paul Baker responded to say that it is not always the patients we expect that require extended access appointments. A range of patients, particularly in rural areas, need out of hours appointments. Can be related to needing a carer to transport to appointments, public transport availability and other reasons, making the solution much more complex.* **Action: Lorraine Webber suggested asking Sam Holden, Patient Experience Manager to work with Paul Baker on this. Paul to contact Sam Holden**	**PB**	
8.2	**Devon CQC Report** Paul Baker reported on the position across our 128 contractors. Validation of data - Castle Place contract held by RD&E. Meeting set up with CQC to share soft data and validate lists Lorraine Webber reported that she had recently looked at themes in CQC inspections. She said that were there are issues that are unique to single providers and some themes that go across the board. If all practices have the same issues, we have responsibility to work on these issues. Nick Ball asked why Clocktower has a much larger average payment per patient. Paul Baker confirmed that this is a service for homeless population in Exeter with entirely different patient profile. The group discussed which Committee quality and safety is being reported through. The group agreed that some things would report to both committees. Dr Kennedy agreed that it would be important for Lorraine Webber to take appropriate items to Quality Committee. The group discussed the importance of drilling into the detail of CQC reports to understand them fully. The group agreed that **i**ndividual CQC reports would be reported monthly. Overarching report to be reviewed on a quarterly basis.		

8.4	**Tracker Practice – Update report** Paul Baker presented on Tracker practice and asked the Committee for decision on whether this activity should be continued. The recommendation is to discontinue this service and invest funds in front line services. LMC supportive of discontinuing. **The group agreed to discontinue tracker practice service and reinvest into patient facing services PPO/expansion of shared care.**		**Agreed**
8.5	**GPFV / Locality Updates** Themes around improved utilisation and engagement around primary care networks is more time consuming than envisaged. More networks needing mediating, influencing and supporting.		
8.6	**GPFV Funding** Mark Procter reported that GP forward view funding streams have been introduced merging funding streams into one, with flexibility to focus of particular areas of need in specific areas. An MoU has been issued to this effect and should be reviewed through GPFV Funding Board. Mark confirmed that this Committee is acting as that Board and confirmed that this is acceptable. Mark highlighted a table included in papers showing how funds are to be allocated. Allocations similar to 18/19 with the addition of GP retention programme. Mark said that a whole cohort of new GPs could be supported with this funding. Dr Kennedy asked the group for questions: Lorraine Webber asked if learning from incident training could be built in? *Mark Procter said that CPEN should be providing that training.* Dr Kennedy commented on the timing of the paper and why he had not had sight of the paper in advance of the meeting? *Mark Procter apologised to Dr Kennedy and said that this paper had to be signed at pace.* **For approval:** **1. Retrospectively approve signing of the MOU. Members approved** **2. Continue to act as GP Funding Board. Members approved** **3. Approve the spending plan as shown in the table, with particular note that supporting GP training is included. Members approved**		**Agreed** **Agreed** **Agreed**
8.7	**Locality Flash reports**		

	Locality flash reports were presented to the group for noting. Paul Baker reported a single red item – shared care work programme that has been moved into 19/20. Jo Turl asked for assurance that we know what is in the 19/20 programme. Paul Baker confirmed that some items will roll over and some new items will come in relating to the GP delivery of contracts. Proposal for new work plan next month. **Action: May agenda to include forward view and time allowed for discussion around detail on 19/20 work plan.**	**AP**	
8.8	**LMC Negotiation Meeting Outcome** Report of outputs of formation negotiation meetings with the Devon LMC was presented, with the following points highlighted: 3.1.5 Annual health checks for people with severe mental health illness – long running issue. Proposal for consultation has gone to the LMC and confidence that there is a viable way to take this forward. 3.1.9 and 3.1.10 – Temporary practice closures – a couple of small tweaks to make and going back to LMC for approval.		
	Planning		
9	**Committee Effectiveness Forward Planner** Forward planner reviewed by the group. Items to be added as required during the year Lorraine Webber highlighted that Safety and Quality report including SAEs to be included. Dr Kennedy asked for an update on networks to be added to the planner. Performance data - Lee Coulson developing a set of metrics. To be included once finalised. **Action: Primary Care Networks and Metrics update to be added to the planner**	**AP**	
Meeting Close at 1115			

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*

*Alison Pearce (AP)**	*(Minute Taker) Business Manager for Director of Primary Care*
Caroline DimondA [A]	*Director of Public Health (Torbay Council)*
John Dowell (JD) [A]	*Chief Finance Officer (NHS Devon CCG)*
John McCormick (JMc) [A]	*Chief Clinical Information Officer (NHS Devon CCG)*
Kevin Dixon (KD) [A]	*Healthwatch Devon Representative*
*Laila Pennington (LP)**	*Head of Primary Care (NHSE)*
Lorna Collingwood Burke (LCB) [A]	*Chief Nursing Officer (NHS Devon CCG)*
*Mark Proctor (MP)**	*Director of Primary Care (NHS Devon CCG)*
*Nick Ball (NB)**	*Non- Executive Director for Finance and Governance (NHS Devon CCG)*
*Nick Kennedy (DrNK)**	*Chair – Secondary Care Doctor on the Governing Body*
*Paul Baker (PB)**	*Deputy Director of Primary Care (NHS Devon CCG)*
Paul Johnson (PJ) [A]	*Clinical Chair (NHS Devon CCG)*
Virginia Pearson (VP)	*Director of Public Health (Devon County Council)*
*Ruth Harrell (RH)**	*Public Health Consultant (Plymouth City Council)*
In Attendance	
Ben Chilcott	*Chief Finance Officer (on behalf of John Dowell)*
Lorraine Webber (LW)	*Deputy Director of Quality and Assurance (on behalf of Lorna Collingwood-Burke*
*Fiona Cartlidge**	*Contracts Manager (NHS Devon CCG)*
*Ginny Snaith**	*Board Secretary (NHS Devon CCG)*

Minutes approved	Date:	Signed by chair:

Audit Committees in Common
Final Approved Minutes

Date: Wednesday, 13th March 2019 Time: 1.30pm - 4.30pm

Location: Meeting Rooms 1a, b & c, Pomona House, Oak View Close, Torquay, TQ2 7FF

Item	Discussion
1.	**Welcome** NB welcomed everyone to the meeting. **Apologies** Dr Paul Johnson, Dr John Womersley, Chris Hanvey, Clare Doble, Alex Walling, Derek Blackford, Lorna Collingwood-Burke, Gilly Champion, John Dowell, Rob Loader, John Micklewright and Kevin Wheller
2.	**Declaration of Interests** There were no further declarations of interests. SK would like to add that he is a member of the Eastern Locality Delivery Group.
3.	**Minutes from the last meeting held on 9th January 2019** The minutes of the meeting held on 9th January were agreed as accurate record with exception to the following amendment being made:- Constitution engagement, 2nd paragraph "JWill referred to the Benefits Realisation and not to forget about this and SM agreed this is a good point." **Action Log** The action log was reviewed and updated. The following actions were closed:- **ACiC040, ACiC056, ACiC057, ACiC062, ACiC063, ACiC064 & ACiC065**

Governance

a) Joint Risk and Assurance Report

SM explained that there was a risk review meeting on Tuesday and there is nothing further to add but she is happy to take any questions. There is still a lot of work to do over the next few months and the next quarter should sharpen up substantially.

Risks 102/103 (DPT SI risks)

LW was asked whether the provider is taking action and she explained that Paul Keedwell agreed to produce a paper with their actions and this will be discussed at Quality Committee on Tuesday.

Risks 98 & 99

JWill referred to workforce capacity and that a number of posts were released through the MARs scheme and to ensure we are not short on capacity. SM added this was raised as a risk of posts not being filled and there are a number that have been recruited to but it doesn't reflect on the posts released through the MARS scheme. JWill didn't think the wording of the risk is correct and SM agreed to speak to the risk owners.
Action: ACiC062 - SM will speak to the risk owners to ensure the wording is re-phrased.

SK referred to IT and RD&Es EPIC system as there have been difficulties. Should this not be in a system risk but SM hasn't seen this risk come up, TB added that this sits with system alignment and that Nick Hopkinson will know more.

4. CP asked where the Torbay Hospital risk sits and SM will need to find out as this would be a provider risk.
Action: ACiC063 - SM agreed to look into the risk and added that there is a risk to harm in relation to 52 week waits and how do we manage this and the options are being considered.

On page 35, the Finance Committee have recommended this risk for closure. SM mentioned that there are corporate risks on the risk register and it was added in the last two weeks.

Annual Report

The Annual Report is set out into sections and lists who reports on this. This has been brought to the Audit Committee for oversight and SM is happy to take any questions. The front sheet of the Annual Report needs the date updating as it still has 17/18. CP couldn't see primary care networks listed and this will be one of our main workstreams. The annual report needs to also look forward and to highlight our plan. SK agreed that we need to include what our specific role is to work with these groups.
Action: ACiC064 - SM agreed to speak to comms in connection with the incorrect date on the front cover sheet and SM will take the other comments on board.

NB referred to the Performance Analysis on page 68, paragraph 3 and asked what do we want to hold ourselves to in relation to key targets and performance and SM agreed and added that our regulators would want the information to be included and will think about the wording. GB will receive an update in March. CP would like to highlight Care in community which has been done in South Devon and the public need to know.

Overall the group agreed the report was good. There was some discussion to include patient feedback. Highlights over the last 12 months should this be included too around maternity and decisions on future children's services and SM said this is mentioned in later pages but will include it in the highlights. CP added we do need to include what hasn't gone well and offered comments from the group. TB added that we do need to be careful on how it is included and NB

	felt we can't single out certain providers but we could include figures on providers and then it is up to the providers to comment on theatres. The group agreed. SM added that there are still changes that need to be addressed and there is a balance and what is the purpose of the report. LW suggested including a link to it and what are our opportunities we have. **Audit Effectiveness review** SM added that all our committees have a review and Lauren has kindly put this together with some recommendations and is happy to take any feedback. SM read through the recommendations and NB felt this a straightforward process and the ToR are statutory. NB asked could Theresa go through all the agendas and categorise what the real balance is and SM will do that. **Action: ACiC065 - SM agreed to discuss this with Theresa.** AS felt it is a valuable piece of work. JWill mentioned that there won't be an Engagement committee going forward and comms NHSE Assessment have gone forward with their report and should it come to Audit Committee around good engagement for the CCG. **Action: ACiC066 - SM is happy to talk to comms about this coming to Audit Committee around good engagement for the CCG.** JMcC referred to item 5.1 on page 202 and to correct the committee attendance as Simon Kerr needs to be included and also Andy Sant. **Action: ACiC067 - SM to ask Governance to update the attendance list.** **Merger Update** SM updated on progress and where we are and included GB transition sub committee and policy review group and support from internal audit and SM offered her thanks. The national team are assured that we are on track. In terms of risk this was around capacity but has now been downgraded to a medium risk and have submitted constitution and governance handbook and formal grant to merger is through but will not be announced formally until 1st April and Simon Tapley is part of that too. SK asked about the voting system for member practices and what are the plans. SM added this was a conversation in Western at a member engagement and one contract one vote is out dated and the membership was can we have a dialogue and wanted to reflect on it. Proper engagement could be talked about in summer and it is an existing contract vote. SM added that there needs to be a conversation across the geography. TB commends everyone who has been involved and workplans have been updated. GB will have authority for the closed down of both CCGs and it will be in public and there will be an audit trail. NB referred to the contracting section – it would be useful to see evidence from Barbara Jones via e-mail. NB would like to see something on payroll and TB added that they have been assured on this and MA confirmed he has been assured that this is included. SM mentioned the change of pay date for SD&T employees and that staff are in agreement and aware. JWill referred to voluntary representatives and has this been looked at and JWill has sent it to Nick Pearson and Clare Doble. **Action: ACiC068 SM asked could JWill send the information regarding voluntary representatives to her so that can ensure this is included.**
5.	**Finance** MA provided an update on the timetable of the accounts and explained that the team are okay to cover and is in line with the year end and merger work is linked in.

	The main accounting policy changes has gone through the process and there will be no changes. There isn't much revenue from contracts and so won't affect the accounts. Financial standing for the merger for the new CCG and this is part of the merger work going forward and will be brought back to Audit Committee in the future. **Review of losses and special payments** There are no new items on the registers for 2018/19 and not expecting any more for year end. It was agreed to write-off the Virgin Care Limited debt.
6.	**External Audit** **a) Agree external audit plans** MB presented the external audit progress report. The interim audit was carried out in January and February 2019. There were no issues arising from most of the interim audit work. The one area where issues were identified were controls around journals. Users shouldn't be able to self-approve journals but there have been instances at SD&T due to the smaller finance team. This is being looked at and it is expected that there will be more capacity in the team going forward following the merger. The final accounts audit will commence on 24th April and the findings from this and the Value for Money (VFM) work will come to the Audit Committee on the 23rd May. SK asked what a journal entry is and Mark explained that it is the way that transactions are entered into the general ledger when they don't come in via a direct feeder system. It is also the mechanism where amounts can be transferred from one code to another within the ledger and main way to correct miscodings. This makes it an area of audit focus as it is a potential way by which internal controls could be overridden and the accounts manipulated. NB asked how do you get invited to a Grant Thornton round table meeting. **Action: ACiC069 - MB and Alex Walling have raised this with Grant Thornton's Regional NHS Lead who is following this up nationally to ensure that clients in the South West, including NHS Devon CCG, are given the opportunity to take part in future round table meetings and similar events.**
7.	**Internal Audit** **1. Internal Audit Update Report** JMcC introduced the report which summarises internal audit activity (including final reports issued, work in progress, and follow-up findings) since the previous ACiC meeting in January. SG presented the detail in the report. One final and one pre-final report had been issued since the January meeting: **Conflicts of Interest – Final Report** SG explained that the pre-final Conflicts of Interest report had been presented to the January meeting and that this final report now includes the completed action plan. No other changes had been made to the report since it was last presented. Management responses in the action plan confirm that all recommendations have been addressed. SK requested that LCFS provide a standard template for recording declarations of interests at meetings (for non-CCG staff/members). **Action: ACiC070 - KF to prepare a template and guidance, and JMcC will share with NB.**

Corporate Governance: Risk Management and Assurance Framework – Pre-Final

SG presented the pre-final report and tabled the completed action plan at the meeting.
A 'Satisfactory' assurance rating was awarded.
In general the CCGs' risk management and assurance framework arrangements are appropriately designed and operate as intended - and a satisfactory audit rating has been awarded.

Two high risk recommendations raised:

- A top down review of strategic level risks against each corporate objective is needed.

- Assurance should be provided to the CCGs' ACiC that STP risk management arrangements are robust and link clearly to risk management arrangements of the statutory organisations within the Devon STP.

Recommendations agreed with SM and action plan completed.

SK commented that an aligned risk management approach across the system is needed in order for it to be effective. SM added that the STP independent chair has asked for a system risk register to be in place and this will look at the system plan and design.

NB commented that the recommendations in the report were very helpful.

Work in Progress

JMcC confirmed that key audit work in progress will be completed before the next ACiC meeting, in support of the delivery of the CCGs' final Head of Internal Audit Opinions for 2018/19, and in accordance with reporting deadlines.

Follow-up

SG presented the follow-up findings. 19 recommendations have been followed-up and of these 16 have been closed (in respect of Quality Assurance Arrangements, IPP Review data, and Plymouth Integration agreements)

3 recommendations remained open and requests were made for extension to deadlines - as follows:

- 2 in respect of updating/improving the CCGs' Quality Assurance Framework

LW: the Quality Team has completed their part of the work and the BI has started doing work on this but it can't be completed until April, due to limited resources.
NB requested that more resources be directed to BI to enable these recommendations to be addressed more quickly.
Action: ACiC071 - LW will find out about additional capacity being put into BI.

- 1 in respect of the need for meetings between the CCGs and providers, to discuss quality and performance openly and in one place.

LW provided further update. LW has had discussions with NHSE and there are already regulator meetings being held and there are weekly quality calls set up and NDHT have been invited to join the call. There is a call with Penny Smith to look at the ToR and to set up local quality surveillance group meetings. LW felt April is a reasonable time but for all providers to be set up would be about 3 months' time. NB commented that it was better for target dates to be realistic and approved the target date being extended by 3 months.

	2. Draft Audit and Assurance Strategy and Plan 2019/20 – 2021/22 JMcC presented the Strategy and Plan for the ACiC's consideration. The plan has been considered by the Executive. Only changes requested are in respect of the Executive leads named against each audit (to be updated following the appointment of the new Board Secretary and the Director of Transformation). These changes will be reflected in the next version of the plan, to be presented to the May AC for final approval. Timing of the proposed STP Strategic Commissioner audit queried by NB. SM commented that the audit will wait for Q4 and should certainly not be sooner than Q2. JMcC to keep in contact with SM regarding timing of the audit. **3. Internal Audit Charter** JMcC presented ASW's updated Charter for the ACiC's information.
8.	**Counter Fraud** **Review Counter Fraud Progress Reports** KF has brought 3 reports to the Audit Committee. Draft Counter Fraud Plan 2019/20 is to provide guidance and to keep the CCG safe and the ensure systems are compliant with the CFA. Risk based approach and to raise awareness to staff and prevent deterrence. Declarations of interest and sickness are what they concentrate on. Appendix A lists key areas and ensure the CCGs' policies meet the CFA standards. **Prevent and Deter** The proactive exercises in areas of risk are included in Appendix B and include Personal Health Budgets, Procurement, Single Waiver Tenders, Supplier Invoices, Delegated Commissioning and Patient Travel Costs. The timing and scope of the reviews will be discussed with the relevant operational managers during the year. **Hold to Account** This is to ensure compliance. NB asked if anyone had any comments. Personal health budgets is an issue and is the money being spent appropriately. Delegated commissioning is being looked at too. JWill referred to the patient travel costs and there is confusion around NHS costs and what can be claimed through benefits and we need to be mindful as it is a complex area. SK asked how will we monitor specifications of work in delegated commissioning and whether there is fraud going on. KF isn't sure of this yet. **Action: ACiC072 - LW explained there is a finance workstream and will take this as an action and will report back for this going forward wef from 1st April.** JMcC felt the Governance arrangements will need to include this. Conflicts of interest will affect a number of committees and LW is aware of this. **Interim report** There have been a couple of changes to the requirements of SRT and there is a requirement of the Chair of the Audit Committee and Chief Finance Officer to review. The date has been

	extended by one month. Counter Fraud newsletter includes a £700,000 procurement fraud (copies handed out). **Fraud Awareness** Presentations have been delivered to staff in the Nursing and Quality Directorate and staff have been asked to complete questionnaires. The responses will be added to Counter Fraud's database to use them to measure staff awareness of fraud, bribery and corruption policy etc and there will be an update at the next Audit Committee in May. KF read through the rest of the report and touched on the fraud alert, NHS Counter Fraud which was on the television on the BBC. **Prevent and Deter** Counter Fraud have conducted an exercise on the Independently Placed Person and this has been a challenging piece of work. **Hold to Account** There have no further reports of fraud or bribery referrals since the last Audit Committee and continue to receive calls from GP surgeries seeking advice around multi-registration and drug seeking issues of patients. **Anti-Fraud and Bribery policy** KF has sent this to the CFO and it provides a guide for employees and how to report a concern. **Action: ACiC073 – KF agreed to amend:** - **Contents page mentions NEWD Devon and Counter Fraud and 3.1 what is the abbreviation.** - **Point 6 chief operating officer and meant Chief Execs.**
9.	**Draft Agenda for the next meeting on 8th May 2019** Noted. **Action: ACiC074 - The membership table will need to be updated as membership will possibly change. AFF to discuss with Governance Team.**
10.	**Forward Planner** Noted.
11.	**Points to raise with Governing Body** Nothing to raise.
12.	**Any other business** **Action: ACiC075 - NB would like the exec attendance to be looked at and SM agreed to look at this.** JWill dialled into the meeting but found it a bit difficult to hear people. BM referred to the move to CH and suggested using the video conferencing facilities as we need to be more professional.

	EU Exit SM wanted to provide an update on EU exit preparations and a briefing note was circulated to the committee members. NHSE has set up an operational response centre which will lead on responding to any disruption to the health and care services. Priority areas have been identified and are listed in the paper. The first 4 are of a high priority. Some medicines are running low and short shelf life of some medicines – there would be an immediate escalation and discussions have been raised. A self-assessment has been included in the papers and it is ongoing and the exec team are sighted. SK said there is a shortage of some medical supplies in primary care ie eardrops and SM asked that this be escalated and reported through the meds team (John Finn) is aware. RB asked for a CCG wide directive to all practices. **Action: ACiC076 - SM will pick this up with the meds team.** SM wanted to give assurance to the committee around reporting of this. NB thanked members of the committee and particularly to those who will be standing down (Jennie Willmott, Chris Peach, Chris Hanvey. Rob Bromige is waiting for direction). The meeting closed at 4.25pm.
13.	**Discussion with internal and external audit** None.

Attendees (attended* / apologies A)	
Name and initials	*Title and organisation*
*(NB) Nick Ball (Chair) **	*Non-Executive Director – Finance & Governance (Both CCGs)*
*(MB) Mark Bartlett **	*Audit Manager, Grant Thornton*
(DB) Derek Blackford A	*Deputy Chief Finance Officer (SD&T CCG)*
*(RB) Dr Rob Bromige **	*Non-Executive Director, Clinical Lead*
(TB) Dr Tim Burke *	*Chairman (NEW Devon CCG)*
(GC) Gilly Champion A	*GP Vice-Chair, Eastern Locality (NEW Devon CCG)*
(LCB) Lorna Collingwood-Burke A	*Chief Nursing Officer (Both CCGs)*
(CD) Clare Doble A	*Head of Governance (Both CCGs)*
(JD) John Dowell A	*Director of Finance (Both CCGs)*
*(AFF) Andrea Fairclough **	*Minute Taker (NEWD CCG)*
*(KF) Kevin Forrest **	*Counter Fraud Officer, Counter Fraud*
*(SG) Sam Gingell **	*Audit Manager, Audit South West*
(CH) Chris Hanvey A	*Non-Executive Director – Safeguarding (NEWD CCG)*
*(SK) Simon Kerr **	*GP Chair, Eastern Locality (NEW Devon CCG)*
(PJ) Dr Paul Johnson A	*Chairman (SD&T CCG)*
(RL) Rob Loader A	*Deputy Director of Internal Audit, Audit South West*
*(BM) Brian Mackness **	*Non-Executive Director – Assurance (SD&T CCG)*
*(SM) Dr Sonja Manton **	*Director of Strategy (Both CCGs)*
*(JMC) Jenny McCall **	*Director of Internal Audit, Audit South West*
(JM) John Micklewright A	*Counter Fraud Specialist, Counter Fraud*
(CP) Chris Peach *	*Non-Executive Director, Patient & Public Engagement (SD&T)*
*(AS) Andy Sant **	*Clinical Commissioning Lead for Mental Health & Children's Services, (NEWD CCG)*
(AWL) Alex Walling A	*Director External Audit, Grant Thornton*
(LW) Lorraine Webber * (on behalf of LCB)	*Associate Chief Nursing Officer (SD&T CCG)*
(KW) Kevin Wheller A	*N&E PDU, Chief Finance Officer (NEWD CCG)*
(JWi) Jennie Willmott *	*Non-Executive Director, Patient & Public Engagement (NEWD)*

(JWo) Dr John Womersley [A]	*GP Chair, Northern Locality*

Minutes approved	Date:	Signed by chair:

NHS
Devon
Clinical Commissioning Group

FINANCE & PERFORMANCE COMMITTEE
MINUTES

Date: Thursday 18th April 2019

Time: 0930 - 1300

Location: Otter Room, County Hall, Exeter

Item	Discussion	*Action*	*Decision taken by Organisation*
1	**Welcome & apologies** BM welcomed all to the first NHS Devon CCG Finance & Performance Committee. Apologies from Sonja Manton (John Finn deputising), Paul Johnson, Lorna Collingwood-Burke (Simon Polak deputising), Jo Turl, Simon Tapley.		
2	**Declaration of Interest** No new declarations.		
3	**Approval of previous minutes on 21st March 2019** – the minutes were approved as an accurate record of the previous meeting. **Review & update action log** FCiC214 – JD updated the committee regarding the T&SDFT finance report as discussed at last month's meeting. This was relating to a deteriorating financial position at Torbay & South Devon in 2018/19, which has an impact on the CCG because of the relationship through the multi-contract risk share agreement. As part of the governance around this, the Finance committee had asked to see some explanation and assurance. A request was sent to T&SDFT to share their finance committee report with the CCG. This report has been shared with this committee. An agreement has been settled between the Trust and the CCG regarding the final contribution of what the risk share was. A further independent examination has been done of the bridge from the previously reported position to the outturn position and the 18/19 outturn position into what has gone into their plan for 19/20. There is much more understanding and clarity now; although a solution to this problem for this organisation hasn't been found. NB questioned a difference from the internal messaging to external messaging regarding this matter. JD confirmed that in the reported position stated the control total would be achieved and that there was always an acknowledged risk of achievement to that of £5.9m. Within this the Trust had a total savings programme requirement and that they had identified schemes to deliver the savings requirement, but they were still £5.9m short. As the year played out this was an acknowledged risk but with a full		

	commitment to identify other saving programme schemes. As part of the movement that happened, the acknowledged risk was being worked on, although no saving programme schemes have been found and therefore it was moved as a risk to a fact, which deteriorated the financial position further. Also, there was further deterioration which was partly due to loss of PSF and partly to do with increasing costs following the closure of theatres and some escalation around social care and continuing care costs. NB stated that the theatre issues were known at month 2 and the social care and continuing care costs have been known all year. This matter needs to be discussed at the GB meeting and BM felt that discussion is required at a Board to Board level. JD recommended that a regular update should be included in the finance report on the performance of Torbay & South Devon Foundation Trust.		
4	**Risk Register report** The Director of Finance presented on this item. The report summarises 11 risks that are currently assigned to this committee for management and are set out on page 25 onwards of the report. Section 3 of the report confirms that there has been no movement in risk scores between this month and last month. Section 4 recommends two risks for closure that the committee were asked to approve i.e. risk numbers 13 and 5. The recommendation to close these two risks was approved by the committee. A discussion was held regarding the type of risks on the register for this committee and how the committee can influence the risks, which was raised as a concern by JW that risks are being managed effectively. JF assured the committee that the CCG has a robust input to actively manage performance risks, although the contractual levers are no longer available, as they were in the past. The Board Secretary declared that the risk report does need reviewing and it needs to be more robust with updates. JF offered to look at some of the operational risks with the new Board Secretary, Ginny Snaith, as it is felt that they sit on the wrong committee risk register. JD reminded the committee that the correct process must be adhered to if any risks are moved from this register to another one. Section 5 confirms that no new risks were assigned to this committee.		
5	**Monthly Finance report** The Associate Director of Finance (Northern & Western) presented on this item. There is no paper report this month due to the timing of the data being available and the date of the committee. KW confirmed that the ledger has been closed and that the team are in the process of producing working papers. The formal set of accounts are due to be submitted to the auditors on Tuesday morning. The auditors will be present for three weeks from 24th April 2019 and will hopefully conclude their audit process and signing off, of the accounts by 29th May 2019. The CCG's have closed their books and both CCG's show a balanced position and will receive the full commissioner sustainability fund (CSF). There have been no major changes between month 11 and month 12 in terms of performance. KW highlighted the following items for NEW Devon CCG. ➢ Taunton & Somerset overspend has been eliminated by year-end, so the activity has decreased in the last couple of months. ➢ Prescribing for NEW Devon is relatively static.		

	KW highlighted the following items for South Devon & Torbay CCG. ➢ Balanced position the movement on placements was slightly worse i.e. CHC managed through the Trust. ➢ Improvements in prescribing for SD&T CCG. The above were the main movements in month 12. The finance team are in the process of producing the working papers and drafting the main parts of the accounts.		
6	**Governing Body Quality & Performance report** The Associate Director of Commissioning (Western) presented on this item and highlighted the following: ➢ Urgent Care continues to be very challenging particularly with UHP and T&SDFT. RD&E's position has strengthened and have maintained their performance in the last month and continues to be very stable. The NDHT position is deteriorating, which is reflective with the number of Opal 3's they have had in the last month. UHP is slightly deteriorating but in terms of assurance their preparations for Easter in the last week or so have been very positive. T&SDFT have improved over the last month following the intervention with the executive level by the CCG, in terms of the daily gold telephone calls has had some effect. ➢ SWAST – there was very good performance in the last month. There are still some handover delays at T&SDFT. ➢ 111 (out of hours) – there are still issues with the sub-contracting arrangements that Devon Doctors have. A paper to confirm or not the CCG's support for these changes is going through the CCG commissioning process. An update should be available on this at the next Finance & Performance Committee. The additional funding going to Devon Doctors is contained within the first quarter and JF requested for this to be noted by the Finance & Performance Committee. ➢ Cancer performance - the cancer standards are stable. Our standard performance for quality is still rated as outstanding across the country. Our diagnostic rates are very good. The national performance standard particularly around the 62-day standard is still one of the worst in the country. The main issue is a referral growth in urology, which has been 15% above the national average in the last 18 months. This has now stabilised. There is a prediction that all the Trusts will achieve the national standard except RD&E by the end of the financial year. ➢ RTT – the performance has slightly declined. It is planned to reduce the size of our waiting lists and this is the prime focus for the operating plan this year, as per NHSE and NHSI. ➢ 52ww's – by using a process through DRSS and our own internal CCG processes, the provider's target has been achieved in three out of the four STP providers. Feedback from both regulators has been positive. ➢ Diagnostics – there has been movement from 15.3% to 11.9%, it is hoped that the final figures of the year will show this below 10%. There has been a considerable amount of work to prevent scans being duplicated unnecessarily if a patient is seen by a different provider than the original one.		

	NB wished to thank JF and his team for the achievement of consultants from different Trusts to not repeat an MRI scan when seen by different consultants across the area. ➢ DTOC's – this is improving, although RD&E are recording this differently to other Trusts. JF has been assured that all Trusts will be recording this in the same way in this financial year. ➢ IPT's – the target has broadly been met. There is still an issue with the dementia diagnostic rate, where little progress has been made in the last year. This is a high priority with the regulators at the System Performance Group. This will need monitoring closely.		
7	**STP Finance report** The Director of Finance presented on this item. The report included in the pack is up to the end of month 11 for the system, as month 12 needs to go through governance with partners at the Finance Working Group meeting this afternoon. JD is expecting the month 12 position to have little change to month 11 in aggregate. The overall system plan was for an agreed deficit with NHSE and NHSI of £61m without sustainability fund, falling to just below £30m with receipt of sustainability fund. This does not include the £25m of commissioner sustainability fund, previously referred to under agenda item 5 by KW. This is because it was never part of the agreed success regime recovery trajectory as commissioner sustainability fund didn't exist when this was agreed, therefore it is excluded for that purpose. It doesn't change the CCG position. Since quarter 2 it has been reported that the system will fall short of that plan by about £20m, so against the plan of £60m deficit before the sustainability funds, it was forecast that the CCG's would outturn at around £80m and the pressure was manifesting in UHP and NDHT. This has been influenced from quarter 3 by the T&SDFT position. The CCG moved off plan at quarter 2 and have been fairly consistent with this ever since. The overall deficit for the system will be £81m, before the receipt of sustainability funds, falling to about £64m after the receipt of sustainability funds. For completeness, the CCG position would reduce this by a further £25m because of the commissioner sustainability fund. Within this overall position the CCG has delivered it's plan and its part of the overall position. In order, to get to this albeit short of the CCG's aspiration, the CCG started out with a requirement of aggregate savings of £151m and the CCG would have delivered savings and efficiencies across the system of £127m or thereabouts, within this year. There is a large amount being delivered, although the issue is that quite a lot of this will be non-recurrent savings. Recurrent savings are forecast to underachieve, and this will have a significant impact in 19/20. The demand and capacity in the system shows referral demand across 18/19 has increased by about 4.4% for NEW Devon CCG and 1.9% SD&T CCG. Within this the overall aggregate figure is significantly impacted by a small number of specialties, where growth has been seen and in some cases in excess of 20%. This has been a significant issue this year and is also significantly impacting on the capacity planning for 19/20. In terms of mental health services and the use of out of area beds has been stabilising and falling but remains reasonably high; with the amount of capacity out of area that is being used for patients on a short-term basis. This remains a key area of focus for 19/20.		

	JW questioned how NDHT demand and capacity planning was going to be done for this year, as NDHT have over-estimated in the past. JD assured the group that NDHT followed a similar process to all the other Trusts. This is a three-year average referral demand model and the Trust takes that demand, to work out what capacity is needed to put in place to deliver a certain performance outcome.		
8	**19/20 Operational Planning** The Associate Director of Finance (South) presented on this item. Apologies were given that a finance planning budget setting paper has not been provided at today's meeting, as originally intended. A power point presentation was shared with the committee. The two CCG's received their allocation separately, even though a plan was submitted for the combined NHS Devon CCG. Devon CCG running costs reduction comes into effect in 2020/21. The first submission for the CCG on 12th February; followed by the system plan on the 19th February. The final submission was on the 4th April and the system submission was on 11th April. The CCG set their control total of break-even for 19/20. The system set their control total of £43m for 19/20. Both submissions of the CCG's financial plan to date maintain the 18/19 position, i.e. a combined £25m deficit. The original allocations didn't include the addition of delegated primary care to the plan, although now they are included. Presently, the plans submitted achieves the required mental health investment standard of 6.1% and sets aside the 0.5% contingency as required. The CCG's plan contains a savings requirement of almost £34m. There is still a requirement to deliver, as have previously, £6m from non-recurrent means or by developing other schemes and a further £4m from taking advantage of opportunities from benchmark etc. This risk has been estimated at around £13m in the submission of the plan. JD assured the group that through this committee the team will be shaping up the financial framework that the CCG will do their best to adhere to, which means that changes will have to be implemented. JD updated the group regarding governance that the committee need to be made aware of. As the CCG are not in a compliant position, as well as the wider system not being compliant due to the control total not being achieved, the system is in escalation. Therefore, from a system perspective, discussion meetings with regional finance directors will take place next Tuesday and with the regional general managers on Wednesday. This is a system problem and as such the CCG is one part of the system. The CCG need to respond to the regulators regarding how to improve the current £25m deficit position. There are several ways to improve this position, although the CCG can only save money if it is not given to the provider sector. The committee were asked to note the acknowledgement that the system is in escalation and having to respond to the challenge set for the CCG, but to put this into the system context. JD also noted that the committee would be pushing to change something from the current service model rather than taking out our change investment. Barbara Jones joined the meeting at 11.35am		

9	**Clinical Effectiveness Review** The Chair of the committee presented on this item. Some recommendations are shown in this review. GS stated that Lauren Wellington, who works in the governance team, is doing a piece of work looking at all the committee clinical effectiveness reviews and is putting a process in place to ensure that the recommendations are implemented. The clinical effectiveness review was approved by the committee.		
10	**Contract Status updates – Novation inclusive of section 75 & Annual Procurement report** The Head of Contracting presented on this item. The report in the pack is for information only. It sets out a brief summary of what the contracting team are doing and what is on the workplan for next year. BJ highlighted the following points: ➢ Last year was a difficult year for the contracting team as part of the restructure, the team reduced in size by up to 30% and have been carrying vacancies up to half of the team, whilst going through the last six months post re-organisation phase. As of today, there are only two vacancies, of which one has been appointed to today. ➢ Over the last year the biggest contractual issue was the changing in Children's services. There is a level of complexity with different elements of the service being hived off, as well as a big arrangement of multi-providers in the main Alliance contract. ➢ The team were supporting the planned care workstream, as well as some urgent care. In the urgent care particularly around the extending contracts with the minor injuries unit and needing to support the re-procurement of out of hospital urgent care. ➢ Á new audiology service has been procured for the Eastern part of Devon. ➢ In March, work took place regarding novating contracts that weren't expiring at the end of March, so that contracts previously held with NEW Devon CCG or SD&T CCG were merged and novated across to Devon CCG. This has been an administrative nightmare; although a straight forward contractual issue. It has been necessary to undertake National variation agreements for all these contracts and BJ wished to thank GP colleagues with their support with this. ➢ The issuing of many of the 19/20 contracts hasn't been progressed, due to waiting for the main contracts to have their agreement contract values. ➢ There are several providers, particularly the hospices who are unwilling to sign on a flat-cash / no inflationary increase, as they are having staffing issues. The hospices haven't been given any funding support of costs for agenda for change. The hospices don't pay according to agenda for change, although if they don't offer matched salaries they will be unable to recruit. They also do not receive any funding support, as they don't pay on agenda for change, but they have been faced with increases. BJ is concerned that if increases in grants for the hospices are not issued, then this will have a catastrophic effect on the hospice's future. ➢ The team are trying to improve the way that contracts are managed in compliance with procurement law. An approach has been re-invigorated to using single action waivers, as the mechanism of		

	awarding contracts that haven't gone through a competitive procurement process. ➢ There has been revised guidance regarding CQIN, as the value has been reduced to 1.25%. ➢ The delegation of Primary Care contract is being reviewed. The contracting team has also taken on the oversight of all the CCG's non-clinical contracts. ➢ Part of the NHS long-term plan is a proposal for possible changes to legislation, specifically in relation to procurement. The contracting team have asked for clarity on these changes for non-NHS contracts. ➢ Single Action waivers currently undertaken are in the appendices. ➢ An annual procurement report from the CSU is also in the pack for information only. BJ left the meeting at 12.05pm.		
11	**Delegated Primary Care** The Associate Director of Finance (Western) presented on this item. Delegation of Primary Care was taken on from 1st April 2019 and is an additional £165m of budget and resource. Generally, the management of this will go through the primary care committee. Although given the size of the new allocation a brief update is being presented to this committee to set a bit of context in terms of allocations versus budgets and the general level of financial risk that will come with this. In terms of the overall context of £762m, the budget that the CCG was working to in 18/19 was £151m, this had to reduce significantly by about £11m. Part of the reason for not working towards delegated primary care previously is the level of risk that it brings with it. £2.8m emergency framework contracts and £851k of exceptional premises are additional allocations that have been agreed by NHSE for 19/20 to give the CCG a balanced budget at the start. BC expects a budget of £165m and currently the budget as set including contingency is £164m and therefore there is still headroom of £1.4m plus contingency of £800k. This is not a significant amount in terms of variability and risk within primary care. JD assured that this information was shared with this committee from a governance point of view for information only and will be included in the monthly finance report. This item will be discussed in more detail at the Primary Care committee.		
12	**Finance & Performance Committee ToR's** GS confirmed that the ToR's at present are likely to stand, apart from one change on the membership, which is that the Clinical Chair will be removed as a member. BM felt that the Clinical Chair should be able to attend any of the sub-committees even though they are not listed as a member. JW felt that the ToR's for this committee were very broad and not specific enough. The terms of reference were acknowledged by this committee.		
13	**Commissioning – service risks & issues** JF raised an issue regarding the process for mutual aid provision through the STP system and a previous issue regarding a stroke consultant for NDHT.		

	There is a similar issue with a cardiologist at RD&E who are requesting mutual aid from other providers and the independent sector.		
14	**Risk Register Review** No new risks added.		
15	**Forward Planner** The forward planner was noted by the committee.		
16	**AOB** None.		

Meeting closed at 12.35pm

Attendees (attended** / apologies [A])	
Name and initials	*Title and organisation*
Brain Mackness (BM) Chair**	Non-Executive Director, Finance
John Dowell (JD)**	Director of Finance
Nick Ball (NB)**	Non-Executive Director, Finance & Probity
John Womersley (JW)**	GP Chair, Northern Locality
Ginny Snaith (GS)**	Board Secretary
Ben Chilcott (BC)**	Associate Director of Finance (Western)
Kevin Wheller (KW)**	Associate Director of Finance (Northern & Eastern)
David Greenwell (DG)**	GP, Clinical Lead
Derek Blackford (DB)**	Associate Director of Finance (Southern)
Simon Polak (SP)**	Associate Chief Nursing Officer (Northern & Eastern)
Sharron Cox (SC)** Minute taker	Business Manager/PA to Director of Finance
John Finn (JF)**	Associate Director of Commissioning (Northern & Eastern)
Barbara Jones (BJ)** agenda item 10 only	Head of Contracting

In Attendance	
David Mehaffey – to observe the meeting	PA Consulting Group