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

via MS Teams (refer to formal invitation for link to join)

24 September 2020 14:00 - 24 September 2020 17:00

AGENDA

#	Description	Owner	Time
1	Patient Experience Speakers	Non-Exec Lay Member Public and Patient Involvement	14:00
2	Welcome and Apologies Verbal	Chair	14:15
3	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 202009... 5	Chair	14:20
4	Minutes of last meeting and action log Paper 1 Draft PUBLIC GB minutes 27.08.2020 v2.docx 10 2 Master Action Log - PUBLIC v2 nc.xlsx 23	Chair	14:25
5	Chair's Report Paper 1 cover sheet chair's report.docx 25 2 Chairs Report September 2020.docx 27	Chair	14:30
6	Accountable Officer's Report Paper NHS Devon CCG - Governing Body - 24 Septembe... 28	Accountable Officer	14:40
7	PROGRAMMES OF WORK		14:50
7.10	Integrated Care System Governance Paper ICS Governance Cover Sheet.docx 33 ICS Structure and Governance Paper (PB approve... 35 Shadow ICS Structure (Final draft) for circulation.pp... 46	Chair/ Accountable Officer	

#	Description		Owner	Time
7.20	BREAK			15:10
8	FINANCE, PERFORMANCE AND QUALITY			15:25
8.10	Month 5 Finance Report Paper 1 FPC_Report_FPC_Month 5_FINAL_2020-21 (GB... 2 FPC_Report_FPC_Month 5_DRAFT_2020-21 (G...	 50 53	Finance Director	
8.20	Performance and Quality Report Paper Public Governing Body Performance 24092020.doc...	 70	Chief Operating Officer/ Chief Nurse	
8.30	BREAK			
9	COMMITTEE CHAIR'S REPORTS			16:00
9.10	Audit Committee (including risk register) 1 Audit Committee Chair Report 09.09.20.docx 4a Appendix 1 Audit Committee Risks 25 Aug 202... 4a Appendix 2 Corporate Risk Register - Significant... 4a Appendix 3 COVID 19 Risk Transfer Summary.... 4a Audit Commitee Risk Report 09 September v1.d... 5b DRAFT Standards of Business conduct policy v2... 5c NHS Devon CCG Use of Seal register.docx 5d Use of the seal Sept 2020cd.docx	 93 96 99 106 111 118 148 149	Chair of Audit Committee	
9.20	Commissioning Committee Paper September GB - Commissioning Committee Report...	 152	Secondary Care Doctor	
9.30	Finance Committee Paper Finance Committee Chair Report 17 Septembert 2...	 154	Chair of Finance Committee	

#	Description		Owner	Time
9.40	Primary Care Commissioning Committee Paper [P] Committee Chair Report - Public PCC - September...	157	Chair of Primary Care Commissioning Committee	
9.50	Quality Assurance Committee Paper [P] QAC Part 1 Chair Report September 2020 V2.docx	159	Chair of Quality Assurance Committee	
10	LOCALITY UPDATES			16:30
10.10	Northern, Eastern, Southern and Western Paper [P] 0 Locality Updates Cover Sheet.docx [P] 1 Northern Locality Report September 2020V2 Fina... [P] 2 Locality Update Report - Eastern September 202... [P] 3 South Locality Update Report September 2020 v2... [P] 4 WL Update Report - September 2020.docx	168 170 173 176 179	Locality Triumvirate	

Declaration of Interests Register - Governing Body

Register updated and generated by the Governance Team - 10 September 2020

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Allcorn	Darryn	Chief Nursing Officer Caldicott Guardian	Member of Governing Body Member of Quality Assurance Committee Senior Leadership Team (SLT) CCG Executive Team Meeting Member of Devon JCEG Commissioning Committee (CC DOI) Member of Audit Committee	Honorary Associate Professor University of Exeter Seconded to NDHT (to 18 September 2020) Strategic Chief Nurse, Nightingale Hospital Exeter System Chief Nurse, Devon STP		11/05/2020		27/08/2020	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Appleby	Gaynor	Non Executive Lay Member (Allied Health Professional)	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee (PCCC) Member of Remuneration and Workforce Committee	CQC Specialist Advisor Therapy Lead for Health and Social Care for North Devon		01/11/2019		05/05/2020	Non Financial	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Atherton	Glynis	Non Executive Lay Member- Quality Geographical remit - Eastern	Member of Governing Body Member Quality Assurance Committee (Chair) Member Primary Care Commissioning Committee (PCCC) Member of Remuneration and Workforce Committee	Consultancy for FORCE cancer charity – not CCG funded but has a relationship with RD&E hospital Trustee for St. Margaret's Hospice, Somerset Volunteer for Hospiscare, Exeter – helping at events and proof reading applications to charitable trusts Volunteer for University of Exeter – mentoring students Member of the Labour party Member of the Devon Ethical Reference Group		14/05/2019		01/09/2020	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geographical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 , Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		10/05/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Blackford	Derek	Deputy Chief Finance Officer	Attendee of Audit Committee (Deputy for CFO) Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Member of Vacancy Control Panel	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Non Executive Lay Member - Patient and Public Involvement Geographical remit - Northern	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Member Primary Care Commissioning Committee (PCCC)	Self-Employment business consultant from September 2019 Associate for Research In Practice Feb 2020 Associate for Research In Practice Supplier/Associate for SWAHSN (Feb 2020) Within my role as SWAHSN associate will be part of their project team which is supporting the Think 111 project Associate for Devon Communities Together		04/04/2019		04/08/2020	Financial/Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Carroll	Jayne	Interim Chief Operating Officer	Member Governing Body Member of Senior Leadership Team (SLT) Member of Integrated Commissioning Executive (ICE) Commissioning Committee (CC DOI) Finance & Performance Committee Urgent Care Board	Independent member of Fostering Panel for Pathway Care.		08/08/2020		08/08/2020	Professional	Indirect		NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt	Partner is employed by Livewell Southwest in position of influence	26/09/2017		15/10/2018	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

	Coles	Anna	Director of Integrated Commissioning Seconded to CCG to Associate Director of Commissioning (Western)	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019	12/03/2019				Plymouth City Council
	Davis	Alison	Associate Non-Executive Lay Member	Attendee Governing Body	Plymouth City Council – Foster panel Chair Torbay Council- Foster panel Chair Pathway Care Fostering- Ashburton- Independent Reviewing Officer University of Exeter – student mentor Somerset County Council- casual employee		19/10/2019	19/10/2019	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015				Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Doble	Clare	Head of Governance Deputy Senior Information Risk Owner (SIRO)	Attendee of Audit Committee Quality Assurance Committee Primary Care Commissioning Committee (PCCC) Governing Body (ad hoc) Health and Safety Group Chair Staff Partnership Forum Data Protection Steering Group	Member of Taunton & Somerset NHS Foundation Trust Godmother to member of governance team's daughter	Partner on secondment to CCG Business Intelligence Team	22/08/2017	21/08/2020	Non-Financial Personal Interest	Indirect/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
	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Member of Primary Care Commissioning Committee (PCCC) Strategic Commissioning Programme Board Commissioning Committee (CC DOI)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	19/06/2018	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body A & E Delivery Board (SD&T)	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher GP Locality Clinical Director Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	28/07/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay and South Devon NHS Foundation Trust
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration and Workforce Committee(Non exec rem) Member of Devon JCEG	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	08/11/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Hargadon	Judy	Non Executive Lay Member - Primary Care and Prevention Geograhical remit - Southern	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) (Chair) Member of Remuneration and Workforce Committee		Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	10/03/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Harrell	Ruth	Director of Public Health, Plymouth City Council	Devon STP Clinical & Professional cabinet NHS Devon CCG Governing Body Member of Devon JCEG	Director of Public Health for Local Authority		26/10/2016	18/08/2020	General	Direct		Plymouth City Council
	Harris	Penny	Management Consultant	Attendee of Governing Body Senior Leadership Team (SLT) Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Finance and Perfomance Committee Strategic Commissioning Programme Board Commissioning Committee (CC DOI) R&T System Management Group	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training Director of Kerr Mediation ltd - working alongside LMC law taking on primary care mediations commissioned by the LMC.		23/07/2019	04/08/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	KERR Darnley Ltd

Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body (Chair) Member of Remuneration and Workforce Committee Transition Sub Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	GP Partner, Cricketfield Surgery (ceased December 2019) Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Clinical Chair NHS Devon CCG 1 March 2017 Church Warden Holy Trinity Church Spouse works in emergency department at RDE and for Exeter Medical School Primary Care Network - Templar Care Network		21/08/2015	04/10/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kennedy	Nick	NHS Devon CCG Governing Body Secondary Care Clinician	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) QEIA Panel Member of Audit Committee Member of Devon JCEG Commissioning Committee (CC DOI) Member of Devon Clinical Cabinet R&T System Management Group	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 national Independent Funding Request Panel NHS England Non-Executive Director GO-OP, GO-OP is a Multistakeholder Co-operative Society (Somerset Rules), registered under the Co-operative and Community Benefit Societies Acts. GO-OPGO-OP will be the UK's first co-operatively owned and run Train Operating Company Introduced PPE supplier (Orthofix International) to Devon CCG. Company part owned by my cousin Non-Executive Director of a start up limited company called LinkExec, an online business aimed at promoting start up businesses and investors. April 2020		26/09/2017	14/08/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Member of Integrated Commissioning Executive (ICE) Attendee Remuneration and Workforce Committee Attendee of Audit Committee Member Strategic Commissioning Programme Board Commissioning Committee (CC DOI)	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Lees	Sarah	Representative of Director of Public Health for Plymouth City Council	Member of Governing Body (Deputy) Member of Primary Care Commissioning Committee (PCCC)	School Governor, College Road Primary School, Plymouth	Husband is an employee of Livewell Southwest	10/11/2017		Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Manton	Sonja	Director of Strategy Interim Director of Commissioning. Northern, Eastern and South Devon and Torbay	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Transition Sub Committee Senior Leadership Team (SLT) Member of Quality Assurance Committee Attendee Audit Committee Member of Devon JCEG	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit from 1st Nov 2018	03/04/2017	09/10/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Governing Body Clinical Lead – Western Locality Chair of Western Primary Care Partnership	Member of Governing Body Member of Quality Assurance Committee Clinical Cabinet QEIA Panel STP Collaborative Board Remuneration and Workforce Committee (Non exec rem) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG)	Elected member, South West Regional Council of BMA Occasional Locum (self-employed) at Access Health Ltd Plymouth. GP Appraiser (NHS England) Working at Church View Surgery as self-employed sessional GP Elected to the Medical managers Committee of the BMA from September 2019	Partner is Medical Secretary and Board member of Devon LMC Partner is GP Partner, Church View Surgery, Plymstock Partner is Clinical Director of Mewstone Primary care Network(PCN)	26/09/2017	25/09/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Director of Communications and HR functions NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	04/03/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

Dr	Pearson	Virginia	Chief Officer for Communities, Public Health, Environment and Prosperity/Director of Public Health, Devon County Council System Director of Population Health and Wellbeing, Devon STP	Co-opted Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Member of Integrated Commissioning Executive (ICE) Strategic Commissioning Programme Board	Member, STP Directors Group Member, STP Programme Delivery Executive Group Member, Devon Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Association of Directors of Public Health Member, British Medical Association Honorary Clinical Professor, University of Exeter College of Medicine and Health		02/02/2017	22/04/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council
	Pearson	Nick	Head of Communications and engagement	Senior Leadership Team (SLT) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for Director of Communications)	Member of the Labour Party Member of the Exeter City Supporters Trust	Spouse is owner of Pearson Creative	13/01/2017	14/08/2019	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. Will not be commissioned by employee	NHS Devon CCG
	Quartermaine	Jade	Senior Administrator	Administrative support to: CCG Senior Leadership Team (SLT) Exec Team Meeting Governing Body	No interests declared		01/08/2016	20/08/2020				NHS Devon CCG
	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee of Quality Assurance Committee Attendee of Finance and Performance Committee Attendee of Audit Committee Attendee of Remuneration and Workforce Committee Attendee of Commissioning Committee (CC DOI) Attendee of Primary Care Commissioning Commitee (PCCC) CCG Executive Team Meeting Senior Leadership Team (SLT) Working with Industry and Sponsorship Group R&T System Management Group Member of Integrated Commissioning Executive (ICE)	No interests declared		22/03/2019	10/08/2020				NHS Devon CCG
	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Attendee of Remuneration and Workforce Committee Strategic Commissioning Programme Board	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	07/09/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	Associate Director of HR and OD	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel CCG R&T Project Team meeting	No interests declared			16/10/2018				NHS Devon CCG
	Turl	Jo	Director of Commissioning - Western	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Quality Assurance Committee	No interests declared		13/08/2015	03/09/2019	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

	Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee (Chair)	Co-opted Councillor on Budleigh Salterton Town Council (Independent Member – non-political)	Son employed by Care Quality Commission as an Information Analyst	16/10/2019	26/11/2019	Indirect interest		Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Wheller	Kevin	Locality Chief Finance Officer (Northern & Eastern)	Attendee of Audit Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Northern and Eastern Preparatory Group Working with Industry and Sponsorship Group CCG R&T Project Team meeting		Spouse is employed as a finance manager at Castle Place Surgery in Tiverton. The Surgery is operated by the Royal Devon & Exeter NHS FT	22/10/2015	25/01/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (Non exec rem) Northern and Eastern Preparatory Group Northern Integrated Delivery Group Meeting	General Practitioner at Coombe Coastal Practice in Ilfracombe (ended 10/09/2017) Member of Royal College of General Practitioners Director of One Ilfracombe Our Place Programme Chair of One Northern Devon		14/02/2017	31/01/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Wooldridge	James	Associate Non Executive Lay Member	Attendee Governing Body	Managing Director of Recovery Devon CIC which is directly funded by Devon Partnership NHS Trust (DPNHST) Proprietor of Positive Notions. A private consultancy providing mental health training services to various organisations including but not limited to: DPNHST, University of Exeter, University of Plymouth, Livewell Southwest There may be an increased reputational benefit to my Positive Notions consultancy through membership of Devon CCG. I will advocate for various mental health groups and organisations including Recovery Devon CIC, that may be in receipt of commissioned funding from Devon CCG In receipt of individually funded treatment My general interest lies in mental health, wellbeing and recovery. I intend advocating for groups and organisations that adopt and demonstrate the values and principles associated with the recovery approach		28/10/2019	28/10/2019	Financial /non Financial Professional Interests/ General	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting
DRAFT minutes held in PUBLIC

Date: 27 August 2020 Time: 14:00 – 17:00 Location: Via Microsoft Office Teams

Item	Discussion	*Action*
1	**Welcome and Apologies** NB welcomed everyone to the meeting and explained that as a result of COVID-19 this meeting is held virtually and is recorded for members of the public. Apologies are noted as follows: PH, AM (PT attending on his behalf), PJ (NB chairing on his behalf), JWo and PK.	
2	**Patient Experience** CB introduced Eleanor Taylor (ET) who has kindly agreed to join the CCG Governing Body meeting today to talk about her personal experiences alongside Dr Stuart Kyle (StK), consultant rheumatologist at Northern Devon Healthcare NHS Trust (NDHT). CB thanked ET and StK for their time today. ET shared a personal story about her condition and her experience with having remote appointments. ET is 34 years old and was diagnosed 12 years ago with psoriatic arthritis and StK has been responsible for most of her treatment. ET was invited to be part of a trial to test out the use of remote appointments and she found this extremely convenient and easy to use. ET explained how this works, where patients are entered into a virtual waiting room following a simple link. ET noted this method of appointment has enabled her to save a considerable amount of time, as previously due to traffic it could take up to 3 hours to get to and from her appointments, which had an impact on her caring commitments. StK acknowledged the exceptional response as a medical workforce to COVID-19 and in particular the capability of utilising the digital platform in a variety of different areas. Remote consultation can work well in a number of circumstances, for example where the patient knows their condition well and is engaged in their healthcare. StK noted that through his own experience he has found video consultation to be more useful than telephone, although both are helpful methods of communication when appropriately used. This is because seeing a patient can also allow a clinician to pick up on other areas where a telephone conversation may not prompt this. CB asked StK if the use of remote appointments has had an impact on non-attendance. StK responded that this does seem to have worsened with telephone appointments, particularly as the patient may feel less engaged or may miss a phone call. The policy around non-attendance and calling patients back who did not answer the first time was discussed. StK noted both mobile and landline numbers would be called, and usually the clinician would call 2-3 times. If running late for a video consultation, patients are notified through a message in the virtual waiting room. AD asked if there are any areas that could be improved from ET's experience. ET noted her condition is well managed and has found remote consultation extremely useful.	

	It was raised that every telephone call is recorded in primary care for training and monitoring purposes and a question was asked around whether video consultations are similarly recorded. StK confirmed this is not generally the case in secondary care outpatient appointments. SK noted seeing growth in e-consult where photographs can be used – will secondary care use any form of e-consult system. Dermatology in particular has been using telederm effectively for many years. SMc asked if ET or StK had any concerns around privacy or confidentiality when accessing appointments remotely. ET confirmed she had no concerns. StK noted it will be important for clinicians to ask questions about who else is in the room at the time of the appointment and if the patient is comfortable they have enough privacy before starting. ST asked how confident ET is that if her condition deteriorates, she can access services quickly. ET confirmed she is very confident and remote access for appointments does not hinder her ability to access consultants or nurses. ET is able to leave an answerphone message for them if requiring further support. Additionally, StK noted that patients will still be clinically examined, face to face, at certain stages of their pathway. **The Governing Body members thanked ET and SK for joining the meeting and for sharing their valuable feedback and experiences.** *ET and StK left the meeting.*	
3	**Register of Interest (ROI)** The members reviewed the ROI and the following changes were noted: GAth noted she is no longer the Chair of the Remuneration and Workforce Committee but is a member of the Devon Ethics Group. DA noted he remains seconded to Northern Devon Healthcare Trust (NDHT) until 18 September 2020. **The Governing Body received and noted the ROI and the additional declaration made.**	
4	**Minutes of the last meeting** NB took the Governing Body through a page by page review of the minutes of the previous meeting held on 30 July 2020. JH had raised an issue at the previous meeting about the locality structure and whether there are 5 Local Care Partnerships (LCPs), as she had understood this was still in discussion. It was noted an action should have been recorded that PJ and JT planned to meet with practices to discuss this. JH asked that this point be minuted, and the action is added to the action log for JT and PJ to feedback. **ACTION: PJ and JT to discuss LCPs with GP practice colleagues and feedback to Governing Body members.** JT noted she has discussed this in several forums already and herself, PJ, SMc and Alex Degan have a meeting next week to discuss further with the Clinical Directors in West and Plymouth about the LCP configuration and how best to support primary care in those conversations. JH noted how hard it must be to note all that is said in the meeting and requested minutes of the Governing Body meetings are sent out to members within a week or so of the meeting to	**JT and PJ** **NB/MB**

	ensure feedback can be provided in a timely manner. **ACTION: NB/MB to feedback to the administrator.** GAth noted she understood that JH had requested that the Peninsula Clinical Services Strategy be on the next agenda. ST confirmed this is in-hand and it is on September's agenda. Philippa Slinger, Lead Chief Executive for the Devon Sustainability and Transformation Partnership (STP) has been invited to attend. The Governing Body members requested an update on the LCP issue, and whether the decision has been made to have 5 LCPs. ST confirmed the Devon system is proceeding around 5 LCPs and whilst he cannot recall which forum made this decision, he noted this is a system decision and not solely a CCG decision. JH noted her concern that primary care was not adequately involved in this process. ST provided assurance that where decisions are solely within the CCG's gift, the CCG will actively involve its membership. ST suggested that Philippa Slinger gives an update on the decision-making process for LCPs at the next meeting. **ACTION: MB to note for the agenda and feedback to the administrator.** **The Governing Body received and noted the minutes of the previous meeting and the amendments provided.**	**MB**
5	**<u>Chair's Report</u>** NB introduced the report and drew the Governing Body's attention to one update. Katy Kerley and NB met yesterday with Jenny Bird Associates, an Executive Coaching company, to discuss an outline for a programme of Executive Coaching sessions for the clinical and non-executive members of the Governing Body. This is to support this group in working better collectively. **The Governing Body received and noted the contents of the Chair's report.**	
6	**<u>Accountable Officer's Report</u>** ST introduced the report and drew the Governing Body's attention to the update on returning to CCG offices. The CCG has taken account of government advice and guidance and has taken the position that where staff can work from home, they should continue to do so. If they wish to go into the office, they must seek approval from a member of the Senior Leadership Team (SLT) and human resources (HR). Risk assessments and guidance for staff has been published on the intranet. ST clarified that clinically vulnerable and extremely vulnerable staff should not feel pressured to return to work in the office. ST informed the CCG is in discussion with Devon County Council (DCC) around the reconfiguration of the office space there to create a welcoming and safe environment. It was noted that at a previous Governing Body meeting staff interviews were held with line managers to offer support and enquire about preferences. SMc asked if this happened with clinical staff members. ST has been assured that it has happened across the CCG but will check and confirm. **ACTION: PJ to confirm if these staff and line manager discussions have taken place with clinicians.** **The Governing Body received and noted the contents of the Accountable Officer's report.**	**PJ**
7	**<u>Devon System COVID-19 Response</u>** John Finn (JF) joined the meeting and introduced the paper. The focus of the paper is to describe the innovative work and good practice taken forward in the Devon System COVID-19 response. JF noted local organisations have worked well together as a single system in phase 3 planning.	

Devon has consistently over-achieved in phase 2 plans around day-case activity, putting the system in a good position for achieving the 80% target in September. The Devon system has maintained good performance against key cancer targets throughout COVID-19. This can be attributed to the way in which Devon utilised the independent sector capacity. It has been recognised Devon has led the way in maximising this capacity available.

There has been much greater use of digital methods and technology. Before the outbreak, 80% of GP appointments were held face to face, whereas now 90% of patients have a remote appointment first. The CCG is working on a communication tool for members of the public who may still prefer a face to face appointment.

The Nightingale Hospital in Exeter is providing safe and fast diagnostic testing for the Peninsula.

The CCG continues to work closely with care homes and out of hospital providers alongside Local Authority colleagues. There has been a regular webinar to provide support to this sector which has been well received.

The need for stringent infection prevention control (IPC) has had a significant impact on diagnostic activity, which was already challenged before the COVID-19 outbreak. This resulted in appointments taking 30 minutes on average, halving productivity levels. With support from the Adapt and Adopt programme, JF reporting this is now reduced to 20 minutes and he is confident this will get to 15 minutes on average putting the diagnostic programme in a much stronger position.

The CCG's Devon Referral Support Service (DRSS) team has supported the system in many ways, including contacting 1500 local businesses for personal protective equipment (PPE), supporting Devon Doctors and contacting 37,000 patients on Devon dental waiting lists.

Looking forward into phase 3, the first return is to be made on Friday and formal phase 3 plan is to be returned on 21 September 2020 *(ST clarified this date during the meeting).* In terms of the steps taken to restore services, the CCG has been working with partners across the system to identify all clinically urgent cancer patients for surgery including the use of the independent sector, reviewing all surgery lists for prioritisation and reintroducing surgery for outpatients when appropriate. The CCG now has good information around prioritisation, and the CCG is working with regional NHS colleagues to establish a prioritisation list across Devon.

The CCG continues to maintain increased community services supported by locality plans. The CCG is seeking to understand the potential mental health impact from the pandemic and providing support for high risk patients. There has been progress made in the enhancing the safe and appropriate discharges programme and it is intended to maintain this going into the winter months. Additionally, the CCG is working to reduce health inequalities as a key part of the phase 3 plan.

The CCG will be guided by local outbreak boards and the system will be capable of responding to the pandemic in line with national guidance. Protecting the long-term welfare of staff will be key, as will ensuring stocks of PPE match service provision.

The CCG wishes to support patients in using services in a different way and will maintain a key focus on the impact of the pandemic on the disruptions to routine care, keeping in regular contact with patients to support this.

	CB noted in relation to maternity services, there are only a few appointments that a partner can attend. CB asked what the impact of this is on the patient particularly as sometimes in these appointments they may receive bad news that they were not expecting or could not have prepared for. CB asked if digital or other solutions are being looked at. **ACTION: JF will clarify the impact and support to patients for maternity services as part of the next report.** JH queried the dental waiting list of 37,000 which seems extremely high. It was noted the commissioning for this sits with NHS England but there has been a longstanding issue around this waiting list, although it has been largely exacerbated by COVID-19. There is also a focus on delays to accessing mental health appointments and part of the phase 3 return on Friday covers this. JT noted there will be a range of issues around how services work together in the system and gaps for mental health services, but JT feels confident there is better understanding of this, and the team is working on a strategy. This will cover a reduction in waiting times to get better outcomes for patients to be in place before winter. SK urged JT to engage Primary Care Networks (PCNs) in this. **ACTION: JF will share this return with SK after this meeting.** *JF left the meeting.*	**JF** **JF**
8	**<u>Modernising Health and Care Services in Teignmouth and Dawlish</u>** JT introduced JeT to the meeting and reminded Governing Body members that back in February 2020 the Governing Body approved the CCG going to consultation on this, including the method and what is being consulted upon. The COVID-19 pandemic then caused this to be delayed. JT noted this is coming back to the Governing Body meeting to describe how this will now be progressed and seek approval from Governing Body members on the way in which the CCG will consult. As a result of the COVID-19 pandemic, the CCG has needed to re-consider the ways in which it can consult the local population. NHS England and NHS Improvement are supportive of the proposals. The CCG has been briefing as would be expected and will be briefing the Overview and Scrutiny Committee soon. JT noted the purpose of this item is to ensure the Governing Body members are assured that sufficient work and consideration has gone into developing these proposals in light of any potential COVID-19 surge, and ensuring Governing Body members are assured around Dawlish Hospital being fit for purpose picking up some additional services. DG reminded Governing Body members of the context of this. The CCG, when it was South Devon and Torbay CCG, consulted with the local population in Teignmouth about changes to the model of care. Teignmouth was the first area the CCG consulted with on this, and since then it has been subsequently reviewed in line with other areas as it is recognised it is now an outlier in terms of numbers of beds. JeT explained that local COVID-19 modelling has been undertaken and it is expected a surge will not be larger than the first wave. The modelling shows that with the Nightingale Hospital there will be sufficient capacity to deal with a surge. Torbay and South Devon NHS Foundation Trust (TSDFT) have looked at how they could increase their community hospital bed base, and they have identified Dawlish, Brixham and Totnes community hospitals as suitable locations for additional beds. Discharge patterns during COVID-19 and the need for rehabilitation services have also been considered, which is what the beds in Teignmouth would supply. Data shows that of the discharges from the discharge hub from April – June 2020 at TSDFT, 77% of those went through the pathway once and the patient went straight to their home with additional support in place. Therefore, the number of patients being discharged requiring bed-based care was about 8% in short term placement. This could be argued as the cohort that would require a rehabilitation bed, and the team has been able to	

provide this short-term bed-based placement in a care home. Teignmouth community hospital outpatient clinics were stood down during the COVID-19 pandemic and GPs were able to move there on temporary basis using the suspended outpatient space to provide their primary care support. Outpatient clinics were also suspended at Teigmouth and Dawlish community hospitals during the pandemic but those services are starting to be restored now; about two thirds of the clinics have been stood up and there are plans in place to restore the remaining clinics and day case procedures. Some day-case procedures did continue for cancer pathways.

The Health and Wellbeing centre was designed pre-COVID-19 therefore teams have been asked to review this to ensure it is fit for purpose if there is a surge once this is built in 18 months – 2 years' time. Operational teams are confident services can be delivered if there is a future surge as the building is large enough for safe flow and social distancing.

The Minor Injuries Unit (MIU) in Dawlish has been closed as the service was suspended in February 2020. The main reason for this was because TSDFT had found it difficult to staff this MIU and these issues were exacerbated by COVID-19, where TSDFT resources were focused on the urgent treatment centre at Newton Abbot. It is also recognised x-ray equipment at Dawlish MIU needs updating. TSDFT have therefore proposed maintaining this current situation over the winter period to enable them to run an efficient and effective urgent treatment centre in Newton Abbot.

GT raised a question about the process of consulting, noting section 6 of the report sets out an innovative way of consulting with people in the context of COVID-19. GT asked what assurance the CCG has that carrying out the consultation in this way will meet one of the five tests for service change around engagement being strong for public and patients. JT noted this is a first for the CCG, but NHS England and NHS Improvement are confident and supportive of this approach and it is felt this approach will have a far greater reach to members of the public. JeT noted the CCG wishes to ensure this consultation is open and transparent, and that as many people as possible can give their feedback. Therefore, as part of this, the CCG will be using a mixed methodology to take account of those people who cannot access the internet. Firstly, the CCG will be delivering a paper consultation document to the 16,000 households in Teignmouth and Dawlish. This will include a hard copy of the questionnaire which can be returned free of charge. To ensure the CCG contacts others in South Devon and Torbay, the CCG will deliver 133,000 leaflets and using telephone advertising, newspaper advertising and contacting community groups to publish documents. There will be online public consultation meetings for people to watch a presentation and offer feedback. Healthwatch will help to target hard to reach groups, Living Options will develop an easy read version of the document. Additionally, telephone clinics will be offered. Healthwatch will collect all data and produce a final report, and evaluation will happen on an ongoing basis.

SK noted this clinic will have space for hot zone and cold zone, but asked whether there would be space for those who are shielding or whether they would be visited at home. JT reminded this is a number of years down the line therefore guidance will continue to be reviewed, the hot hub that was in operation has closed but there is another site if it is needed.

GAth asked whether digitalisation of clinics going forward is taken into account. The CCG has sought assurance from both the Integrated Care Organisation (ICO) and general

	practice that these plans are fit for future provision and ensure they are fit for the new care model. CB noted she welcomes the evaluation of this model of consultation and would wish to see it at a future Governing Body meeting. ST met with the local MP Ann Marie Morris recently to discuss the consultation. She has raised a number of questions and ST wishes to ensure the Governing Body is sighted on the questions. The CCG will write a detailed response. She wanted to ensure pandemic planning is right, there is enough clinical evidence, and how the CCG can be assured there is enough nursing and residential home beds in coastal and across county. There was also a question around the intention to move surgical services from Teignmouth to Dawlish hospital and wishes to understand if there is same standard and room to support this. Concerned about site at Torbay Hospital to take outpatient work and volume of work, and questions about floor plans. JeT noted she has reviewed all questions put forward by MP Anne Marie Morris and is confident the information provided as part of the consultation documentation will answer these questions. In relation to the question around market sufficiency, the CCG works closely with local authorities to develop a care home market that is fit for purpose. Devon County Council leads on this work and has responsibility under the Care Act 2014 to ensure the sufficiency of this market. As part of this, they publish and maintain a market position statement looking at demand. This will be available as part of the consultation to members of the public. It describes potential challenges for the future such as nursing beds for long-term needs, but these are long-term needs rather than short term placements Teignmouth hospital would provide. Within 10 miles of Teignmouth, there are 55 beds in care homes without nursing and 12 beds in care homes with nursing. It is believed this describes a sufficiency in market provision whilst recognising the need to develop the complex care market with nursing. DG noted timescale is important to understand as the sale of site unlikely to be concluded for at least 18 months. *JeT left the meeting.* **Following the discussion, the Governing Body members noted and approved the recommendations in the report as follows:** • **The format for remote consultation using the consultation channels as outlined in section 6** • **The consultation meeting dates and timeline**	
9	**<u>Month 4 Finance Report</u>** It was agreed to take this item earlier in the agenda. JD talked to the report in the pack, and noted the CCG is still operating under the emergency financial regime put in place as part of the COVID-19 response. The report in the pack contains the position to the end of July 2020. The CCG has had confirmation the emergency response period will be extended to the end of September 2020. The CCG has confirmed block arrangements with providers and the value of these were nationally set. Section 3 of the report sets out the expenditure against plan set for the 4-month period. The CCG has had confirmation that it has received reimbursement for all COVID-19 related costs for the first 3 months of the year of year; a variance of £6m still appears in the report relating to the month of July and would expect to receive reimbursement for those costs. Section 4 of the report gives details on what the	

	CCG has spent directly in response to COVID-19, totaling £26.3m. The most significant element is around costs associated with faster hospital discharge **The Governing Body received and noted the contents of the report.**	
10	**<u>Devon Integrated Care System (ICS) Lead/Accountable Officer (AO) Devon CCG - recruitment process approval</u>** GT took the Governing Body members through the paper as the Governing Body representative on this panel. At the end of July 2020, the Governing Body approved the combination of the roles of ICS Lead and AO of Devon CCG. A group has been put together to oversee the robust appointment process to this role and the group undertook to bring back this appointment process to this Governing Body meeting. GT noted the members of the working group are confirmed in the report. Since the last meeting the group has appointed GatenbySanderson to lead the appointment process. They have contacted key stakeholders as part of this process for their involvement in forming the job description and person specification, which is still being worked through. The selection process includes a variety of panels of different key stakeholders including non-executives and clinicians, local authority leaders and patient and public representatives. The timetable is being adapted to ensure good availability. GT went through the recommendations of the report as follows: • Recommendation 1: Approval of appointment process approach and timetable outlined in section 2. • Recommendation 2: Delegate the CCG Clinical Chair and Chair of Remuneration and Workforce Committee to sign off the final version of the Job Description and Person Specification and appointment process. • Recommendation 3: Approval of the salary negotiation parameters of between £175,000 and £215,000 per annum pro rata. JH noted her thanks to GT and PJ for taking the brief forward from the last meeting. JH noted when there is a selection of panels, it is important that those in the sub panels understand their decision-making powers. Additionally, JH noted the different sub-panels should look at different aspects of the person specification, but it is helpful to see involvement by a number of people. NB asked if it is the intention that only the interview panel will hold decision-making powers, and only take feedback from the other panels. GT confirmed it is clear there is an interview panel, and this panel will take feedback from other panels. NB noted he had thought best practice in recruitment was for weighted scoring across panels. GT noted the current system does not rule out a scoring system. JH commented this is a wide-ranging job, with a range of skills, therefore it is important the sessions with different groups focus on different skills and experience. Therefore, there does need to be an accountable group for this to feed into. NB suggested this may devalue the sub-group feedback. JH confirmed the process will need to be robust to ensure this is not the case. SMc noticed that only two referees will be sought, but for such an important and senior post SMc asked if this should be reconsidered. PT confirmed it is standard process but can be reconsidered. **ACTION: PT and GT to give further thought to the number of referees.** GAth noted in the protocol for system appointments it says the selection interview process to include host and at least 3 system partner organsiations. GAth asked for assurance that this process meets that requirement. It was confirmed it does. **The Governing Body noted the report and approved the recommendations.**	**PT/GT**

11	**Performance and Quality Report** STh introduced the paper and noted it is a joint paper between herself and DA. STh noted the paper reflects a set of actions that have been undertaken to effect change and by September 2020 the report will be able to demonstrate the evidence of the impact of these. The CCG has reviewed the phase 3 national guidance which has added to the performance agenda through setting a variety of specific measurable targets in relation to elective performance for the months of August, September and October 2020. Furthermore, important work is being undertaken around winter planning and the Governing Body will receive a further update on this at the next meeting. DA drew the Governing Body's attention to the numbers of long waiters in the emergency department particularly 12-hour breaches, crowding and delays from ambulances. The CCG continues to monitor this from a quality and safety point of view. There has also been a small number of Never Events reported as procedures are starting to be restored. The CCG will complete work on this to look at evidence in relation to some of the safety standards. The programme around digitalisation in care homes has been a success, providing a better ability to communicate and conduct training with care homes ahead of winter. Continuing Healthcare (CHC) assessments recommence on 1 September 2020 and the CCG will monitor the impact of this on a fortnightly basis. Equally, complaints processes are returning to pre-COVID-19 position. Lastly, DA noted flu planning continues and looking at impact around increased ambitions to widen the campaign and criteria. NK noted the use of the independent sector and asked DA for assurance that any adverse impact in terms of serious incidents or never events will be picked up in the same way as they would be for NHS services. DA confirmed the process in place covers all services, including the independent sector. SK noted the backlog of CHC assessments to be done going into winter and asked whether there will be enough capacity to mitigate against delayed transfers of care. There is a piece of work to do to give a better level of assurance around this and to understand the size of challenge and any gaps. DA will ensure this is updated on at the next Governing Body meeting to give assurance. **The Governing Body noted the contents of the report.**	
12	**Governing Body effectiveness** GS noted this is a process the CCG undertakes every year to review progress of Governing Body meetings and its committees. It includes feedback from monthly surveys after each of the meetings. The report contains 7 recommendations which are listed within the report. **ACTION: GS to add timescales for implementation of the recommendations.** **The Governing Body noted the report and approved the recommendations.**	**GS**
13	**Commissioning Committee including update from first meeting and chair's report** This report is for noting, the Commissioning Committee has met once, and SK is the Governing Body clinical representative on this committee. It is a new committee to ensure the CCG meets its obligations with regards to commissioning. It is chaired by Claire Hooper, one of the CCG clinicians. The terms of reference were discussed, and a checklist has been established to ensure that papers that come to this committee go through appropriate preparation. There is a commissioning workplan to ensure appropriate issues come to this committee. The committee has approved three proposals that came from the Clinical Policy Committee (CPC) as follows:	

	• The Committee accepted the recommendation made by CPC of Prasterone for the treatment of vulvar and vaginal atrophy. • The Committee accepted the recommendation made by CPC of Ospemifene for the treatment of vulvar and vaginal atrophy. • The Committee agreed to the extension of the evaluation in service for Prostatic artery emoblisation for the treatment of benign prostatic hyperplasia. CB asked if the Governing Body will review the draft commissioning intentions or if they will go directly to this committee. JT confirmed the commissioning priorities will be discussed at the commissioning committee. The Governing Body members requested a copy of the forward planner and terms of reference. **ACTION: A copy of the forward planner and terms of reference to be circulated to Governing Body members.** NB noted in the effectiveness of the Governing Body paper it made reference to the HFMA audit committee handbook, within which there is a requirement for a committee structure which strengthens the role of the Governing Body in strategic decision-making and supports the role of non-executive directors. NB asked how this sub-committee of the Board therefore can operate without a non-executive member on it. GS noted the aim of this committee is to ensure a robust and coordinated approach to decision-making. Previously these decisions were made by individual executives or the executive team collectively therefore this committee does not remove any elements of decision-making from the Governing Body. Decisions will continue to be reported to the Governing Body, but the difference will be that the process is more robust. JH noted the other difference is to the Primary Care Commissioning Committee (PCCC). Some matters are now discussed at the Commissioning Committee, that might previously have come to PCCC because of their impact on primary care, or the role primary care contractors play in resolving the issue. PCCC now receives these items for information. **The Governing Body noted the contents of the report.**	**JT / MB**
14	**<u>Finance and Performance Committee Chairs Report</u>** GT introduced the report and noted the performance and quality report was discussed there. GT noted this committee is trailing a combined committee meeting with the Quality Assurance Committee. The committee added three new risks to the risk register, two of which are financial risks and the third concerns pressures on 111 service. These are noted in the report. The committee received a report on the commissioning of contracts which end in 2020/21. This had been drafted before the commissioning committee was up and running. Therefore, it will be referred to the commissioning committee to pick up and series of recommendations around a robust workplan. GT noted the report was written openly and transparently and raised issues about commissioning and risks, including where there is inadequate information. The committee, having been notified of these risks, has asked for a report in due course to give assurance those issues have been picked up. **ACTION: A copy of the report on commissioning of contracts ending in 2020/21 to be shared with Governing Body members.** **The Governing Body noted the contents of the report.**	**MB**
15	**<u>Primary Care Commissioning Committee Chairs Report</u>**	

	JH introduced the paper and noted there are no issues to escalate to the Governing Body. **The Governing Body noted the contents of the report.**	
16	**<u>Quality Assurance Committee</u>** CB introduced the paper and highlighted that the Children and Family Health contract was discussed. Safeguarding was also a theme. **The Governing Body noted the contents of the report.**	
17 17.1 17.2 17.3	**<u>Locality Updates</u>** <u>Northern</u> CB introduced the report and noted she has nothing further to add. <u>Eastern</u> SK introduced the report and noted the eastern locality has been working with the Royal Devon and Exeter NHS Foundation Trust (RD&E) around winter planning. Primary care had instigated some additional support to the urgent care response in the east last winter which had good outcomes, therefore this will be replicated. <u>Western</u> SMc noted the key workstreams are around preparing for winter and the mobilisation of the Integrated Care Partnership contract. There is continued support for the COVID-19 hot hub for primary care. SMc noted more patients are being referred into this service and there is now capability of testing individuals who are referred there. There has been only one positive test so far in six weeks. Additionally, there is a large amount of working supporting flu vaccinations across the county. SK noted in the media there were a number of COVID-19 cases reported in Plymouth. There was a small group of young people that had visited Zante, VP confirmed they are being followed up by public health and Plymouth City Council. Additionally, it was reported on the Plymouth Health Protection Board and the CCG is assured the follow-up actions are being taken. There was also a separate case from a manufacturing unit in Croatia but similarly actions are in-hand. ST referred to anecdotal feedback around GP referrals to A&E without 'eyes on' by a GP in advance. SMc confirmed this is usual practice if history suggests a referral to the emergency department if necessary. SMc is aware of concerns that patients are attending the emergency department as they are seeking a face to face assessment. JT will be speaking with the Chief Operating Officers across the county to gather any further evidence. 17.4 <u>Southern</u> DG noted most time and resource is being taken up on the Teignmouth consultation. DG informed there is an important piece of work going on about the co-design of the voluntary community and social enterprise sector to run the hospital discharge service. DG referred to the discussion around LCPs and noted there is a PCN in the South Hams which receives services from University Hospitals Plymouth (UHP) and Livewell Southwest but work is being undertaken to bring that area into the southern locality with a single Clinical Director. Additionally, the care home visiting service is under development and there is an agreement place for all practices to use the money for the care home Local Enhanced Service (LES) to instead put it into this care home visiting service, alongside money previously paid to support the intermediate care team, to create a robust process and provide GP cover for all care homes in Torbay. ST noted the need to remember TSDFT is carrying a large deficit; the CCG is investing more in the south locality than fair share. There is a large benefit of the	

	care home visiting services therefore the CCG needs to help to support primary care colleagues in a discussion about how best to fund this service. SK would be interested to understand the benefits and outcomes of this work. STh noted bed occupancy in the south in community beds is the highest across all providers. **The Governing Body noted the contents of the locality reports.**	
18	**Any other business** JW informed that, following the success of 'One Northern Devon', there is now 'One South Molton' established and the first meeting was held recently. There is also a new South Molton Medical Centre. ST noted his thanks to STh as it is her last working day for the CCG. ST noted her experience and calming influence has been invaluable to the CCG and her attention to detail and process has brought discipline and focus. ST also shared his thanks to PK, who has been undertaking the position as Interim Chief Nursing Officer. ST noted his last day with the CCG is 31 August 2020, and his expertise and support has been invaluable.	
19	**Close of meeting** The meeting closed at 16:47.	

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*
Alison Davis (AD) **	Associate Non-Executive Director, Devon CCG
Andrew Millward (AM) A	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Darryn Allcorn (DA) **	Chief Nurse, NHS Devon CCG
David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Gaynor Appleby (GApp) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT) **	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG
James Wooldridge (JW) **	Associate Non-Executive Director, Devon CCG
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Womersley – Dr (Jwo) A	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF) A (in absence of DG)	Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **	Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **	Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) A	Clinical Chair, Devon CCG
Penny Harris – (PH) A	Director, Devon CCG

Philip King (PK) [A]		Interim Chief Nurse
Ruth Harrell – Dr (RH) [A]		Director of Public Health, Plymouth City Council
Sarah Thompson (STh) **		Chief Operating Officer, Devon CCG
Simon Kerr – Dr (SK) **		Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc)**		Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST)**		Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SM) **		Executive Director and SRO for the Integrated Care Partnership in Western, Devon CCG
Virginia Pearson – Dr (VP) **		Director of Public Health, Devon County Council
In Attendance		
Molly Bishop (MB) ** **Minute Taker**		Executive Assistant, Devon CCG
Eleanor Taylor (ET)**		Patient
Dr Stuart Kyle (StK)**		Consultant Rheumatologist, Northern Devon Healthcare NHS Trust
Piers Tetley (PT)** (on behalf of AM)		Associate Director of HR, Devon CCG
John Finn (JF)**		Associate Director of Commissioning, Devon CCG
Jenny Turner (JeT)**		Head of Integrated Care, Devon CCG
Minutes approved	Date:	Signed by chair:

NHS Devon Clinical Commissioning Group

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**		**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential order	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action is very clear to the owner and the committee members	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertakenYes/No confirmation if all actions		This will be the lead or person to whom the action was designated	Confirmation that committee that raised the action is content the action has been completed	Confirmation if action complete
1	27-Aug-20	PJ and JT to discuss LCPs with GP practice colleagues and feedback to Governing Body members.	24-Sep-20	Paul Johnson/Jo Turl	08.09.20 To be discussed at the collaborative board meeting on 15 September 2020				**IN PROGRESS**
2	27-Aug-20	JH requested minutes of the Governing Body meetings are sent out to members within a week of the meeting to ensure feedback can be provided in a timely manner.	24-Sep-20	Nikki Coombes	08.09.2020 NC confirmed the draft minutes of the meeting held on 27 August were circulated to GB for comment and feedback within the set deadline. The recommendation is to formally close this action				**FOR CLOSURE**
3	27-Aug-20	ST suggested an update on the decision-making process for LCPs at the next meeting.	24-Sep-20	Simon Tapley	Integrated Care System Governance on agenda for 24 September 2020				**FOR CLOSURE**
4	27-Aug-20	SMc asked if individual conversations had taken place with clinical staff members to offer support and enquire about prefernces of working from home or work base.	24-Sep-20	Paul Johnson					**OPEN**
5	27-Aug-20	JF to clarify the impact and support to patients for maternity services as part of the COVID-19 response report	24-Sep-20	John Finn	17.09.2020 update on impact and support to patients for maternity services as part of the COVID-19 response has been circulated to the Governing Body for information. Therefore recommendation for formal closure of this action.				**FOR CLOSURE**
6	27-Aug-20	JF to share the Phase 3 return with SK	24-Sep-20	John Finn	16.09.2020 confirmation received that JF has actioned. Therefore recommendation for formal closure of this action.				**FOR CLOSURE**
7	27-Aug-20	SMc noticed that only two referees will be sought for the appointment of the Devon STP CEO Lead/ CCG Accountable Officer. It was confirmed this was standard process but could be reconsidered. PT and GT to give further thought to the number of referees	24-Sep-20	Piers Tetley/ Graham Turner	15.09.2020 Consideration given to 3-4 referees and Piers Tetley linking with GatenbySanderson the number appropriate for this level. To be confirmed.				**IN PROGRESS**

8	27-Aug-20	GS to add timescales for implementation of the recommendations for Governing Body effectiveness.	24-Sep-20	Ginny Snaith	14.09.2020 An action plan has been developed (available on request) including identified leads for each recommendation along with deadlines. This plan will be overseen and monitored by Governance and the Governing Body administrator. Two of the recommendations have been actioned and have been closed the remaining five recommendations are on-going through business as usual.				**FOR CLOSURE**
9	27-Aug-20	The Governing Body members requested a copy of the forward planner and terms of reference for the commissioning committee.	24-Sep-20	Nikki Coombes	08.09.2020. NC confirmed this has been circulated to the Governing Body members and the recommendation for formal closure of this action.				**FOR CLOSURE**
10	27-Aug-20	A copy of the report on commissioning of contracts ending in 2020/21 to be shared with Governing Body members.	24-Sep-20	Nikki Coombes	08.09.2020. NC confirmed this has been circulated to the Governing Body members and the recommendation for formal closure of this action.				**FOR CLOSURE**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Chair's Report				
Date of committee: 24 September 2020 **Date report produced: 16 September 2020**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive:** **Name and Title:** **N/A** **Contact Details:** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date: 16 September 2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

- Introduction
- ***System Lead Executive and CCG Accountable Officer Recruitment***
- ***Integrated Care System (ICS) Partnership Board***
- ***Torbay and South Devon Foundation Trust Medical Director***

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

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

N/A

Key recommendations and actions requested:
This report is for information and the Governing Body are asked to note the contents.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
Item 7.1 of the Governing Body agenda re: Integrated Care System Governance.
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services		√
Health Inequalities		√
Equality (staff or public)		√
Resource and Finance		√
Legal		√
Engagement and Consultation		√
Risk		√

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

NHS
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GOVERNING BODY – CHAIRS REPORT

1. Introduction

My thanks to Nick Ball for chairing the last Governing Body in my absence. At a time when so much is required of us and things are changing and moving so fast, it's important we look after ourselves and I hope, just as I was able to have some time away, that all the CCG staff and Governing Body members have had an opportunity this summer to recharge and re-energise for what will certainly be a hugely challenging winter.

2. System Lead Executive and CCG Accountable Officer Recruitment

We are now in the next phase of recruitment for this combined role. My thanks to those of you who were either interviewed by GatenbySanderson or completed an online questionnaire. This has helped us develop a process and job description that, I believe, gives us the best chance of recruiting the right person in this pivotal role. The job is now out to advert and GatenbySanderson are managing this process on our behalf. The advert is present on multiple online sites including Guardian Jobs, LinkedIn and Health Service Jobs (HSJ) Jobs (https://www.hsjjobs.com/job/2603852/ics-executive-lead-and-ccg-accountable-officer/?LinkSource=PremiumListing).

Interviews are planned for 18 November.

3. Integrated Care System (ICS) Partnership Board

The ICS Partnership Board met in shadow form on 2 September. Details of the board membership and the wider ICS governance it sits within are presented within todays Governing Body agenda and were agreed for recommendation to boards at this shadow meeting. The ICS Partnership Board will be key in ensuring we maintain a system focus for both commissioners and providers, and health and local authority.

4. Torbay and South Devon Foundation Trust Medical Director

I was pleased to be invited to be part of the appointment process for the Torbay and South Devon Medical Director and even more pleased that Ian Currie, Consultant Vascular Surgeon, has been successful and appointed. I wish him all the best in his new role and look forward to working with him in the coming months and years.

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GOVERNING BODY

Report title: Accountable officer's Report				
Date of committee: 24 September 2020 **Date report produced:** 14 September 2020				
Author (s) Name and Title: Simon Tapley, accountable officer Sam Cush, internal communications manager **Contact Details:** sam.cush@nhs.net 01392 675 367		**Supporting Executive:** **Name and Title:** Simon Tapley, accountable officer **Contact Details:** **Report Approved by:** **Name and Title:** Simon Tapley, accountable officer **Date:** 14 September 2020		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

1. Phase 3 COVID response
2. Return to offices
3. Teignmouth consultation
4. Senior leadership structure
5. Staff awards
6. Devon People Plan
7. Think 111 First

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

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

N/A

Key recommendations and actions requested:
This report is for information only.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
N/A
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	No
Quality of Services		X
Health Inequalities		X
Equality (staff or public)		X
Resource and Finance		X
Legal		X
Engagement and Consultation		X
Risk		X

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.

Accountable officer's report

1. Devon's phase three COVID-19 response

Work is progressing on Devon's third phase of the NHS response to COVID-19.

We're taking a system-wide approach to ensure the plan is comprehensive, consistent and addresses the requirements of the national guidance, which outlines the need to:

- Accelerate the return to near-normal levels of non-COVID-19 health services, making full use of the capacity available between now and winter
- Prepare for winter demand pressures, while continuing to be ready for potential increases in coronavirus cases
- Learn from the first phase of coronavirus to embed beneficial changes and tackle fundamental challenges

Our draft plan was submitted to NHS England and NHS Improvement on 1 September 2020 and we are currently refining this to take account of feedback received.

The revised plan will be reviewed and after it has been approved by system Chief Executive Officers will be submitted on 21 September 2020.

Devon's winter plan is also in development, overseen by the Devon Urgent Care Programme Board and with a focus on local system planning, including demand and capacity planning and escalation.

Our key objectives in terms of the restoring elective (planned) activity as we move into phase three includes:

- Continuing to maximise our use of independent sector capacity
- Accelerating the development of patient-initiated follow-ups (PIFU)
- Expanding diagnostic capacity through use of the NHS Nightingale Hospital Exeter.

2. Returning to CCG offices

On 1 September, our offices were declared COVID-safe, meaning staff could work from them if needed. That said, we're continuing to encourage staff to continue working from home, if they can – especially those in vulnerable groups.

Staff whose role or personal circumstances mean they need to come into the office are supported to do so safely with strict risk assessments, cleaning protocols and attendance rotas that meet the national guidance.

To support our staff, we've communicated it in regular staff webinars, published updates in our weekly Staff Bulletins and uploaded all the information – including presentations, videos and risk assessments – to our intranet.

We've also held wellbeing conversations with every single member of staff to discuss their personal circumstances and any worries they may have, as well as individual risk assessments for those in vulnerable groups.

Each directorate is allocated desks at our sites to cater for those staff who want to work in the office. Given the preferences of staff, we are confident that requests can be catered for.

Our staff have been incredible over the past few months – regularly going above and beyond to ensure local people are cared for and services are supported.

I have never been prouder to lead this organisation, and I'm confident our staff will continue to excel themselves over the coming months.

3. Teignmouth and Dawlish consultation

We held our first online public consultation meeting on the future shape of health and care services in the Teignmouth and Dawlish area on Friday 11 September.

We have received good feedback from those who participated and I'm looking forward to presenting the remaining sessions which are being held between now and Saturday 17 October.

With COVID-19 still circulating, the consultation is taking place in a different way with six live meetings held online so that the risks of public gatherings are avoided.

We're also delivering the consultation document and survey to 16,000 local people and offering telephone conversation with someone from the NHS for those without the internet.

We are asking people to consider a proposal for moving services from Teignmouth Community Hospital, given that a new £8million Health and Wellbeing Centre is due to be built in the heart of Teignmouth.

The centre will bring GP services, community health and care and voluntary sector services together under one roof in the centre of town, meaning that care can be much more easily coordinated for each patient.

4. Senior leadership structure

Following the merger of our CCGs and our coronavirus response, we made some transitionary changes to our Accountable Officer direct reports with effect from Monday 14 September.

Evolving our current structures will help us to mirror the commissioning cycle as we move towards becoming a strategic commissioner as part of an Integrated Care System (ICS) next year.

We held a consultation with affected staff and our Staff Partnership Forum in August and are supporting those staff who have been affected by the proposals.

While there are some minor changes to how teams work or who staff report to, most of our staff are unaffected.

The changes predate the appointment of the new ICS Executive Lead and CCG Accountable Officer, which we currently recruiting to. This is currently out to advert.

5. Staff awards

I was delighted to launch our second Celebrating You Awards at the end of August, giving our staff the opportunity to recognise their colleagues for their incredible work.

There are nine categories that any member of staff can make a nomination for by completing a short form. We have already had some nominations.

While much of our work in the past few months has been coronavirus-related, the awards will celebrate the work of all staff throughout the past year.

Given the restrictions around face-to-face events, the ceremony will take place virtually through Microsoft Teams in early November, which all staff are invited to.

Our staff regularly demonstrated how dedicated, professional and talented they are – never more so than over the past few months. Our Celebrating You Awards will go some way towards recognising their exceptional achievements.

6. Devon People Plan

We are developing a Devon People Plan to grow, train and support our workforce, while introducing new ways of working to improve patient care.

Developed in collaboration with health providers across Devon, our plan will outline our ambitions and commitments to deliver change for our people through four key priorities:

1. Looking after our people
2. Belonging in the NHS
3. New ways of working and delivering care
4. Growing for the future

Building on our learning from the COVID-19 response, our plan will ensure we can attract the brightest and best new talent to our system while continuing to develop our existing fantastic staff.

Our local plan is being developed in response to the national NHS People Plan, which sets out practical actions for employers and systems, as well as the actions that NHS England and NHS Improvement and Health Education England will take.

7. Think 111 First

The Think 111 First Programme Board and clinical workstream is underway and the programme Board is working towards launch in October.

Workstreams are considering clinical pathways, direct bookings to emergency departments, minor injury units and primary care, impact assessments and a public promotion campaign.

The Devon approach aims to redefine and improve urgent care pathways by ensuring that patients receive the right care in the most appropriate setting with the lowest level of risk of acquiring a hospital or healthcare-related infection.

This need has been brought into focus during the COVID-19 pandemic, particularly given the capacity in our A&Es, the need to meet nationally targets for treatment and bed occupancy, while maximising the use of capacity to respond to winter pressures and plan for surge.

Taking learning from the Cornwall and Isles of Scilly Health and Care Partnership, who are an early adopter in this approach, we will be seeking to understand the learning from this to build upon areas of good practice for our population.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Integrated Care System (ICS) Governance Proposed Structure				
Date of committee: 24th Sept 2020 **Date report produced: 11th August 2020**				
Author (s) Name and Title: **Ginny Snaith, Board Secretary**		**Supporting Executive:** Paul Johnson, CCG Clinical Chair Simon Tapley, CCG Accountable Officer		
		Report Approved by: **Name and Title:** **Date**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): **To provide opportunity for discussion with System AO**				
Executive Summary: The STP has review previous governance arrangements and developed proposals to incorporate lessons learnt during the COVID pandemic. The attached proposal was agreed at the first meeting of the Shadow ICS Partnership Board which includes the Chairs (and Council Leaders) and AOs of all the partner organisations. The paper has now been circulated to all partners for formal approval through their Boards/Governing Boards. The STP is currently going through the ICS Development process with the expectation that it will be approved as an ICS from 1st April 2021. **The Governing Body is asked to approve this proposal.**				
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:				
Shadow ICS Partnership Board				

Key recommendations and actions requested:
For approval

Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources

Reference to other documents or accompanying papers:

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

	If Yes, please give details	No
Quality of Services	The new arrangements will underpin system working in Devon and may have impacts in all of these areas. Further detailed development work is required.	
Health Inequalities		
Equality (staff or public)		
Resource and Finance		
Legal		
Engagement and Consultation		
Risk		

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

Proposed Structure and Governance Arrangement for Devon Integrated Care System

1. Introduction and Context

The NHS Long-Term Plan set the ambition that every part of the country should be an integrated care system (ICS) by 2021. It encourages all organisations in each health and care system to join forces, so they are better able to improve the health of their populations and offer well-coordinated efficient services to those who need them.

NHS England and NHS Improvement (NHSE/I) set out a consistent approach to how systems are designed highlighting three levels at which decisions are made and described the broad functions to be undertaken at each level:

- **Neighbourhoods (populations circa 30,000 to 50,000 people)** -served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services through primary care networks (PCNs).
- **Places (populations circa 250,000 to 500,000 people)** -served by a set of health and care providers in a town or district, connecting PCNs to broader services including those provided by local councils, community hospitals or voluntary organisations.
- **Systems (populations circa 1 million to 3 million people)** -in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale. An ICS is not a legal entity and has no authority and powers other than those afforded it by its constituent sovereign organisations that are the NHS and Local Authority (LA) organisations in the area.

Level	Functions	Priorities from the NHS Long-Term Plan
Neighbourhood (c.30,000 to 50,000 people)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).	• Integrate primary and community services • Implement integrated care models • Embed and use population health management approaches • Roll out primary care networks with expanded neighbourhood teams • Embed primary care network contract and shared savings scheme • Appoint named accountable clinical director of each network
Place (c.250,000 to 500,000 people)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance	• Closer working with local government and voluntary sector partners on prevention and health inequalities • Primary care network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long-Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes (EHCH) model
System (c.1 million to 3 million people	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes	• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• Increased autonomy to systems • Revised oversight and assurance model • Regional directors to agree system-wide objectives with systems • Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams	

More recently, "the Phase 3 letter" from NHSE/I received on 31st July 2020 set out the following requirements for systems:

"*Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:*

• Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

• Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

• Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

• A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health."

2. Current position in Devon

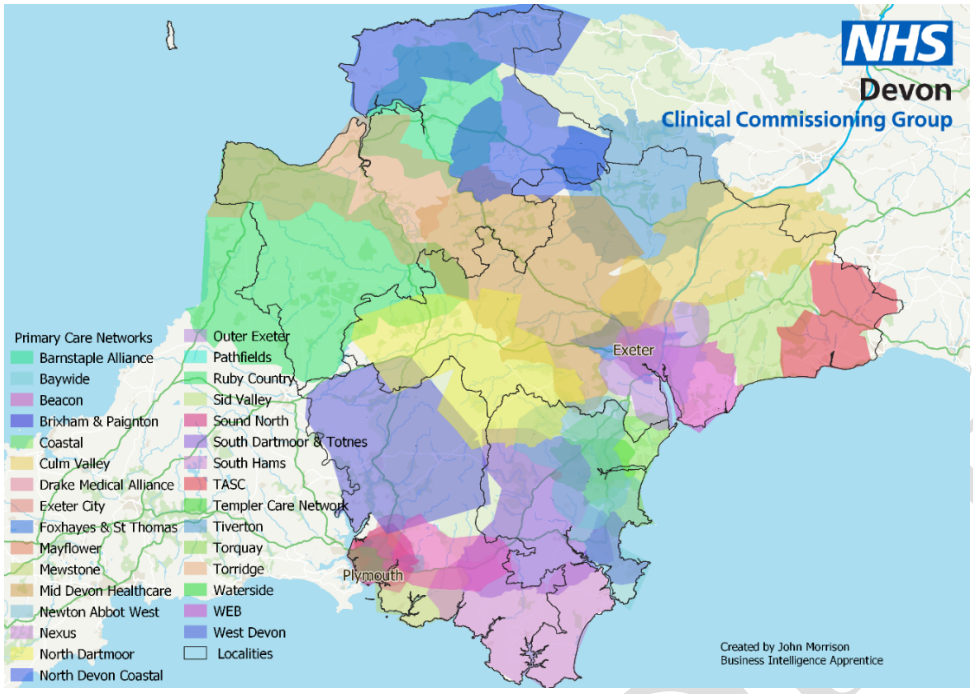
In Devon this new mechanism for setting strategies and developing and implementing plans to improve the health of a whole population is in the early stages of evolution. At system level Devon is currently a Sustainability and Transformation Partnership (STP), the precursor to an ICS, and has been since 2016.

There is an ICS "maturity matrix". The matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs. For a system to be formally named an ICS, they will need to meet the attributes of a maturing ICS[1], assessed by the regional office of NHSE/I, that will include delivering performance and financial outcomes that meet plans agreed with NHSE/I. We are anticipating meeting the deadline of April 2021.

The development of informal structures for working "at place" is also at early stage with different approaches and levels of progress in each of the 5 LCP areas. There is a clear commitment across the county that place arrangements need to be suited to the circumstances and priorities of each place and there will be no centrally imposed governance structure. However it is important that each place is able to demonstrate that it has the capacity and capability to deliver on its objectives before it's accountability and budgetary responsibility can be increased. Each LCP has a Development Lead who is co-ordinating and supporting this work.

From the 1 July 2019, 31 PCNs came into being so creating the "neighbourhood" tier.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf



Each PCN has a Clinical Director and within each LCP there is a Primary Care Collaborative Board that brings together all the PCN Clinical Directors in the area to provide an opportunity for collective consideration of issues as required. In the early stages the priority for PCNs is to offer a way of stabilising primary care and improve access for the population.

3. Developing the Governance and Accountability Arrangements

It is the role of the ICS to set the governance and accountability arrangements across the system that support each level to fulfil it's function. Consultation with all partners in the ICS has identified a number of principles for these arrangements as set out below:

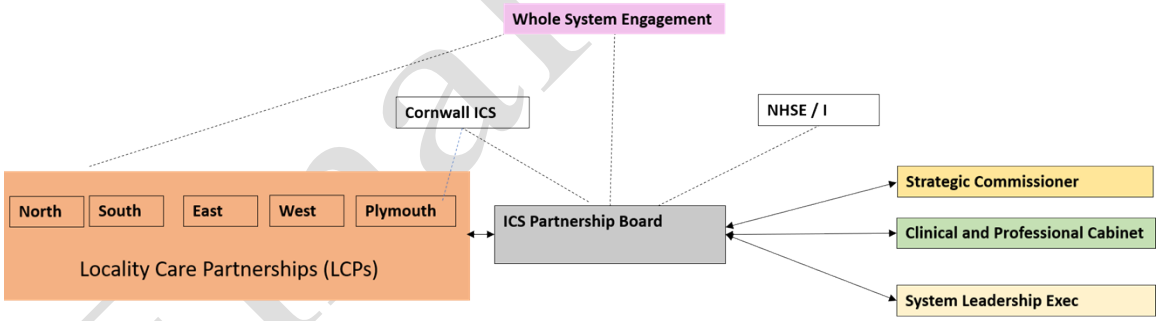
- System governance needs to be light touch with minimal bureaucracy
- Arrangements need to be flexible, responsive and emergent
- The ICS recognises existing and continuing statutory roles and responsibilities
- The ICS, engaging with all system partners is responsible for setting strategy, direction and policy. The ICS will make recommendations to statutory organisations where required.
- There is an imperative to establish new arrangements but recognition that initial arrangements may be subject to change pending future NHSE guidance/ gateway criteria. This is an evolutionary process
- The principle of subsidiarity is accepted and all partners will hold each other to account for working to this principle. Subsidiarity means that the delivery of integration is happens as close to the citizen as possible - at Place or Neighbourhood. System activity is reserved for when the objectives of an action can be better achieved at system level by reason of the scale and effects of the proposed action or when an action is required by regulators.
- System and place will work together to drive transformation at all levels

- Meetings will be held virtually whenever possible

The overall structure, delivery architecture and governance of an ICS is currently not mandated, and nationally each system is developing its own model. It is possible that there may be some mandated national alignment about the nature and structure of an ICS and all associated governance at a future date but, as outlined in the principles above, the Devon system partners are keen to establish new arrangements to ensure that the momentum and engagement are not lost. Discussions with NHSE/I suggest that the arrangements proposed within this document will be in line with any future requirements.

Interim governance arrangements were established in 2019 but this way of working was put on hold during the COVID incident. A review of these previous arrangements has been undertaken in light of new approaches to partnership working across health and social care during the COVID incident and there has been an opportunity to learn from past experience, both in Devon and more widely.

Discussions with individual organisations and their leaders were used to develop a draft structure which was also shaped by a review of arrangements in other systems. This structure was refined through further discussions and two system-wide meetings involving Chairs, Council Leaders, CEOs and place development leaders to produce this document. On 31st July 2020 this group agreed that a Shadow Partnership Board should meet for the first time early in September 2020. Following discussion with NHSE/I this document will be socialised more widely with other system stakeholders for feedback before the first Shadow Partnership Board meeting. Subject to approval it will then be shared with organisational Boards and Cabinets for formal approval.



(A more detailed structure is shown at Appendix B)

3.1 The ICS Partnership Board will consist of

- Health Chairs / Council Leaders,
- Health CEOs /Council CEOs
- System CEO
- Chair Clinical and Professional Cabinet

It will be responsible for:

- Setting system strategy, direction and policy and oversight of strategy development
- Strategic planning and consideration of the proposed resource allocation

- Holding itself to account for system performance.
- Sharing, scaling and spreading good practice
- Solving wicked system issues (such as system infrastructure, competing priorities etc) and enabling development at place
- Influencing and strengthening Regional and National links
- Championing Equality and Challenging Inequality
- Citizen Engagement working with Place and individual organisations to prevent duplication of effort.

The Partnership Board will work closely with the following groups to ensure delivery of system wide objectives and ensure a robust framework for planning and performance management:

- System Leadership Executive
- Clinical and Professional Cabinet
- Strategic Commissioner

The Partnership will not replicate the Boards or Cabinets of the Health and Social care organisations as its role is not to provide or commission services. There were concerns that if it did in any way replicate those structures that it may start "doing" as opposed to setting a framework for others to "do" within and create a conflict with the function of LCPs and at neighbourhood with Primary Care Networks (PCNs).

The Terms of Reference for the Partnership Board are at Appendix A

3.2 Working at Place

Local Care Partnerships (LCPs)will lead the delivery and development of services at place level. Their constituent organisations will take responsibility for a range of functions, previously assigned to providers and commissioners to ensure that services meet the needs of the local population and population health is improved.
The LCP is an arrangement for joint leadership of multifunctional teams, integrated by a shared plan and objectives, common processes and deployment of joint resources.
The aims of the LCPs are to

- Deliver Devon system strategies at local level
- Improve health and wellbeing outcomes for the local population
- Reduce inequalities
- Improve people's experience of care
- Improve the sustainability of the health and care system
- Support local engagement including with PCNs

In order to achieve these outcomes the LCPs will

- Co-produce plans with ICS Partnership Board which will deliver improved health and care services at population level
- Develop integrated services

- Create the conditions for healthy living
- Manage resources within available budget
- Plan services through engagement with citizens
- Develop community assets

It is recognised that the success of LCPs will be dependent on a wide network of relationships within a local area. Culture and the approach to working together will be as important as the formal structures. Therefore the membership of the LCP leadership team will be based on local circumstances but should include at a minimum:

- Local Provider Organisations (Health and Care)
- PCN Clinical Directors
- Local Authorities (officers and elected members) to include social care provision, housing, employment and communities
- Public Health leadership
- Community, Voluntary and Social Enterprise Sector
- Independent Sector

LCPs should also be able to demonstrate clearly how they will work with Health and Wellbeing Boards and Scrutiny Committees

Appendix A

Devon Shadow Integrated Care System Partnership Board

Terms of Reference

Introduction and Purpose

The Integrated Care System (ICS) Partnership Board will be responsible for setting the overarching vision and plan for the Devon Health and Care system and for holding the system accountable for delivery

Aims and Responsibilities

- To agree the Devon Health and Care System strategic vision, ambitions and priorities in line with the Long Term Plan.
- To set the framework within which the system will operate. This will support flexibility for working at place and local decision making whilst having standardised approaches to improving efficiency.
- To consider commissioning intentions , set by the strategic commissioner seeking to influence and align them with system strategic plans and see they are reflected in local Place based plans
- To inform and engage patients, the public and staff and their representatives in the work of the ICS
- To consider and give a view on the proposed Capital and Investment Strategy and funding allocations and criteria where required.
- To receive regular update reports from the System Leadership Executive on the ongoing process of delivery of the Long Term Plan and associated delivery plans
- To agree the Devon ICS Outcomes Framework as developed by the Strategic Commissioner.
- To oversee an annual review of the Long Term Plan and the development of annual delivery plans
- To hold the system to account for quality and performance
- To develop strong relationship with Regulators and wider Health and Social Care System and ensure that the system complies with regulatory duties and assurance reporting requirements.
- To develop and maintain relationships with organisations outside Devon where this is appropriate to support delivery of objectives.
- To work across system to promote provider resilience and to co-ordinate response in the event of failure

- To advise and act upon key strategic issues and risks on performance delivery and transformation of the Devon System
- To share good practice and promote its spread
- To provide a forum for solving “wicked issues”
- To act as the Devon Champion for Equality and Diversity

Membership

System Independent Chair

System Chief Executive

Chief Executive and Chair of all health organisations in the ICS

Council Leader and CEO of each of the Local Authorities in the ICS

Chair of the Clinical and Professional Cabinet

Frequency - Monthly

Meetings will be held monthly and will be planned for the calendar year ahead.

Meeting Review

A review of the efficiency of the ICS Board and delivery of its responsibilities will be undertaken at least annually in line with annual refresh of system governance arrangements. A review of the membership of the Partnership Board will take place roughly six months from the first meeting of the Board.

Reporting

The ICS Partnership Board is accountable to NHSE and NHSI on regulatory and oversight functions currently exercised outside of the system and will report accordingly.

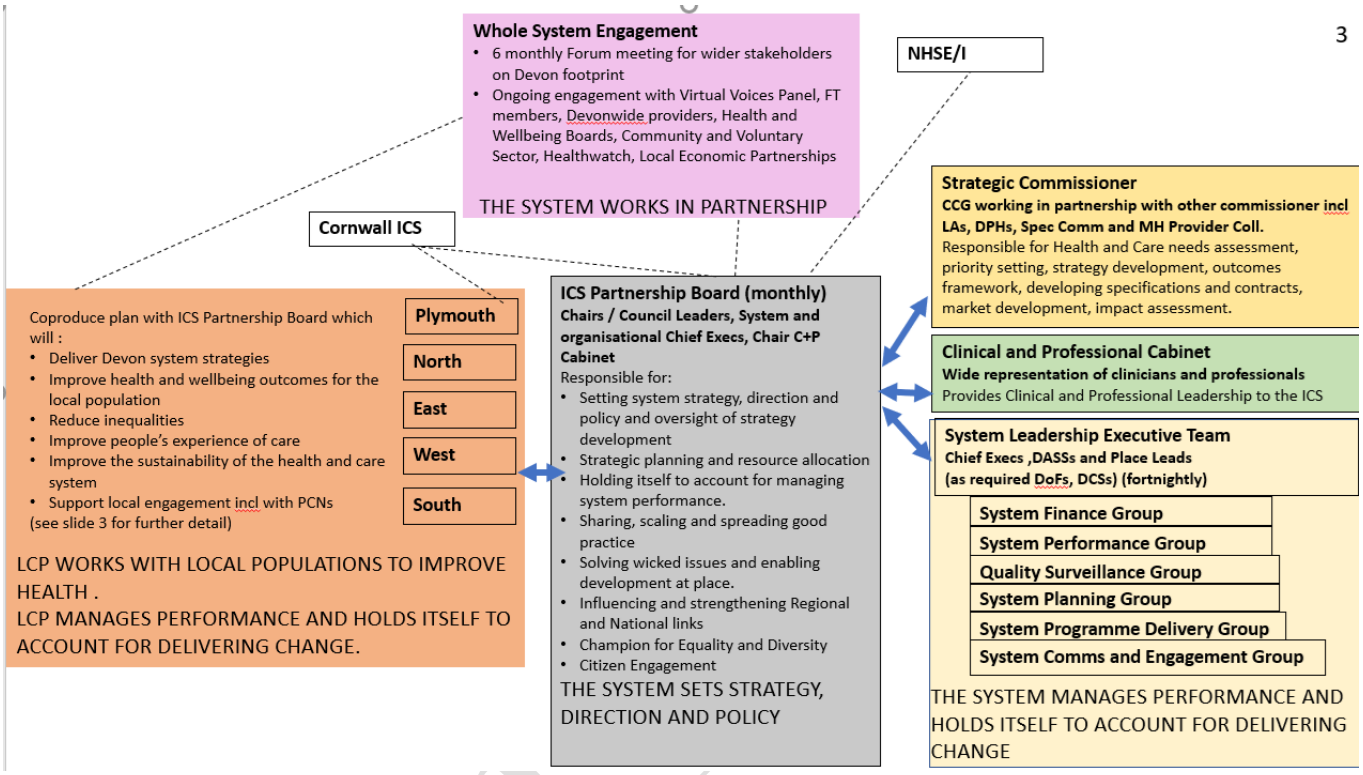
The ICS Partnership Board is the system's principal governance forum but it is not a statutory body.

The ICS Partnership Board will operate on the basis of consensus decision making. The Independent Chair will promote this model of working.

The ICS Partnership Board will work closely with the following groups to ensure delivery of system wide objectives and ensure a robust framework for planning and performance management:

- System Leadership Executive
- Clinical and Professional Cabinet
- Strategic Commissioner

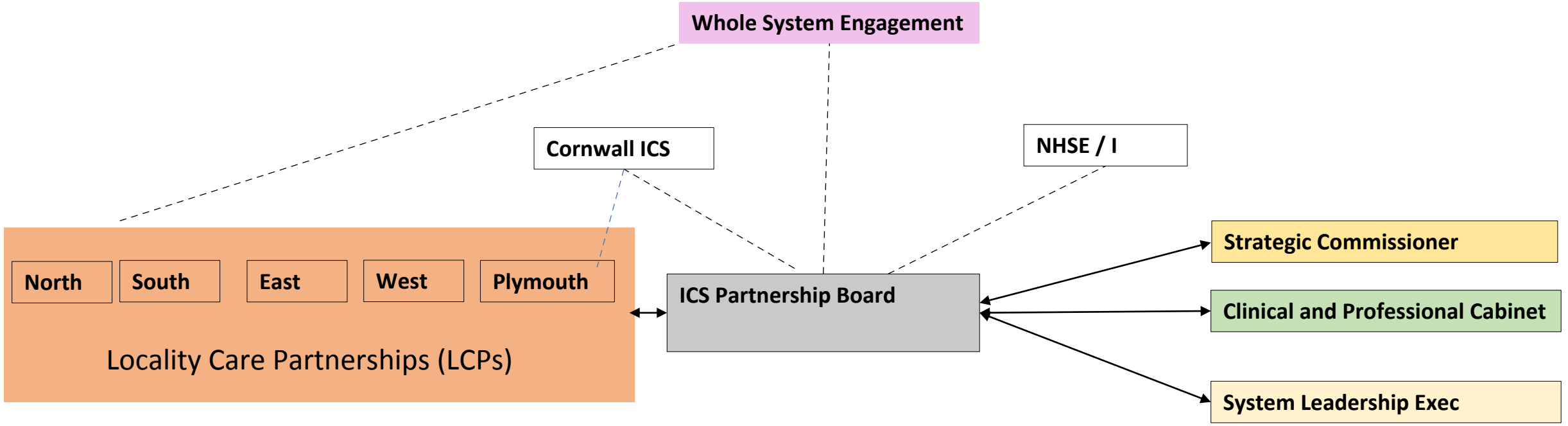
Appendix B – Detailed Governance and Accountability Structure



Principles for Development of System Working in Devon

- System governance needs to be light touch with minimal bureaucracy
- Arrangements need to be flexible, responsive and emergent
- The ICS recognises existing and continuing statutory roles and responsibilities
- The ICS, working with all system partners is responsible for setting strategy, direction and policy. The ICS will make recommendations to statutory organisations where required.
- There is an imperative to establish new arrangements but recognition that initial arrangements may be subject to change pending future NHSE guidance/ gateway criteria. This is an evolutionary process
- The principle of subsidiarity is accepted and all partners will hold each other to account for working to this principle.
- System and place will work together to drive transformation at all levels
- Meetings will be held virtually whenever possible

SHADOW ICS GOVERNANCE STRUCTURE



Whole System Engagement

- 6 monthly Forum meeting for wider stakeholders on Devon footprint
- Ongoing engagement with Virtual Voices Panel, FT members, Devonwide providers, Health and Wellbeing Boards, Community and Voluntary Sector, Healthwatch, Local Economic Partnerships

THE SYSTEM WORKS IN PARTNERSHIP

NHSE/I

Cornwall ICS

Coproduce plan with ICS Partnership Board which will :

- Deliver Devon system strategies
- Improve health and wellbeing outcomes for the local population
- Reduce inequalities
- Improve people's experience of care
- Improve the sustainability of the health and care system
- Support local engagement incl with PCNs

(see slide 3 for further detail)

Plymouth

North

East

West

South

LCP WORKS WITH LOCAL POPULATIONS TO IMPROVE HEALTH .

LCP MANAGES PERFORMANCE AND HOLDS ITSELF TO ACCOUNT FOR DELIVERING CHANGE.

ICS Partnership Board (monthly)

Chairs / Council Leaders, System and organisational Chief Execs, Chair C+P Cabinet

Responsible for:

- Setting system strategy, direction and policy and oversight of strategy development
- Strategic planning and resource allocation
- Holding itself to account for managing system performance.
- Sharing, scaling and spreading good practice
- Solving wicked issues and enabling development at place.
- Influencing and strengthening Regional and National links
- Champion for Equality and Diversity
- Citizen Engagement

THE SYSTEM SETS STRATEGY, DIRECTION AND POLICY

Strategic Commissioner

CCG working in partnership with other commissioner incl LAs, DPHs, Spec Comm and MH Provider Coll.

Responsible for Health and Care needs assessment, priority setting, strategy development, outcomes framework, developing specifications and contracts, market development, impact assessment.

Clinical and Professional Cabinet

Wide representation of clinicians and professionals

Provides Clinical and Professional Leadership to the ICS

System Leadership Executive Team

Chief Execs ,DASSs and Place Leads (as required DoFs, DCSs) (fortnightly)

- **System Finance Group**
- **System Performance Group**
- **Quality Surveillance Group**
- **System Planning Group**
- **System Programme Delivery Group**
- **System Comms and Engagement Group**

THE SYSTEM MANAGES PERFORMANCE AND HOLDS ITSELF TO ACCOUNT FOR DELIVERING CHANGE

LCPs will lead the delivery and development of services at place level. Their constituent organisations will take responsibility for a range of functions, previously assigned to providers and commissioners to ensure that services meet the needs of the local population and population health is improved.

The LCP is an arrangement for joint leadership of multifunctional teams, integrated by a shared plan and objectives, common processes and deployment of joint resources.

South

The aims of the LCPs are to

- Deliver Devon system strategies at local level
- Improve health and wellbeing outcomes for the local population
- Reduce inequalities
- Improve people's experience of care
- Improve the sustainability of the health and care system
- Support local engagement including with PCNs

North

East

In order to achieve these outcomes the LCPs will

- Coproduce plan with ICS Partnership Board which will deliver improved health and care services at population level
- Develop integrated services
- Create conditions for healthy living
- Manage resources within available budget
- Plan services through engagement with citizens
- Develop community assets

West

Plymouth

It is recognised that the success of LCPs will be dependent on a wide network of relationships within a local area and that the culture and approach to working together is as important as the formal structures. Therefore the membership of the LCP leadership team will be based on local circumstances but should include at a minimum:

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- Public Health leadership
- Community, Voluntary and Social Enterprise Sector
- Independent Sector

LCPs should also be able to demonstrate clearly how they will work with Health and Wellbeing Boards and Scrutiny Committees

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 24th September 2020 **Date report produced: 15th September 2020**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date:** 15th September 2020		
Public or Private (Governing Body only):	**Public**		**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

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

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

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

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

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

NHS England has confirmed that, to support restoration, and enable continued collaborative working, the current financial arrangements for CCGs and trusts will be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

On the above basis the CCG has received an allocation of £1,037.3m, including £19.3m for COVID19 related expenditure, to the end of July, together with an expectation that budgets are set within the parameters stipulated by the NHSE Model. Whilst the financial framework for the latter part of 2020/21 is being finalised the current report covers the period to the 31st August only.

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

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

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

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

None.

Key recommendations and actions requested:

The Governing Body is requested to:

Consider, review and discuss the month 5 year to date performance including the current risks.

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

N/A

Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**Yes**
Quality	Safety: Effectiveness: Experience:	
Equality		
Resource and Finance	Risk to delivery of CCG control total	√
Legal		
Engagement and Consultation		
Risk	Risk to delivery of CCG control total	√

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

NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 5 – 2020/21

Contents

Appendices

1. Executive Summary

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

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NHS England has confirmed that, to support restoration, and enable continued collaborative working, the current financial arrangements for CCGs and trusts will be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

On the above basis the CCG has received an allocation of £1,037.3m, including £32.2m that provides funding for the overspend to the end of July including COVID19 related expenditure. Whilst the financial framework for the latter part of 2020/21 is being finalised the current report covers the period to the 31st August only.

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

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

Financial Position

The following detailed report reflects the budget set by the NHSE model compared with our expectations of commitments against that budget for the period to 31st August 2020.

August 2020 (Month 5)	Budget £'000	Actual £'000	Variance £'000	Additional Allocation £000	Revised Variance £'000
Year to date position	869,754	877,768	8,014	-8,014	0

The variance against the original allocation to the end of August is £40.2m of which £32.2m has currently been reimbursed. The variance mainly arises from additional costs linked to the COVID19 pandemic £31.5m. These costs are detailed in section 4.

The remaining variances are detailed in the sections below with the significant variances being a product of Better Care Fund, delegated commissioning and running costs being greater than budget, offset by underspends relating to Non-Contract acute activity, continuing healthcare and a revised assessment of in year prescribing spend to date.

Savings Plan

The CCG's original plan included a saving requirement of £22.6m. The five-month budget to the 31st August is based on 19/20 forecast expenditure and by inference does not include an implicit savings target. The CCG will be reviewing its original planning assumptions and actions to deliver savings as we move into the next stage of the financial framework post 30th September 2020.

Risk

The main risk to delivering against the temporary financial regime for the period to 31st August 2020 is the possibility that some of the excess costs over and above the budget set are not funded by NHSE through the top up process. Whilst we have received funding to cover the CCG's first four months of COVID19 and non-COVID costs, it is not guaranteed that this arrangement will continue.

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

STP Plan

The STP planning process was put on hold in March. As mentioned above, NHSE has confirmed that the current financial arrangements for CCGs and Trusts will be extended to cover August and September 2020.The CCG and STP partners will be

addressing the next steps through the restoration and recovery programme and its response to the financial regime post 30th September once the detail is published.

2. Financial Assurance Dashboard

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

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

- Financial plan
- In Year Financial performance

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

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	16.8	8.0	47.6%	GREEN
3	Forecast Outturn deficit to 31st August	16.8	8.0	47.6%	GREEN
4	Running Costs	9.0	9.4	104.6%	RED
5	Risk adjustment to deficit (% of allocation)	0.0	0.0	0.0%	GREEN
6	Cash Position (% drawn down)	41.7%	48.9%	117.3%	RED
7	BPPC (% paid - value)	95.0%	99.3%	104.5%	GREEN

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

3. Detailed Financial Performance

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

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 AUGUST 2020 Month 05 August	DEVON CLINICAL COMMISSIONING GROUP Year To Date				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES					
Acute Services	378,625	377,913	-0	377,913	-712
Mental Health Services	89,013	88,891	548	89,438	426
Community Health Services	125,930	116,005	16,606	132,611	6,681
Placements	55,216	53,143	1,614	54,757	-459
All Other Healthcare	23,365	18,634	4,152	22,786	-579
Primary Care Services					
Prescribing	93,656	90,596	2,515	93,111	-545
Delegated Commissioning	70,954	71,778	-	71,778	824
Other Primary Care	25,001	20,827	5,160	25,988	986
Primary Care Subtotal	189,611	183,201	7,675	190,876	1,265
Commissioned Services Subtotal	861,760	837,787	30,595	868,381	6,622
CORPORATE					
Running Costs	7,994	8,511	876	9,386	1,392
EARMARKED RESERVES AND CONTINGENCIES					
Earmarked Reserves	-	-	-	-	-
Contingency	-	-	-	-	-
Other Reserves	-	-	-	-	-
Reserves Subtotal					
TOTAL COMMISSIONED SERVICES	869,754	846,297	31,471	877,768	8,014

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

3.1 Acute Services

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

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

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

The underspend of £0.7m at Month 5 relates mainly to the reduction of Non-contract activity compared to the budget set.

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

3.2 Mental Health Services

The Mental Health budget commissions services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and Livewell Southwest with the CAMHS service for Northern, Eastern and Southern localities being provided by Children and Families Health Devon through a contract with Torbay and Southern Devon NHS Foundation Trust. This section also includes spend relating to adult placements for mental health and learning disability services.

In 2020/21 the CCG had planned to invest £11.9m (5.63% increase) in Mental Health Services. Based on the recent Phase 3 guidance the expectation that MHIS will still be honoured over the course of the financial year and we are working with our providers to understand the current position against this plan and trajectory for investment for the remainder of the year.

At month 5 there is an overspend of £0.4m for all mental health services and is driven mainly by the temporary budget setting process when compared to actual commitments. The largest of which relates to Learning Disability and s117 placements where the budget compared to commitments and other pressure presents a £0.3m adverse variance at Month 5.

3.3 Community Health Services

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

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

Much of the year to date overspend of £6.7m relates to COVID19 costs within the Devon Better Care Fund and the Plymouth Integrated Fund (detailed in section 4), however £0.5m relates to the NHS budget model not reflecting the BCF uplifts agreed.

3.4 Placements

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

This area in total is underspent by £0.5m at Month 5. This is largely as a result of exceptional costs during the current pandemic (uplifts to market rates) and variance between NHSE/I budget setting model verses local plan but offset by client number reductions and additional budget received from NHSE/I for COVID19 costs and 19/20 FNC uplift.

The following table provides an analysis of the forecast variance.

Placements FOT Variance	
Variance Type	**£m**
Additional Covid related costs e.g. fee uplifts	1.7
Additional Budget for Covid costs M1-4 & M4 variance top up	-0.8
Budget variances (NHSE/I model vs local plan) & profiling	0.8
Non delivery of QIPP savings plan	1.0
Cost reduction due to client number movements (partly Covid related)	-3.4
FNC Uplift over and above plan assumption	1.0
Additional Budget for 1920 FNC Uplift	-0.8
Total	- 0.5

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

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

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

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

The Phase 3 planning guidance includes provision that CHC assessments should be re-commenced for new placements from the 1st September with reviews of those placements made between 19th March and 31st August to be undertaken. We are expecting detailed guidance to clarify the specifics in order that we can predict the financial consequences going forward.

3.5 All Other Healthcare

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

Overall, the underspend in this area are as a result of the budget setting methodology compared to actual commitments.

3.6 Primary Care Services

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

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

Prescribing

Prescribing is underspent by £0.5m at month 5. The current Prescribing Monitoring Document (PMD) did not include the necessary forecasting information and so the YTD position has been calculated using the first 3 months prescribing spend and last year's profile.

The No Cheaper Stock Obtainable (NCSO) spend has decreased meaning no further risk to us outside of the forecast at present.

Delegated Commissioning

The month 5 delegated commissioning figure is reported as a £0.8m overspend reflecting the recurrent commitments and pressures anticipated in 20/21.

Other Primary Care

The variances here are driven by the primary care COVID19 costs that have been funded by the CCG less the allocation received for the first four months.

3.7 Running Costs

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

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

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

The CCG's allocation for 2020-21 was set to reduce from £25.4m last year to £22.4m for this financial year but as part of the framework set for this period to 30th September this has been revised. The CCG is reporting expenditure for the 5 months at £9.4m, of which £0.9m are specific short-term costs in relation to COVID19.

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

3.8 Resource Allocation

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

Planned revenue resources	£'000
Allocation after place based pace of change	1,759,720
Primary care commissioning	170,193
Running costs allocation	22,411
Recurrent adjustments	-1,768
Non recurrent adjustments	-945,496
Non recurrent allocation COVID19 (to month 4)	19,303
Non recurrent retrospective top-up (to month 4)	12,900
Total revenue resources	**1,037,263**

The resources include non recurrent COVID19 allocations totalling £19.3m, but excludes the assumed additional allocation to cover the overspend position reported. The high level parameters under which the allocation was set are as follows:

Plan modelled as follows:

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

4. COVID19 Specific Costs

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

The CCG has incurred costs of £31.5m to date, as detailed below.

COVID 19 Commitment Analysis	**YTD** £m
Nightingale Hospital	2.2
CHC - Market Enhancements	2.1
Prescribing	2.5
Primary Care	5.2
PPE, Staffing and other costs	3.0
	15.0
Hospital Discharge	
Devon CCG	1.0
Devon Council	11.6
Plymouth Council	2.5
Livewell Southwest (Social Care)	1.4
	16.5
Total	31.5

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

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

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

In addition to these measures a national initiative to speed up discharge from Hospital and reduce the burden of assessment on decisions supporting discharge NHSE and Local Authority's regulators agreed a hospital discharge programme supported by £1.3bn of NHSE funding. It allows Local Authorities to reclaim the cost of discharge packages and enhanced costs of care to prevent hospital admissions to be reclaimed via the CCG. We continue to work without Local Authorities on the developing strategies for the market management of the care home sector and responding to the Phase 3 guidance in relation to the Hospital Discharge Programme.

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

5. Risks

The main risk to delivering against the temporary financial regime for the period to 31st August 2020 is the possibility that some of the excess costs over and above the budget set are not funded by NHSE through the top up process. Whilst we have received funding to cover the CCG's first four months of COVID19 and non-COVID costs, it is not guaranteed that this arrangement will continue.

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

6. Other Financial Information

6.1 Statement of Financial Position

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

The CCG's position at 31st August 2020 is shown in appendix 1.

6.2 Capital

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

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non NHS Creditors - % of bills paid within target	99.40%	98.59%
NHS Creditors - % of bills paid within target	96.75%	99.59%

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

6.4 Cash

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

7 Recommendations

The Governing Body is requested to:

Consider, review and discuss the month 5 year to date including the current risks.

Appendices

Appendix 1: Statement of Financial Position

AS AT 31 AUGUST 2020	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	1,808
Intangible Assets	3
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	1,811
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	108,516
Trade & Other Receivables - Non NHS	32,120
Other Current Assets	-
Cash & Cash Equivalents	6,522
Non-current Assets held for Sale	-
Total Current Assets	147,557
Total Assets	149,369
CURRENT LIABILITIES	
Trade & Other Payables - NHS	- 9,969
Trade & Other Payables - Non NHS	- 147,841
Other Liabilities	- 1,226
Borrowings / Cash in Transit	- 4,302
Provisions	-
Total Current Liabilities	- 163,339
Total Assets less Current Liabilities	- 13,971
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 89
Total Non Current Liaibilities	-
Total Assets Employed	- 14,059
FINANCED BY TAXPAYERS EQUITY	
General Fund	14,059
Total Taxpayers' Equity	14,059

Appendix 2: Cash

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

Measure	Month 5
CCGs must operate within their expected annual cash drawdown requirement. *The expected annual cash drawdown requirement 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 £2,009.876m for Devon CCG the year.*	48.9% of the MCD has been utilised as at month 5 (41.7% is expected based on a straight-line trajectory at month 5). Over utilisation is due to the requirement by NHS England to pay Providers one month's block payment in advance.
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £5,748 for August.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has not met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

Appendix 3: Operating Expenditure

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 AUGUST 2020 Month 05 August	DEVON CLINICAL COMMISSIONING GROUP Year To Date				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's
ACUTE CARE					
NHS Royal Devon & Exeter Foundation Trust	115,130	115,131	-	115,131	1
NHS University Hospitals Plymouth NHS Trust	95,152	95,151	-	95,151	-1
NHS Northern Devon Healthcare Trust	50,367	50,367	-	50,367	-0
NHS South Devon Healthcare Foundation Trust	84,274	84,274	-	84,274	-0
NHS Taunton and Somerset	4,022	4,022	-	4,022	0
NHS South Western Ambulance Trust	21,040	21,040	-	21,040	0
Independent Sector	546	624	-	624	79
Other Acute	8,095	7,304	-0	7,304	-791
Subtotal	378,625	377,913	-0	377,913	-712
PLACEMENTS					
Continuing Healthcare	49,409	47,721	1,321	49,041	-367
Funded Nursing Care	5,325	4,982	293	5,275	-51
Individual Patient Placements	482	441	-	441	-41
Subtotal	55,216	53,143	1,614	54,757	-459
COMMUNITY & NON ACUTE					
Livewell Southwest	21,948	20,493	2,424	22,917	969
Royal Devon and Exeter Community	24,473	24,473	-	24,473	-0
Northern Devon Healthcare Community	12,755	12,755	-	12,755	-0
South Devon Healthcare Community	29,379	29,379	-	29,379	-
Children and Families Health Devon	4,683	4,681	-	4,681	-2
MIU Contracts	350	342	-	342	-8
Plymouth Integrated Fund	5,669	3,898	2,534	6,431	762
Better Care Fund_Devon CC	20,046	13,195	11,648	24,843	4,797
Better Care Fund Torbay	1,287	1,373	-	1,373	86
Other Community Services	5,339	5,417	0	5,417	78
Subtotal	125,930	116,005	16,606	132,611	6,681
MENTAL HEALTH SERVICES					
Devon Partnership NHS Trust	54,143	54,143	-	54,143	-
Livewell MH Services	16,150	16,150	-	16,150	0
Children and Families Health Devon	4,567	4,617	-	4,617	49
Individual Patient Placements	11,537	11,365	458	11,823	287
Other Mental Health	2,616	2,616	90	2,706	90
Subtotal	89,013	88,891	548	89,438	426

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 AUGUST 2020 Month 05 August	DEVON CLINICAL COMMISSIONING GROUP Year To Date				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)
OTHER COMMISSIONED SERVICES					
NHS 111	1,527	1,526	-	1,526	-0
Integrated Urgent Care Service	259	258	-	258	-0
Hospices	3,485	3,497	141	3,638	153
Patient Transport Services	3,600	3,473	135	3,608	8
All Other Commisionned Services	14,495	9,879	3,877	13,756	-739
Subtotal	23,365	18,634	4,152	22,786	-579
PRIMARY CARE					
Prescribing	93,656	90,596	2,515	93,111	-545
Enhanced Services	6,148	6,223	-	6,223	75
Delegated Commissioning	70,954	71,778	-	71,778	824
GP Out Of Hours	6,132	5,753	411	6,164	32
Other Primary Care	12,721	8,852	4,749	13,601	880
Subtotal	189,611	183,201	7,675	190,876	1,265
TOTAL COMMISSIONED SERVICES	861,760	837,787	30,595	868,381	6,622
RUNNING COSTS					
Pay	6,090	6,671	740	7,411	1,320
Non Pay	1,944	1,897	136	2,033	90
Income	-40	-58	-	-58	-18
Subtotal	7,994	8,511	876	9,386	1,392
EARMARKED RESERVES AND CONTINGENCIES					
Earmarked Reserves					
Contingency					
Other Reserves	-	-	-	-	-
Subtotal	-	-	-	-	-
NET TOTAL OPERATING COSTS	869,754	846,297	31,471	877,768	8,014

NHS Devon Clinical Commissioning Group

NHS DEVON GOVERNING BODY - PUBLIC

Report title: Performance and Quality Report				
Date of committee: 24 September 2020 **Date report produced:** 10 September 2020				
Author (s) Name and Title: Sarah Zanoni – Associate Director of Professional Practice & Workforce Alison Wilkinson – Deputy Chief Operating Officer Kelvin Grabham – Associate Director of Business Intelligence		**Supporting Executive:** **Name and Title:** Jayne Carroll – Interim Chief Operating Officer **Report Approved by:** **Name and Title:** Jayne Carroll – Interim Chief Operating Officer Darryn Allcorn – Chief Nursing Officer Date: 10 September 2020		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The purpose of the paper is:

- To present the 1st April 2020 to 31st July 2020 (month 4) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.
- To present the quality, nursing and safety performance position for the period 1st April to 31st August 2020 (month 5).
- To update on progress in relation to Phase 3 and performance targets for the remainder of 2020/21.

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:

- Finance and Performance Committee

Key recommendations and actions requested:

Members of the Governing Body are asked to:

- Agree the 1st April 2020 to 31st July 2020 (month 4) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.
- Agree the quality, nursing and safety performance position for the period 1st April to 31st August 2020 (month 5).
- Note the update in relation to performance in Phase 3 (from August 2020 to March 2021).

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

Appendix 1 - Performance Report

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

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

Engagement and Consultation		√
Risk	Reputational risk due to non-achievement of trajectories	

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

NHS Devon CCG
GOVERNING BODY (PUBLIC)
24 September 2020

Performance and Quality Report

1. Introduction

This paper builds on the last performance paper presented to the Governing Body on 27 August 2020. The purpose of the paper is:

- To present the 1st April 2020 to 31st July 2020 (month 4) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.

- To present the quality**,** nursing and safety performance position for the period 1st April to 31st August 2020 (month 5).

- To update on progress in relation to Phase 3 and performance targets for the remainder of 2020/21.

2. Constitutional Standards Performance from 1st May to 31st July 2020

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

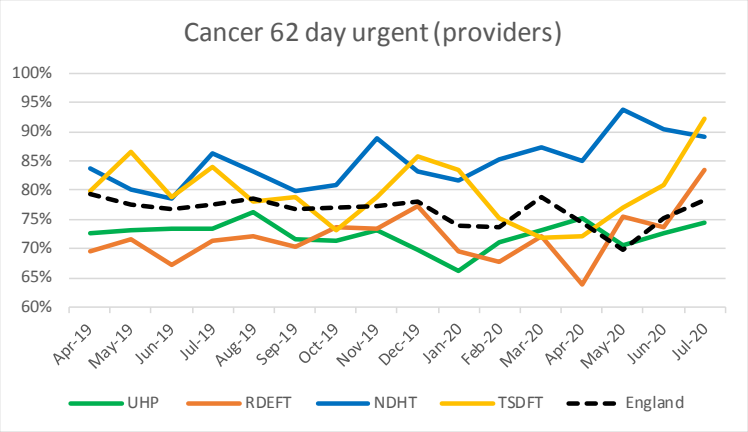
It should be noted that providers are not currently running full validation processes, so there may be an element of data quality issues which adversely affects performance.

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

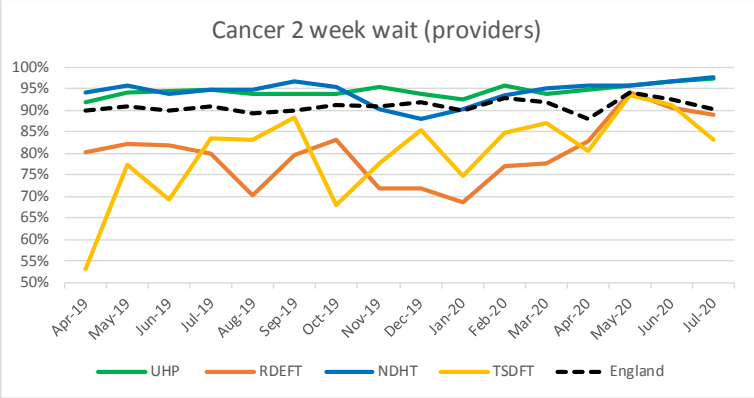
Appendix 1 shows the detailed performance information, but the key Constitutional targets are summarised below.

Cancer Waiting Times

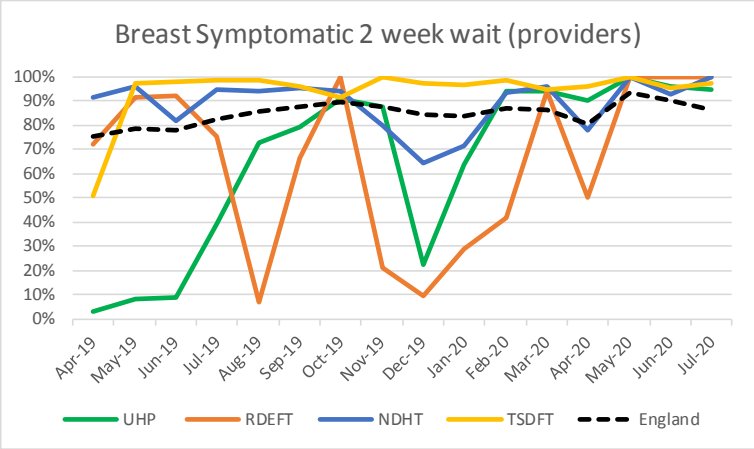
There has been a further increase in performance in July against the cancer 62-day urgent standard, with the STP position rising from 76.7% to 84.8%. NDHT and TSD both achieved the 85% target, at 89.2% and 92.3% respectively. UHP improved from 72.5% to74.6% and RD&E improved from 73.8% to 83.5%



Performance against the main two week wait standard fell below target in July, at 90.9%, NDHT & UHP both achieved the target (97.7% and 97.4% respectively). However, RD&E fell from 90.7% to 89.1% and TSD fell from 91.4% to 83.4%. This follows an increase in referrals back to pre-Covid levels, with rises at all providers.

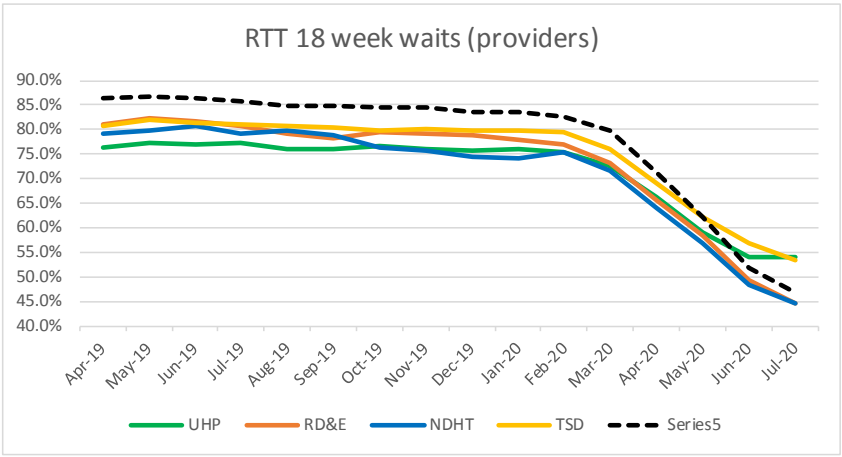


Breast symptomatic performance continues to be above target in July at 97%. With all providers achieving the target.



Referrals to Treatment (RTT) Waiting Times

July validated data shows a further fall in RTT 18-week performance, from 52.5% to 49.6% at STP level, compared to the national standard of 92% and current national performance of 52%.



Waiting lists have risen in July, as referrals increase back towards expected levels and activity. The table below shows the RTT waiting list movement between June and July by provider:

	RD&E	NDHT	UHP	TSD
June	30777	11611	25734	21968
July	31626	12194	27064	23733
Variance	**849**	**583**	**1330**	**1765**

The number of long wait patients also continued to increase, with over 52 week waits rising quickly at all providers in July, as can be seen in the table below. Breaches are expected to continue to rise in August.

	RD&E	NDHT	UHP	TSD
June	836	366	620	344
July	1204	630	766	524
Variance	**368**	**264**	**146**	**180**

The adapt and adopt (ANA) programme has given us the opportunity to increase capacity to support patients accessing surgery and our management of RTT waiting times. Through our system working we are working towards a system wide PTL (Patient Treatment List) which will support patients with greatest need accessing a surgical intervention. The ANA programme will augment capacity across the system and maximise our current capacity via a number of system-agreed interventions, such as:

1. Capital investment in endoscopy across the North and East localities will augment current capacity and improve both the volume of activity delivered and resulting performance;

2. Capital investment in Cardiac CT provision at UHP will increase the volume of activity and subsequently improve performance.

Diagnostic Waiting Times

Diagnostic waiting times have also been significantly affected by the Covid-19 pandemic. All providers saw an improvement in performance in July, with University Hospital Plymouth NHS Trust (UHP) performance rising to 76.3%, the Royal Devon and Exeter NHS Foundation Trust (RD&E) at 50.4%, Torbay and South Devon NHS Foundation Trust (TSD) at 67.7% and Northern Devon Healthcare NHS Trust (NDHT) at 47.4%.

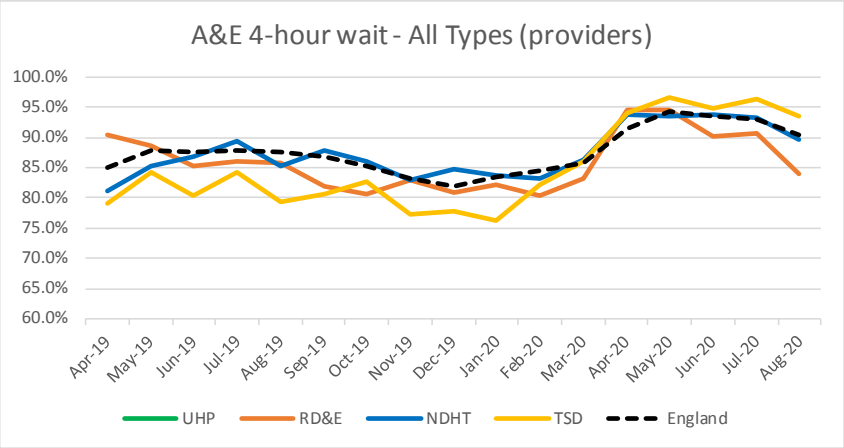
The table below shows the number of patients seen within 6 weeks, as compared to the national 99% target, and the movement between June and July. The STP position of 59.9% remains well below the 99% target but is slightly better than the England position of 52.2%.

	RD&E	NDHT	UHP	TSD
June	43.00%	41.60%	62.50%	58.70%
July	50.50%	47.20%	76.30%	67.60%
Variance	**7.5%**	**5.6%**	**13.8%**	**8.9%**

The ANA programme looks to minimise the operational impact of Covid-19 and thus increase our capacity. Local plans to increase capacity of MRI and CT are in place, with our local Nightingale unit delivering CT, MRI and Non-Obstetric Ultrasound, which will impact positively on future performance.

A&E Waiting Times – August position
In contrast with the position against elective waiting times, performance against the A&E 4-hour wait target improved as a lower number of patients presented in emergency departments from late March and into April. Overall attendance volumes fell by 40% in April and but are beginning to return to pre-Covid levels, with August seeing 5% a rise in A&E attendances.

STP performance was 89.43% in August for All Types and 86.3% for Type 1 attendances, below the 95% national target and the England position at 90.4%.



111 Performance – August position
The proportion of 111 calls answered within 60 seconds fell again, from 57.8% in July to 51.4% in August, which is significantly below the target of 95%. Actions being taken by the CCG to address this include additional investment of circa £800k (full year) in 111 call handler capacity and the Think 111 programme, which has a demand/capacity workstream with objectives linked to ensuring that the 111 service has enough capacity to deal with additional demand when the campaign is launched.

3. Quality and Safety Performance for August 2020 (month 5)

Urgent & Emergency Care
Time lost to ambulance handover delays across Devon in August increased to 415 hours. There has been no reported harm in relation to delays either to the patient in the ambulance/ or patients still waiting for an ambulance, but it is likely to have impacted on patient experience. Call stacking has become a challenge across the SWASFT footprint, and the SWASFT risk score has been increased to 20 following a period of low risk during COVID-19 where patient demand was less. The CCG risk score remains at 12 as there is no evidence to demonstrate either the level of stacking in Devon or any associated harm.

Six 12-hour breaches were reported in August, all by UHP. Further details have been requested to assess any patient harm.

The NHS 111 service continues to report significant pressure. Call abandonment rate in August increased to 21.19% from 16.87% in July against a target of less than 5%. Calls answered within the target time of 60 seconds in August fell to 51.40% from 57.77% in July against a target of 95%. This call answering position may lead to poor patient experience, although complaints to the service remain low.

Planned Care & Diagnostics

Pre COVID-19 escalated quality issues have been exacerbated by the pandemic, including long waits. With excellent examples of innovation, providers are now being asked to provide assurance they are 'adopting and adapting' new models of working to drive improved safety and experience. Impact of changes, be they stepping up or transforming, continue to be evidenced by providers, supported through the CCG Quality and Equality Impact Assessment (QEIA) process.

As the System strives to 'restore, transform, adopt and adapt', the CCG are working collaboratively with providers to ensure patients remain safe when waiting for long periods and that harm reviews are undertaken in a way to maximise learning. The CCG and NDHT Heads of Nursing and Quality are jointly presenting to the Devon Quality Surveillance Group in September with principles and recommendations that support a consistent approach to equity of access to services across Devon, risk stratification whilst patients are on a long waiting list and the harm review process.

Mental Health (MH)

The Care Quality Commission (CQC) undertook an inspection of DPT Acute wards for adults of working age and psychiatric intensive care units in June 2020 where the need for improvements have been identified. The report can be found here.

Work continues to ensure restoration of mental health services across the STP as described above to ensure safe and effective services for the population of Devon.

Primary Care

With more patients being seen virtually by acute providers, the apparent shift in work to primary care continues to be addressed by the CCG, through working to support primary care and other providers in the short term to understand and resolve this issue. The CCG are communicating closely with the LMC and facilitating providers to meet and plan how best services can potentially be delivered closer to home for patients in the longer term.

The CCG is also mindful of the potential impact winter, the influenza period and potential further COVID-19 surges will have on primary care. CCG plans therefore include how the CCG continue to support primary care, and its already challenged workforce, to mitigate potential risk and ensure continued high-quality care.

Care Home & Home Care Support
There continue to be low levels of COVID-19 in Devon. Recent data analysis has shown that care homes in Devon have the lowest COVID-19 mortality rate in the South West, although the reasons for this are not yet clear. Care home COVID-19 education will continue to be offered by the community infection management service (a collaboration between the four acute trusts and the CCG) after the national programme finishes at the end of September 2020.

The source of the long-term supply of FFP3 masks (required for aerosol generating procedures) for clients with a personal health budget who require advanced PPE is still not clear. The CCG stores management team have a limited stock, but a sustainable system position is needed for the supply of all FFP3 masks in all out of hospital settings across Devon. There is not yet a national or a local process for clients with personal health budgets to access FFP3 masks in a sustainable ongoing manner. The issue has been repeatedly escalated both regionally and nationally.

Collaborative Working between NDHT and RDE
There is evidence of sustained improvements, including a more robust leadership and governance process, since the collaborative relationship between NDHT and RDEFT began.

An example of significant improvement in governance and process is how the provider has resolved the clinical coding backlog and maintained this reduction for several months. Despite this success, the Trust have also demonstrated they recognise the need for long-term sustainability of the clinical coding team, and additional recruitment is underway to ensure ongoing stability; the recognition of long-term preventative investment requirements after a crisis is evident and positive.

NDHT is demonstrating how it is a learning organisation and is sharing innovation. For example, NDHT's Leg Ulcer Service team, Trauma and Orthopaedic team, and Acute Oncology Service team were shortlisted in the Health Service Journal (HSJ) Value Awards in September 2020.

Children and Young People
Information provided by Children and Family Health Devon continues to describe children and young people experiencing long waiting times (for CAMHs, Autism and SALT). Developments are being reported through the provider board; an improvement plan is being agreed and will be shared with the CCG.

4. Nursing and Quality Functional Performance for August 2020 (month 5)

Continuing Health Care (CHC)
As part of 'phase 3' restoration of services, this operational function has recommenced as of 1 September 2020. In addition, a CHC reset will work towards clearing a backlog of referrals, starting with pre-March 2020, followed by deferred standard referrals received during March – August 2020 and COVID-19 funded referrals (funding runs until March 2021). And finally, new referrals from September 2020. Options are being considered on how best to achieve this requirement and this will be presented to the CCG executive team this month.

A new nationally funded, 6-week discharge process has been established from 1st September 2020; this will generate new CHC assessment referrals, as well as those generated from the community setting.

The backlog and associated financial risk is noted on the CCG corporate risk register.

The CHC Control Centre meeting has been re-established and will oversee this work.

Safety Systems & Patient Experience
The overall position for serious incidents continues to improve, particularly for UHPT who currently have no overdue serious incidents. Processes are in place to continue to drive improvement and learning across the provider footprint.

Influenza Planning & Support Programme 2020/21
The CCG has a system oversight group to support providers across Devon in the delivery of the national programme. The publication of new national PPE guidance has enabled both community and hospital flu vaccination clinics to function safely. Both frontline healthcare worker and community flu vaccination projects are on track and no delays are anticipated. National messaging has indicated that 50-64 year-olds will be offered vaccination, but there are challenges around sufficient vaccine remaining later in the season (November 2020).

LeDer Programme
The LeDeR team have undertaken significant forward planning to ensure that NHSE targets are met all reviews notified prior to 31st July 2020 to be completed by 31st December 2020. The CCG have taken steps to improve capacity, including requesting reviewers from organisations across the STP.

Equality, Diversity and Inclusion
From October 2020 the Quality and Equality Impact Assessment panel will be resuming normal business activities; a monthly panel meeting and reporting to the Quality Assurance Committee. The panel has been dormant since April 2020, however a reduced membership of the panel has been able to support the CCG Clinical Effectiveness Team with policy reviews during the COVID-19 period.

There is a clear focus on delivering an inclusive 'phase 3' recovery and two areas of this work are currently in focus; the collection of protected characteristic data and the digital agenda. The CCG role is to support providers to meet the phase 3 recovery deadline of December 2020 for the collection of ethnicity data; to ensure that the focus on ethnicity does not mean the voices of people within other protected characteristics are lost; and to continue to stress the importance of supporting the digital agenda whilst maintaining a range of service delivery methods that include inclusive means of access to services. This is being carried out through the Health Inequalities and Understanding Population Needs working groups of the phase 3 recovery programme and in partnership with provider EDI leads via the Devon-wide Equality Co-operative.

Safeguarding
There has been a whole service Safeguarding Adults strategy meeting in relation to a DPT unit. Though it was agreed that the threshold for whole service safeguarding was not met, it was agreed that the unit will require ongoing monitoring through CCG Quality Assurance processes.

The number of S42 concerns raised to local authorities have continued to rise towards levels seen prior to the pandemic, though on occasions the concerns appear to be more complex. Local authorities are currently undertaking some initial analysis to understand themes and trends. CCG designated safeguarding adults nurses continue to support concerns regarding People in a Position of Trust (PiPoT) in NHS commissioned organisations, following regionally developed protocols that have been recently adopted by the local authorities across Devon.

There continue to be a high number of whole service care home concerns requiring involvement of the safeguarding adult team and CCG commissioners as appropriate.

5. CCG Performance Reporting from 1st August 2020 to 30th March 2021

As detailed in the last report to the Governing Body, the 31st July letter ***Third Phase Response to COVID-19*** set out expectations for the period August 2020 to March 2021. As part of the Devon system restoration process, providers submit weekly information to the CCG on activity and key performance measures, which, whilst unvalidated, gives the CCG a view of the current position against requirements of the letter.

The latest weekly performance against key targets (as at 30 August 2020) is:

RTT performance	53.4%
52+ weeks	4,017 (increase of 157 on previous week)
Diagnostic performance	61.3%
Cancer 2WW	85.3%
Cancer 62-day	91.4%

The System is working to finalise activity and performance trajectories as part of the Phase 3 planning work, and we will incorporate these into our performance reporting as soon as possible following agreement as part of our phase 3 submission on the 21 September.

6. Recommendations to Members

Members of the Governing Body are asked to:

- Agree the 1st April 2020 to 31st July 2020 (month 4) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.

- Agree the quality**,** nursing and safety performance position for the period 1st April to 31st August 2020 (month 5).

- Note the update in relation to performance in Phase 3 (from August 2020 to March 2021).

Appendix 1

Governing Body (Public)– Performance Report

September 2020

Performance and Quality indicators

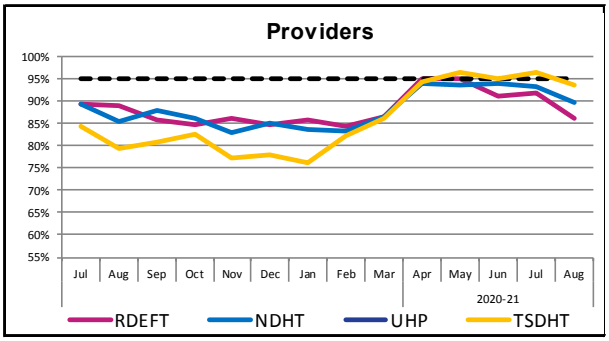
NHS Constitution Performance

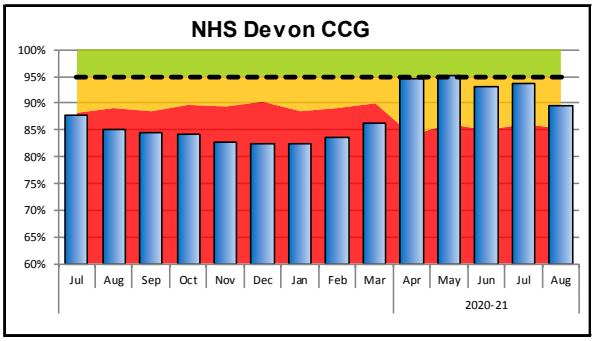
A&E Performance - Percentage of patients waiting less than 4 hours.

All types (including MIU and WiC)

Trust	Trajectory	August	2020/21
RDEFT	86%	86.0%	91.2%
NDHT	88%	89.7%	92.6%
UHP	N/A	N/A	N/A
TSDFT	82%	93.5%	95.1%

CCG	Trajectory	August	2020/21
NHS Devon	95%	89.4%	92.8%
ENGLAND		90.4%	92.5%

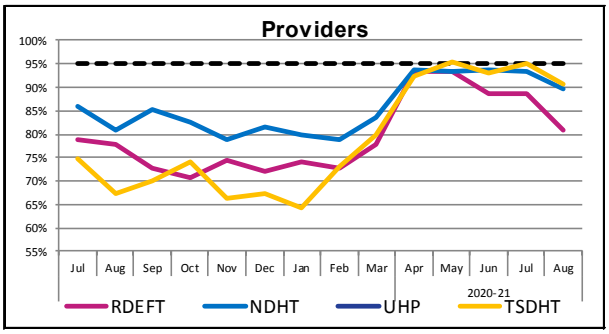


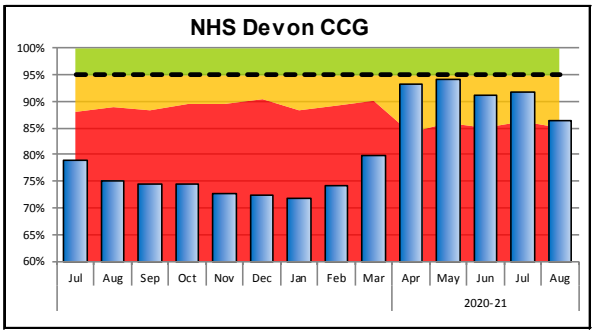


Type 1 A&E only

Trust	Trajectory	August	2020/21
RDEFT	86%	81.0%	88.2%
NDHT	88%	89.7%	92.6%
UHP	N/A	N/A	N/A
TSDFT	82%	90.7%	93.3%

CCG	Trajectory	August	2020/21
NHS Devon	95%	86.3%	91.0%
ENGLAND		86.3%	89.6%



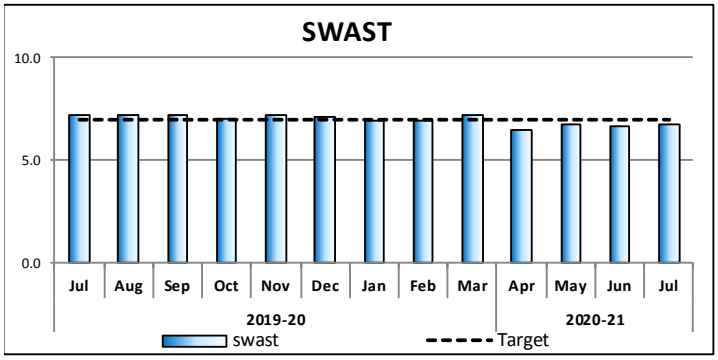


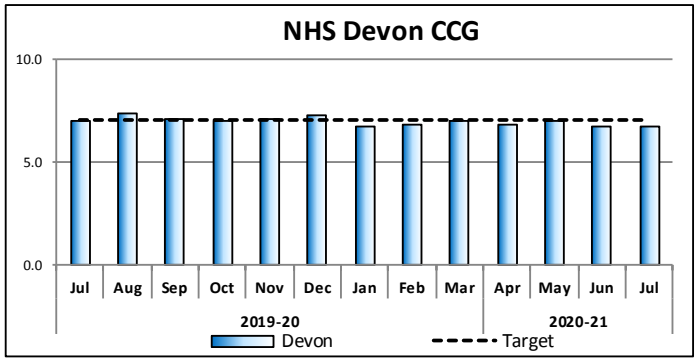
Performance Commentary

The August STP 'all types' position was 89.4%, down from 93.7% in July follow an increase in attendances. TSD continued to see the highest level of performance at 93.5%, with NDHT at 89.7% and RD&E at 86%. Type 1 performance also fell to 86.3% compared to the England position of 86.3%.

SWAST Cat 1 Mean response time

Trust	Target	July	2020/21
NHS Devon	7.00	6.70	6.90
SWAST	8.00	6.80	6.60



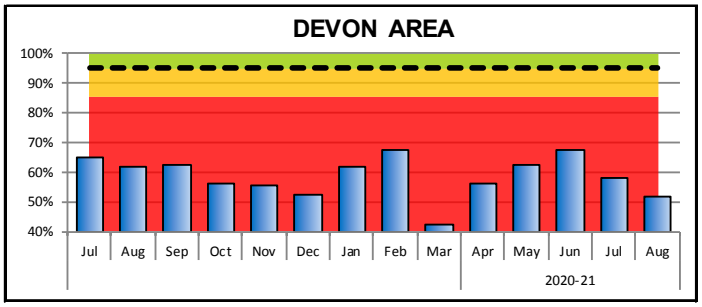


Performance Commentary

At STP level the 7-minute response time performance was within target in July at 6.7 minutes for Devon.

NHS 111 answering calls within 60 Seconds

Trust	Target	August	2020-21
DEVON	95%	51.4%	58.8%
ENGLAND	95%	85.5%	84.1%



Performance Commentary

The proportion of calls answered within 60 seconds fell from 57.8% in July to 51.4% in August. Performance remains well below the target of 95% and continues to be the lowest in the South West.

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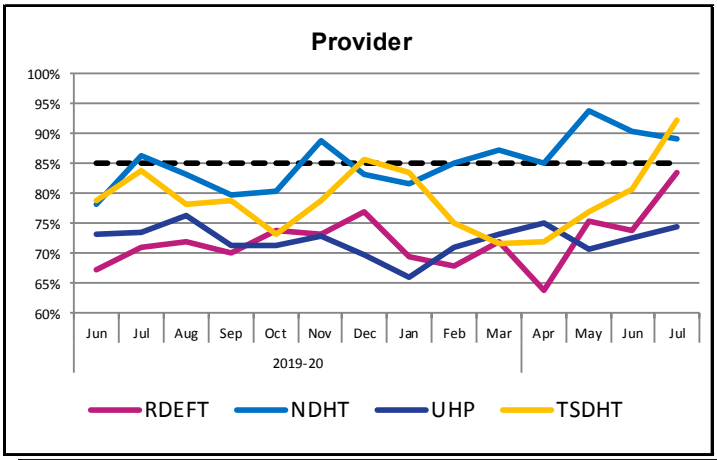
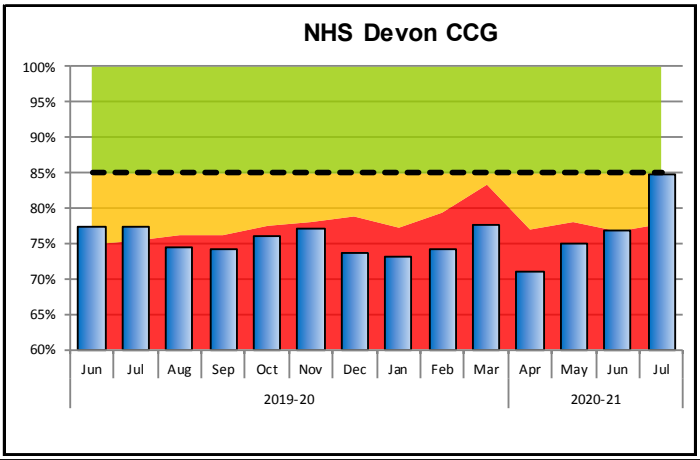
Cancer 62 day Urgent Referral

Trust	Trajectory	July	2020/21
RDEFT	74.7%	83.5%	73.8%
NDHT	84.5%	89.2%	89.3%
UHP	73.3%	74.6%	73.4%
TSDFT	85.6%	92.3%	80.6%

CCG	Trajectory	July	2020/21
NHS Devon	78%	84.8%	77.0%
ENGLAND	85%	78.4%	74.8%



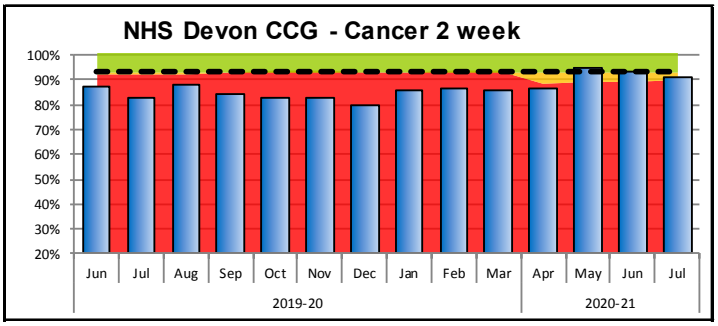


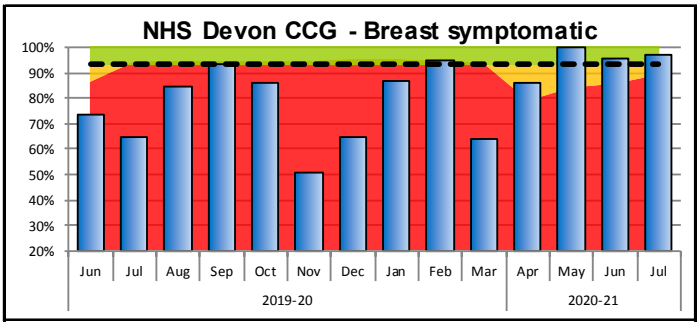
Performance Commentary

There was a further increase in performance in July with the STP position rising from 76.7% to 84.8%. Provisional provider figures show NDHT and TSD achieved the 85% target at 89.2% and 92.3% respectively. RD&E rose from 73.8% to 83.5% and UHP improved from 72.5% to 74.6%. Whilst the STP very slightly underperformed against target it remains above the national position of 78.4%.

Cancer Targets (July-2020)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	90.9%	89.1%	97.7%	97.4%	83.4%
93%	2 week breast	97.0%	100.0%	100.0%	94.6%	97.4%
90%	62 day screening	57.1%			73.7%	0.0%
85%	62 day consultant	84.3%	85.7%	92.3%	81.6%	
96%	31 day first	98.0%	94.3%	98.8%	98.4%	99.4%
94%	31 day surgery	90.3%	79.4%	100.0%	97.4%	96.4%
98%	31 day drugs	99.7%	99.3%	100.0%	100.0%	100.0%
94%	31 day radiotherapy	95.4%	98.5%		85.3%	100.0%





Performance Commentary

TSD and UHP achieved five of the cancer waiting times measures in July, RDEFT achieved four and NDHT met all six targets applicable to them. At STP level four of the eight measures where achieved with the 62 day screening measure underperforming due to small numbers.

Performance against the 2ww breast symptomatic measure remained above target but the STP slipped under target for the main 2ww target.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

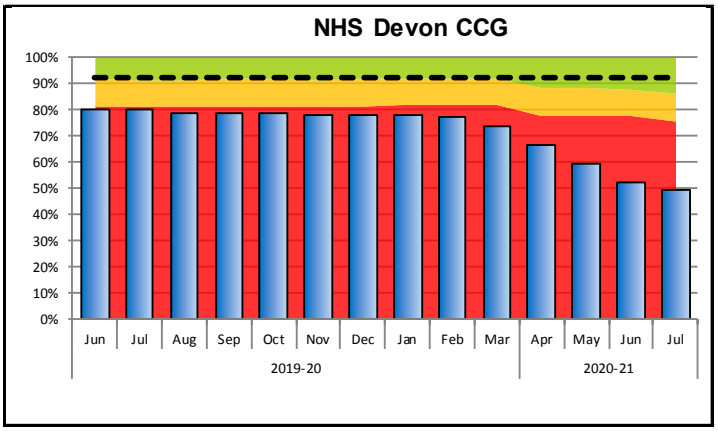
Trust	Trajectory	July	2020/21
RDEFT	72.5%	44.8%	54.5%
NDHT	74.3%	44.5%	53.3%
UHP	76.2%	53.9%	58.4%
TSDFT	78.6%	53.5%	60.1%

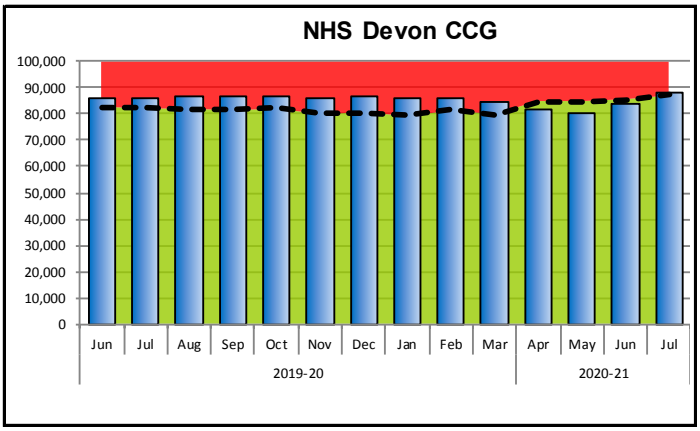
CCG	Trajectory	July	2020/21
NHS Devon	75.7%	49.6%	56.8%
ENGLAND	92.0%	46.8%	58.0%

RTT incomplete waits volume

Trust	Trajectory	July
RDEFT	34,374	31,626
NDHT	11,396	12,194
UHP	28,533	27,064
TSDFT	18,398	23,733

CCG	Trajectory	July
NHS Devon	82,054	87,791





Performance Commentary

The STP level RTT position continued to fall in July from 52.5% to 49.6% compared to the target of 92% and national performance of 52.0%. All providers saw a worsening position with UHP performance decreasing to 54.1%, RD&E at 49.2%, NDHT at 48.3% and TSD at 57.0%. All providers are under target and performance is expected to show a further decline when August data is released.

The RTT waiting list increased back to pre-Covid levels with rises at all providers.

RTT Incomplete Pathways long waiters

40-52 week waits

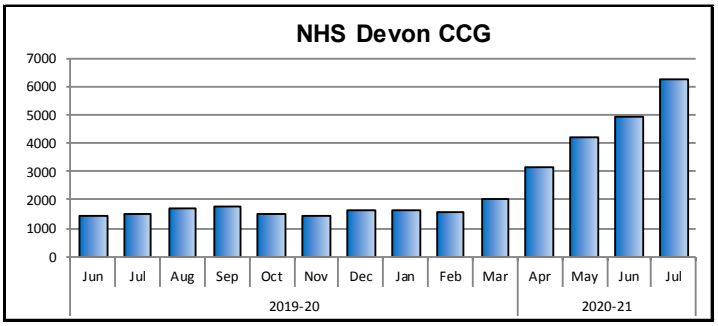
Trust	July	2020/21
RDEFT	2583	7456
NDHT	1080	3463
UHP	1709	5797
TSDFT	1324	3661

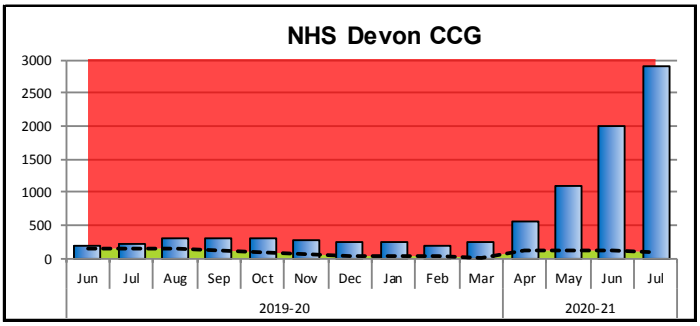
CCG	July	2020/21
NHS Devon	6223	18545

Over 52 week waits

Trust	Trajectory	July	2020/21
RDEFT	0	1204	2787
NDHT	0	630	1168
UHP	43	766	2028
TSDFT	120	524	1153

CCG	Trajectory	July	2020/21
NHS Devon	146	2911	6578





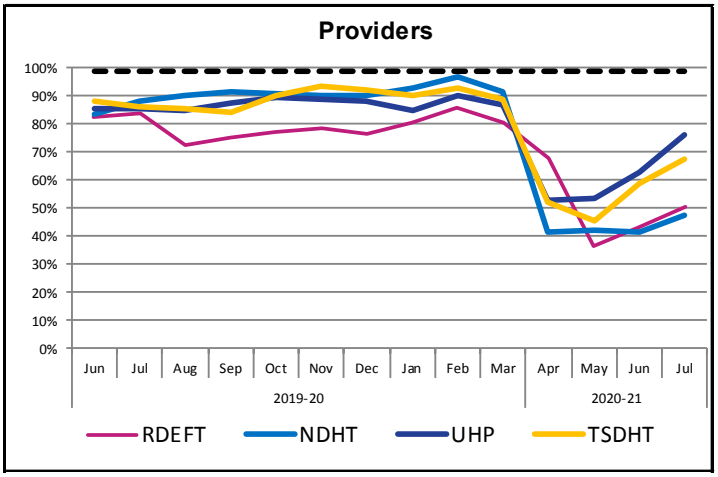
Performance Commentary

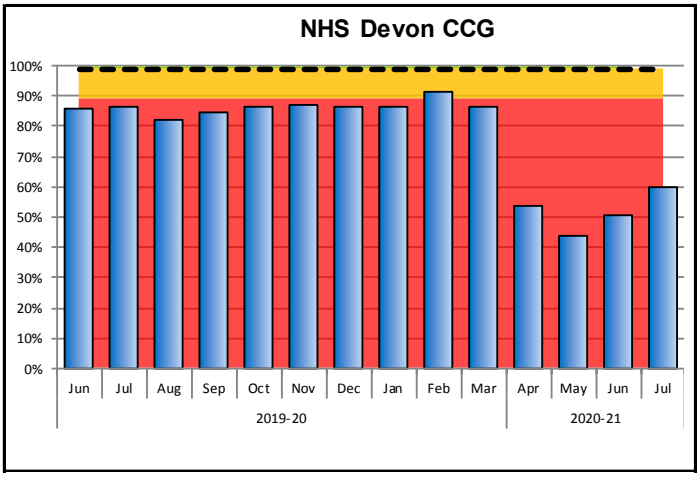
Over 52-week waits have continued to increase. There were 2,006 people waiting over 52 weeks in June and this has risen to 6,223 in July. All providers have seen an increase in breaches with RD&E rising to 2583 (from 839), UHP at 1709 (620), TSD at 1324 (344) and NDHT at 1080 (366). September is expected to show a further increase.

Diagnostic Seen within 6 weeks

Trust	Trajectory	July	2020/21
RDEFT	96.6%	50.5%	51.4%
NDHT	88.6%	47.2%	56.4%
UHP	94.6%	76.3%	38.6%
TSDFT	89.2%	67.6%	43.0%

CCG	Trajectory	July	2020/21
NHS Devon	93.3%	59.9%	52.3%
ENGLAND	99.0%	60.4%	50.5%





Performance Commentary

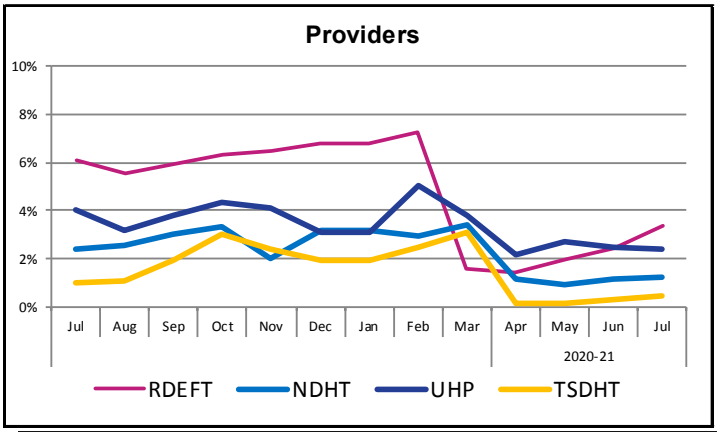
The STP position improved in July as test volumes increased, with 59.9% of patients being seen within the 6 week target compared to a national threshold of 99% and an England position of 52.2%.

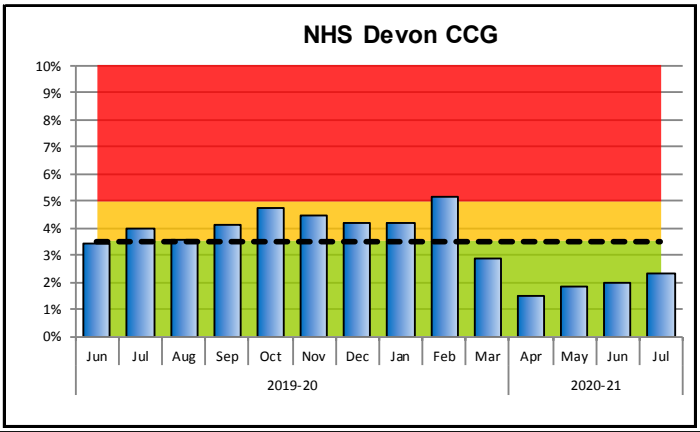
July figures show all providers saw an improvement with UHP performance rising from 62.5% in June to 76.3%, RD&E increasing from 42.9% to 50.5%, NDHT improving from 41.6% to 47.2% and TSD increasing from 58.7% to 67.6%

Acute Delayed Transfers of care

Trust	Target	July	2020/21
RDEFT	3.50%	3.4%	2.3%
NDHT	3.50%	1.3%	1.1%
UHP	3.50%	2.4%	2.4%
TSDFT	3.50%	0.4%	0.3%

CCG	Target	July	2020/21
NHS Devon	3.50%	2.30%	1.9%





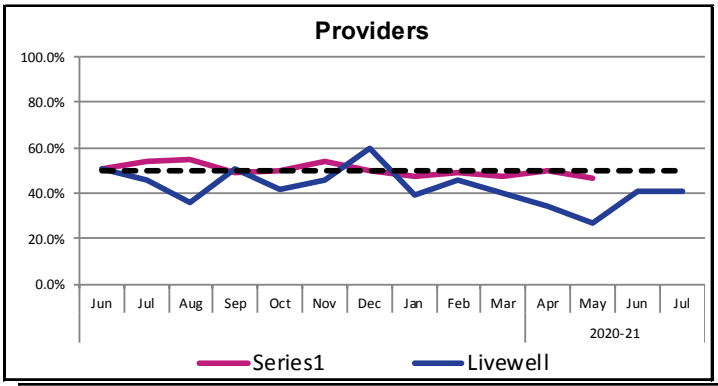
Performance Commentary

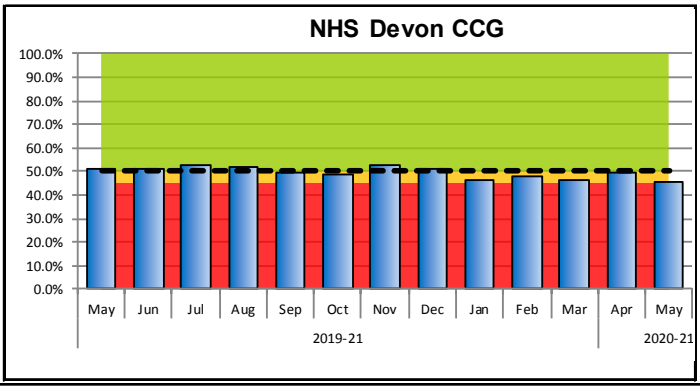
In July acute delayed transfers of care (DTOC) continued to be within the 3.5% target at 2.3%. All providers were meeting the target.

IAPT Recovery rate

Trust	Target	May	2020/21
DPT	50%	46.4%	48.1%
LIVEWELL	50%	40.7%	37.2%

CCG	Target	May	2020/21
NHS Devon	50%	45.1%	47.3%





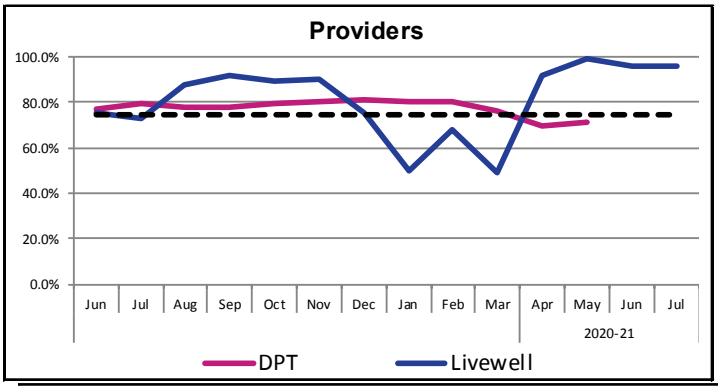
Performance Commentary

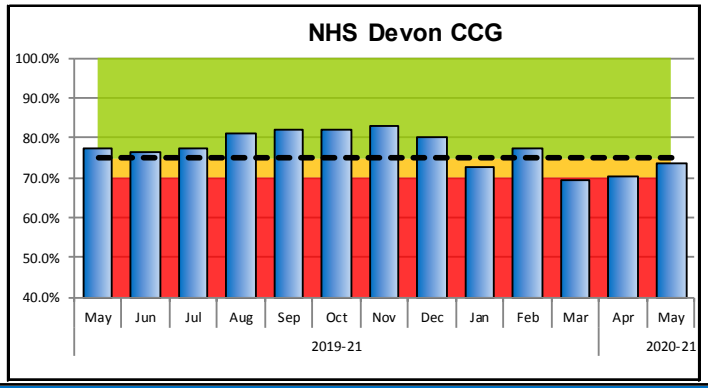
May IAPT recovery data shows performance continuing to be under the 50% target at 45.1% for the STP. DPT fell to 46.4% and Livewell continue to perform lower at 40.7%.

IAPT waiting 6 weeks

Trust	Target	May	2020/21
DPT	75%	70.9%	70.1%
LIVEWELL	75%	96.3%	96.5%

CCG	Target	May	2020/21
NHS Devon	75%	73.6%	72.0%



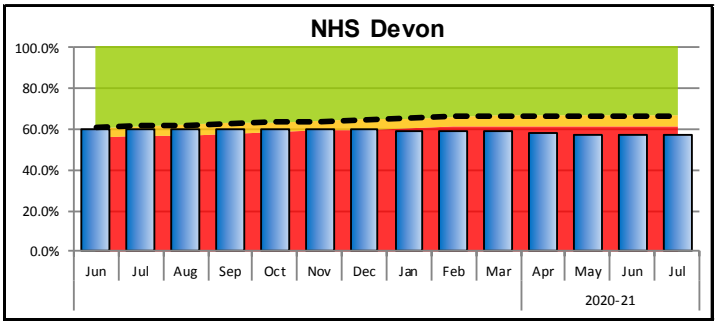


Performance Commentary

IAPT 6-week waits improved but continued to be below target in May at 73.6% for the STP against the 75% target. Livewell continue to perform well but DPT were below target at 70.9%.

Dementia Diagnosis Rate

CCG	Trajectory	July	2020/21
NHS Devon	66.7%	56.9%	56.9%
ENGLAND	67.0%	63.2%	64.2%



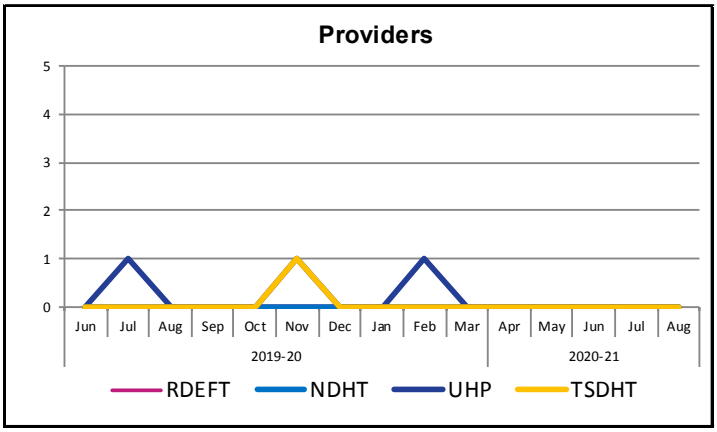
Performance Commentary

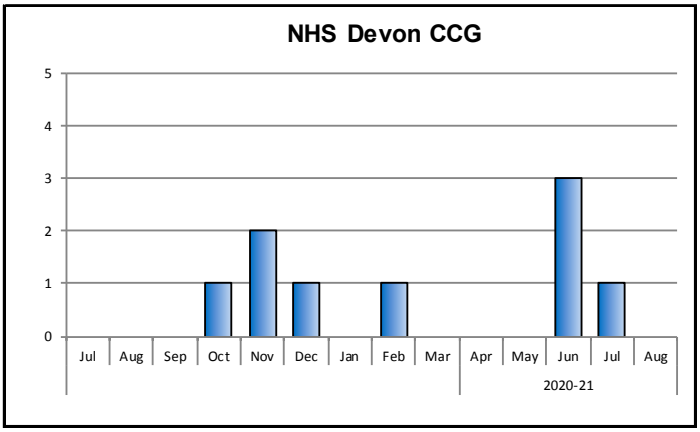
STP level performance remained static in May and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (42.2%), Mid Devon (51.1%) and Plymouth (56.5%). Conversely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

MRSA breaches

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

CCG	Target	August	2020/21
NHS Devon	0	5	4





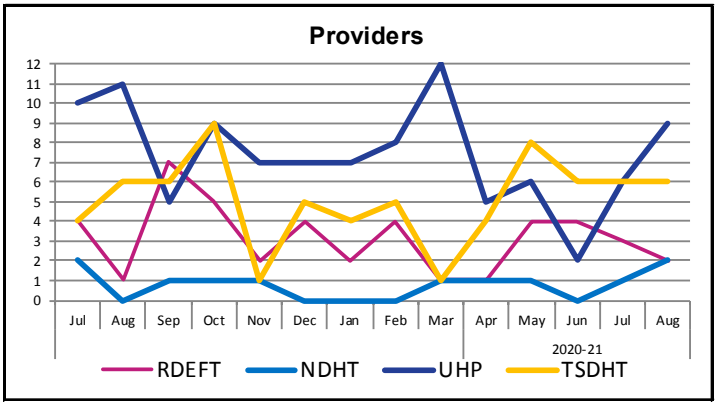
Performance Commentary

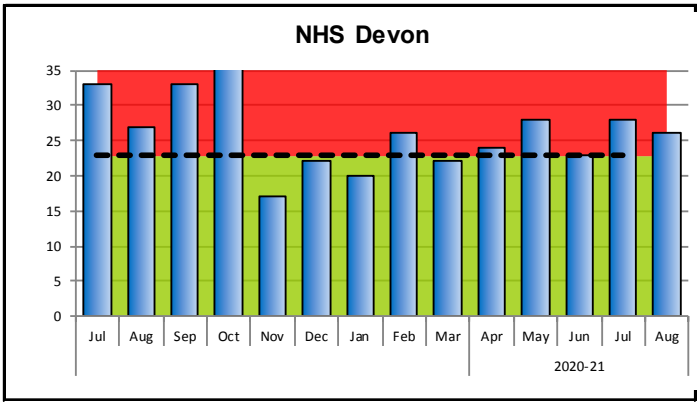
There were five reported cases of MRSA in August for the CCG, but none in Devon providers.

C-Diff breaches

Trust	Target	August	2020/21
RDEFT	<31	2	14
NDHT	<9	2	5
UHP	<63	9	28
TSDFT	<36	6	30

CCG	Target	August	2020/21
DEVON STP	<274	24	129





Performance Commentary

There were 19 C-Diff cases acquired within the Devon acute providers and 26 across the STP in August.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: 24th September 2020

Dates of Committees covered in this report: 9th September 2020

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

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

Contact Details: nick.ball1@nhs.net

Reports received and noted

- Risk Report – The corporate risk register is being monitored in accordance with the risk management framework policy as appropriate, this is being overseen by the Governance Team. Six new risks have been added to the corporate risk register, the risks will be operationally managed to seek assurance that mitigating actions and controls are in place. New risk 121 Mental Health Inappropriate Out of Area bed trajectory has been added with a score of 16 (likelihood 4 x impact 4) and is included in appendix 2, the risk will be reviewed by the Commissioning Committee.

- Standards of Business Conduct Policy – the audit committee received and approved minor changes to the policy.

- Use of the seal – The Audit Committee received and noted the report stating the common seal and the register of the common seal is held and maintained by governance, with a clear procedure in place of the circumstances in which it is applied, including the governance arrangements around its application. Since the authorisation of NHS Devon CCG the seal has been used once and a copy of the register is appended for oversight. The CCG has had no need to sign any new lease agreements so far this year.

- Procurement Policy – The Audit Committee received and approved the policy. Concerns raised around single use waivers which will be monitored through the Commissioning Committee.

- Financial Standard Operating Procedures – presented to the Audit Committee to note that a set of accounting procedures are in place to satisfy business as usual functions of the finance team.

- Internal Audit Update Report – The internal audit service provides a service in accordance with the requirements set out in the mandatory Public Sector Internal Audit Standards, comprising the Definition of Internal Auditing, the Code of Ethics and the International Standards for the Professional Practice of Internal Auditing. Adopts a risk-based auditing approach and maintains an Internal Audit Manual to support compliance with Internal Audit Standards. The Audit Committee received a September 2020 Internal Audit Update Report which summarises the work of ASW Assurance since the previous Audit Committee meeting in July 2020.

- External Audit Progress report – The Audit Committee received and noted the report on progress in delivering Grant Thornton's responsibilities as the CCG's external auditors.

- External Audit Annual letter – The Audit Committee received and noted the letter which brings together all findings of the financial statements and the value for money work in 2019/20.

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

Risk Register Review Updates

- Summary review of updates to corporate risk register and COVID risk registers as at 25 August 2020 were reviewed at this meeting and are available as appendices to this report.

Committee Decisions

The Audit Committee

- Noted Risk Report
- Noted and approved the Standards of Business Conduct Policy
- Noted the Use of the Seal Report
- Noted and approved the Procurement Policy
- Noted the Financial Standard Operating Procedures
- Noted the Internal Audit Update Report
- Noted the External Audit progress report
- Noted the External Audit Annual Letter
- Noted the Counter Fraud Progress Report

Items of concern to be escalated to the Governing Body

- N/A

Recommendations for Governing Body

- Approval of Standards of Business Conduct Policy

Recommendations for other Committees

- **N/A**

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.

NHS DEVON CCG
Risk Report (Audit)

Date produced: 25-08-2020 - 02:00
Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners

109	We will continue to commission safe, effective and accessible services [Reporting Committee] Audit	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •Reduced quality of care with impact on patient safety leading to increased public and media attention and reputational damage •Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (HISTORIC ID: Na)	For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group on a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. 26/06/2020 - For the period August 20 to March 21 we are currently planning to have demand/capacity planning with quantified activity from August onwards reflecting system transformation and senior planning in relation to capital bids these will inform our trajectory for national performance standards ending 2021 21/04/2020 - We are currently not monitoring performance on this standard in line with national guidance 27/02/2020 - The 2 weekly oversight by NHSIE has shown that we are on plan to meet the agreed trajectories for 52 week waits and diagnostics. There was a risk of losing 50% of the 52 week funding for RDE due to a gap in assurance however we have provided further info and the funds are now available 13/01/2020 - The system has maximised the opportunity to minimise the risk of delivery for 52w by obtaining and committing to revised trajectory as a result of 1.7 million of elective winter monies. This investment for UHP reduces the overall size of the waiting list as it does in South Devon and RD&E the investment in orthopaedics reduces the forecast to 38 these investments are monitored by detailed reporting template supplied by NHSE. The RD&E position improves to 38 while the other providers are still on trajectory to have zero 52ww breaches. The investment of winter elective monies will improve the overall STP position for diagnostics to 6.5% [Control Gaps] 13/01/2020 - Opel 4 esculation at the start of January puts some risk into this delivery 19/11/2019 RD&E ability to deliver the 5 endoscopy lists per week for 6 months within their organisation needs to be carefully understood and assurance gained. 16/10/2019 uncertainty around funding for endoscopy still an issue. Sufficient commissioning support to support recovery action plans at place. 13/09/2019 staffing at RD&E to provide increased endoscopy	16 [22/10/2019] = 16 (L=4 x I=4) [31/07/2019] ▲ 16 (L=4 x I=4) [06/06/2019] 9 (L=3 x I=3)	Risk Opened: 06/06/2019 Reviewed: 20/07/2020	[27/08/2019] System performance meeting monthly with providers,	Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. 13/01/2020 scrutiny at Dec SPG has provided assurance on these plans and elective board 19/11/2019 scrutiny at Nov SPG has provided assurance on these plans 16/10/2019 The quality of financial forecasting has been significantly improved with high degree of accuracy looking forward 3 months now achievable 13/09/2019 RAPS recovery action plans over the pervious 2 weeks have been quantified and outputs reflected in revised forecasts [Assurance Gaps] none identified	Executive Lead: Sonja Manton Owner: John Finn
38	We will continue to commission safe, effective and accessible services [Reporting Committee] Audit	As the CCG increases its level of collaborative working within the Sustainability Transformation Partnership and as part of the wider Devon sustainability and transformation partnership governance arrangements, there is a risk that the CCG may fail to adhere appropriately to one or more of its statutory duties or internal governance requirements, thus potentially failing in one or more of its legal duties. (HISTORIC ID: 319)	01/11/2019 Over the next couple of months the system will be reviewing and discussing new governance mechanisms. 06/08/2019 06/The CCG is undertaking work to strengthen its internal governance and risk management mechanisms. The CCG is engaging with system partners to develop appropriate governance structures and mechanisms to support system working. These governance arrangements will ensure each organisation is able to meet its statutory requirements whilst working together to deliver system objectives. 06/01/2020 reviewed at Executive Team Meeting [Control Gaps] No agreed governance arrangements for the system. No agreed governance lead to undertake the work	9 [23/06/2020] ▲ 9 (L=3 x I=3) [01/10/2019] = 6 (L=2 x I=3) [02/08/2018] ▼ 6 (L=2 x I=3) [23/05/2018] 12 (L=3 x I=4)	Risk Opened: 10/10/2016 Reviewed: 23/06/2020	[17/12/2019] Arrange workshop for system organisation Audit Chairs to review proposed system Risk Management arrangements GS,	06/08/2019 Review by PA consulting under discussion by system partners. The CCG has an approved Assurance Framework in place and further work is planned to review partner organisations strategic / principal risks. The CCG is undertaking committee mapping to strengthen its internal governance this includes three domains to manage its business which include local CCG governance arrangements, Locality working and Devon wide working. All organisations have their own processes for risk management and decision making and these take priority over system arrangements. [Assurance Gaps] Lack of non-executive oversight of system working and decision making. Lines of accountability from the Sustainability Transformation Partnership to statutory organisation are not clear	Executive Lead: Ginny Snaith Owner: Ginny Snaith

113	We will make best use of resources [Reporting Committee] Audit	There is a risk that the CCG will be unable to respond effectively in the event of an emergency or business continuity incident, through not meeting its statutory and policy obligations to be prepared to respond to emergencies and disruptive incidents. The impact is that the CCG would be in breach of our legal and contractual responsibilities which could place the health response to an emergency at risk. (HISTORIC ID: Na)	05/08/2020 CD EPRR Lead recruited to lead on preparedness work stream; An EPRR workplan in place to ensure that preparedness is maintained and that new requirements are implemented in a timeous manner; Suite of business continuity plans and emergency plans in place On-call system in place, supported by trained on-call staff, available to initiate a response 24/7; Trained Directorate Business Continuity Leads in place to maintain their business continuity plans Regular training is undertaken by On-call staff and BC Leads to maintain knowledge and skill sets Regular exercising of business continuity plans and participation in the exercising of multi-agency emergency plans is undertaken to ensure skills are maintained, plans are tested and the CCG is integrated into the multi-agency response to emergencies; EPRR Lead is engaged with NHS and multi-agency (LRF) EPRR planning to ensure the CCG is integrated into these plans. EPRR Lead will fulfil the CCG responsibility of undertaking an annual assurance of Providers preparedness in line with the NHSEI EPRR Core Standards and annual assurance process, and reporting upon this to the AEO & GB. [Control Gaps] 05/08/2020 CD The incident response to COVID has placed most other EPRR work on hold, meaning that wider preparedness activities are not currently being undertaken.	6 [05/08/2020] ▼ 6 (L=2 x I=3) [24/04/2020] ▲ 16 (L=4 x I=4) [29/08/2019] 6 (L=2 x I=3)	Risk Opened: 03/09/2019 Reviewed: 05/08/2020	[11/09/2019] Executives have been signed up Strategic leadership in crisis training with NHSE 14 October 2019., [11/09/2019] Internal audit is being undertaken by ASW during the second week in October to review the CCGs business continuity plans. , [11/09/2019] Severe weather plans and communications plans are being reviewed by relevant service area (Urgent control leads and communications team) and feedback awaited in anticipation of NHSE assurance visit October 2019. , [11/09/2019] Cascade lists of staff have been developed and HR have recently published a staff structure by directorate/service provision, [11/09/2019] Overarching BCP has been drafted and is to be presented to Executive for consideration of approval 24 September 2019, [11/09/2019] The Head of Governance is meeting with BCP Leads across the CCG to test their BCPs,	05/08/2020 CD - CCG and Provider emergency preparedness reviewed annually against NHS England EPRR Core Standards as part of a national NHSEI process; the 2019 assurance rated the CCG as Substantially compliant with work required on only 2 of 43 standards. Business Continuity Plans audited in December 2019 with a Significantly assured outcome. [Assurance Gaps] 05/08/2020 CD NHSEI National have indicated thet the 2020 EPRR Assurance process will not involve the full review against the EPRR Core Standards due to the ongoing COVID incident response. A less onerous assurance is expected but has not been distributed. The two Amber rated areas identified in the 2019 EPRR Assurance have been remedied, they were: Strategic Leadership training for on-call staff - completed in Dec 2019 BCPs not up-to-date as review was ongoing - review was completed	Executive Lead: Sonja Manton Owner: Phil Coutie

NHS DEVON CCG
Risk Report (High Risks Only)

Date produced: 25-08-2020 - 02:02

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners
108	We will make best use of resources [Reporting Committee] Primary Care Commissioning	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand and capacity) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system, including patient safety, could be affected. This risk replaces risk 09 (SDT) and 68 (NEW Devon) (HISTORIC ID: Na)	GP Strategy STP Workforce Group & Strategy Locality Workforce Groups GP Provider Collaborative Groups Regional Workforce Board 100 day plan in design for Plymouth system Regular review at Primary Care Operational Group Regular review at Primary Care commissioning committee Feb 19 - The GP framework associated with the long term plan, having been released, is being reviewed for opportunities to further mitigate this risk Apr 19 - Work continues to support practices in working closer together and with wider parts of the system and also building on the skill mix development as outlined in the contract reform GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments 20 Jun 19 - risk reviewed at Primary care operational group. No further update Jul 19 - 100 day plan in design for Plymouth system 7 Aug 19 - Reworked as Plymouth Prospectus; financial implications being reviewed; on track for 1 Sept 19 launch. 2 Sept 19 - Plymouth Prospectus circulated to Plymouth practices. Others were sent to practices in South Hams, West Devon and the rest of Devon to inform them of the prospectus and encourage them to send expressions of interest for when CCG launch our longer term transformation plans 10 Oct 19 - BMJ Job Fayre in London on 4th & 5th October 19; stand promoting SW region - supported by CCG staff and Plymouth GP. 14 Nov 19 - Risk score has been reviewed in light of CQC contract suspension of one practice within Western system, given (material) impact on 3 practices covering circa 25,000 patients. Score has not been adjusted as this was felt to be a manifestation of the risk rather than an escalation of it. 16.12.19 risk score not adjusted due to current list dispersals (from 2 practice closures) [Control Gaps] Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support In part a lack of evidenced change to new models	20 [29/05/2019] 20 (L=5 x I=4)	Risk Opened: 29/05/2019 Reviewed: 10/08/2020	[10/08/2020] Feb 20 - Implementation of GP Strategy being drawn up. New PCN DES specification confirmed. Development teams to work with networks to support maximum use of funds available. BMJ subscription confirmed – all GP vacancies to be advertised nationally. Scheme beginning 1 April and in collaboration with LMC. Apr 20 - risk currently being managed as part of the COVID risk management process May 20 - work to support practices including implementation of digital applications, reduce admin burden by clarifying the expectations re reporting, claiming and payment methods for LES / DES and other activities during the period of COVID Jun 20 - there has been some early successful interest through BMJ subscription. work continues to support including the implementation of digital applications, reduce admin burden by clarifying the expectations re reporting, claiming and payment methods for LES / DES and other activities during the period of COVID July 20 – Exec approved funded learning events from Covid being arranged. Many likely to be in the Autumn due to timing and be at PCN rather than locality level. Review of PCN Development plans in progress; may see shift in plans due to Covid. CD support also being reviewed. Locality recover huddles in place to ensure continued weekly interface between providers and commissioners across system as services are stood up or amended . 22 Jul 20 - Following 9th July letter from NHS England, CCG working to provide comms to practice re standing up of LES, DES and QOF activity and understanding of implication on capacity to safely deliver any catch up exercises. 10 Aug 20 - Proposal regarding reporting, claiming and payment methods for LES and DES payments beyond 31st July to be shared with Execs. ,	Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. practice resilience toolkit Heat map devised to identify vulnerable GP practices Regular resilience meetings with Devon LMC Work continues to develop Primary Care Networks and fill roles [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Paul Baker

109	We will continue to commission safe, effective and accessible services [Reporting Committee] Audit	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •Reduced quality of care with impact on patient safety leading to increased public and media attention and reputational damage •Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (HISTORIC ID: Na)	For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group on a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. 26/06/2020 - For the period August 20 to March 21 we are currently planning to have demand/capacity planning with quantified activity from August onwards reflecting system transformation and senior planning in relation to capital bids these will inform our trajectory for national performance standards ending 2021 21/04/2020 - We are currently not monitoring performance on this standard in line with national guidance 27/02/2020 - The 2 weekly oversight by NHSIE has shown that we are on plan to meet the agreed trajectories for 52 week waits and diagnostics. There was a risk of losing 50% of the 52 week funding for RDE due to a gap in assurance however we have provided further info and the funds are now available 13/01/2020 - The system has maximised the opportunity to minimise the risk of delivery for 52w by obtaining and committing to revised trajectory as a result of 1.7 million of elective winter monies. This investment for UHP reduces the overall size of the waiting list as it does in South Devon and RD&E the investment in orthopaedics reduces the forecast to 38 these investments are monitored by detailed reporting template supplied by NHSE. The RD&E position improves to 38 while the other providers are still on trajectory to have zero 52ww breaches. The investment of winter elective monies will improve the overall STP position for diagnostics to 6.5% [Control Gaps] 13/01/2020 - Opel 4 esculation at the start of January puts some risk into this delivery 19/11/2019 RD&E ability to deliver the 5 endoscopy lists per week for 6 months within their organisation needs to be carefully understood and assurance gained. 16/10/2019 uncertainty around funding for endoscopy still an issue. Sufficient commissioning support to support recovery action plans at place. 13/09/2019 staffing at RD&E to provide increased endoscopy	16 [22/10/2019] = 16 (L=4 x I=4) [31/07/2019] ▲ 16 (L=4 x I=4) [06/06/2019] 9 (L=3 x I=3)	Risk Opened: 06/06/2019 Reviewed: 20/07/2020	[27/08/2019] System performance meeting monthly with providers,	Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. 13/01/2020 scrutiny at Dec SPG has provided assurance on these plans and elective board 19/11/2019 scrutiny at Nov SPG has provided assurance on these plans 16/10/2019 The quality of financial forecasting has been significantly improved with high degree of accuracy looking forward 3 months now achievable 13/09/2019 RAPS recovery action plans over the pervious 2 weeks have been quantified and outputs reflected in revised forecasts [Assurance Gaps] none identified	Executive Lead: Sonja Manton Owner: John Finn

115	We will continue to commission safe, effective and accessible services [Reporting Committee] Commissioning Committee	There is a risk that Learning Disability and Autism Programme will not meet its "building the right support" trajectory and NHS LTP metric to reduce the number of children with LD and or Autism in a hospital place by 2023/24. The impact of this is Children will be place in out of area hospital placements a long way from home and their families, which will have a reputational risk for the CCG. (HISTORIC ID: Na)	Controls are the arrangements made or precautions taken, to reduce risk. (e.g. Governance processes / statutory frameworks, management structure & accountabilities, communications & patient / public feedback, policies & procedures / reviewed at team meetings etc). Please provide details of controls in place, below: - Developing proposals to submit to Executive team - Seeking additional resources from NHSE to implement proposals - Considering existing resources which could be redirected - Re-structure adults TCP team to support Children's TCP - Recruitment process underway for Clinical lead post to March 2020 - Additional co-ordination of CETR process UPDATE 27.04.20: •In line with national guidance, the Learning Disability and Autism Programme is continuing and performance monitoring is ongoing during COVID-19. •Good progress has been made with dedicated resource focused on reducing the number of Children and Young People in placement from 16 to 8 (21.04.2020). This is regularly reviewed and overseen by a fortnightly tracker meeting and reporting to the monthly Learning Disability and Autism Programme (LDAP) Group •Risk remains, as there is increasing activity in admission avoidance,(new admissions or re admissions) acerbated by COVID and risk to children with LD & Autism being restricted within their homes. UPDATE 02.07.20: - Recruitment for Complex Care Quality Assurance Lead near complete. Interviews 7th July. Individual CYP Admission Avoidance calls chaired by CCG continue to operate with multi agency input. NHSE funded key worker pilot EoI to be submitted July 10th - in line with LTP. Function and role will support the admission avoidance agenda. Proposed review of CYP who were in Tier 4 prior to COVID to track current situation. UPDATE 07.08.2020 - Nursing & Quality Directorate: - CYP discharges continue on tract with current trajectory. - CCG Quality Assurance Lead nurse recruited to commence 2nd November 2020. CCG Clinical Lead attends or Chairs multi-agency admission avoidance calls increasing CCG capacity, previously not available Feb 20. - Dynamic risk register reviewed with all providers at fortnightly CYP tracker meetings. [Control Gaps] Additional capacity needed to deliver Greater work needed to join up system approach to service Lack of project management to deliver CAMHS Capital Tier 4 admission avoidance project	16 [02/12/2019] 16 (L=4 x I=4)	Risk Opened: 23/01/2020 Reviewed: 07/08/2020	[23/01/2020] Draft proposal to be delivered at hot topics which details plans and resources required to address risk. This has now been approved. Ongoing conversations with NHSE re assurance. UPDATE 02.07.20: - Issues and risk are escalated as appropriate through the MH/LD Cell. Annual review with NHSEI 15th June 2020. CCG Secured additional capacity (1xday/wk) of Clinical Lead. Reviewing existing resources to support Children's TCP plan. Meeting to be set up for Feb between CCG Director of Commissioning, and Directors of Children's in the Local Authorities. UPDATE 02.07.20: This did not go ahead. Changes in Personnel. Action plan reviewed and updated. Continued risk around progression of capital admission avoidance bid, however mutli agency project group established and working through 'statement of purpose' and how will link to the NHSE funded crisis bed and key worker pilot. ,	For each of the risks and controls a source of assurance is set out ie. What provides evidence that the organisation has identified the risks and has controls in place. (e.g. Internal audit report, report to Board or Board Committees) Please provide details of assurances below: TCP Tracker meeting Care and Education Treatment reviews Performance data Escalation calls from NHSE Learning Disability and Autism Programme Steering Group CYP LDAP Sub Group Fortnightly Mental Health and Learning Disability Cell CCG secured extra capacity of lead clinician to continue to lead. [Assurance Gaps] Joined up with NHSE Specialised Commissioning Linking in with Children's services, social, EHCP's	Executive Lead: Jo Turl Owner: Shona Charlton
105	We will make best use of resources [Reporting Committee] Quality Assurance	There is a risk that patient safety will be compromised and / or harm may occur due to delays in out of hours GP response times. Delays occur due to Devon Doctors being unable to fill rota slots. The impact of this is upon public and professional confidence in the system; patient experience and safety and CCG reputation. (This risk supersedes risk 25). (HISTORIC ID: Na)	September 2020 - Following the peak of the pandemic when demand for out of hours care was reduced, a significant increase in demand is now being seen leading to call stacking and patients waiting for lengthy periods for a clinical response. 'Comfort calling' is in place but capacity is not adequate and many long waiters receive no such contact. Weekly meeting with Devon Doctors Ltd to review and monitor CQC improvement plan are now in place (SZ) March 2020 - call stacking in the out of hours service remains problematic. The improvement plan includes recruitment of further ANPs and paramedics. Risk score to be reviewed next month in light of COVID-19 impact (SZ) [Control Gaps] None identified	16 [21/08/2020] ▲ 16 (L=4 x I=4) [15/07/2020] ▼ 4 (L=2 x I=2) [15/04/2020] ▼ 8 (L=2 x I=4) [10/02/2020] ▼ 15 (L=5 x I=3) [14/10/2019] ▲ 16 (L=4 x I=4) [01/05/2019] 12 (L=3 x I=4)	Risk Opened: 01/05/2019 Reviewed: 21/08/2020	[21/05/2020] May 2020 - The CCG will monitor the impact of the increased demand on the call stack, in terms of patient experience & safety June 2020 - Demand is still increasing but call stacking is not currently an issue,	August 2020 - Ongoing monitoring indicates that calls are beginning to stack at weekends as demand for out of hours services continue to increase. No evidence of harm in relation to this has been reported (SZ) July 2020 - Devon Doctors have provided assurance that call stacking is not currently an issue, has significantly reduced & is being monitored (SZ) June 2020 - Demand is increasing although call stacking not currently an issue (SZ) May 2020 - Demand for out of hours is increasing but call stack risk remains controlled (SZ) April 2020 - Risk has reduced significantly as there has been a reduction in demand for out of hours services during the COVID-19 incident (SZ) [Assurance Gaps] None identified	Executive Lead: Darryn Allcorn Owner: Sarah Zanoni

121	We will continue to commission safe, effective and accessible services [Reporting Committee] Commissioning Committee	There is a risk that the Mental Health Inappropriate Out of Area trajectory, agreed by MH providers (Devon Partnership Trust and Livewell Southwest), is not met. The impact of this is damage to the CCG's reputation due to not meeting the nationally derived target to eliminate OOA placements by 20/21. (HISTORIC ID: Na)	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: - Daily bed management call in place chaired by DPT to ensure efficient flow of beds and reduce inappropriate placements. - Review of patient flows to ensure timely discharge from in patient units in place. - 16 bedded inpatient unit has been commissioned and re-classified as in area. - DPT have undertaken bed capacity modelling - Additional beds to be commissioned to increase capacity due to impact of Covid [Control Gaps] None at present	16 [13/07/2020] 16 (L=4 x I=4)	Risk Opened: 13/07/2020 Reviewed: 13/07/2020		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: - Monthly progress reports to the STP MH Programme Board with Out of Area numbers reported (paused during COVID-19) - Regular reporting from both MH providers (paused during COVID-19) available through the monthly performance book - Review of capacity plans within Devon to assure [Assurance Gaps] No formally agreed trajectory for the reduction in OOA COVID-19 delayed progress in the reduction of OOA placements	Executive Lead: Jo Turl Owner: Liz Cosford
116	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that there will be a system impact from the COVID-19 outbreak (caused by a strain of coronavirus), affecting routine business among provider organisations and the CCG. The impact of this is; a) that both the CCG and provider organisations have a reduced capacity for routine business. b) that the CCG loses lines of assurance and accountability from provider organisations, reducing overall sight of, and assurance levels around, provider organisations. Potential mortality and morbidity impacts are included in this risk. Staff morbidity would exacerbate individual provider and system impact. (HISTORIC ID: Na)	August 2020 - The risk states that there is a risk that Covid-19 could have the following impacts: a) that both the CCG and provider organisations have a reduced capacity for routine business, b) that the CCG lose lines of assurance and accountability from provider organisations, reducing overall sight of, and assurance levels around, provider organisations. I have reviewed the entries on the CCG's Covid risk register and the proposals for their future management, to assess if these potential impacts are adequately addressed: Covid 7 - addresses oversight of changes to provider service provision and is proposed to be transferred to the corporate RR Covid 8 - addresses timely access to services during the pandemic and is proposed to be transferred to the corporate RR Covid 9 - addresses outbreaks in care home and care at home services and the potential system service effects including capacity. It is proposed this risk is transferred to the Nursing & Quality team risk register Covid 27 and 20 - address management of delays to diagnosis and treatment. It is proposed these risks are transferred to the corporate RR For impact b) Covid 24 addresses vulnerable groups and CCG assurance that providers safeguarding arrangements remain effective during the pandemic. It is proposed this risk is transferred over to the corporate RR For impact a and b) - Covid 4 addresses ensuring assurance of quality standards and safety standards. It has been recommended for closure as quality surveillance through safety systems remained in place and all provider committees have resumed so levels of intelligence available as pre-Covid. The impact identified in Risk 116 are addressed by the risks on the current Covid 19 risk register and will continue to be once transferred to other risk registers, therefore recommended for closure in lieu of these (JP) July 2020 - There has been a system impact because of Covid 19 as described & mitigated by the controls as listed. A new risk may now be required to document the risks associated with the systems current management of the effects of lower incidence of disease and the potential for this to increase (JP) June 2020 - Since the risk was developed in March, there has certainly been a system impact & the system as a whole has worked to mitigate this. All regional and local system command and control structures remain in place including a range of incident cells and the CCG Incident Management teams to ensure continuation of business and service provision in line with national guidance (JP/LW) [Control Gaps] Resource required within the CCG in collaboration with provider organisations to support the COVID-19 response, coupled with anticipated staff sickness related to same, is resulting in cancellation of assurance meetings/work and de-prioritisation of other facets of organisational assurance.	15 [11/03/2020] 15 (L=5 x I=3)	Risk Opened: 11/03/2020 Reviewed: 11/08/2020	[10/04/2020] Incident control room functions as evidenced in action log,	August 2020 - The impact identified in Risk 116 are addressed by the risks on the current Covid 19 risk register and will continue to be once transferred to other risk registers, therefore recommended for closure in lieu of these (JP) June 2020 - All regional and local system command and control structures remain in place including a range of incident cells and the CCG Incident Management teams to ensure continuation of business and service provision in line with national guidance (LW) [Assurance Gaps] None identified	Executive Lead: Darryn Allcorn Owner: Jonathan Plumb

102	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that the number of Devon Partnership Trusts overdue Root Cause Analysis Serious Incident (SI) reports might affect the embedding of learning and improvement. The impact of this to the CCG is a lack of assurance that patient safety improvements from incident learning are identified and actioned in a timely way (Previously linked to mirrored risk 103 which is now closed) (HISTORIC ID: Na)	August 2020 - PK is due to provide a verbal update at QAC P2 on 20/08/20. DPT have outsourced 17 RCA's so aiming to improve the number of outstanding investigations in the short term however this is not a long term solution. The CCG are yet to see any change in DPT's governance process that would suggest long term embedded change in either completing investigations or applying action/learning (IL) July 2020 - Exec to Exec level discussions continue, in relation to quality assurance & support to improve (SW) June 2020 - QAC paper planned for July 2020 (joint CCG DPT CNO's) (SW) [Control Gaps] April 2020 - The number of overdue SIs has increased. DPT remain committed to resolving but have lost staff to the COVID-19 frontline reducing their capacity to undertake RCAs (SZ) March 2020 - DPT are not meeting trajectory, 31 remain overdue, this continues to be escalated to DPT Director of Nursing via DPT Head of Safety and Risk (IL) Assurance still lacking at Quality Committee in Common due to the written report on the management of Serious Incident's not being submitted – CCG chasing	15 [21/02/2019] ▼ 15 (L=5 x I=3) [25/01/2019] 20 (L=5 x I=4)	Risk Opened: 25/01/2019 Reviewed: 17/08/2020		March 2020 - The quality of investigations has greatly improved with less being returned for further information. The number of reported investigations has reduced to average 7 a month opposed to 12-13 a month, this is due to work with CCG / DPT/safeguarding and NHSE, reduced duplication and ensured only appropriate incidents reported. The number of overdue investigations has plateaued. There are now more clinical reviewers so more capacity in the team following training undertaken (IL) [Assurance Gaps] Action planning for overdue incidents is not visible whilst overdue. The quality of 'immediate' 72hr reporting is important in assuring that identified safety issues have been implemented.	Executive Lead: Darryn Allcorn Owner: Sara Wright

44	We will continue to commission safe, effective and accessible services [Reporting Committee] Commissioning Committee	There is a risk that children and young people will experience significantly delayed waiting times for Autism (ASD) assessment. This risk is applicable to all under 18s across the STP footprint, although the numbers and wait times would be higher in NEW Devon so this could be seen as the higher area of risk. Historically demand has far outweighed capacity for ASD assessment and currently there are a number of services that Children and Young People and families cannot access without a formal diagnosis across the local area. Referral rates continue to rise despite significant work within health services and the wider system to make processes leaner, increase capacity for assessments and offer better needs led increase capacity for assessments and offer better needs led support for CYP and their families. UPDATE SEP 19: A new STP wide risk is with the Director of Commissioning for final sign off, while this risk has been updated it should not be considered in isolation to other ASD risks which were in place before the CCG merger. UPDATE OCT 19: Risk still awaiting sign off 31.10.19. (HISTORIC ID: 111)	Senior Managers have discussed a business case for allocating additional resources to ASD assessment services, (although none were able to be allocated at this time), and waiting lists have been presented to senior managers as a cost pressure for 2019/20. Regular reporting between TSDFT and children's commissioner. Waiting times and improvement work monitored through CRM with VCL. Action plans and trajectory work with both VCL and SDHFT have been supported by commissioners and monitored through contractual routes, CRM and JTWG respectively. Multi provider, system wide ASD forum led by VCL to support continuous development. The Reprocurement of Children's Community Health and Wellbeing Services has set out expectations for improved services as part of the NDITS specification and action plans will be required as part of mobilization of the new provider of CCHWS from April 2019. Sitrep reporting instigated for all providers, following Devon SEND inspection highlighting long waits for ASD assessment. ASD strategic group is now meeting monthly and the Neurodevelopmental Strategy Project Group has agreed to develop some of the operational aspects linked to the WSoA for DCC. Update Oct 2019; Childrens Commissioners and providers are attending adults AIG for ASD funding to ensure there is focus on the14-18 cohort. Updated 13.07.20 work has paused on neuro developmental pathway development and operational delivery, due to Covid and inability to carry out the face to face assessments required for diagnosis. Although referrals for assessment have decreased waits will continue to build. Some assessments are being completed using existing information collected and on line platforms however this is taking longer to assess and those more complex cases or where school observations required will be dependent of child going back to school. As staff unable to undertake all assessments focus during COVID has shifted to providing support to families on wait list and those diagnosed, offering phone support, on line workshops, video resources etc. The CCG has been closely linked to the to CFHD's new stakeholder workgroup which is moving the pathway development work forward. April 2020 Numbers waiting for CFHD is 2800 with average wait time is 70.24 weeks [Control Gaps] The re-procurement of Children's Community Health and Wellbeing Services across the STP, has not supported conditions conducive to enabling system wide performance improvement work and Current providers are unlikely to make major changes/ investments into the system when they are unclear what the new provider of CCHWS will want. Additional finances can not be allocated due to the re-procurement of CCHWS. There is a pause on improvement planning work by VCL because of their contract ending. The multi agency ASD forum will postpone working until there is clarity on what the new provider for CCHWS wants to put in place from April 2019. The focus of the ASD Strategic Group is Devon and does not incorporate Plymouth or Torbay, although it is anticipated that service development will be shared through the wider system. Updated 13.07.20 although there has been some reporting during the Covid pandemic contract assurance meetings have paused as have key work stream meetings. Restoration plans covering ASD wait list revised trajectory; proposed additional investment by Alliance Board and use of alternative providers has been requested	15 [31/10/2019] ▲ 15 (L=5 x I=3) [25/09/2019] ▼ 10 (L=2 x I=5) [25/09/2019] = 10 (L=5 x I=2) [19/09/2019] ▲ 15 (L=5 x I=3) [24/04/2018] 10 (L=5 x I=2)	Risk Opened: 01/04/2013 Reviewed: 11/08/2020	[22/01/2020] UPDATE JAN 2020: A new STP wide risk is with the Director of Commissioning for sign off, to combine risks 15, 44 and 75., [19/09/2019] Reason: Risk 44 (NEWD CCG)/ 15 (SDT CCG) is proposed for step down from the Corporate Risk Register to the Women's and Children's Team Risk Register as the scoring sits below 16. This risk will be reviewed and updated at monthly team meetings. Performance against waiting times will benefit from more structured monitoring as part of the new contract for Children's Community Health and Wellbeing Services from April 2019 and through situational reporting to commissioners following the Devon SEND inspection and Written Statement of Action. https://nww.newdevonccg.nhs.uk/riskregister/ UPDATE SEP 19: A new STP wide risk is with the Director of Commissioning for final sign off, while this risk has been updated it should not be considered in isolation to other ASD risks which were in place before the CCG merger. ,	Business cases have identified what additional resources could achieve across the STP. Priorities for ASD have not been challenged in the Children's Community Health Wellbeing Services reprocurement process. A significant amount of patient/ family engagement was undertaken as part of the reprocurement of children community health and wellbeing services, so commissioners understand what is important and length of wait for assessment was less so where families are communicated with effectively and feel supported. Virgin Care Limited also undertook an engagement exercise in 2017/18. Devon SEND inspection highlighted significantly high waiting times for ASD assessment and providers have responded to regular meetings to discuss ways to move forward jointly with commissioners. A bid to NHSE for funding to reduce ASD waiting times was partially successful. Providers are expected to use any additional resource in 2018/19. A business case has been developed alongside the Adults business case, requesting funding to the waiting list crisis and to support post and pre diagnosis. National picture is similar to ours. Updated 13.07.20 providers are working on an and NHSE bid with adults services, focused on pre and post diagnostic support. However any funding gained will only be sufficient to address very small number of CYP and families. the CCG led an ASD stocktake event in June 2020 which was productive in considering and sharing the learning coming from the Covid position, in particular Covid has increased multi agency discussion of cases and sharing of information as well as enabling the use of technology to support assessment. During COVID the ASD service continues to prioritise those CYP in transition and those who are highlighted as urgent to complete assessments. [Assurance Gaps] Virgin Care Limited , who hold a significant majority of the waiting times have paused development work while the new provider of CCHWS confirms their long term plans and mobilisation starts. Due to the service's inclusion in the reprocurement of children's community health services no additional resource can be given from the CCG to address the waiting lists or develop new ways of working, at this time. There is a lack of understanding as to why parents are asking for an ASD assessment, to inform the wider system barriers to not having a diagnosis. There is a lack of clarity as to why referral rates are increasing generally. There is a lack of clarity as to which services are referring in for an ASD assessment. Funding from NHSE for waiting times is not enough to have a significant or sustained impact. Aspirations within the WSOA, including the reduction in waiting times will not be achieved if additional funding is not	Executive Lead: Jo Turl Owner: Siobhan Grady

					received for services. UPDATE SEP 2019 Waiting list initiative funding will ensure a meaningful number of assessments are carried out but this will still leave a significant number of CYP waiting. Updated 13.07.20 Any successful NHSE bid will only non recurrently fund post diagnostic support to a very limited number of families with no identified impact on wait list (decision made to submit an additional bid to recruit strategic lead for all age pathway development). The proposal for increased investment (for Helios and other alternative providers) to the original £750k made available by the CCG is dependend on the Alliance Board (Board mtg July 30).	

Appendix 3 - COVID Incident Risk Register - Report to Audit Committee September 2020

Risk Reference	There is a risk that….....	Risk score	Exec Lead	Risk Owner	Close risk. Please give rationale for risk closure	Transfer to Corporate Risk Register Please indicate which Committee the risk will report to	Transfer to Team Risk Register please indicate the name of the Team
COVID 01	The CCG does not have effective and efficient mechanisms for incident management	8	Sonja Manton	Ginny Snaith/ Clare Doble	Reviewed by GS - request to close as no longer relevant		
COVID 02	The activity and performance requirements nationally mandated are not fulfilled due to local system capacity response to COVID 19, reducing critical care and elective capacity.	8	John Dowell	Derek Blackford	Risk to delivery against NHS priorities including financial plan delivery is already a risk on the corporate risk register. Recommendation to close this risk as it is limited to COVID-19 but to review existing entries to ensure they accurately reflect risk in the current climate. Action for DB through Finance & Performance Committee		
COVID 03	The CCG is unable to discharge its mandated and constitutional role due to the need to respond to the COVID outbreak and diverting its resource and expertise to lead this response at local level	8	Simon Tapley	Sarah Thompson/ Ginny Snaith	Request to close - no longer relevent GS/STh		
COVID 04	Mandated quality and safety standards are compromised as resource is diverted to support COVID response, with less focus on normal quality reporting and intervention	16	Phillip King/ Darryn Allcorn	Lorraine Webber	REQUEST CLOSE Quality surveillance through safety systems remained in place and all provider committees have resumed so levels of intelligence available as pre Covid.		
COVID 05	Governance and accountability channels are compromised or not followed as required due to the constantly changing environment, speed at which tasks or guidance require enactment or lack of knowledge and understanding of governance requirements	8	Ginny Snaith	Clare Doble	Reviewed by GS and request to close as no longer relevant		
COVID 06	There will be insufficient critical care capacity and capability to respond to the modelled surge/increase of COVID positive patients in Devon	15	Penny Harris	Penny Harris	Request to close - Critical care because there is an agreed surge arrangement and two nightingale units available across region		
COVID 07	Decisions to make changes to services commissioned by the CCG through providers are done so without full cognoscente, clinical oversight and agreement whilst responding to the COVID 19 outbreak and management of capacity and resource	15	Simon Tapley	Sarah Wright		Quality Assurance Committee - to remain open as fundamental to the CCG & not solely the R&T cell or a separate N&Q directorate team risk register	
COVID 08	That patients across the age spectrum, who require urgent or ongoing care will not access care in a timely way due to fears or uncertainty about attending or contacting hospital services	10	Simon Tapley	Lorraine Webber		Quality Assurance Committee - Risk remains as public behaviour & impact of Covid related anxiety will potentially continue to impact how and when they feel able to access health care services	
COVID 09	Care home and care at home could become compromised, due to outbreak risk, PPE, staffing and pathway issues. LW 05/06/2020	12	Simon Tapley	Jo Shill			CHC Control Cenre - Risks continue to be anticipated and revaluated accordingly with local responses mitigating many prior to their manifestation.

COVID 10	The CCG will have insufficient plans in place to move the Devon system back into business as usual following COVID due to the capacity of staff to focus on recovery and re-establishment of elective and planned care.	**16**	Simon Tapley	John Finn			
COVID 11	COVID-19 outbreak could adversely affect the primary care teams ability to deliver current workplan and business as usual tasks.	**6**	Jo Turl	Mandy Seymour	Close - Have now incorporated this work into BAU within the team and are revewing the structures to ensure we can accommodate this. JT		
COVID 12	COVID-19 may result in GP practices being unable to return to business as usual in line with guidance if GPs are still actively dealing with COVID issues.	**8**	Jo Turl	Mandy Seymour			We are managing in each of the localities in a systematic way and plans to have hot hubs and PPE available to reduce risk. This is becoming the new way of managing the outcome of the incident. To be monitored at PCOG and Primary Care SLT and maintained on team risk register for Primary Care MS 28/07/2020
COVID 13	Other primary care providers (other than GP or pharmacy) are not fully briefed or supported at a local level because NHSE commissioners and resource is redeployed to support COVID adding additional pressure on the Devon Primary Care commissioning team.	**6**	Jo Turl	Mandy Seymour	Close - NHSE are the commissioner of these services JT		
COVID 14	There is insufficient access to digital solutions to support new ways of working in primary care	**6**	Andrew Millward	Jim Goodwin	The CCG is holding a stock of laptops still which can be deployed in there are local outbreaks or a second wave. All laptops deployed for the initial Covid situation are still with GP practices and will remain there. Provision of sufficient technology to practices for them to meet their patient needs is business as usual. JG 23/07/2020		
COVID 15	Decisions will not be made based on an ethical framework	**10**	Penny Harris / Paul Johnson	Penny Harris	Request to close - Ethical framework has been drafted and is going to all boards now		
COVID 16	There are insufficient numbers and capable workforce to support the required response to the COVID outbreak	**6**	Andrew Millward	Piers Tetley	First phase dealt with professionally. No issues. There are currently adequate staff to fulfil work requirements. If an outbreak occurred, Business continuity plans would support next steps and any escalation of further capacity requirements.		
COVID 17	Staff will suffer an increase in mental health issues due to social isolation, lone working and reduced direction driven by home working	**9**	Andrew Millward	Piers Tetley		This will need careful ongoing review, which HR and managers are undertaking. Robust staff support in place and we continue to grow that offer in line with direct feedback/engagement with staff.	

COVID 18	CCG staff are not fully utilised during COVID response if BAU not required in their area and redeployment not forthcoming	**12**	Andrew Millward	Piers Tetley	This has now been dealt with and all staff are appropriately utilised. The CCG are transitioning back to BAU and therefore this is no longer a concern.		
COVID 19	There is an insufficient supply and access to appropriate PPE equipment to support the clinically safe management of COVID spread both to protect staff from already infected individuals and to contain further spread	**16**	Phillip King/ Darryn Allcorn	Vanessa Crossey		Report to Quality Assurance Committee. Risk remains as PPE cell capacity and function is reducing whilst still in pandemic situation. May struggle with supply in sudden rise of cases. Risk can be reduced as; the four acute hospitals have good stocks; CCG is procuring PPE for primary care; national stock supply is good; LRF and LA stock is good. National stock reporting system is in place. CCG has some stock and can procure more in open markets at the moment. Still occasional issues with obtaining specific PPE, for example gowns and gloves. Issues with delivery, laundry, reusable supply, fit testing for FFP3 masks and occasional care home issues and discharges. Mitigation ongoing towards these issues and a STP wide PPE cell.	
COVID 20	Front line staff including community staff do not have ready and easy access to testing	**5**	Sonja Manton	Fiona Peck	Recommend closure - Sufficient testing capacity in place - total or maximum capacity has never been needed yet and planning numbers suggest that this is currently sufficient across all pillars. SM		
COVID 21	Residents and staff in the Devon system will have inequitable access to testing and interpretation of guidance because there is no overarching single point of contact in Devon to co-ordinate this because responsibility lies with multiple stakeholders (three different local authorities serving the wider Devon population and regulatory bodies)	**10**	Sonja Manton	Fiona Peck	Recommend closure -single management of all testing and testing strategy now in place across peninsula and supported by the two Local Outbreak Management Boards (Devon & Torbay/Plymouth) SM		
COVID 22	Patients who are on or will need to access an End of Life pathway are unable to access the support and care they need due to the focus on the COVID-19 outbreak	**12**	Phillip King/ Darryn Allcorn	Lorraine Webber			Nursing & Quality Directorate Risk Register - monitored at N&Q Senior Leadership Team Meeting
COVID 23	Individuals across Devon system are falling through gaps in the nationally described process for identifying patients who should be shielding	**8**	Jo Turl	Mandy Seymour	Close - Relaxation of sheilding guidelines. If we need to reinstate this due to another surge the CCG will pick this work back up. This is is being led by the Community. JT		
COVID 24	Safeguarding arrangements during the COVID-19 incident are continuing, but may not be as effective during this period due to the limitations all organisations are required to work to during the incident.	**12**	Phillip King/ Darryn Allcorn	Michele Thornberry		Report to Quality Assurance Committee. Risk remains as services continue to have reduced activity and lower levels of face to face interactions so identifying abuse more cahllenging. Ongoing	

COVID 25	As the Government relaxes lockdown arrangements the Devon health and social care system may become compromised as more patients and public take advantage of relaxed social distancing measures	**12**	Simon Tapley	John Finn			
COVID 26	As the number of Covid cases increases this will impact on ventilator use across the Devon system. Oxygen supply will need to be closely monitored and commissioned systems maintained to ensure that they are recalibrated by professionally trained staff to accommodate capacity and demand.	**10**	Sonja Manton	John Finn	Recommend closure - mitigating actions are in place (engagement with critical care network, Nightingale in place, community supplies restored, very low prevalence of COVID). Early warning dashboard in place and being monitored weekly formally by Nightingale GOLD, so can raise again and mitigate further if risk occurs again. SM		
COVID 27	Oversight of patients, including children, who are 'on hold' for cancer diagnostics or care is inadequate	**15**	Phillip King/ Darryn Allcorn	Lorraine Webber		Commissioning Committee with oversight by nursing & quality	
COVID 28	There is a national shortage of consumables being commissioned for renal replacement therapy for ventilated patients	**15**	Penny Harris	John Finn			
COVID 29	Impact of implementation of National Guidance: Patients who have been assessed and diagnostics or treatment deferred or who have chosen to self defer may have inappropriate outcomes. There is a risk that changes in predictions of disease prevalence for the Peninsula will result in a period of deferment in excess of that recommended by the national guidance.	**15**	Phillip King/ Darryn Allcorn	Lorraine Webber		Report to **Quality Assurance Committee**. Risk remains as all providers are challenged with backlogs of planned surgery and this will form key component of the restoration of services.	
COVID 30	Mandated commissioned primary care quality and safety standards are compromised as resource is diverted to support COVID response, with less focus on normal quality reporting and intervention	**6**	Jo Turl	Mandy Seymour	Close - Have now incorporated this work into BAU within the team and are revewing the structures to ensure we can accommodate this. JT		
COVID 31	Individuals across Devon system may not be accessing mental health services	**12**	Jo Turl	Liz Cosford (Louise Arrow)			Transfer to Local Mental health Risk Register JT
COVID 32	There is a risk that in line with national guidance issued on Revised Arrangements for NHS Contracting and Payment during COVID-19 Providers will not be able to maintain adequate information collection and reporting arrangements whilst they are managing the incident. Therefore, the CCG will not receive robust information. That NHS Devon CCG will not be able to maintain a business intelligence function and that information reporting and management will not occur. That the CCG will not be able to fulfil the revised national guidance and provide accurate reporting and give suitable assurance to the Governing Body over the period of March to end July 2020	**12**	Sarah Thompson	Sarah Thompson	It covered the period March – July and during that time providers maintained the core reporting of key performance and the CCG was able to maintain its BI function and give assurance to the Governing Body. Phase 2 we established the weekly dashboard shared with the system restoration group We will now need to look at what information we need on a ongoing basis to support the performance framework, but this will come once we have the phase 3 guidance and progress the engagement around this with localities.		

COVID 33	Seven-day discharge processes are not able to be consistently applied across the week by all providers	**9**	Sarah Thompson	Locality Leads			Risk 33 will move to the four locality risk registers.
COVID 34	Pressure on UHP as key provider for the peninsula impacts on occupancy levels	**16**	Sarah Thompson	Western Locality Team			Risk 34 will move to the Western Locality risk register.
COVID 35	Capacity planning is not comprehensive nor timely enough to manage flow through the system	**12**	Sarah Thompson	Locality Leads			Risk 35 will move to the four locality risk registers.
COVID 36	There are gaps in out of hospital care services that are contributing to delayed discharges and these include access to care homes with dementia care	**9**	Sarah Thompson	Locality Leads			Risk 36 will move to the four locality risk registers.
COVID 37	Maturity of system arrangements come under strain through pressure of pandemic especially in relation to newly formed PCNs	**9**	Sarah Thompson	Locality Leads			Risk 37 will move to the Eastern Locality risk register and the scoring will be reassessed.
COVID 38	The CCG may be subject to fraud as there is a increased incident of activity during the pandemic	**6**	Simon Tapley	Ginny Snaith/ Clare Doble		Transfer to CRR with change in scoring to 2 x 3 as no increase through pandemic a/d no history of prvious loss (GS 31/07/2020)	

NHS
Devon
Clinical Commissioning Group

AUDIT COMMITTEE

Report title: Risk Report				
Date of committee: 09 September 2020 **Date report produced: 25 August 2020**				
Author (s) Name and Title: Theresa Farris, Risk and Governance Manager theresa.farris@nhs.net **Contact Details:**		**Supporting Executive:** Ginny Snaith, Board Secretary **Contact Details: g.snaith@nhs.net** **Report Approved by:** As above		
Public or Private (Governing Body only):	**Public**		**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This paper provides the Audit Committee with relevant assurances regarding the risk process that is embedded within the CCG through the risk management framework policy. The data for this report was accessed on 25 August 2020.

The Audit Committee is presented with a report from the corporate risk register of risk reporting to this committee (Appendix 1) and risks scored as significant (Appendix 2) showing status and management of these risks at this time. The corporate risk register is being monitored in accordance with the risk management framework policy as appropriate, this is being overseen by the Governance Team. The corporate risk register will be reported to the Senior Leadership Team meeting monthly, Audit Committee bimonthly and to Governing Body through the Audit Chairs report.

Six new risks have been added to the corporate risk register, the risks will be operationally managed to seek assurance that mitigating actions and controls are in place.

New risk 121 Mental Health Inappropriate Out of Area bed trajectory has been added with a score of 16 (likelihood 4 x impact 4) and is included in appendix 2, the risk will be reviewed by the Commissioning Committee

The COVID- 19 risk register has been reviewed by the executive team and the recommendations from the Executives and risk owners have been considered and approved. Risks are in the process of closure or transfer to either the corporate risk register or team level risk registers. A Summary of these risks is attached as appendix 3 and summarised in section 3

The assurance framework (AF) was reviewed by the Executive leads in June 2020 and has been closed and a new version of the AF will be produced to support the CCGs revised corporate objectives when approved.

The report outlines the outstanding internal audit recommendation and management response for audit and assurance oversight in relation to corporate governance (section 4)

Report section	Item	Appendix
Section 2	Corporate Risk Register	Appendix 1 Audit Committee Risk Report Appendix 2 Corporate Risk Register - Significant Risks
Section 3	COVID Risk Register	Appendix 3 COVID-19 Risk Register transfer summary
Section 4	Internal Audit Recommendations	
Section 5	Risk Management Training	

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:

The Executives have responsibility for the risks identified on the Corporate Risk Register.

Each committee of the Governing Body, following discussion with appropriate Executive(s), has approved any additions and / or closures to risk.

Key recommendations and actions requested:

1. **Note that the risk is being managed appropriately through the Corporate Risk Register**
2. **Note the addition of risk 121 - Mental Health Inappropriate Out of Area bed trajectory has been added to the corporate risk register with a significant/very high-risk score of 16.**
3. **Note the actions being taken to stand down the COVID-19 risk register appendix 3**
4. **Note current position of Assurance Framework**

Impact on Strategic Objectives

We will continue to commission safe, effective and accessible services
We will work as a strategic partner in Devon
We will improve the physical and mental health of our population
We will make best use of our resources

Reference to other documents or accompanying papers:		
Corporate Risk Register COVID-19 Risk Register		
Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality of Services		NO
Health Inequalities		NO
Equality (staff or public)		NO
Resource and Finance		NO
Legal		NO
Engagement and Consultation		NO
Risk		NO

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

Risk Assurance Report

Audit Committee

09 September 20200

1. Introduction

1.1 This paper provides the Audit Committee with relevant assurances regarding the risk process that is embedded within the CCG through the risk management framework policy. The data for this report was accessed on 25 August 2020.

1.2 The report is being presented as follows:

Report section	Item	Appendix
Section 2	Corporate Risk Register	Appendix 1 Audit Committee Risk Report Appendix 2 Corporate Risk Register - Significant Risks
Section 3	COVID Risk Register	Appendix 3 COVID-19 Risk Register Transfer Summary
Section 4	Internal Audit Recommendations	
Section 5	Risk Management Training	

2 Corporate Risk Register

2.1 At the time of writing the report there are 30 risks being monitored with five risks pending closure subject to executive approval and/or reporting committee agreement.

2.2 There are three risks on the Corporate Risk Register which report to the Audit Committee and are detailed in appendix 1

2.3 Two risks on the corporate risk register have seen movement in the risk score during this reporting period:

Risk 113 -- EPRR Core Standards EPRR Lead recruited to lead on preparedness work stream; An EPRR workplan in place to ensure that preparedness is maintained and that new requirements are implemented in a timeous manner. The risk score has been reduced from 16 to 6 following review to reflect the current status.

Risk 105 -Devon Doctors Call Stacking Following the peak of the pandemic when demand for out of hours was reduced, a significant increase in demand is now being seen leading to call stacking. The risk score has been increased from 4 to 16 to reflect the change in circumstances.

2.4 At the time of writing this report the CCG has eight risks scored significant summarised in the table below and detailed in appendix 2.

** Risk is scored using a 5x5 matrix which does not produce the following risk scores 7, 11, 13 & 14.

Period of report - 23 June 2020 to 25 August 2020	
Total Risks on Corporate Risk Register	30
Low risks (scored 1-3)	1
Moderate/Medium risks (scored 4-6)	7
High risks (scored 8-12)	14
Significant/Very high risks (scored 15 to 25)	8
New Risks	6
Risk score reduced since last report	1
Risk score increased since last report	1
Total Risks Closed (detail is within the committee minutes of the following committees)	0
Quality Committee	*1*
Primary Care Committee	*0*
Finance & Performance Committee	*1*
Audit	*0*
Commissioning Committee	*2*

2.5 A review of each risk is undertaken by the risk owner and the risk co-ordinator on a schedule appropriate to each risk. Requests to close risks and add new risks are being approved by the named executive lead.

2.6 Six new risks have been added to the corporate risk register, the risks will be operationally managed to seek assurance that mitigating actions and controls are in place.

2.7 New risk 121 Mental Health Inappropriate Out of Area bed trajectory has been added with a significant/very high risk score of 16 (likelihood 4 x impact4) and is included in appendix 2. The risk is reviewed by the Commissioning Committee

Risk Number	Risk Description	Reporting Committee	Executive Lead	Risk Score
121	There is a risk that the Mental Health Inappropriate Out of Area trajectory, agreed by MH providers (Devon Partnership Trust and Livewell Southwest), is not met. The impact of this is damage to the CCGs reputation due to not meeting the nationally derived target to eliminate OOA placements by 20/21.	Commissioning Committee	Jo Turl	**16** **L = 4** **I = 4**

3 COVID Risk Register

3.1 The CCG Executive Team introduced a COVID-19 risk register to record risks that impacted the CCG during the management of the coronavirus incident. This register was a concise record of our key risks during the incident and how the risks are being managed.

3.5 The risks on the COVID-19 risk register have been reviewed at the conclusion of the incident and consideration given to closing risks, transferring risks to the corporate risk register or team risk registers for ongoing review and management.

3.6 There are 38 risks visible on the Covid-19 risk register, summarised in appendix. Of these:

- 18 are being requested for closure;
- 8 are being requested to transfer to the Corporate risk register as these impact across the whole CCG
- 9 are being requested to transfer to a directorate/ team / locality risk registers which will be operationally and actively monitored and managed by the team through monthly directorate team meetings. The remaining three are pending decision from the Executives.

4 Internal Audit Recommendations

4.1 Audit South West (ASW) provides the CCG with robust and a regularly monitored internal audit service. Below are the audit recommendations from the internal audit completed in February 2020, showing and current status to provide the Audit Committee a progress update for the recommendations. All recommendations have now been completed.

Risk Management Audit 2019/20

Rec no.	Recommendation	Risk rating	Manager responsible	Action date	Update	Status
Corporate Risk Register						
2	Risks relating primary care quality and safety issues, actual and potential closure of GP practices, and limited resources available within the CCG to and respond to/manage such issues, and to monitor the quality and safety of services in general, should be recorded on the CCG's CRR.	Moderate 6	Theresa Farris	30.5.20	Risk relating to primary care (108) has been reviewed to reflect wording around quality and safety. Request to close and process to identify and add risks as appropriate is covered by the Quality Surveillance process managed by the Quality and nursing directorate this monitors quality and safety as commissioned in primary care and secondary care providers within the system. Risks are identified via this route	Complete

4.2 Further to the recommendation 'closure and transfer of risks' from the internal audit, the Governance Team have held training sessions with the risk coordinators to explain the introduction and use of team level risk registers. A template has been shared and is available on the intranet and risk coordinators teams channel to ensure that team level risks are recorded on the agreed template as required by internal audit.

4.3 The Governance team is working with Business Intelligence to further develop the web based corporate risk register database to accommodate team risk registers in one place.

4.4 The Governance team is also arranging to attend team meetings to discuss risk and the risk escalation and de-escalation process to achieve a consistent approach to the management and recording of team risks.

5 Risk Management Training

5.1 The Governance team have produced a risk management presentation to give all staff an overview of risk management process within the CCG. The training presentation on teams can be found via this link Risk Management Presentation

5.2 A Risk Coordinator's Teams site brings everything together in a shared workspace where the risk coordinators can chat, hold meetings online, web conferencing and share files. This will enable ongoing development and support.

5.3 Regular bi-monthly Risk Co-Ordinator meetings have been established to offer support and ongoing training opportunities.

6 Recommendations

The Audit Committee are requested to:

1. Note that the risk is being managed appropriately through the Corporate Risk Register (Appendix 1)

2. Note the addition of risk 121 - Mental Health Inappropriate Out of Area bed trajectory has been added to the corporate risk register with a significant/very high-risk score of 16.

3. Note the actions being taken to stand down the COVID-19 risk register appendix 3

4. Note current position of Assurance Framework

NHS
Devon
Clinical Commissioning Group

Standards of Business Conduct policy

NHS Devon Clinical Commissioning Group

Owner(s): Clare Doble, Head of Governance Theresa Farris, Risk and Governance Manager	Directorate Contact Details: D-CCG.governance@nhs.net	
Approved by:	Date of formal approval	Review Date:
Date Issued:		Version *2.3* *DRAFT*
All policies are held centrally by Governance: d-ccg.governance@nhs.net		

Document Change History:		
Version	**Date**	**Comments (i.e. reviewed/amended/approved)**
V1	July 2017	Review and produce a joint policy for NHS NEW Devon Clinical Commissioning Group and NHS South Devon and Torbay Clinical Commissioning Group. To include NHS England statutory guidance issued June 2017
V1	25 July 2017	Discussed and approved by Staff Council SDTCCG
V1	7 August 2017	Discussed and approved by Chief Officers meeting in common
V1	8 August 2017	Discussed and approved by Staff Forum, NEW Devon CCG
V1	10 August 2017	Discussed and approved by Audit Committee, SDTCCG
V1	22 August 2017	Discussed and approved by Audit Committee, NEW Devon CCG
V1	28 September 2017	Discussed and approved Governing Bodies, meeting in common
V1.1	1st April 2019	Formatted in line with single Devon CCG
V2	July 2019	Review and update to reflect NHSE Call to Action
V2.1	August 2019	Reviewed by Head of Governance and Board Secretary in light of revised guidance from NHSE https://www.england.nhs.uk/publication/conflicts-of-interest-management-ccgs/
V2.2	04 September 2019	Discussed and approved Policy Committee September 2019
	11 September 2019	Discussed and approved Audit Committee September 2019
	12 September 2019	Approved version for circulation and upload to website
V2.3	August 2020	Annual Review of Policy Updates: • Whistleblowing Policy replaced with Freedom to Speak Up: Raising Concerns (whistleblowing) Policy). • Anti-Fraud and Anti -Bribery Policy replaced with Anti-Fraud and Bribery Policy
V2.3	August 2020	Reviewed and approved by Board Secretary
V2.3	09 September 2020	Discussed and approved Audit Committee September 2020
V2.3	10 September 2020	Wording added to sections 6 and 10 as identified by internal audit to confirm responsibilities of actions to be taken by line manager.

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

Contents		
Section	**Title**	**Page**

1. Introduction

1.1 This policy seeks to describe the public service values, which underpin the work of the NHS and to reflect the current guidance and best practice to which all individuals within NHS Devon CCG (the CCG) must have in regard to their work for the CCG.

1.2 This policy includes specific requirements relating to the Bribery Act 2010 which came into force in July 2011 and NHS England: Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017 https://www.england.nhs.uk/commissioning/pc-co-comms/coi/ which provides guidance on the following:

- Gifts and hospitality
- Sponsorship
- Declaration of interests
- Preferential treatment in private transactions
- Outside employment
- Requisitioning goods and services

1.3 The CCG aspires to the highest standards of corporate behaviour and responsibility.

1.4 The Code of Conduct and Code of accountability in the NHS (second revision July 2004) sets out the following three public service values which are central to the work of the CCG.

- **Accountability** – everything done by those who work in the NHS must be able to stand all tests of parliamentary scrutiny, public judgements on propriety and professional codes of conduct
- **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, officers, members and suppliers, and in the use of information acquired in the course of NHS duties
- **Openness** – there should be sufficient transparency about NHS activities to promote confidence between the CCG and its staff, patients and public.

1.5 All individuals within the CCG must abide by the Seven Principles of Public Life ("Nolan Principles") as set out by the committee on Standards of Public Life and set out in Appendix A of this policy.

1.6 Additionally, to support the management of conflicts of interest, the CCG must:

- **Do Business appropriately**: Conflicts of interest are easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are adequate from the outset, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny
- **Be proactive, not reactive**: Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possibility, for instance by:
  - Considering potential conflicts of interest when electing or selecting individuals to join the Governing Body or other decision-making bodies
  - Ensuring individuals received proper induction and training so that they

understand their obligations to declare conflicts of interest;
    - Agreeing in advance how a range of possible conflicts of interest situations and scenarios will be handled, rather than wait until they arise.
- **Be balanced and proportionate**: Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision making is transparent and fair whilst not being overly constraining, complex or cumbersome
- **Be transparent**: Document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident.

2. Scope of Policy

2.1 This policy applies to:

- The CCG's governing body;
- Lay members / Non-Executive Directors of the CCG;
- Clinical leads and clinicians working for the CCG
- The CCG's employees (whether their remit is clinical or corporate) to include employees of the wider Devon system hosted by the CCG;
- Community representatives of the CCG
- Third parties' action on behalf of the CCG under a contract (including contract for services);
- Students and trainees (including apprentices);
- Agency staff engaged by the CCG;
- Volunteers; and
- Secondees.

2.2 In this policy, "third party" refers to any individual or organisation that staff may come into contact with during the course of their work for the CCG, and includes actual and potential clients, suppliers, distributors, business contacts, agents, advisers, and government and public bodies, including their advisors, representatives and officials, politicians and political parties.

2.3 All CCG staff should be impartial and honest in the conduct of their official duties and should not abuse their official position for personal gain or advantage. It is the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their CCG duties or is detrimental to the performance of their CCG duties.

2.4 The standards of business conduct and managing conflicts of interest guidance defined in the NHS Constitution should be adhered to by all staff. It is therefore important that all members of staff are aware of what is expected regarding the conduct of business in the NHS. If staff require further guidance or if they have any doubt about how to proceed, they should refer the matter to the Governance team via the following email address D-CCG.governance@nhs.net .

3. CCG Constitution

3.1 All CCG staff must carry out their duties in accordance with the CCG Constitution. The Constitution sets out the statutory and governance framework in which the CCG operates and there is considerable overlap between the contents of this policy and the provisions of the CCG Constitution. The CCG Constitution is the main governing document under which, the CCG operates.

3.2 The CCG's staff must at all times refer to and act in accordance with the Constitution to ensure that current processes are followed. In the event of any doubt, staff should seek advice from their line manager or the Governance team.

4. Bribery and Corruption

4.1 It is the policy of the CCG to conduct all of our business in an honest and ethical manner. The CCG is committed to acting with integrity in all our business dealings and relationships and to implementing effective systems to prevent bribery. Bribery and corruption are punishable for individuals by up to ten years imprisonment and if the CCG is found to have taken part in corruption, we could face an unlimited fine and face incalculable damage to our reputation. The CCG therefore takes its legal responsibilities very seriously.

4.2 The CCG has a responsibility to ensure that all staff are made aware of their duties and responsibilities arising from the implementation of the Bribery Act 2010. Under this act, there are four main offences:

- Individuals who give, promise or offer bribes
- Individuals who request, agree to receive or receive bribes
- Individuals who bribe or offer to bribe a foreign public official
- Companies who fail to prevent bribery.

4.3 The CCG will uphold all laws relevant to countering bribery and corruption, including the Bribery Act 2010, in every aspect of our conduct, including our dealings with public and private sector organisations and the delivery of treatment and care to patients.

4.4 All CCG staff are required not to use their position to gain financial advantage. Additionally, staff who are in any way involved with approving invoices or requisitioning goods and services must make sure that they adhere to the Ethical Code of the Chartered Institute of Purchasing and Supply

4.5 Staff who are engaged in the process for awarding other contracts for services must ensure that fair and open competition (as required by NHS standing orders) applies. Staff must ensure that they do not misuse or make available internal information of a "commercial in confidence" nature (staff with concerns about disclosure of information should refer to the CCG's ~~Whistleblowing Policy~~Freedom to Speak Up: Raising Concerns (whistleblowing) Policy~~)~~.

4.6 The Bribery Act 2010 places specific requirements on potential bidders and suppliers of contracts. Potential bidders should be referred to the CCG's Procurement Strategy.

4.7 The CCG is keen to prevent fraud and encourages staff with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. CCG staff must inform the Chief Finance Officer or the Alice Lee, Alicelee1@nhs.net Local Counter Fraud Specialist immediately who will decide on the appropriate course of action to be taken. CCG staff must not ignore any suspicion and must not under any circumstances investigate the matter themselves or inform colleagues or members of the public about their suspicions.

4.8 Anonymous letters, telephone calls or e-mails are occasionally received from individuals who

wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously. The Chief Finance Officer and LCFS will make appropriate enquiries to establish whether or not there is any foundation to the suspicion that has been raised.

4.9 CCG staff can also call the NHS Fraud and Corruption reporting line on 0800 028 40 60 or https://cfa.nhs.uk/about-nhscfa/contact-us. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced and trained staff and any caller who wishes to remain anonymous may do so.

4.10 All CCG staff are required to read through the CCG's Anti-Fraud and Anti-Bribery policy in conjunction with the completion of training provided by the LCFS.

5. Raising a Concern or Reporting a breach

5.1. It is the duty of every member of staff to speak up about genuine concerns in relation to criminal activity and breaches of legal obligations (including negligence, breach of contract or breach of administrative law, miscarriage of justice, danger to health and safety or the environment, and the cover up of any of these in the workplace).

5.2 The CCG has a Freedom to Speak Up: Raising Concerns (whistleblowing) Policy). Whistleblowing policy which sets out the arrangements for raising and handling staff concerns. The process for reporting specific concerns relating to fraud are described in the Anti-Fraud and Bribery policy and in section four of this document.

5.3 Any such breaches must be reported to the Governance Team and an investigation will be undertaken and reported to the Conflicts of interest guardian and line manager of the employee. Any recommendations from the investigation will be clearly documented and actioned by the line manager in accordance with the timelines allocated. Assurance will be sent to the head of governance who will finalise the report for the conflicts of interest guardian and Audit and Assurance Committee. Any disciplinary action required will be discussed with HR and the line manager and the disciplinary policy will be applied.

6. Declaration of Interest

6.1. This section describes the CCG's policy in relation to the identification and management of conflicts of interest for staff. Adherence to these provisions is mandatory in order to identify and manage current or potential conflicts which may arise between the interests of the organisation and the personal interests, associations and relationships of its staff or representative family members.

6.2. CCG staff should not allow their judgement or integrity to be compromised. They should be, and be seen to be, honest and objective in the exercise of their duties and should understand fully their terms of appointment, duties and responsibilities.

6.3. Failure to adhere to these provisions relating to the declaration of interests may result in removal from office, formal action (up to and including termination of employment) and constitute the criminal offence of Fraud and/or Bribery, as an individual could be gaining unfair advantages or

financial rewards for themselves or a family member/friend or associate. Any suspicion that a relevant personal interest may not have been declared should be reported to the CCG Head of Governance.

Examples of situations to be avoided are:

- Authorising the discharge of a patient into a nursing home in which you, your family, friend, or business acquaintance has a financial interest
- Purchasing, authorising, or persuading another CCG employee to purchase or authorise the purchase of goods or services from an organisation in which you have a financial interest
- Using the CCG's resources i.e. time or materials or NHS email address to provide private gain through a private company in which you, your family, friends, or business acquaintances have a financial interest

The CCG is required to maintain a register of interests to record formally, declarations of interest of:

All CCG employees, including:

- All full and part time staff
- Any staff on sessional or short-term contracts
- Any students and trainees (including apprentices and work placements)
- Agency workers
- Casual workers
- Joint/shared posts
- Externally Seconded staff
- Volunteers
- Any self-employed consultants
- Other individuals engaged by the CCG under a contract for services

- Any General Practice staff who are involved with CCG business or CCG decision making processes
- Members of the Governing Body
- All members of the CCG's committees, sub-committees/sub-groups, including:
  - Co-opted members
  - Appointed deputies
- Any members of committees/groups from other organisations including General Practice
- Any members of specific groups
- Any individual directly involved with the business or decision- making of the CCG.

6.4. It is the responsibility for the line manager to review employee's completed Declaration of interests for CCG members, employees and contractors form. Any actions identified to mitigate the risk will be discussed with the employee and line manager. Further review may be completed with the Governance team if required. Positive declarations should be shared with Procurement and relevant Contract Managers.

6.5 In addition, any self-employed consultants or other individuals working for the CCG under a contract for services should make a declaration of interest as part of the CCGs HR process and in accordance with this guidance, as if they were CCG employees. Managers who agree contracts with these individuals are responsible for ensuring that a declaration of interests is made before commencement of work.

6.6 All CCG staff must declare any interest which is less than three years old, or if older, relevant (i.e.

a continuing shareholding or Directorship) , either on appointment or when the interest is acquired, which may directly or indirectly give rise to an actual or potential conflict of interest or duty. Interests can be captured in five different categories:

Financial Interests	Indirect Interests
Individual may get direct financial benefits from the consequences of a commissioning decision	Individual has a close association with an individual who has any type of interest in a commissioning decision
Examples include: • Directorship or employment in a private or public company or other organisation which is doing, or may do, business with health or social care organisations • A shareholder (more than 5% of the issued shares), partner or owner of a private or not for profit company, business or consultancy which is doing, or may do, business with health or social care organisations • A management consultant for a provider • Secondary employment • Receipt of secondary income from a provider • Receipt of a grant from a provider • Receipt of any payments (e.g. honoraria, one off payments, day allowances, travel or subsistence) from a provider • Receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role • Having a pension that is funded by a provider (where the value of this might be affected by their success or failure).	**Examples include:** • Spouse / Partner • Close relative e.g., parent, grandparent, child, grandchild or sibling • Close friend - any confusion relating to the declaration of friendship should be discussed with the Head of Governance to ensure that all declarations are appropriate (e.g. a friend who works as a checkout operator in a shop that supplies the NHS need not be declared but a contracts manager with an NHS supplier should be) • Business partner • Any other relationship which may influence or may be perceived to influence the judgement of the individual (e.g. a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house) • Where the individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.
Non-financial Professional Interests	**Non-financial Personal Interests**
Individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career	Individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit
Examples include: • An advocate for a particular group of patients • A GP with special interest e.g. in dermatology, acupuncture etc. • A member of a particular specialist professional body (routine GP membership of the RCGP, BMA or a medical defence organisation would not usually in itself amount to an interest which needs to be declared) • An advisor to for the CQC or NICE • A medical researcher	**Examples include:** • A voluntary sector champion for a provider • A volunteer for a provider • A member of a voluntary sector board or any position of authority in or connection with a voluntary organisation • Suffering from a particular condition requiring individually funded treatment • A member of a lobby or pressure groups with an interest in health • A financial advisor.

General Interest
This could be any position held in another public body organisation, NHS, Local Authority or a community group which may have potential to give rise to influence decisions made by the CCG. Similarly, if you have made a declaration that you are a member of the CCG or attend any of its committees/working groups to another organisation, this information MUST be reciprocated back to the CCG to ensure consistency across organisations and vice versa

6.7 GP's and Practice Managers undertaking work for the CCG should declare details of their roles and responsibilities held within the member practices of the CCG. This includes:

- Directorships, including non-executive directorships held in private companies or PLCs (Public Limited Company, with the exception of those of dormant companies)
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the Group
- A position of authority in an organisation (such as a charity or voluntary organisation) in the field of health and social care
- Any interest that they (if they are registered with the General Medical Council - GMC) would be required to declare in accordance with paragraph 55 of the GMCs publication Management for Doctors or any successor guidance
- Any interest that they (if they are registered with the Nursing and Midwifery Council) would be required to declare in accordance with guidance. Material share holdings of companies seeing to do business with the Group
- Any research funding or grants that may be received by the individual from the Group or from any organisation seeking to do business with the Group
- Contracts commissioned by the Group in which the individual has a beneficial interest
- A member of a lobby or pressure groups with an interest in health
- Interests in pooled budgets that are under separate management (any relevant company included in this fund that has a potential relationship with the Group)

6.8 When considering if an interest is relevant, the Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

6.9 Lead Clinical Professionals (constitutionally known as member practice representatives) who form part of the CCG's Member Practices should ensure that they complete the declaration form, where necessary, in Appendix C and return this to the Governance Team. This declaration need only highlight Directorships and employments with organisations, from whom the CCG commissions services. It is recommended that member practices should ensure that they maintain their own internal register of interests to support this requirement from NHS England.

6.10 Conflicts or declarations of interest should be given at the following points:

- **On appointment** – applicants to the CCG or its governing body should be asked to declare any relevant interests. When appointment is made, a formal declaration of interests should again be made and recorded

- **At meetings** – All attendees should be asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if an interest is declared in the register of interests, it should be declared in meetings where matters relating to that interest are discussed.

- Where a conflict of interest is identified, appropriate action to manage this should be agreed before or at the beginning of the meeting. Advice on appropriate management may be sought from the Governance Team. Actions taken must be recorded in the minutes of the meeting"
- **On changing role or responsibility** – it is the responsibility of all staff to ensure that their details held on the register are up to date with the most current employment details
- **On any other change of circumstances** – whether the individual's circumstances change in a way that affects the individual's interests (e.g. where an individual takes on a new role outside the CCG or sets up a new business or relationship), a further declaration should be made to reflect the change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising
- **Annually** – as part of the PADR process, all staff should confirm if they have any conflicts of interest and fill out the appropriate declaration in appendix C. Nil returns are required on annual basis if there are no interests to declare.

6.11 Staff should not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the CCG (except where schemes are introduced for the benefit of staff).

6.12 Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they must make a verbal declaration before witnesses, and provide a written declaration within 28 days of a relevant event to the Governance team via the following email D-CCG.governance@nhs.net .

6.13 Such declarations will also be documented by the minute taker in the minutes of the meeting and communicated by the minute taker to the Governance team via email to D-CCG.Governance@nhs.net

6.14 Declarations over six months old and which are deemed no longer relevant need not be declared, but a transparent audit record trail will be held in line with the retention periods of the records management policy – recommendation is corporate records are held for 6 years.

6.15 All employees will be asked to review and update their declaration of interests annually via the appraisal process. This will require staff submitting their form to the governance team directly where a conflict exists D-CCG.governance@nhs.net

6.16 NHSE has set a requirement for CCGs to include a robust process for managing any breaches, which is held by the Governance Team and for anonymised details of the breach to be published on the CCGs website for the purpose of learning and development. Section 5.

A breach is where there is 'knowledge that an individual has knowingly failed to disclose one of the following':

- a declaration of financial interest,
- a declaration of non-financial professional interest
- a non-financial personal interest
- an indirect interest
- a gift, hospitality or sponsorship received

7. Managing Conflicts of Interest and the Register of Interests

7.1. The CCG needs to have in place principles and procedures for the minimising, managing and registering potential conflicts of interest which could be deemed or assumed to affect the decisions made by those involved in the CCG. These decisions could include the awarding of contracts, procurement, policy, employment and other decisions. A copy of the declaration of interest form can be seen in Appendix C

7.2. If members have any doubt of the relevancy or pertinence of a current or potential interest, or an interest of another individual connected to them, this should be discussed with the Governance team, who will provide an independent view. If in doubt, the individual concerned should assume that a potential conflict of interest exists.

7.3 Any conflicts of Interest which are no longer of relevance (i.e. resigned Directorships) will remain on the CCG register for a period of six months , After which the declaration must be approved for removal by the Line Manager, Director or committee chair where the conflict of interest is reported.

The register of interests for the CCG~~s~~ can be found on its website. https://devonccg.nhs.uk/?s=conflict+of+interest and is updated at least annually.

7.4 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). Where an individual believes that substantial damage or distress may be caused, to him/herself or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing. Decisions not to publish information must be made by the Conflicts of Interest Guardian for the CCG, who should seek appropriate legal advice where required, and the CCG should retain a confidential un-redacted version of the register(s).

7.5 In line with GDPR staff have been informed about the public nature of the DOI register and as such are aware that information is kept up to date, for clear purpose and for no longer than necessary. To support this further the CCGs privacy/fair processing notice is available to view on the public website or available through contacting d-ccg.dataprotection@nhs.net or the CCG data protection officer.

8. Managing Conflicts of Interest at Meetings and Minute taking at Meetings

8.1 CCGs must make arrangements for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making.

8.2 The chair of a meeting of the CCG Governing Body or any of its committees, sub-committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.

In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted, then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s)

To support chairs in their role, they will have access to a Conflict of Interest checklist prior to meetings, which will include details of any declarations of conflicts which have already been made by members of the CCG or meeting members.

The chair will ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the meeting should declare any interests which are relevant to the business of the meeting regardless of whether or not these interests have previously been declared.

8.3 It is essential that the CCG ensures complete transparency in its decision-making processes through robust record-keeping and clear minutes.

It is important that an effective record is made and kept in the form of clear minutes of any interests that arise, the agenda item concerned and their subsequent management.

If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes:

- who has the interest;
- the nature of the interest and why it gives rise to a conflict, including the magnitude of any interest;
- the items on the agenda to which the interest relates;
- how the conflict was agreed to be managed; and
- evidence that the conflict was managed as intended (for example recording the points during the meeting when particular individuals left or returned to the meeting).

8.4 Any changes to the register of interest or new declarations must be recorded in the minutes and immediately notified to the Governance Team email: d-ccg.governance@nhs.net

9. Procurement Decisions

9.1 The CCG is also required under NHS England Statutory guidelines to maintain a register of healthcare procurement decisions, to be updated any time a healthcare procurement decision is made and to include:

- The details of the decisions;
- Who was involved in making the decision (i.e. governing body or committee members and others with decision making responsibility);
- A summary of any conflicts of interest in relation to the decision and how this was managed by the CCG; and
- The award decision taken.

9.2 The Register of Healthcare Procurements is published on the website for NHS Devon CCG's and a hard copy can be obtained from the CCG Finance and Contracting Team at d-ccg.financeenquiries@nhs.net . The Register of Healthcare Procurement decisions must be updated whenever a healthcare procurement decision is taken - all CCG healthcare contracts can be located on the website. https://devonccg.nhs.uk/

9.3 All declaration of interests relating to procurement made by CCG staff will be reviewed by the Finance Committee on a quarterly basis.

9.4 As part of any procurement (healthcare or non-healthcare) process, it is good practice to request that bidders must declare any conflicts of interest. This allows commissioners to ensure that they comply with the principles of equal treatment and transparency. When a bidder declares a conflict, the commissioners must decide how best to deal with it to ensure that no bidder is treated any differently to any other.

9.5 It would not be appropriate to declare the bidder's conflicts on the register of healthcare procurement decisions, as it may compromise the anonymity during the procurement process. Commissioners must however, retain an internal audit trail of how the conflict or perceived conflict was dealt with, which will allow them to provide information at a later date if required.

9.6 Meetings of all committees and working groups within the CCG must minute any declarations of conflicts of interest – the template for minutes is held on the respective CCG intranet site. Updates must be forwarded to the respective Governance Team to ensure the master register is updated appropriately.

9.7 Where members of any decision making body have an interest which could conflict with the decision being made, it is recommended that they either be excluded from the relevant parts of the meeting(s), or take part in discussions but not take part in the vote.

9.8 The Chair of the meeting has responsibility for deciding whether a conflict of interest exists and the appropriate course of action. Decisions regarding interests and any appropriate actions will be made on an individual basis. All decisions and details of the management of conflicts of interest should be recorded in the minutes of meetings and published on the Register of Interests.

9.9 Arrangements must be made regarding conflicts of interest for the following situations:

- If the Chair has a conflict of interest - it must be decided which other Governing Body or committee member will take on the role and make any decisions regarding conflicts of interest;
- If all GPs or other practice representatives could have a conflicting interest in a decision
- If 50% or more of Governing Body or committee members have a conflicting interest, but the committee remains quorate.
- Specific arrangements relating to the Patient and Public Engagement Committee can be found in Appendix B

9.10 The CCG will undertake an audit of conflicts of interest management as part of their internal audit program on an annual basis. The results of the audit would be reflected in the CCG's annual governance statement and should be discussed in the end of year governance meetings with NHS England South (South West).

9.11 A flow chart summarising the process for declaring conflicts of interest is attached as appendix D

10. Gifts and Hospitality

Gifts

10.1 All offers of gifts of any nature offered to a CCG staff, governing body and committee members and individuals within GP member practices by suppliers or contractors linked (currently or

prospectively) to the CCGs business should be declined, whatever the value. (Subject to this, low cost branded promotional aids may be accepted and not declared where they are under the value of a common industry standard of £6). The person to whom the gifts were offered should also declare the offer to individual who has designated responsibility for maintaining the register of gifts and hospitality so the offer which has been declined can be recorded on the register to D-CCG.governance@nhs.net

10.2 Gifts from non-suppliers and non-contractors can be accepted with regard to items of little financial value (i.e.. Less than £50.00) such as diaries, calendars, stationery and other gifts acquired from meetings, events or conferences, and items such as flowers and small tokens of appreciation from members of the public to staff for work well done. Gifts of this nature do not need to be declared to the individual who has designated responsibility for maintaining the register of gifts and hospitality, nor recorded on the register.

10.3 However, Gifts offered from such sources should also be declined if accepting them might give rise to perceptions of bias or favouritism, and a common-sense approach should be adopted as to whether or not this is the case.

10.4 Gifts with a value of over £50 can be accepted on behalf of the organisation, but not in a personal capacity and must be declared. Prior written approval must be obtained from the appropriate line manager following due consideration in cases where it is deemed appropriate to accept a gift. The declaration should be done by completing the form attached (Appendix D). In such cases, it should be clarified with the donor that it is accepted on behalf of the CCG and will be shared with colleagues. Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50

10.5 In addition, as from June 2016, the Association of the British Pharmaceutical Industry (ABPI) publish 'transfers of value' of benefits or sponsorships in cash or in kind to healthcare organisations and individual healthcare professionals. For each declaration the CCG is provided annually with details to access the pre-publication disclosures allocated to the CCG. The entries can be checked and challenged prior to being published on the public ABPI website. A record of gifts, hospitality and sponsorship is published on the CCG website.

Hospitality

10.6 A blanket ban on accepting or providing hospitality is neither practical nor desirable from a business point of view. However, individuals should be able to demonstrate that the acceptance or provision of hospitality would benefit the NHS or CCG.

10.7 Hospitality must be secondary to the purpose of the meeting. The level of hospitality offered must be appropriate and not out of proportion to the occasion; and the costs involved must not exceed that level which the recipients would normally adopt when paying for themselves, or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting. Hospitality of this nature (i.e. tea, coffee or light refreshments) does not need to be declared to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality, nor recorded on the register, unless it is offered by suppliers or contractors linked (currently or prospectively) to the CCG's business in which case all such offers (whether or not accepted) should be declared and recorded.

10.8 Hospitality under £25 can be accepted and does not need to be declared. Hospitality between

£25 and £75 can be accepted but must be declared. If the value of the hospitality is over £75, it must be declared and should be refused unless senior approval is given.

10.9 There is a presumption that offers of hospitality which go beyond modest or of a type that the CCG itself might offer, should be politely refused. A non-exhaustive list of examples includes:

- Hospitality of a value of above £75; and
- In particular, offers of foreign travel and accommodation.

10.10 There may be some limited and exceptional circumstances where accepting the types of hospitality referred to in the above paragraph may be contemplated. Express prior approval should be sought from a senior member of the CCG (e.g. the CCG governance lead or equivalent) before accepting such offers, and the reasons for acceptance should be recorded in the CCGs register of gifts and hospitality. Hospitality of this nature should be declared to individual who has designated responsibility for maintaining the register of gifts and hospitality, and recorded on the register, whether accepted or not.

10.11 In addition, particular caution should be exercised where hospitality is offered by suppliers or contractors linked (currently or prospectively) to the CCG's business. Offers of this nature can be accepted if they are modest and reasonable but advice should always be sought from the Head of Governance as there may be particular sensitivities, for example if a contract re-tender is imminent.

10.12 Prior written approval should be obtained from the appropriate line manager following due consideration, in cases where it is deemed appropriate to accept hospitality in excess of £75. The declaration should be completed using the template in Appendix D.

10.13 In respect of the Governing Body, where it is deemed appropriate to accept hospitality in excess of £75, Governing Body members must obtain prior approval from the Chief Officer. Lay members and the Chief Officer will obtain prior written approval from the Chair, and the Chair will inform the Chair of the Audit and Assurance committee, Conflicts of Interest Guardian and Head of Governance.

10.14 Staff should consider if offers of hospitality made outside of works time will be indirectly linked to the CCG, if so, they should treat the offer of hospitality as if it were offered within work time and seek appropriate approval as documented above.

10.15 Further information regarding specific commercial sponsorship, hospitality and gifts ie from the pharmaceutical industry can be located in the NHS Devon CCG policy Working with Industry and Sponsorship Policy

10.16 Members of staff should declare any such sponsorship or potential sponsorship within the register of gifts and hospitality/commercial sponsorship and in particular note that:

- Trips, conferences etc. financed by external organisations (e.g. suppliers) should be declared
- Any offers of sponsorship that could possibly breach the guidance on "Commercial Sponsorship – Ethical Standards for the NHS", should be declared
- Professional registration and/or status should not be used in the promotion of commercial products or services
- Bias may be generated as a result of sponsorship arrangements. Due care should be

taken to ensure that professional judgement and impartiality are not affected

- Conditions which compromise professional independence or judgement, or impose such conditions on other professionals should not be agreed or practised
- Offers by suppliers to pay the travelling/accommodation costs for CCG staff should be declined unless the Director of Finance gives prior approval for the potential supplier to take responsibility for the costs
- If there are any financial implications associated with potential interests not yet entered into, staff are strongly advised not to proceed further until permission has been granted in writing
- All offers of hospitality from actual or prospective suppliers or contractors (whether or not accepted) should be declared and recorded, completing the form attached (Appendix D) and sending it to the Governance team via D-CCG.governance@nhs.net

10.17 All gifts will be registered in the Register of Gifts, Sponsorship and Hospitality and published on the CCG website.

10.18 It is the responsibility for the line manager to review the employee's completed Declarations of Gifts, Hospitality and Commercial Sponsorship form and state their reasoning why the gift, hospitality or commercial sponsorship has been accepted or declined on behalf of the CCG. Further review may be completed with the Governance team if required. Positive declarations should be shared with Procurement and relevant Contract Managers.

10.19 If in any doubt, staff should seek advice from their line manager, the Governance Team or Local Counter Fraud Specialist on 07813 540022 ~~01872 258057~~.

11. Commercial Sponsorship

11.1 CCG staff, governing body and committee members, and GP member practices may be offered commercial sponsorship for courses, conferences, post/project funding, meetings and publications in connection with the activities which they carry out for or on behalf of the CCG or their GP practices.

11.2 All such offers (whether accepted or declined) must be declared so that they can be included on the CCG's register of gifts and hospitality, and the team or individual designated by the CCG to provide advice, support, and guidance on how conflicts of interest should be managed should provide advice on whether or not it would be appropriate to accept any such offers.

11.3 If such offers are reasonably justifiable and otherwise in accordance with this statutory guidance then they may be accepted. The CCG has in place a commercial sponsorship group who consider prior approval for acceptance of such sponsorships as part of good governance and due diligence. This group reports to the Audit committee no less than annually.

11.4 Notwithstanding the above, acceptance of commercial sponsorship should not in any way compromise commissioning decisions of the CCG or be dependent on the purchase or supply of goods or services. Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event.

11.5 When sponsorships are offered, the following principles must be adhered to:

- Sponsorship of CCG events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the CCG

and the NHS;

- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied;
- At the CCG's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event;
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency;
- The CCG~~s~~ should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event;
- Staff should declare involvement with arranging sponsored events to their CCG.

11.6 Before entering into any sponsorship agreement, the CCG should:

- Satisfy itself, with reference to information available, that there are no potential irregularities that may affect a company's ability to meet the conditions of the agreement or impact on it in any way e.g. checking financial standing by referring to company accounts
- Assess the costs and benefits in relation to alternative options where applicable, and to ensure that the decision-making process is transparent and defensible, which will be determined by the relevant Director
- Ensure that legal and ethical restrictions on the disclosure of confidential patient information, or data derived from such information, are complied with. Additionally, disclosure for research purposes should not take place without the approval of the appropriate research ethics committee
- Determine how clinical and financial outcomes will be monitored
- Ensure that sponsorship agreements have break clauses built in to enable the CCG to terminate the agreement if it becomes clear that is not providing expected value for money or clinical outcomes

11.7 Therefore, the following must be adhered to:

- Meetings, events or conferences organised by the CCG may be sponsored by a commercial company subject to the approval of the Governing Body or delegated authority through the relevant Director (Appendix D).
- Publicity at the event by the company is allowed but it should be separate from the educational content or purpose of the meeting. Promotion of the sponsor should be secondary to the event.
- An acknowledgement of the support received will be made.
- Acceptance of commercial sponsorship should not in any way compromise commissioning decisions of the CCG or be dependent on the purchase or supply of goods and services.

11.8 The CCG will publish on an annual basis a list of sponsoring organisations as part of its publication scheme.

11.9 On receipt of a completed form declaring the offer of Gifts, hospitality or sponsorship the Governance team will review and confirm that the correct procedure has been followed. In

addition, the Governance team will confirm to the individual and their line manager that an appropriate entry has been made on the register of Gifts, hospitality or sponsorship.

12. Outside Employment

12.1 Staff are advised not to engage in outside employment which may conflict with, or be detrimental to, their NHS work. Any outside employment must be done in the staff members' own time

12.2 Employees of the CCG (depending on the details of their contracts as regards to outside employment and private practice) are required to inform the CCG if they are engaged in or wish to engage in outside employment in addition to their work with the CCG (using the form in Appendix C) and obtain express permission to do this, the CCG reserve the right to refuse permission where it believes a potential conflict may arise with their CCG employment. Examples of work which might conflict with the business of the CCG may include:

- employment with another NHS body
- employment with another organisation which may be in a position to supply goods/services to the CCG
- self-employment, including private practice, in a capacity which may be in conflict with the work of the CCG or which might be in a position to supply goods/services to the CCG

12.3 All staff are asked to review and agree their conflict of interests annually as part of the annual appraisal process and inform the governance team directly where a conflict arises. In addition, where a register of interests is included in a committee meeting papers each individual is responsible for checking the content and identifying any updates required.

13. Personal Conduct

13.1 Lending or Borrowing

The lending or borrowing of money between staff should be avoided, whether informally or as a business, particularly where the amounts are significant.

13.2 It is a particularly serious breach of the Devon CCG Disciplinary policy for any member of staff to use their position to place pressure on someone in a lower pay band, a business contract, or a member of the public to loan them money.

13.3 Gambling

No member of staff may bet or gamble when on duty or on CCG premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among colleagues.

13.4 Trading on Official Premises

Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-CCG interests of staff or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for staff.

13.5 Collection of money

Charitable collections must be authorised by Head of Governance

- Other Flag Day appeals are not permitted, and collection tins or boxes must not be placed in offices. With line management agreement, collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events. Please note that all collections must be considered as to whether they may be inadvertently be supporting extremism causes.
- Permission is not required for informal collections amongst immediate colleagues on an occasion like birthdays, retirement, marriage or a new job.

14 Prevent

14.1 If you have concerns regarding the possibility of a potential link to extremism or radicalisation in relation to the areas covered by this policy please refer to the PREVENT Policy available on ~~both~~ the CCG~~s~~ website~~s~~, as this will provide guidance on how to seek advice. Alternatively contact the CCG Prevent Lead: safeadultnotifications.sdtccg@nhs.net Tel:01803 652535

- This policy will be reviewed by the Head of Governance every three years from approval, or as required due to:
  - Legislative changes;
  - Good practice guidance;
  - Case law;
  - Significant incidents reported;
  - New vulnerabilities; and
  - Changes to organisational infrastructure.

15 Further Information

15.1 Disciplinary action may be taken against any individual who fails to comply with the requirements set out in this document, in accordance with the CCG's Disciplinary Policy.

15.2 This policy is an interpretation of guidance and is based on examples of good practice. In addition to referring to the CCG Constitution, CCG staff should refer to:

- Anti-Fraud and ~~Anti~~-Bribery policy
  Freedom to Speak Up: Raising Concerns (whistleblowing) Policy).~~Whistleblowing policy~~
- Arrangements for declaring member's interests
- NHS England: Managing Conflicts of Interest: Statutory Guidance for CCG's https://www.england.nhs.uk/commissioning/pc-co-comms/coi/
- Co-Commissioning conflicts of interest audit: https://www.england.nhs.uk/commissioning/wp- content/uploads/sites/12/2016/04/co-comms-coi-audit-summ-rep.pdf
- NHS England Guidance on appearance of bias: http://www.england.nhs.uk/revalidation/ro/con-of-int/
- The National Health Service Act 2006 & the Health and Social Care Act 2012;
- The Code of Conduct for NHS Managers 2002;
- The Nolan Principles on Conduct in Public Life;
- Commercial Sponsorship – Ethical Standards for the NHS
- The NHS Codes of Conduct and Accountability; (NHS Appointments
- Commission & Department of Health – amended July 2004);

- Policy for the sponsorship of activities and joint working by the pharmaceutical industry with NHS Devon CCG~~Northern, Eastern and Western Clinical Commissioning Group (CCG) (including rebate schemes)~~; Working with Industry and Sponsorship Policy V3
- The Code of Practice on Openness in the NHS; and
- The Code of Conduct and Code of accountability in the NHS (second revision July 2004).

Further information and/or guidance on any aspect of this policy can also be obtained from the Head of Governance and the Governance team d-ccg.governance@nhs.net

16 Reporting

16.1 The table below show the frequency of reporting conflicts of interest

Committee	Report	Frequency
Governing Body	Declaration of Interests	Every meeting
Audit Committee	Declaration of Interests	Every Meeting
	Report of Conflict of interests, gifts, hospitality and sponsorship	annually
	Breaches	When necessary
Quality Assurance Committee	Declaration of Interests	Every Meeting
Finance and Performance Committee	Declaration of Interests	Every Meeting
	Declaration of interest report relating to procurement activities	Quarterly
Primary Care Commissioning Committee	Declaration of Interests	Every Meeting
Commissioning Committee	Declarations of Interests	Every Meetings
Remuneration Committee	Declaration of Interests	Every Meeting
Integrated Commissioning Executive	Declaration of Interests	Every Meeting
Senior Leadership Team	Declaration of Interests	Every Meeting
Other Committees/decision making groups	Declaration of Interests	As requested
NHSE	Quarterly Self-Assessment of conflict of interests to NHSE	Quarterly

Appendix A

Nolan Principles

The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

1. Selflessness – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

2. Integrity – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

3. Objectivity – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

4. Accountability – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5. Openness – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. Honesty – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7. Leadership – Holders of public office should promote and support these principles by leadership and example.

Source: The First Report of the Committee on Standards in Public Life (1995) (available at http://www.public-standards.gov.uk/).

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Declaration of interests for CCG members, employees and contractors

Please return a signed copy by email to D-CCG.Governance@nhs.net and to d-ccg.hr@nhs.net

If you have any queries please contact Theresa Farris, theresa.farris@nhs.net or Clare Doble, clare.doble@nhs.net , Governance Team

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

Name	
Position within or relationship with the CCG	
CCG meetings attended	
Is this in addition to interests currently recorded or replaces all existing information? *(Delete as appropriate)*	• In addition to interests currently recorded • Replaces all existing information

Please provide details of interests held, complete all that are applicable.

Type of interest *See overleaf for more details*	**Description of interest** *Including, for indirect interests, details of the relationship with the person who has the interest*	**Date interest relates** **From**	**To**	**Actions to be taken to mitigate risk** *To be agreed with line manager*

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the Governance Team of the CCG and Line Manager as soon as is practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I do / do not *(delete as applicable)* give my consent for this information to published on registers the CCG holds.

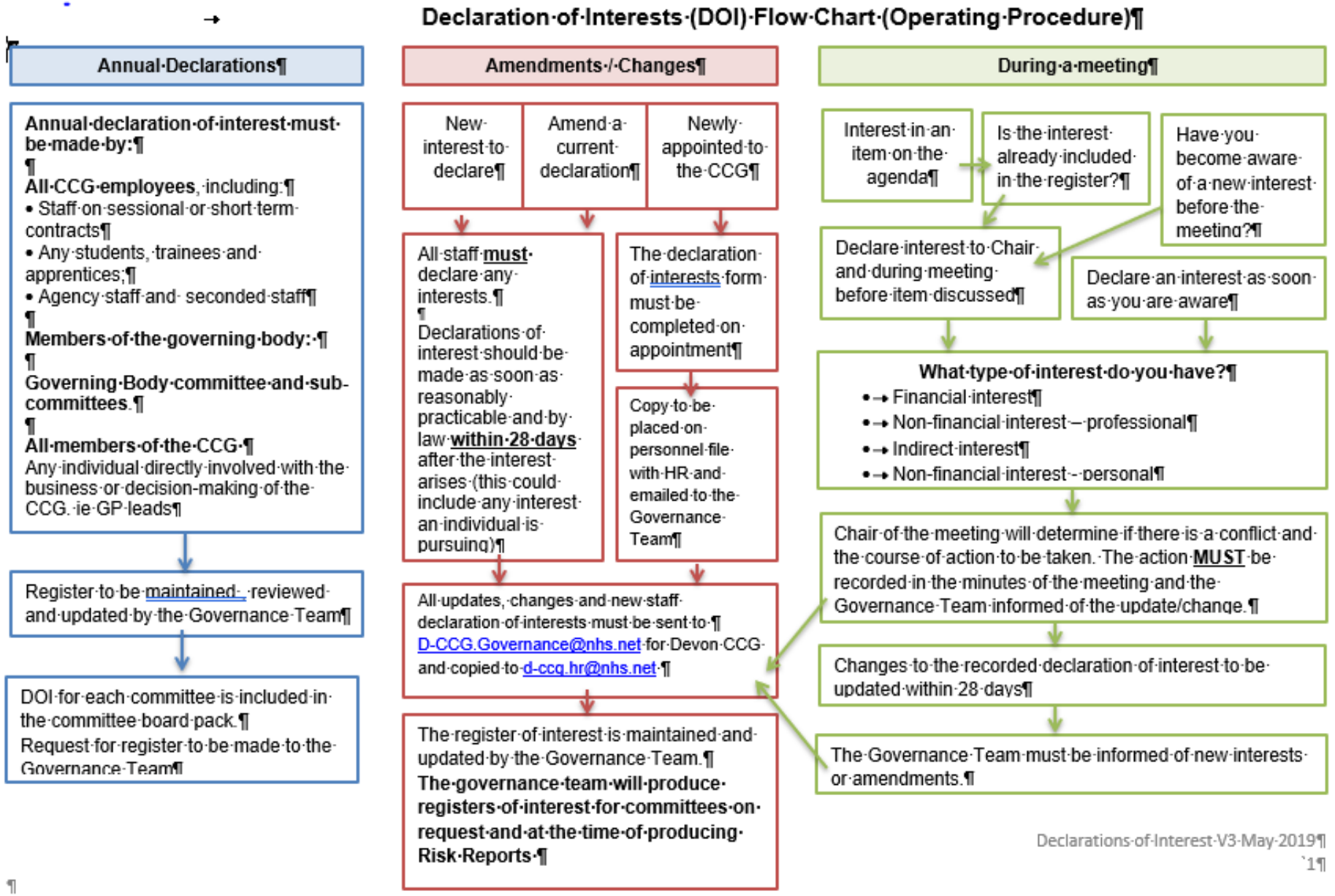
If consent is NOT given please state reasons:

Employee name		Employee signature		Job title		Date	
Manager name		Manager signature		Job title		Date	

Types of conflicts of interest

Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (of more than 5% of the issued shares), partner or owner of a private or not for profit company, business or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A consultant for a provider; • In secondary employment; • In receipt of a grant from a provider; • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for CQC or NICE; • A medical researcher.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • A member of a political party; • Suffering from a particular condition requiring individually funded treatment; • A financial advisor.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). This should include: • Spouse / partner; • Close relative e.g., parent, [grandparent], child, [grandchild] or sibling; • Close friend; • Business partner.
General Interest	This could be any position held in another public body organisation, NHS, Local Authority or a community group which may have potential to give rise to influence decisions made by the CCG. Similarly, if you have made a declaration that you are a member of the CCG or attend any of its committees/working groups to another organisation, this information MUST be reciprocated back to the CCG to ensure consistency across organisations and vice versa

Declaration of Interests (DOI) Flow Chart (Operating Procedure)



Declarations of Interest V3 May 2019
1

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Declarations of Gifts, Hospitality and Commercial Sponsorship

Name & Job Title	
Details of gift, hospitality or commercial sponsorship	
Date of offer	
Date of receipt (if different)	
Estimated value	
Supplier or Name making offer	
Nature of business	
Details of previous offers or acceptance by from this person/company making the offer.	
State any conflict of interest with provider, supplier/pharmaceutical company	
Declined or accepted	
Reason for accepting or declining	
Comments	

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as is practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that the CCG holds. If consent is NOT given, please give reasons:

Signed: _____ Date:

Signed (line Manager): _____ Date

Position: _____

Please return by email to D-CCG.Governance@nhs.net and provide a signed hard copy to your team administrator for inclusion in your personnel file. If you have any queries, please contact the Governance Team

For Governance Team action Initials……	Respond to individual to confirm the declaration has been added to the database. Confirm DOI register check for any potential conflict Date……

Appendix E

Standard Operating Procedure Hire of Rooms

Standard operating procedure to be followed by staff member taking a room booking from a person external to the CCG

In 2011, the Government set out the 'Prevent' strategy to tackle violent extremism of all kinds, as well as some aspects of non-violent extremism. Prevent is part of the Government's counter-terrorism strategy, and is ultimately about safeguarding people and communities from the threat of terrorism. Since 2015, the CCG has had a statutory duty to "have due regard to the need to prevent people from being drawn into terrorism". For more detail please see the CCG Prevent Policy

https://devonccg.nhs.uk/?s=prevent

To ensure the CCG is compliant with statutory duties, amongst others, the CCG is required to ensure that its premises are not used by extremists.

The CCG will make available their meeting rooms to staff, partner organisations and for official Council business free of charge and subject to corporate needs may make the rooms available to other organisations and the public for a charge.

The CCG will not permit its accommodation to be let:

- For political rallies or demonstrations
- For purposes which are illegal i.e. be they forbidden by law or unauthorised by official or accepted rules
- For functions attended by people whose presence may cause civil unrest or division within the community
- To an organisation or individual which has been banned by law.

The CCG also reserve the right to cancel any booking where it considers:

1. that such events may be contrary to the interest of the general public or contrary to any law or act of Parliament. Any bookings will also be subject to consideration from the police to ensure the safety of the community and staff is assessed against the request for a venue booking.
2. the users of the premises may do something that may cause or pose a risk of loss, damage or significant expense to the CCG or harm the reputation of the CCG

The CCG will ensure that the application of any part of this process does not discriminate directly or indirectly against anyone on the grounds of race, disability, sex, gender reassignment, sexual orientation, religion or belief, age, marriage or civil partnership.

Each Business Manager is responsible for setting the terms of hire and booking arrangements.

Staff who are responsible for the hiring of any CCG owned premises/rooms should complete the Home Office online E-Learning Module level 3 on Prevent available via ESR

Staff should ensure that there is appropriate consideration of inadvertently supporting extremism when engaging outside speakers.

When booking a room for an outside speaker, the following questions will assist staff in determining whether a booking is considered controversial or there is any risk associated with the booking:

1. Establish what the venue will be used for and what type of event the customer is wishing to hold.
2. Is the name given linked to any community group or organisation?
3. Request a copy of the programme details and names of any speakers.
4. Request all contact details (address, mobile, home and business contact number).
5. If the customer is not a local resident, establish why they are holding an event in this area.
6. Ask the customer if they have used any other venues in the country, if so contact the previous venue(s) to establish what the event was.

If you are concerned with the answers provided by the customer, speak to your manager. If the manager deems it appropriate they will cross reference the booking details provided with the web links and contacts below, or ask you to do so (in the order listed):

1. Inform the Corporate Services Manager

2. Check the government list of proscribed organisations https://www.gov.uk/government/publications/proscribed-terror-groups-or-organisations--2 (provides a list of all known terrorist groups within UK and Ireland).

3. Contact The CCG Prevent Lead for the CCG ~~both CCGs~~ : d-ccg.safeadults@nhs.net t Tel:01803 396350

4. Contact Devon and Cornwall Police Prevent Team: Email: prevent@devonandcornwall.pnn.police.uk Tel: 101 The Prevent lead may support you in this or make the referral.

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Use of the NHS Devon Seal

Financial Year	Date	Folio	Description	Amount	Signatory	Title
2019/20	10/12/2019	001	Framework Partnership Agreement between Devon County Council and Devon CCG relating to the Commissioning of Health and Social Care Services – Better Care Fund	£55233206 contribution to pooled Better Care Fund	Sonja Manton	Interim director of commissioning (northern, eastern and southern)
					Andrew Millward	Director of Communications and Human Resources

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AUDIT COMMITTEE

Report title: Use of Common Seal				
Date of committee: 09 September 2020 **Date report produced: 21 August 2020**				
Author (s) Name and Title: Clare Doble, Head of Governance **Contact Details: clare.doble@nhs.net**		**Supporting Executive: Ginny Snaith** **Name and Title: Board Secretary** **Contact Details: g.snaith@nhs.net** **Report Approved by:** **Name and Title: As above** **Date**		
Public or Private (Governing Body only):	**Public**		**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

All NHS organisations' are required to have a common seal. The constitution of NHS Devon Clinical Commissioning Group provides that the seal shall only be affixed under the authority of the Accountable officer, Chair of the Governing Body or Chief Finance Officer.

The Audit & Assurance committee has the delegated responsibility for regularly reviewing the register of the use of the common seal, and this report is presented in order to satisfy that requirement no less than annually.

Management of Conflict of interests:

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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:
The Audit & Assurance Committee is recommended to note the content of this report.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
N/A
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	No
Quality of Services		X
Health Inequalities		X
Equality (staff or public)		X
Resource and Finance		X
Legal		X
Engagement and Consultation		X
Risk		X

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.

Use of the Common Seal

1. Introduction

1.1 All NHS organisations' are required to have a common seal. The constitution of NHS Devon Clinical Commissioning Group provides that the seal shall only be affixed under the authority of the Accountable officer, Chair of the Governing Body or Chief Finance Officer.

1.2 The application of CCG's common seal must be attested by one of the above plus one other member of the Governing Body.

1.3 The Audit committee has the delegated responsibility for regularly reviewing the register of the use of the common seal, and this report is presented in order to satisfy that requirement no less than annually.

2. Background and purpose of the report

2.1 The seal is applied in the following circumstances:

a) contracts for the purchase/lease of land and/or building;
b) contracts for capital works;
c) lease agreements with annual lease charges and where the period of the lease exceeds beyond five years; and
d) any other lease agreement where the total payable under the lease exceeds limits as set out in the Use of the Seal Standard Operating Procedure. Any contract or agreement with organisations other than the NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed limits as set out in the Use of the Seal Standard Operating Procedure.

2.2 Where the common seal is not used for any of the above the Head of Governance seeks assurance through the Chief Finance Officer, Head of Finance and Head of Contracting that senior officers have signed in accordance with their financial limits authority, as detailed in the Scheme of Reservation and Delegation and Financial Limits described in the constitution and associated governance handbook.

2.3 The common seal and the register of the common seal is held and maintained by governance, with a clear procedure in place of the circumstances in which it is applied, including the governance arrangements around it's application.

2.4 Since the authorisation of NHS Devon CCG the seal has been used once and a copy of the register is appended for oversight. The CCG has had no need to sign any new lease agreements so far this year.

3. Recommendation

3.1 The Audit Committee is recommended to note the content of this report.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Commissioning Committee

Date of Governing Body: Thursday 24th September 2020

Dates of Committees covered in this report: Thursday 10th September 2020

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

Chair's Name and Title: Dr Claire Hooper, Strategic Lead for Planned Care

Presented by Dr Nick Kennedy, Independent Secondary Care Clinician

Contact Details: claire.hooper2@nhs.net / nick.kennedy3@nhs.net

Reports discussed and assurances received

Referral to Patient Treatment List

- **An overview of the Referral to Patient Treatment List was presented to the Committee. It was noted that a decision may be required in a future meeting.**

Winter Plan – with reference and alignment to Operating Plan and Phase 3 Winter Plan

- **The Committee were provided with an update on the Winter Plan and Phase 3. A further update will be provided to the Committee at the November meeting.**

Reports received and noted

Governance for ICS

- **The Committee noted the Governance for ICS. Further clarity will be received following the Governing Body Development Session on 30th September.**

Procurement Plan and Contract End Dates

- **The Committee received a report outlining the out of hospital care contracts that are due to end in March 2021. A further meeting is being arranged to discuss the North and East Contract prior to a decision being made at a future Committee meeting.**

Risk Register Review Updates

- **A further review of the Commissioning Risk Register will take place ahead of the next Commissioning Committee.**

Committee Decisions

- **The Committee accepted the recommendations made within the Health Navigator Service paper.**

- **The Committee accepted the recommendations within the Clinical Policy Committee Annual Report 2019-20.**
- **The Committee accepted the recommendations within the Clinical Policy Engagement and Consultation Panel Annual Report 2019-20.**
- **The Committee accepted the recommendations within the NICE Planning Advisory Group Annual Report 2019-20.**
- **The Committee endorsed the recommendations for the Leg Ulcer Service Review.**
- **The Committee approved the Community Urgent Care Recommendation Report.**

Items of concern to be escalated to the Governing Body

- **None**

Recommendations for Governing Body

- **None**

Recommendations for other Committees

- **None**

Terms of Reference or other committee effectiveness issues

- **The Terms of Reference are being presented to the Committee on 23rd September for formal sign off.**

Management of Conflict of interests:

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NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 24 September 2020

Dates of Committees covered in this report 17 September 2020

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

Chair's Name and Title: Graham Turner, Non-Executive Director, Finance & Remuneration

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- Risk Register Reports – see Risk Register review below.

- Quality & Performance Report – the Committee received information on key quality and performance indicators for the period 1 April to 31 July 2020, including those contained in the NHS Constitution. The report had previously been considered at a joint Committee meeting with the Quality Assurance Committee. The following areas were highlighted: -

    - Performance against the Cancer Waiting Times standards remained relatively stable through the initial Covid-19 period and has further improved in July. The STP position against the 62-day standard rose from 76.7% to 84.8%. NDHT and TSD both achieved the 85% target. Performance against the main two-week wait standard fell below target in July, at 90.9%; NDHT & UHP both achieved the target (97.7% and 97.4% respectively). However, RD&E fell from 90.7% to 89.1% and TSD fell from 91.4% to 83.4%. This follows an increase in referrals back to pre-Covid levels, with rises at all providers.

    - Referral to treatment times - a further fall in RTT 18-week performance from 52.5% to 49.6% at STP level compared to the target of 92% and national performance of 52%. This is a ten percentage point's fall over two months. Long wait patients continued to increase, with over 52 week waits rising quickly at all providers in July. The Committee was informed that we are working towards a system wide Patient Treatment List that will support patients with greatest need accessing a surgical intervention.

    - Diagnostic waiting times have been significantly affected by the Covid-19 pandemic. All providers saw an improvement in performance in July, but the STP position of 59.9% remains well below the 99% target but is slightly better than the England position of 52.2%.

    - A&E waiting times - In contrast with the position against elective waiting times, performance against the A&E 4- hour wait target improved as a lower number of patients presented in emergency departments from late March and into April. Overall attendance volumes fell by 40% in April and but are beginning to return to pre-Covid levels, with August seeing 5% a rise in A&E attendances. STP performance was 89.43% in August for All Types and 86.3% for Type 1

attendances, below the 95% national target and the England position at 90.4%.

- 111 Performance - The proportion of 111 calls answered within 60 seconds fell again, from 57.8% in July to 51.4% in August, which is significantly below the target of 95%. Actions being taken to address this include additional investment of circa £800k (full year) in 111 call handler capacity and the Think 111 programme, which has a demand/capacity workstream with objectives linked to ensuring that the 111 service has enough capacity to deal with additional demand when the campaign is launched.

- Urgent & Emergency Care – Time lost to ambulance handover delays across Devon in August increased to 415 hours. Call stacking has become a challenge across the SWASFT footprint, and the SWASFT risk score has been increased to 20 following a period of low risk during COVID-19 where patient demand was less. Six 12-hour breaches were reported in August, all by UHP. Further details have been requested to assess any patient harm.

- Mental Health (MH) – The Care Quality Commission (CQC) undertook an inspection of DPT Acute wards for adults of working age and psychiatric intensive care units in June 2020 where the need for improvements have been identified.

Reports received and noted

- Devon CCG Monthly Finance Report - the report reminded the Committee of the draft budget previously agreed (a deficit position of £47.8m with a savings requirement of £22.6m). This draft budget had not received approval by NHSE, who had instead put in place a temporary financial regime for the period 1 April to 31 July 2020, with an expectation that CCGs will break even during this time. Variance against plan will be reviewed, with a retrospective allocation being made if considered reasonable. The Committee noted that the temporary arrangement had been extended to cover August and September. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

- STP Monthly Finance Report – the paper was presented for information to the Committee, outlining the position at Month 3.

    - All providers receive block contract payments from commissioners including specialist. The current regime gives providers a top up payment where their plan shows a deficit position to bring each provider to breakeven.

    - A true up payment is also received by providers where there is an adverse variance to the planned position. Devon CCG will also receive a top-up payment where expenditure is greater than the April – July allocation.

    - Additional expenditure for COVID-19 is covered through the top-up and true-up payments.

    - As at month 3 the Devon system required a true-up payment of £48.9m to break even after any top-up payments. The forecast for the first four months of the year requires £61.6m (Month 2 £73.2m) of true-up.

    - Total costs for COVID-19 was £66.3m for M1-3 (M2 £39.2m)

    - Year to date overspend on bank of £3.2m (£0.8m M2) is partially offset by an underspend on agency of £2.1m (M2 £1.5m).

    - Forecast overspend on bank £4.2m (M2 £1.4m).

- The Committee received a further update on the Financial Framework Post Covid-19 Emergency, under which systems are being issued with funding envelopes, within which providers and CCGs must achieve financial balance. The Committee was updated last month on the development of the full year forecast for the CCG, and the assumptions on which that was based. It was also reported that work was underway in relation to the underlying position to be carried into 2021-22 and the swift restart of the CCG's QIPP plans, necessary to support delivery.

- The Committee was informed that the initial headline assessment upon receipt of the system envelopes, as part of the financial framework for the remainder of 2020-21, is that in broad terms the funding allocated to the CCG is in line with expectations, in that it reflects adjustments for Mental Health Investment Standard, Delegated Primary Care and Running Costs. Adjustments were also made in relation to block contracts and non-recurrent allocations and the Committee noted that a more detailed assessment of risk to delivering financial balance for both the CCG and in the context of the wider system would now follow.

Risk Register Review (changes and areas of concern)

- There have been no changes to risk scores.
- Following discussion, in respect of Risk 125 (There is a risk that there is a possibility that some of the excess COVID19 costs over and above the budget set are not funded by NHSE through the top up process leading to an inability to deliver against the temporary financial regime for the period to 31st July 2020. Whilst we have funding to cover the CCG's first two months of COVID19 costs, it is not guaranteed that this arrangement will continue) the Committee agreed to the removal of this risk from the Corporate Risk Register and de-escalation to the Finance & Performance Team Risk Register.
- The Committee noted the closure of the COVID risk register.

Committee Decisions

- None

Recommendations for Governing Body

- None.

Recommendations for other Committees

- None.

Terms of Reference or other committee effectiveness issues

- None.

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NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 24th September 2020

Date of Committee covered in this report: 3rd September 2020 (Minutes of this committee meetings to be available as an addendum)

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Reports discussed and assurances received:

Members of the Committee discussed the following reports:

The PCOG report: The Primary Care Operational Group meeting were given updates on:

- Teignmouth Health and Wellbeing hub consultation.
- Estover practice new contract agreement

The Quality report: – for information on Key improvement areas that support quality surveillance and assurance across primary care moving forwards are being developed by the CCG.

The Primary Care Strategy overview: - The Primary Care Senior Leadership Team gave a presentation on the current position of and future plans for the 6 Pillars of the Primary Care Strategy for interrogation and comment.

1) Better access to care through technology
2) Clinical leadership
3) Workforce
4) Primary Care Networks
5) Population Health Management
6) Infrastructure and estates

Reports received and noted:

The Committee noted:

The Finance report: including a section on Primary Care Prescribing for increased context.

1. We are still operating in the emergency financial framework for COVID 19 response – all costs will be covered until the end of September.
2. On the original plan we are set to break even.
3. In prescribing efficiencies are being reviewed.

4. There is a variance against the interim budget – some monies are already being reimbursed others are being worked through by NHSE but full reimbursement is expected.

Risk Register Review (changes and areas of concern)

The Risk Register was reviewed by the Committee,

No risks have been closed.
No new risks have been added
No risk score movement in the reporting period.
The Covid risk register has been closed and the risks have been reviewed and either closed or transferred to the Corporate or Team registers.
Risks are reviewed monthly by PCOG.

Committee Decisions

None

Recommendations for Governing Body

None

Recommendations for other Committees

None

Terms of Reference or other committee effectiveness issues

The Primary Care commissioning committee yearly forward planner was presented to the committee for information and comment.

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NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chairs Report Public Quality Assurance Committee Part 1				
Date of committee: 17 September 2020 **Date report produced: 17 September 2020**				
Author (s) Name and Title: **Glynis Atherton Chair Quality Assurance Committee** **Non-executive lay member (Chair of Quality Committee)** **Contact Details: glynis.atherton@nhs.net**		**Supporting Executive:** **Name and Title:** **Darryn Allcorn System Chief Nursing Officer, NHS Devon CCG** **Contact Details: darryn.allcorn@nhs.net** **Report Approved by:** **Name and Title:** **Date**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The Quality Assurance Committee Chair Report is to inform the Governing Body of reports discussed and assurances received, changes and areas of concern resulting from review of risks, decisions and recommendations - to include terms of reference or other committee effectiveness issues.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				

Key recommendations and actions requested:

Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources

Reference to other documents or accompanying papers:
Quality Assurance Committee 17 September 2020

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

	If Yes, please give details	No
Quality of Services		☞
Health Inequalities		☞
Equality (staff or public)		☞
Resource and Finance		☞
Legal		☞
Engagement and Consultation		☞
Risk		☞

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NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chairs Report – Quality Assurance Committee (QAC) Public
Date of Governing Body: 24 September 2020 **Dates of Committees covered in this report: 17 September 2020**
Chair's Name and Title: Glynis Atherton Chair Quality Assurance Committee **Non-executive lay member (Chair of Quality Committee)** **Contact Details: glynis.atherton@nhs.net**
Reports discussed and assurances received
The Committee received updated reports as detailed below
Reports received and noted
Patient Safety and Quality Report **Provider Specific Issues** **Northern Devon Healthcare Trust (NDHT) -** There is a CCG risk (risk 90) regarding concerns around quality and safety at NDHT. Given evidence of sustained improvements in these areas, combined with and attributable to a more robust leadership and governance process, the Nursing and Quality Directorate are recommending closure of this action. **University Hospitals Plymouth NHS Trust (UHP) -** Whilst the CCG attend the Trusts Governance Committee and is observing evidence of planned long-term solutions to current issues, until sustained improvement is seen, these issues remain escalated. However, at August's provider Quality and Safety Committee, despite the challenge that COVID-19 has had on the Trust, the Director of Nursing evidenced improved, robust quality governance processes are beginning to impact. Additionally, UHP's board are revisiting and strengthening their Board Assurance Framework. **Torbay and South Devon NHS Foundation Trust (TSDFT) -** Attendance at the Trust Quality Improvement Committee and CQC Compliance Assurance Group has given assurance that the Executive Team are now providing a robust and rigorous "check and challenge" to their senior leadership team in relation to the Trust's CQC action planning. The new Chief Nurse has attended these meetings and communicated how she expects compliance to be measurable and evidence embedded across the organisation. **Devon Partnership Trust (DPT) -** Due to on-going and escalated concerns around safety, described in detail during part 2 of August's QAC, a single item Quality Surveillance Group (QSG) meeting took place 28 August 2020. The outcome of this meeting is a four-weekly meeting between the Trust, CCG, NHSEI and the CQC. The CCG will continue to update QAC on a monthly basis for the foreseeable future.

Children and Family Health Devon - The information provided by the provider continues to describe children and young people experiencing long waiting times (for CAMHs, Autism, SALT) and concern remains as to whether the provider has the leadership capacity and capability, as well as governance to improve the current situation at the pace required. An improvement plan is being agreed and will be shared with the CCG.
Royal Devon and Exeter NHS Foundation Trust (RDEFT) - Recent incident reporting highlights concerns within cardiology care pathways, specifically relating to safety processes in checking for harm. Provider safety and risk colleagues have provided partial assurance to the CCG, and cardiology colleagues are providing monthly reports to the Trust's Incident Group (IRG) and Governance Committee, as internally the Trust also recognise more assurance is required. The CCG Quality team attend both risk and governance meetings and will review actions following September 2020 Governance Committee. A further update will be included in the October QAC Report.

Devon Referral Support Services (DRSS) - Operational capacity has returned to a near normal level (75% of referral activity). The CCG Nursing and Quality Team continue to work closely with DRSS in improvement and assurance roles. This ensures quality remains at the centre of DRSS business, who are embedded in the restoration of safe services.

System Service Specific Issues
Elective and Planned Care - Pre COVID-19 escalated quality issues have been exacerbated by the pandemic, including long waits. With excellent examples of innovation, providers are now being asked to provide assurance they are 'adopting and adapting' new models of working to drive improved safety and experience. Impact of changes, be they stepping up or transforming, continue to be evidenced by providers, supported through the CCG Quality and Equality Impact Assessment (QEIA) process.

The CCG and NDHT's Heads of Nursing and Quality are jointly presenting to Devon Quality Surveillance Group in September 2020, with principles and recommendations that support a consistent approach to equity of access to services across Devon, risk stratification whilst patients have delayed treatment and the harm review process.

Primary Care - With more patients being seen virtually by acute providers, the apparent shift in the work to primary care continues to be an on-going concern. The CCG are working to support primary care and other providers in the short term to understand and resolve this issue; the CCG are communicating closely with the LMC and facilitating providers to meet and plan how best services can potentially be delivered closer to home for patients in the longer term.

The CCG is also mindful of the potential impact winter, the influenza period and potential further COVID-19 surges will have on primary care. CCG plans therefore include how the CCG continue to support primary care, and its already challenged workforce, to mitigate potential risk and ensure continued high-quality care.

Urgent Care - Time lost to ambulance handover delays across Devon in August increased to 415 hours. There has been no reported harm in relation to delays either to the patient in the ambulance / or patients still waiting for an ambulance, but it is likely to have impacted on patient experience. Call stacking has become a challenge across the SWASFT footprint, and the SWASFT risk score has been increased to 20 following a period of low risk during COVID-19 where patient demand was less. The CCG risk score remains at 12 as there is no evidence to demonstrate either the level of stacking in Devon or any associated harm.

Six 12-hour breaches were reported in August, all by UHP. Further details have been requested to assess any patient harm.

The NHS 111 service report significant pressure. Call abandonment rate in August remains unacceptably high at 21.19% (an increase on July) against a target of less than 5% calls abandoned. 51.40% (a decrease on July) calls were answered within the target time of 60 seconds against a target of 95%. This call answering position may lead to poor patient experience, although complaints to the service remain low.

CCG Functions/ Roles

Continuing Healthcare - As part of 'phase 3' restoration of services, this operational function will recommence as of 1 September 2020. There is the expectation, through the reset work, that the new backlog of assessments will be cleared. This backlog has now been assessed as 913 outstanding assessments.

A new nationally funded, 6-week discharge process has been established from 1st September 2020. This discharge process will generate new CHC assessment referrals, as well as those generated from the community setting. As part of the 'CHC reset', to clear the backlog of the 913 CHC assessments, a range of options are being considered of how this can be met. Also, to note, there is significant financial risk to the CCG if the backlog is not cleared. A paper describing a range options is being presented to the CCG executive team for consideration during September.

In conjunction with the above, the CCGs internal Audit team have just completed a review of the CHC operational function and made a number of recommendations. One of which is that risk of the backlog of CHC assessments and the associated financial risk, is included on the CCGs corporate risk register. The details of this is being worked through at the time of this report.

Safeguarding

Adults - There has been a whole service Safeguarding Adults strategy meeting in relation to a DPT unit. Though it was agreed that the threshold for whole service safeguarding was not met, it was agreed that the unit will require ongoing monitoring through CCG Quality Assurance processes. The number of S42 concerns raised to local authorities have continued to rise towards levels seen prior to the pandemic, though on occasions the concerns appear to be more complex. Local authorities are currently undertaking some initial analysis to understand themes and trends.

Children - Work is ongoing with the children's commissioning team to write a business case to provide additional health personnel for Plymouth MASH. The safeguarding team are working with other members of the Nursing and Quality Directorate to ensure that the safeguarding training and supervision and support arrangements are robust for CAMHS staff working as part of CFHD.

Looked after Children - NHS Devon CCG has a statutory requirement to cooperate with the Local Authority to commission initial and review health assessments for children in care within clear timeframes. Initial health assessments (IHA) are commissioned through our paediatric block contracts. Last year a service specification for the Named Doctor role, who's role is to manage the IHA process with in each of the acute trusts, was introduced and adopted. It has a requirement to submit monthly key performance data to demonstrate compliance with statutory timeframes. Due to the pandemic this has not be available, but having moved to the restoration and transformation phase, a request to re-establish the data flow has been submitted by the CCG.

Review health assessments (RHA) are commissioned from Child and Family Health Devon (CFHD) and Livewell. Both Specialist Children in Care Nurse teams provide monthly data on performance. Face to face health reviews where stood down between March- July. Livewell have recommenced face to face assessments, but CFHD have not recommenced face to face contacts to date, a timeframe has been requested by the CCG for when they will restart.

Patient Experience - PITCH: 100 submissions were received last month and 22 remain currently open. Themes include, shift of workload, in particular asking GPs to re-refer after COVID. There is evidence of a slight increase in received PITCH's around 111 and the advice they are providing.

PALS: 72 cases were received last month within the CCG and 16 cases remain open. No particular themes were identified, although 5 related to COVID 19 in some way; either delayed appointment, testing questions or contacting GP surgery during COVID 19.

Complaints: 6 cases were received last month, and 22 cases remain open. 1 is in relation to CCG decision making around an SI, 1 in relation to 111 services, 1 in relation to diagnosis from sentinel, 1 from Plymouth Council asking for input into a complaint and 2 in relation to Continuing Healthcare Assessment Delays.

Safety Systems - The overall serious incident position continues to improve.

LeDeR - The team have undertaken significant forward planning to ensure that the NHSE targets are met. These are for all reviews notified prior to 31st July 2020 to be completed by 31st December 2020. The CCG have procured a number of block and zero hour contracts and have requested a minimum of 2 reviewers per organisation across the STP. This has been taken through the Chief Nurse and would provide the capacity required. NHSE have shared an Action into Learning programme which the CCG are required to submit evidence for. This is due in October 2020 and will be taken to the Steering Group in September 2020.

Infection, Prevention & Control
Influenza - The publication of new national PPE guidance has enabled both community and hospital flu vaccination clinics to function safely. Both frontline healthcare worker and community flu vaccination projects are on track and no delays are anticipated. However, there are communication concerns with the new vaccination cohort of 50-64-year olds with no pre-existing conditions. The national messaging has been that this cohort will be offered vaccination, but there are challenges around sufficient vaccine remaining later in the season (November 2020). Careful local messaging may be required to minimise issues arising from this.

COVID-19 - There continues to be low levels of COVID-19 in Devon. Recent data analysis has shown that care homes in Devon have the lowest COVID-19 mortality rate in the South West, although the reasons for this are not yet clear.

PPE - The source of the long-term supply of FFP3 masks (required for aerosol generating procedures) for clients who have a personal health budget which require advanced PPE is still not clear. The CCG stores management team have a limited stock, but a sustainable system position is needed for the supply of all FFP3 masks in all out of hospital settings across Devon. There is not yet a national or a local process for clients with personal health budgets to access FFP3 masks in a sustainable ongoing manner. The issue has been repeatedly escalated both regionally and nationally.

Equality Diversity and Inclusion Annual Report
The report sets out how well the CCG has performed against the Public Sector Equality Duty (PSED). It includes the required information including:

- Information about the protected characteristic demographics of the populations in scope
- What actions have been taken during the period covered by the report
- What evidence tells us of the experience of people with protected characteristics
- What has been done well
- Where there are areas for development
- Equality objectives

Findings from the available evidence indicate that there are protected characteristics we serve better than others (age, sex, disability [Mental health and learning disability]) and that meeting our PSED is stronger in relation to our staff than for service users.

The key finding is the lack of data both quantitative and qualitative, what we ask of the data we have and inconsistencies in what, when and how we collect data.

Improved collection and analysis of data must be a priority area of work going forward if we are to properly understand the experiences and outcomes of people with protected characteristics in a way that enables us to meet their needs appropriately and effectively. Capturing and recording our equality activities will help to better reflect the work done by staff to improve the experience and outcomes for people from protected characteristics.

The Committee approved the proposed equality objectives.

End of Life
The report aims to provide an update for the Committee on the work of the Devon End of Life Care Group during the Covid-19 pandemic. It provides a summary of the actions taken and the measures available to ensure good end of life care is maintained during the pandemic. It also outlines the review of capacity to support any 'surge' in demand for palliative, end of life or after death administration and bereavement care.

The recently published National Palliative & End of Life Care (PEoLC) Strategy has also provided the Devon EOLC group with an opportunity to review and plan for strengthening and improving EOLC across Devon in line with the 6 National PEoLC workstreams:

1. Clinical Excellence
2. Commissioning, contracting & finance
3. Digital
4. Patient Experience
5. Workforce
6. Stakeholder engagement and communications

The Devon EOLC group workplan provides the Committee with an overview of the key work programmes aligning to these national requirements.

The Committee noted the contents of the report and support the plan to align the Devon EOLC workplan to the key national PEoLC requirements.

Risk Register Review Updates

Quality Risk & Assurance Report including Risk Register:
Please see below with regards to Risk Register Review (changes and pertinent areas).
Data extracted for this report on the 2 September 2020,NHS Devon CCG has 30open on the corporate risk register.

- There are two risks pending closure reporting to the Commissioning Committee.
- There are 12 risks reporting to the Quality Assurance Committee.
- There have been two risks added to the Corporate risk register reporting to this committee.
- There has one increase of risk score movement in this reporting period.
- There are two risks recommended for closure at this committee.
- The Committee agreed the removal of risk 90 from the corporate risk register and move to the Nursing and Quality Directorate risk register.
- The Committee agreed the removal of risk 116 from the corporate risk register and move to the Nursing and Quality Directorate risk register.
- The COVID- 19 risk register has been reviewed by the Executive Team and the recommendations from the Executives and risk owners have been considered and approved. Risks are in the process of closure or transfer to either the corporate risk register or team level risk registers.

Committee Decisions

- No specific decisions required.

Items of concern to be escalated to the Governing Body

- None

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

Management of Conflict of interests:

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

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

NHS
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GOVERNING BODY

Report title: Locality Update Reports				
Date of committee: 24 September 2020 **Date report produced: 15 September 2020**				
Author (s) Name and Title: **Locality Triumvirates**		**Supporting Executive:** **Name and Title: Nick Ball, Vice Chair/Audit Chair** **Contact Details:** **Report Approved by:** **Name and Title:** Locality Triumvirates **Date 15 September**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Southern and Western Devon Localities.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				
The Governing Body are asked to receive and note the contents of the locality update reports.				
Impact on Strategic Objectives				

(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
None

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

	If Yes, please give details	No
Quality of Services		X
Health Inequalities		X
Equality (staff or public)		X
Resource and Finance		X
Legal		X
Engagement and Consultation		X
Risk		X

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Locality update report

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

Key achievements/progress

- **Discharge Planning**. The revised Discharge Policy was released nationally 26th August for implementation 1st September. Whilst confirming some aspects of the previous Discharge to Assess (D2A) guidance there were new standards expected of both the acute provider and community Health and Social Care. Both DCC and NDHT have named individuals/committees holding responsibility for delivery of :
    - A robust gap analysis against the revised policy
    - An action plan to deliver the required changes
    - An agreed process for identifying and approving the costs of the requirements.

- It has been agreed to bring RAG-rated plans back to the Discharge and Out-of-Hospital Cell chaired by Jayne Carroll week commencing 21st September.

- Devon Cares the Lead provider for Domiciliary Care for the Northern Locality Zones 1 & 2 will be starting a 90-day Challenge in September with a number of aims but the principle purpose is to reduce the “Awaiting Care List” to zero as well as reducing wastage and improving data quality as part of the same intensive process. Further reports will be shared when available

- The Phase Three Out-of-Hospital Demand and Capacity was submitted on time detailing the current and future work plans relating to the Discharge-to-Assess pathways 1, 2 and 3. This consists of work by Stella Doble and her team in reviewing the Short-Term-Services (STS) review in the Northern Locality, undertaking a post-action analysis of the system benefits of the Durrant Hotel beds and their developmental plans around all three of the D2A pathways above Pathway

- Additionally, the CCG note that NDHT's Leg Ulcer Service team, Trauma and Orthopaedic team, and Acute Oncology Service team have all been shortlisted in the Health Service Journal (HSJ) Value Awards

- The Locality has just completed the formal consultation aspect of our **accommodation review**. Positive feedback from staff assisted with this process. A potential site for the Northern Locality has been identified and is being progressed. A possible alternative site is also being reviewed as a backup in case there are any complications with the lease negotiations.

- There are ongoing conversations around the siting of further hot hubs in the Northern Locality if the demand increases

- Primary Care Networks (PCN) – as part of the Enhanced Health in Care Homes Specification care homes in North Devon have now been aligned to a single PCN. All north devon PCNs have submitted their workforce planning returns

Key priorities for the next three months

- **Urgent Care Demand** in the NDHT Emergency Department has now returned to the levels experienced pre-COVID-19. Feedback continues that changes in seeing patients across the system as a result of COVID-19 have resulted in an uplift in attendance to the Emergency Department (ED) with ambulatory non-ED conditions.

- **Phase 3 of the Out-of-Hospital Capacity Plan.**
  The Key priorities emerging from the unplanned/out of hospital workstream in Northern are:

  1. Short Term Services development
  2. Implementation of the revised national Discharge Policy
  3. Market sufficiency, personal care and enhanced health in care homes
  4. Admission avoidance and keeping people at home

- **Winter Planning** continues within the locality with NDHT leading on the work with input from all system partners and the Locality.

Issues of concern or risk

- There are continuing concerns around a shift in workload from secondary care to primary care, such as phlebotomy, because of the increase in virtual appointments happening in secondary care and other new pathways of care. A review of this is being led by Dr Alex Degan

- Community services readiness for a potential COVID-19 second wave/winter is a concern however good joint working between all parties in the North is mitigating this risk.

Support required from CCG/system or barriers to progress

- The locality is continuing to progress with the development of a Local Care Partnership (LCP) The Northern Integrated Delivery Meeting is expediting joint working however this process will be further expedited by a formal agreement on the intended governance structure for the central components of Devon Integrated Care System and the anticipated functions expected from each LCP.

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Locality update report

Locality:	Eastern
Period covered by update:	September 2020
Locality clinical representative:	Simon J Kerr
Locality executive lead:	John Dowell
Locality non-executive representative:	Glynis Atherton

Key achievements/progress

- The Eastern system has been preparing the Winter Plan for submission with the Phase 3 planning returns. This are plans to ensure acute and community capacity is sufficient to meet the expected demand alongside COVID restrictions.

- Updated Discharge to Assess Guidance was published during August which further develops the standards set earlier this year. This embeds the classification of four discharge Pathways and sets reporting and monitoring standards around these which commissioners are working with providers to ensure are in place. A reconciliation process is currently underway to evaluate where the Royal Devon & Eastern NHS Foundation Trust (RD&E) meets the guidance standards and any areas which may need to be developed, such as specifics of data recording and reporting. This process is being undertaken during September, with a view to report full compliance by the end of the month.

- The Phase 3 letter also reimplemented the care assessment process after a 6 week initial funding stream. The reapplication of assessments and the capacity required to complete these has fed into demand and capacity planning system-wide. From 1st September, a programme of work to address the backlog of Continuing Healthcare (CHC) and social care assessments has also been implemented by the various system teams.

- Close monitoring of RD&E discharge position and occupancy levels remains in place, with weekly system-wide commissioner calls to maintain oversight of these measures.

- The out of hospital demand and capacity plan has been formulated for the Eastern locality. This sets the intention to develop additional capacity within the personal care market through a number of stimulus measures, alongside an assessment of whether additional investment is required into the RD&E's Urgent Community Response team if the personal care market is able to offer sufficient capacity. Additionally, further capacity for short term beds may be required according to early modelling data and this is being scoped current with the care homes market. This programme of work is being developed by social care colleagues and more detail will be available in next month's report.

- Discussions initiated by the clinical team at the RD&E to understand how to provide a COVID safe Emergency Department and service by redesigning how the care is provided in partnership with local Primary Care Networks and the 111/ Clinical Assessment Service (CAS). This redesign work will ensure the RD&E Emergency Department pathways of triage and care are aligned to the emerging national model of "NHS 111 First" that requires people to ring 111 before attending an Emergency Department to enable the 111/CAS service to act as a system navigation tool to ensure patients receive the "right care at the right time in the right place" while protecting staff and patients from the nosocomial risks associated with overcrowded Emergency Departments.

- The planning for the next stage of the work to review and recommend future community urgent care services in East and mid Devon has commenced.

- A development session is taking place on Thursday 10th September between the core membership of the Eastern Operational Delivery Group (EODG)(previously titled Eastern System Tactical Call) to develop a set of priorities and working principles so that the Delivery group can act appropriately for the evolving Local Care Partnership. It is expected that this workshop will further embed the strong working relationships between the system providers present and will include primary and secondary care colleagues, representatives from Devon Partnership Trust (DPT) and adult social care as well as commissioners.

- A profile of the Eastern locality is being drawn together from all commissioning areas to provide a single assessment of the commissioning landscape in the locality, the challenges likely to be faced specifically in Eastern and the evolving commissioning priorities for this. The development session of the EODG mentioned above will provide additional perspective for this.

Key priorities for the next three months

- Support the Devon-wide development of Think 111 First and Emergency Department demand management.
- Take forward the recommendations made in the out of hospital capacity plan and implement these changes to ensure robust winter response and maintaining acute occupancy levels.
- Establishing longer-term clinical leadership for each care home and continuing to shape the response to care home resilience plans.
- Further develop the hospital discharge partnership to continue reducing in hospital length of stays
- Specify and commission leg ulcer services in response to practices notice to cease services previously provided under the Leg Ulcer Local Enhanced Service as part of a Devon-wide review of services.
- Early Supported Discharge for stroke patients across the whole of east to reduce the length of stay for this specific patient group.
- Strengthening the role and acuity capacity of community urgent care sites to develop them into viable alternatives for patients to attend other than an emergency department and therefore less likely to result in a patient admission.
- Continuing to strengthen the role and function of the discharge teams within the RD&E to promote reduced lengths of stay and Discharge to Assess as the primary discharge model, in particular the patients waiting 7+ and 14+ days.

Issues of concern or risk

- The RD&E are implementing their new IT and health records system Mycare in October. In preparation for this, as well as during the implementation phase, there will be some impact on staff capacity and operational availability due to ongoing training requirements and as clinical and operational teams embed the new ways of working.

Support required from CCG/system or barriers to progress

- Support from the CCG to further develop the emerging cross organisational relationships in the East to progress locality system into a partnership approach to care pathway planning and service delivery.

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Locality update report

Locality:	South
Period covered by update:	September 2020
Locality clinical representative:	Dr David Greenwell
Locality executive lead:	Jo Turl
Locality non-executive representative:	Judy Hargadon

Key achievements/progress

Local Care Partnership (LCP) development: a development session was held on 8 September to discuss purpose and priorities. The group will meet every two weeks. The Southern Locality profile in under development.
Demand and capacity planning: Phase 3 of the out of hospital demand and capacity plan was submitted and is informing COVID-19 Phase 3 planning and Winter planning.
Winter planning: A first draft of the south locality winter plan was submitted at the beginning of September; constructive feedback was received and furthermore a revised reiteration has been re-submitted. It has been agreed that the established Working Group will continue to meet on a weekly basis. Additionally, a series of tabletop exercises (Trust and CCG colleagues) are diarised to focus on specific components, for example escalation plans and triggers. It has been noted and agreed that winter planning will be iterative, and the plan will be very much a live working document.
The role out of the Flu programme across the South continues to be reviewed
Public Consultation: public consultation on services in Teignmouth started on 1 September and will run for 8 weeks. A consultation cell is managing the process including documentation, correspondence, briefings and digital meetings.
Voluntary, Community and Social Enterprise Sector (VCSE): The voluntary sector have been involved in the development of the winter plans and have identified several projects that will be able to support the system over winter.
Torbay and South Devon Frailty Partnership Group: Has met for the second time, a number of subgroups are being established which include; identification, stratification and proactive management of frailty (whole system), falls and bone health, acute setting / pathway. This Group is now aligned to the Enhanced Health in Care Homes Delivery Board. T&SD NHS FT are joining the Acute Frailty Network (12-month programme) later this month.
Enhanced Health in Care Homes: All Care Homes in the south locality are now aligned to Primary Care Networks (PCN's) and guidance is being drafted for a number of stakeholders to advise of / illustrate the benefit of this process.

Primary care: Primary care via the South Collaborative Board has taken part in the LCP development and developed proposals to support system winter pressures.
Long Term Conditions: Local steering group meetings have been reinstated/established for respiratory, diabetes and cardiac. All three areas have improvement delivery plans drafted with initial priorities being identified and agreed.

Key priorities for the next three months

Locality Care Partnership: Governance and Terms of Reference (ToR) will be determined. South Locality Profile complete by October and will inform development of local strategy.
Locality Dashboard: to develop a data dashboard to support an overview of performance and identify triggers for escalation.
Demand and capacity plan: Implementation of the out of hospital demand and capacity plan recommendations. Review and audit of new Discharge guidance to ensure the south locality is compliant. Develop in hospital demand and capacity plan.
Winter planning: Further develop and delivery of the locality winter plan in parallel to the flu programme.
Public Consultation: 6 public meetings planned plus attending community group meetings – these will all be held remotely. The team will be responding to queries and requests for information. The consultation ends on 26 October 2020.
Enhanced health in care homes framework: Stocktake of the framework and identification of gaps for development continues.
Frailty: Continue to set up of sub-groups and governance under the Frailty Partnership Group and develop a comprehensive integrated frailty pathway and strategy.
Population health management: Newton Abbot PCN is taking part in the Population Health Management pilot, supported by a very multidisciplinary approach including district council, DPT, TSDFT and the voluntary and community sector. First workshop is 10 September.
Urgent Community Care: develop plans for community place-based teams to provide an enhanced urgent community care offer to avoid Emergency Department (ED) attendance. As part of this the locality planning a “care coordination concept” pilot, supported by the Emergency Care Intensive Support Team (ECIST), in conjunction with SWASFT and TSDFT. It will enable access to community alternatives for the ambulance service via the hub and to crews on scene.
Urgent treatment centres/minor injury units (MIUs): use of Newton Abbot Urgent Treatment Centre and Dawlish and Totnes MIUs to be reviewed.
Voluntary, community and social enterprise sector (VCSE): To co-design a mechanism for the VCSE sector (particularly in Torbay) to receive referrals for short term response to enable discharge and avoid ED attendance/admission where appropriate. A process mapping session for connection with the VCSE part of pathways is being planned for September
Primary Care: Support the PCNs to consolidate the South footprint to include the South Hams and South Brent practices to the wider system. Work with the Southern Collaborative Board to support system winter pressures.
Long-term Conditions: Finalisation and sign off, of the draft improvement delivery plans. Task and finish groups formed for key priorities linking in with regional networks and national guidance. Developing a proposal for an interim solution to spirometry testing for

respiratory patients during C19 to deal with the backlog along with a delivery model moving forwards. Engagement with PCNs regarding Diabetes high risk patients and outcomes. Publish Diabetes Resource Library for Primary Care on GP Team.Net. Establish Devon wide Respiratory Steering Group.

Issues of concern or risk

Recovery and restoration: Ensuring central Devon-wide programmes have links to the locality commissioning team so we are sighted on work and are able to coordinate with and support what is required.
Staffing capacity: capacity to manage priorities at pace especially the public consultation. Recruitment of administrative staff will help this, but it is not expected to have staff in post until October.
Workforce capacity: specifically, for care at home. This will be mitigated through the winter planning process.
Primary care: Transfer of workload from secondary to primary care. The need to take a sensible and proactive approach to ensure the best management of patients while some services are not available. Concern that a transactional approach may not support this.

Support required from CCG/system or barriers to progress

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Locality update report

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

Key achievements/progress

- Integrated Care Partnership (ICP) Team continuing to work on procurement, focusing on Due Diligence.
- Effective and positive engagement continues with partners including University Hospital Plymouth, Livewell, Local authorities, and Primary Care Network Clinical Directors through various channels including a fortnightly system video-conference. This forum will support with system winter planning.
- Agreement on use of, and funding for COVID Hot Hubs resolved and scope being developed to support winter planning
- Flu plan developed with GP practices; majority of practices running own flu vaccination clinics with a smaller proportion collaborating and using model developed with CCG and support of Plymouth City Council. Model for vaccination of additional cohort (aged 50 – 64 years) will be reviewed and may see further collaboration.
- Steering Group mobilised to oversee production of proposals for Fair Shares funding.

Key priorities for the next three months

- Continuing the Integrated Care Partnership procurement, due diligence process, NHSE/I Checkpoint 2 assurance preparation and completion including development of draft contract
- Development of Western Locality profile.
- Implementation of Phase 3 of Restoration and Transformation.
- Winter planning
- The nationally procured NHS use of Information System (IS) providers is changing and it will be essential to ensure that we continue to use this to the maximum benefit to ensure access to elective care across the system.
- Ensuring benefits reaped from escalation and rapid transformation are locked into local system.

- Development of programmes to utilise the Fair Shares funding.
- Continued use of the community wide capacity planning to support the system to be prepared for winter, restoration of elective capacity and any further COVID surge.
- Ensuring providers remain focussed on agreed demand and occupancy reduction plans.
- Support to Emergency Care Intensive Support Team (ECIST) who will be working with the system to reduce ambulance conveyances through improved community service access.
- Progress Primary Care Network (PCN) development in delivery of the Directed Enhanced Service (DES) including alignment of PCNs with care homes as part of the Enhanced Health for Care Homes framework
- Balancing urgent care demand with need to increase elective capacity, Intensive Care Unit (ICU) capacity and consistent access to the Major Trauma Unit.
- Operationalising the collaborative approach to the delivery of primary care flu vaccinations and reviewing for the additional cohort of patients, ensuring accessibility and good uptake for the whole of the eligible population.

Issues of concern or risk

- Staffing capacity across the commissioning team to manage conflicting priorities at pace.
- COVID-19 – system-wide risks including to patients due to non-availability of services and healthcare and social care staff and wellbeing (various mitigations being actioned and will be considered and acted upon through Restoration and Transformation process)
- Workforce capacity – nursing, domiciliary care, pharmacy, voluntary sector (being managed during COVID escalation, will require review and mitigation through Restoration and Transformation process)
- Community capacity for future COVID-19 peaks in activity needs to be understood as a priority, both in terms of demand and the impact of restarting routine work.
- Urgent care occupancy levels at University Hospital Plymouth (UHP) impacting on elective restart. (not related to discharge for western locality, but Cornish processes, internal processes over the seven days in UHP and high levels of front door demand.
- Capacity to focus on admission avoidance priorities whilst managing impact of demand from high ambulance conveyances and attendances to site with reduced capacity due to social distancing requirements.

Support required from CCG/system or barriers to progress

- Continued deployment of additional capacity to support Integrated Care Partnership (ICP) procurement
- Capacity to support co-ordination of urgent care system through winter
- Alignment of resources to support delivery of operating plan at locality.