PUBLIC - NHS Devon CCG Governing Body

Newton Abbot Racecourse, Newton Road, Newton Abbot, Devon, TQ12 3AF

26 September 2019 15:00 - 26 September 2019 17:00

AGENDA

#	Description	Owner	Time
1	Welcome and Apologies Verbal	Chair	15:00
2	Register of Interests (ROI) Verbal DOI NHS Devon Governing Body September 2019.... 7	Chair	15:05
3	Minutes of the last meeting and action log Paper 1. draft Public GB minutes 29.8.2019 v2 NB.docx 11 2. Master Action Log - PUBLIC v2 nc.xlsx 19	Chair	15:10
4	Chair's Report Paper 1 cover sheet chairs report.docx 21 2 Chairs Report September v1 PJ.docx 23	Chair	15:15
5	Accountable Officer's Report Paper 1 Cover sheet template (002) Interim AO Report Pu... 25 2 AO Report Public Devon CCG September 2019... 27	Director of Communications and HR	15:25
6	FINANCE		
6.10	Finance Committee Chair's Report Paper Finance Performance Committee Chair Report for... 31	Finance Committee Chair	15.35

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6.20	Month 5 Finance Report Paper FPC_Report_FPC_Month 5_FINAL_2019-20 (GB C... 33 FPC_Report_GB_Month 5_FINAL_2019-20 (GB Ve... 37	Associate Director of Finance (South)	15:40
7	GOVERNANCE		
7.10	Audit Committee Chair's Report including full Risk Register Paper 0 Audit Committee Chair Report - September 2019.... 57 1 4a. Appendix 1 Master Assurance Framework do... 61 2 4a. Appendix 2 Corporate Risk Register Very high... 79 3 Standards of Business conduct policy v2.3 appro... 83	Corporate Secretary	16:00
8	INFORMATION		
8.10	Quality Assurance Committee Chair's Report Paper QAC September Public Committee Chair Report Te... 113	Quality Assurance Committee Chair	16:15
8.20	Quality and Performance Report Paper 01 Quality and Performance cover sheet.docx 117 September GB Performance and Quality Report v2.... 119	Director(s) of Commissioning	16:20
8.30	Primary Care Committee Chair's Report Paper Committee Chair Report - Public PCC September 1... 147	Chair Primary Care Committee	16:35

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8.40	Locality Updates (North, East, South and West) Paper 0 Locality Updates Cover Sheet.docx 151 1 Northern Locality Report SEPT 19 rev 1.docx 153 2 Eastern GB localitry report September 19.docx 159 3 WL Update Report for Sept 2019 GB - 10.9.19v3.... 165 4 Locality update report- Southern - Sept 2019 v2.d... 169	Locality Triumvirate Representatives	16:40

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Declaration of Interests Register - NHS Devon CCG Governing Body
Report generated by the governance team on 17 September 2019

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Atherton	Glynis	Lay Member - Quality	Member Governing Body Member Quality & Assurance Committee (Chair) Member Primary Care Commissioning Committee Member of Remuneration 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		14/05/2019		21/05/2019	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Director - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG	Member of Governing Body (Vice Chair) Member of Audit 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 Governing Body (Deputy for CFO)	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Lay Member - Patient and Public Involvement	Member of Governing Body Member of Quality and Assurance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	I am chair of the Devon Maternity Voices Partnership (MVP) a collective of parents (and parents to be) and organisations who support maternity services (health professionals, charities, Healthwatch, non-health professionals) working together to review and contribute to the development of local maternity care across Devon. Devon CCG provide funding to the MVP		04/04/2019		09/04/2019	General Interest	Direct	Resigned as Chair from the Devon Maternity Voices Partnership. (formally leaves July 2019) Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt	Partner is employed by Livewell Southwest in position of influence	26/09/2017		15/10/2018	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Coles	Anna	Director of Integrated Commissioning Seconded to CCG to Associate Director of Commissioning (Western)	Senior Leadership Team (SLT) Member Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019		12/03/2019				Plymouth City Council
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015					Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Member of Primary Care Commissioning Committee (PCCC)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015		19/06/2018	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body A & E Delivery Board (Sd&T)	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher GP Locality Clinical Director Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016		28/07/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration and Workforce Committee(Non exec rem)	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	08/11/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Hargadon	Judy	Lay Member - Primary Care and Prevention	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) Chair Member of Remuneration and Workforce Committee	Independent Member on Council of University of Exeter NED on Board of Restorative Solutions CIC Ltd	Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	20/05/2019	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Harrell	Ruth	Director of Public Health Plymouth City Council	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)			26/10/2016	26/10/2016	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Harris	Penny	Management Consultant	Attendee Governing Body Senior Leadership Team (SLT) Integrated Commisioning Executive (ICE) CCG Executive Team Meeting	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training		23/07/2019	24/07/2019	Fininicial 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 Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Clinical Chair NHS Devon CCG 1 March 2017 Church Warden Holy Trinity Church Spouse works in emergency department at RDE and for Exeter Medical School Primary Care Network - Templar Care Network		21/08/2015	04/10/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kennedy	Nick	Secondary Care Doctor	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) QEIA Panel Member of Audit Committee	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer Partner, Staplegrove Anaesthetists LLP, Taunton Partner Blackdown Orthopaedic and Spinal Services, Taunton Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of Data safety monitoring committee (DSMC), The GAP study (safety of gabapentin) United Hospitals Bristol Member of national Independent Funding Request Panel NHS England Non-ExecutiveDirector GO-OP, GO-OP is a Multistakeholder Co-operative Society (Somerset Rules), registered under the Co-operative and Community Benefit Societies Acts. GO-OPGO-OP will be the UK's first co-operatively owned and run Train Operating Company		26/09/2017	06/10/2018	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Member of Integrated Commissioning Executive (ICE) Attendee Remuneration Committee (REMCOM) Attendee of Audit Committee Northern and Eastern Preparatory Group	Chair of East Devon GP Members Forum Partner Coleridge Medical Centre Undertakes DDOC shifts 5. Shareholder in Devon Doctors Ltd Shareholder in Devon Health Member of East Devon Health Practice part of the East Devon Federation (March 2018) Chair of East Devon Members forum. Chair Eastern Locality Delivery Group Primary Care Network - Honiton/Ottery/Sid Valley (HOSMS)	Spouse works for Social Services	14/02/2017	13/05/2019	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Lees	Sarah	Representative of Director of Public Health for Plymouth City Council	Member of Governing Body (Deputy) Member of Primary Care Commissioning Committee (PCCC)	School Governor, College Road Primary School, Plymouth	Husband is an employee of Livewell Southwest	10/11/2017		Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

Dr	Manton	Sonja	Director of Strategy Interim Director of Commissioning. Northern, Eastern and South Devon and Torbay	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Transition Sub Committee Senior Leadership Team (SLT) Member of Quality and Assurance Committee Attendee Audit Committee	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit from 1st Nov 2018	03/04/2017	09/10/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Governing Body Clinical Lead – Western Locality Chair of Western Primary Care Partnership	Member of Governing Body Member of Quality Assurance Committee Clinical Cabinet QEIA Panel STP Collaborative Board Remuneration and Workforce Committee (Non exec rem) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG)	Elected member, South West Regional Council of BMA Sessional GP (self-employed) at Access Health Ltd Plymouth. GP Appraiser (NHS England)	Partner is Medical Secretary and Board member of Devon LMC Partner is GP Partner, Church View Surgery, Plymstock	26/09/2017	18/12/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Director of Communications and HR functions NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University.		19/06/2018	26/02/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Pearson	Nick	Head of Communications and engagement	Senior Leadership Team (SLT) Primary Care Operational Group (PCOG) Member Governing Body (Deputy for Director of Communications)	Member of the Labour Party Member of the Exeter City Supporters Trust	Spouse is owner of Pearson Creative	13/01/2017	14/08/2019	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. Will not be commissioned by employee	NHS Devon CCG
Dr	Pearson	Virginia	Director of Public Health, Devon County Council Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee	Member, Devon Health and Wellbeing Board Member, Exeter Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Devon Safeguarding Children Board Attends Governing Body of Devon CCG Council Member, Association of Director of Public Health Member, British Medical Association		02/02/2017	02/02/2017	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council
	Polak	Simon	Interim Director of Quality Assurance (July 2019) Head of Nursing and Quality/Deputy Chief Nursing Officer	Member of Quality Assurance Committee Northern and Eastern Preparatory Group QEIA Panel Joint Clinical Effectiveness Group Attendee Governing Body Senior Leadership Team (SLT) CCG Executive Team Meeting		Spouse: Wife works for Devon County Council Public Health as Assistant Director of Public Health	17/06/2015	08/08/2017	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Polak	Tracey	Public Health Consultant (Devon Council) Honorary Clinical Associate Professor – University of Exeter Medical School	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Northern and Eastern Preparatory Group	Honorary contract with Exeter University	Spouse: Deputy Chief Nursing Officer and Interim Director of Quality Assurance (July 2019) Devon CCG	24/10/2017	21/01/2019	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Sansom	Solveig	Associate Director of Commissioning	Senior Leadership Team (SLT) Member Governing Body (Deputy for Director of Commisioning - Northern, Eastern and South Devon and Torbay) Senior Leadership Team meeting Business Meeting South Devon and Torbay Executive Delivery Group South Devon and Torbay System Improvement Board Long Term Conditions Meeting Risk Share Oversight Group SDT Preparatory Group Local Partnership Delivery Group	Sister in law is employed by the RDEFT		28/04/2019	09/06/2019			Will not engage in meetings or decisions affecting the relevant service	NHS Devon CCG
	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee Audit Committee CCG Executive Team Meeting Senior Leadership Team (SLT)	No interests declared		22/03/2019	09/04/2019				NHS Devon CCG

	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Attendee of Remunerationand Workforce Committee	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	07/09/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	STP Director of HR	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee Governing Body/Member Governing Body (Deputy for Director of Communications)	No interests declared			16/10/2018				NHS Devon CCG
	Turl	Jo	Director of Commissioning - Western	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting	DELT Board Member, CCG Devon nominated director		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
	Webber	Lorraine	Associate Chief Nursing Officer (South & West) Interim Director of Nursing (Caldicott Guradian) July 2019	Member of Quality Assurance Committee A & E Delivery Board QEIA Panel Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Member Governing Body CCG Executive Team Meeting	No interests declared		14/03/2017	29/08/2018				NHS Devon CCG
	Wheller	Kevin	Locality Chief Finance Officer (Northern & Eastern)	Attendee of Audit Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member Governing Body (Deputy for CFO) Northern and Eastern Preparatory Group		Spouse is employed as a finance manager at Castle Place Surgery in Tiverton. The Surgery is operated by the Royal Devon & Exeter NHS FT	22/10/2015	25/01/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (Non exec rem) Northern and Eastern Preparatory Group	General Practitioner at Coombe Coastal Practice in Ilfracombe (ended 10/09/2017) Member of Royal College of General Practitioners Director of One Ilfracombe Our Place Programme Chair of One Northern Devon		14/02/2017	31/01/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

NHS
Devon
Clinical Commissioning Group

NHS Devon Governing Body Meeting
Draft Minutes held in PUBLIC

Date: 29 August 2019 Time: 15:15 – 17:00

Location: South West AHSN, Vantage Park, Pynes Hill, Exeter, Devon

Item	Discussion	*Action*	
1	**Welcome and Apologies** NB, chair welcomed everyone to the meeting and the following apologies were noted: PJ – NB chair JD – KW deputy SMc – AS deputy RH – SL deputy VP – TP deputy		
2	**Questions from Members of the Public** NB noted that a question had been submitted in advance of the meeting but due to confidentiality reasons relating to an individual patient this question was not read out and would be dealt with outside of this meeting.		
3	**Register of Interest (ROI)** NB directed the members to the ROI included in the pack and there were no amendments or new declarations. **The Governing Body received and noted the ROI**.		
4	**Minutes and action log** The minutes of the last meeting held on 25 July 2019 were agreed as a true and accurate record of the meeting. Action 1 – an update was provide around waiting times for mental health including access rates and it was agreed that this action should remain open Action 2 – this action had been completed and it was agreed for this to be formerly closed		
5	**Patient Experience Story – Devon Virtual Voices** Nicola Bonas (NBo), Deputy Head of Communications and Jonathan Sewell (JS) Strategic Engagement Manager delivered a power presentation and gave a **flavour of** what the Devon Virtual Voices panel is about and how it has been formed, how we worked with a specialist agency to set up and recruit the panel. They explained how some of our early learning from the survey we issued as part of the Long-Term Plan (LTP).		

	The survey strategy will be developed further to ensure that future topics need to include an interest for all panel members. Patient engagement and experience will be captured using this and other methodologies. JWo said it was important and encouraging that we were using ACORN mapping for the Devon populations to analyse data to improve the services for the population of Devon, and there was also an ambition to increase the size of the panel members. **The Governing Body received and noted the Devon Virtual Voices Presentation.**		
6	**Chair's Report** NB presented the chairs report in the absence of PJ although there was nothing further to add to the report, he drew attention to the recruitment process for the GB membership. ST noted that following the GB Development session held in July and action plan is being developed and will be presented to the Governing Body in October. **The Governing Body received and noted the content of the Chair's Report.**		
7	**Accountable Officer's Report** ST signposted the members to the smaller list of focused priorities following this request at the July Governing Body Development which are an addition to the contribution of the system priorities: Performance Improvement 52 week waits A&E Improvement Diagnostics In addition to improvement requirements there will also be a focus on the CCG fit for the future and ST drew attention to the bullet points listed on page 27. We will be working with organisations and a call to action with CCG teams to focus on our priorities ensuring we use our resources efficiently and effectively. It was agreed these were the right set of priorities and ST gave assurance that other commissioning metrics would be closely monitored. SK queried our strategic intentions and our partnership working with the local authority and alignment of commissioning intentions. ST responded that it was not a surprise that not all intentions were aligned, however he assured the Governing Body that we would be clear with our providers about our intentions and make sure they are aligned wherever possible. **The Governing Body received and noted the contents of the Accountable Officer's Report.**		
8	**Quality Assurance Committee Chair's Report** GA presented this report and noted that Mental Health (IAPT/GAP) would be further discussed at the Quality Assurance Committee in September. GA highlighted that the infection contract report identified that in some areas showed 75% update for flu vaccinations, but other areas update was significantly lower at around 40-50% and has asked that good practice is shared to increase flu vaccination figures. LW responded that the there are challenges with front line heath workers vaccinations and noted that it was a choice to be vaccinated and that we cannot mandate them to uptake the offer.		

	JWo suggested that patient participation groups (PPGs) could be used to support the uptake of vaccinations by using their links with GP practices and would be a useful resource to communication positive messages. **The Governing Body received and noted the contents of this report and the assurance given by the Quality Assurance Committee.**		
9	**Quality and Performance Report** JT referred to the report in the pack and pointed out that the narrative had seen improvements and proposed to give an up to date briefing to the Governing Body on the following areas: • 52 week waits • Emergency Departments • Diagnostics <u>52 week waits</u> We are currently over trajectory as of June (report is June data) and 199 patients showing as waiting over 52 weeks, the trajectory is 143. A deep dive into those patients waiting longer to be treated at the System Performance Group chaired by JT. All providers in the system are currently experiencing issues around this performance target. JT assured the Governing Body that action plans have been agreed and are being managed. JT was disappointed to report that we had not achieved our trajectory, but that we are working with the planned care team around the offer of choice and the best use of local capacity and the independent sector. University Hospitals are leading as a system on the independent sector and analysing data and information to understand whether we need more capacity and the cost of that. JT confirmed that we have made specific changes with the independent sector: • Spinal – commissioning individual activity with Newhall and the Nuffield • Kernow CCG – Royal Cornwall have offered orthopaedic capacity • Care UK – are taking on patients in the Western system that are at a higher risk LW confirmed that actions agreed have been underpinned by a Quality, Equality Impact Assessment (QEIA) for patient safety and JT acknowledged this and thanked the quality team for undertaking this process. SK was pleased to see that we are working as a system but wondered about the plans for the patients that were approaching 44 – 46 weeks of waiting. JT responded that in order that we don't have waits over 52 weeks by the end of the year choice will be offered earlier and we are currently modelling that. JT stated that it was important to receive the information from University Hospitals Plymouth as soon as possible, so we can assess our needs versus commission and that demand and capacity scoping is required. GA wondered about the patients that have chosen to delay surgery and patient safety, and assurance was given that all patients waiting 52 weeks or long are clinically reviewed as a safety net and to ascertain whether their treatment is still required. NB asked whether we offer travel and transport costs for patients that choose to be treated outside of area and JT confirmed that we are already doing this.		

Diagnostics

National target performance is set at 1% and the local trajectory is set at 8.9%. Currently Devon is off trajectory reporting performance at 13%. Torbay and South Devon are achieving trajectory however important to note this is variable and does fluctuate.

Deep Dive scrutiny is being undertaken in two areas and system has been tasked with actions:

- Proposal for mobilization endoscopy support for RDE/ Torbay and South Devon to assist with their waiting list issues and there is a potential that UHP will have support from Care UK
- MRIs will be upgraded

CT scanning are experiencing issues and SM noted that acute trusts have individual actions in this area.

Emergency Departments

The July data is currently showing system performance of 87.7% – 88% and acknowledged that the CCG is mindful of this performance especially that we are approaching a more difficult time of the year with winter. Significant pressures have been identified in South Devon and Plymouth and was pleased to report that RDE were back on trajectory.

The CCG is focusing on Western actions, and it was agreed that demand management was an issue as well as workforce, acute and primary care. JT explained the growth in the system and reported that 5 demand management plans have been put in place commencing in September.

JT informed the Governing Body that a check is being undertaken around international recruitment and the numbers of net increase. Primary Care also have recruitment issues and the announced that a primary care prospective for Plymouth had been signed off and will be launched in October. The prospective includes positive narrative reasons for working in Plymouth and how we may use the workforce differently to help with sustainability for Primary Care.

Same day urgent opportunities will be reviewed at the next Western A&E delivery board and we will be trialing new standards in A&E. There will be regular updates on these new standards to show the mean time for length of waits in A&E.

SMa briefed the board on the concerns and fragility for Southern Devon. Actions consist of weekly assurance calls through the system improvement board and deep dive investigations to understand what is driving poor performance.

SMa stressed the need for insight around the gradual increase in average length of stays (LOS) and what we are doing. ESIS, and intensive elective care/ demand management team are supporting three of our key workstreams and the review and findings will be available in September:

- Same day emergency care
- Ward focus – weekend discharge and handovers
- Home first – flow

	LW mentioned Clostridium Difficile (CDiff) and the breach increase that has been seen since April and this has been due to the changes in reporting requirements which now includes community cases and noted that there had been an outbreak in South Devon. NB gave thanks for this update and welcomed the improved Quality and Performance Report. **The Governing Body received and noted the contents of the Quality and Performance Report and the assurances given.**		
10	**Finance Committee Chair's Report** There was nothing further to add this this report, however it was noted that the Finance Committee would be reviewing the long-term financial plan at the next meeting held in October. **The Governing Body received and noted the Finance Committee Chair's Report.**		
11	**Moth 4 Finance Report** KW presented this report and drew attention to the executive summary on page 67 and that since the writing of this report financial contracts with our system providers have been agreed and signed. He referred to the month 4 management accounts detailed in the table on page 73 and that these were on track to deliver our control total of a planned deficit of £9m. There are significant unmitigated risks and our assessment of this has not changed at this point. The members were signposted to page 76 and the savings plan and reducing demand in the acute system. We are testing this with our providers with a mix level of performance and activity against our plans. This will e tested and triangulated against those patients waiting 52 weeks. It was noted that coding activity for Northern Devon Healthcare Trust (NDHCT) was higher than reported due to coding issues. **The Governing Body received and noted the month 4 financial position as at 31 July 2019 and the level of risk to delivery of the CCGs control total.**		
12	**Locality Updates** <u>Northern</u> There was nothing further to add to the report, however JWo highlighted the single system services for Northern Devon, Physiotherapy and Primary Care Networks (PCNs) and that support still required to continue to align Peninsula Clinical Services Support (PCSS) and the LTP. <u>Eastern</u> SK noted that since the publication of this report that a recruitment process has been undertaken to secure 3 GPs for clinical sessions to support mental health, prevent and urgent care. On the 18 September 2019 a digital event is taking place giving an opportunity to spend time on how we may digitise records and free up space in buildings. <u>Southern</u> There was nothing further to add to this report, but DG noted that time has been spent looking at the Integrated Care Model (ICM) for health and wellbeing centres, and		

	discussions had been had in Torbay to understand the difficulties they have experienced in A&E. Delay in works on TSDFT theatres has had an impact on performance and their trajectory is being re-profiled and SMa anticipated that the theatre re-opening would take place in September. <u>Western</u> The Mayflower procurement process is progressing and that we are currently in the evaluation and moderation phase with a move towards the dialogue phase. This would be further discussed in private, due to commercial in sensitive in September. **The Governing Body received and noted the contents of the locality reports.**		
13	**Primary Care Committee Chair's Report** The report was taken as read and JH noted that a Primary Care Workshop is planned for September to further develop the Primary Care Strategy. JT updated the Governing Body that the mental health and physical health checks business case has been developed to assist with closing the gap in physical mental health illness. **The Governing Body received and noted the contents of the Primary Care Chair's Report.**		
14	**Clinical Policy Committee (CPC) Annual Report 2018-19** **The Governing Body noted and received for information and assurance the CPC Annual Report of the CCGs process for clinical policy information.**		
15	The meeting closed at 17:00pm		

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*
Andrew Millward (AM)**	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Dr Andy Sant (AS) ** (for SMc)	Clinical Lead Representative, Western Locality, Devon CCG
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Dr Matt Fox (MF) A (in absence of DG)	Clinical Representative, Southern Locality, Devon CCG
David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Glynnis Atherton (GA) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
John Dowell (JD) A	Chief Finance Officer, Devon CCG
John Womersley – Dr (JWo) A	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Commissioning – West, Devon CCG

Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Lorraine Webber (LW)**	Interim Director of Nursing, Devon CCG
Nick Ball (NB) **Vice Chair** **	Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **	Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) A	Clinical Chair, Devon CCG
Ruth Harrell - Dr (RH) A	Director of Public Health, Plymouth City Council
Sarah Lees – (SL) (for RH)	Consultant in Public Health, Plymouth City Council
Simon Kerr – Dr (SK) **	Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc) A	Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST) **	Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **	Interim Director of Commissioning – North, East and South, Devon CCG
Tracey Polak (TP) ** (for VP)	Assistant Director Public Health, Devon County Council
Virginia Pearson – Dr (VP) A	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) ** **Minute Taker**	Executive Assistant, Devon CCG
Jade Quartermaine (JQ)** **admin support**	Senior Administrator, Devon CCG
Simon Polak (SP) **	Interim Director of Quality Assurance, Devon CCG
Nicola Bonas (NBo) ** - **item 5**	Deputy Head of Communications, Devon CCG
Jonathan Sewell (JS)** **item 5**	Strategic Engagement Manager, Devon CCG

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**		**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertakenYes/No confirmation if all actions		This will be the lead or person to whom the action was	Confirmation that committee that raised the action is content the action	Confirmation if action complete
1	23-May-19	Governing Body to receive an update on waiting times for Mental Health IAPT/ recovery and access rates.	TBC	Lorna Collingwood-Burke/ Lorraine Webber	27.06.19 - LCB informed a piece of work is being done with Devon Partnership Trust (DPT) and commissioners. There is a perceived gap at the moment, the CCG is gaining assurance that this gap does not exist. Work is underway to look at the ways mental health professionals practice and it is on the DPT Quality Committee. The review will be completed to go to the CCGs Quality Committee and will be escalated through the Quality Committee Chairs report to Governing Body in September. This action will remain open until the update is given in September. 25.07.2019 - Mapping work being undertaken to identify the gap in statutory services and update report will be presented to Quality Assurance Committee in August. 29.08.2019 - an update was provided around waiting times for mental health including access rates and it was agreed that this action should remain open				**IN PROGRESS**

NHS Devon Clinical Commissioning Group

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertakenYes/No confirmation if all actions		This will be the lead or person to whom the action was	Confirmation that committee that raised the action is content the action	Confirmation if action complete
1	23/05/2019	NC to liaise with the communications team to include an update on LMS and MVP in the next GP update.	27-Jun-19	Nikki Coombes	Post meeting update action completed and recommended for closure. 27.06.19 - Agreed to close.				**CLOSED**
2	23/05/2019	NC to add Better Care Fund (BCF) to Governing Body forward planner for 19/20.	27-Jun-19	Nikki Coombes	Post meeting update this action is recommended for closure. 27.06.19 - Agreed to close.				**CLOSED**
3	23/05/2019	NC to add digital interoperability to the Governing Body 19/20 forward planner.	27-Jun-19	Nikki Coombes	Post meeting update action completed and recommended for closure. 27.06.19 - Agreed to close.				**CLOSED**

NHS
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GOVERNING BODY

Report title: Chair's Report				
Date of committee: 26 September 2019 **Date report produced: 18 September 2019**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive:** **Name and Title:** **N/A** **Contact Details:** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date: 18 September2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

- Governing Body Development
- STP Collaborative Board
- Parliamentary Inquiry into Rural Health and Social Care
- Devon Doctors
- Southwest Clinical Senate
- NHS Devon CCG Annual General Meeting (AGM)
- Governing Body Membership Update

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

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

N/A

Key recommendations and actions requested:
This report is for information and the Governing Body are asked to note the contents.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
None
Does this report have implications in any of the areas highlighted below?

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

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

NHS
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GOVERNING BODY – CHAIRS REPORT

1. Introduction

As summer draws to a close, winter is now fast approaching with the expected increased demand on our urgent care services that comes with this seasonal effect on long term conditions and illnesses such as influenza. However, as many of our providers have experienced, the usual partial respite of Summer has not really occurred with many parts of our system being as busy and strained as they have been during the height of winter. On top of this, we still face extremely challenging performance issues and finances, and we need to continue our development to becoming an Integrated Care System. There is much for the CCG to do over the next few months and in such times it is always helpful to pause briefly and appreciate all we have done and are doing to give confidence and learning. To that effect I hope many of you were able to join us for the Annual General Meeting on 19 September and that this was such a chance to celebrate success and energise us for the road ahead.

2. Governing Body Development

To progress the work done by PA Consulting over recent months with the Governing Body, the HR team of the CCG have agreed to support the GB in continuing that development work. This will continue to be an integral part of our monthly meetings. My thanks to Judy Hargadon who has offered her support and experience in OD to work with the HR team on this development.

3. STP Collaborative Board

The STP Collaborative Board was held on 4 September with key stakeholders represented including providers, local authorities and commissioners. Key agenda items included a review of month 4 system finances, progression towards becoming an integrated care system, the Devon Long Term Plan and an update on Primary Care Networks.

4. Parliamentary Inquiry into Rural Health and Social Care

On 9 September I was invited to give evidence to the Parliamentary Inquiry into Rural Health and Social Care with a particular focus on primary care education, training and remuneration. My thanks to all my GP colleagues in Devon who gave their views and experience of working within rural settings. It meant I was able to give a much wider perspective and represent Devon within this national Inquiry.

A formal summary of discussions is currently being written and I will ensure this is made available to Governing Body and the GP membership.

5. Devon Doctors

Devon Doctors is a vital part of our primary care provision in Devon, providing our out of hours urgent primary care service. As with many parts of our system, they have been facing the pressure of increased demand and workforce challenges. On 11 September I spent an evening in Devon Doctors to experience how they are managing within such pressures. My thanks to Dr Chris Campbell who showed me round and helped me experience the various aspects of their work including call triaging, treatment centre and home visiting. A summary of my experience and video diary will be produced in due course.

6. Southwest Clinical Senate

Matt Fox (GP and joint Locality Clinical Representative, South Devon) and I presented at the Clinical Senate on 19 September on our experience of consultation and decision making around Community Hospitals and Services, and our learning from current models of the ICM in place in Devon.
Due to timings of Governing Body papers, a verbal update will be provided at Governing Body.

7. CCG Annual General Meeting

The CCG Annual General Meeting took place on 19 September at Sandy Park in Exeter and live on-line via Facebook. Due to timings of Governing Body papers, a verbal update will be provided at Governing Body.

8. Governing Body Membership Update

Recruitment of additional non-executive Governing Body members continues with interviews in early October for the following posts:

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

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GOVERNING BODY MEETING

Report title: Accountable Officer's Report				
Date of committee: 26 September 2019 **Date report produced: 12 September 2019**				
Author (s) Name and Title: Simon Tapley, Interim Accountable Officer Andrew Millward, Director Communications and Human Resources Molly Bishop, Executive Assistant to Interim Accountable Officer		**Supporting Executive:** **Name and Title:** Simon Tapley, Interim Accountable Officer **Report Approved by:** **Name and Title:** Simon Tapley, Interim Accountable Officer **Date** 12 September 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				

Executive Summary:

This report contains updates on:

- CCG Executive Team Priorities
- Green Star classification awarded for the Improvement and Assessment Framework (IAF): Public Engagement and Participation 2018/19
- Staff signal that we are making progress since merger
- Launch of Plymouth Prospectus for Primary Care
- EU Exit Preparations
- Key meetings and visits
- Integrated Commissioning Executive meeting

Management of Conflict of interests:

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

N/A

Key recommendations and actions requested:		
This report is for information only.		
Impact on Strategic Objectives		
We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources		
Reference to other documents or accompanying papers:		
N/A		
Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality	Safety: Effectiveness: Experience:	✓
Equality		✓
Resource and Finance		✓
Legal		✓
Engagement and Consultation		✓
Risk		✓

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

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Accountable Officer's Report

1. CCG Executive Team Priorities

The CCG executive team met with the Senior Leadership Team on 12 September to discuss the priorities as shared at the last Governing Body meeting; for reference these are listed below.

1- Performance Improvement

- 52 week waits
- A&E improvement
- Diagnostics

2 - Finance

- Continuing Healthcare (CHC)
- Medicines Optimisation
- Demand Management
- Fair Shares

3 – Getting the CCG fit for the future

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

At the meeting on 12 September, the CCG Senior Leadership Team agreed three deliverables to sit underneath a number of these priorities and identified a range of resources that could be utilised to support them. The Senior Leadership Team will now be working with the identified leads to agree action plans for the priority areas as appropriate.

2. Green Star classification awarded for the Improvement and Assessment Framework (IAF): Public Engagement and Participation 2018/19

NHS England has published ratings for every CCG in England on how effectively they manage engagement with patients and the public. Out of 195 CCGs nationally, our two

former CCGs (Northern, Eastern and Western Devon CCG and South Devon and Torbay CCG) were part of a cohort of 25 who were rated as outstanding and given the Green Star classification. Devon was also successful in being awarded funding to further develop engagement work with the Citizens Panel, and we now have access to over 1,700 people from across Devon, with whom we can test ideas and seek views. I would like to thank our colleagues involved in this work; this outcome is testimony to their hard work and leadership in this area, and it is a clear endorsement of the efforts of both CCG's to engage local people on the health services that affect them.

As a new CCG we have put a lot of effort in to improving how we work. We undertook a recent survey of our staff to gauge progress. The survey was conducted during August 2019. There were 240 respondents to the survey. 21 questions were developed based on some of the questions in the national annual NHS Staff Survey, so a comparison could be made with the latest report for the CCG.

Given cultural change takes many years, this latest survey shows that many significant improvements have been made since merger.

A full briefing will be given in October 2019, but here are a few of the highlights:

Positive highlights

Statement	Strongly agree / agree	Comparison - Staff Survey report 2018 for the two CCGs
During my appraisal my line manager discussed with me organisational values and how I can contribute to them	84%	26%
My recent appraisal will help me to improve how I do my job	68%	23%
Senior managers are acting on staff feedback	52%	34%
I am part of a team that works well together	80%	66%
Communications between senior managers and staff is effective	52%	40%
Where I work, relationships are strained	21%	48%
I have reported being unwell because of stress at work in the last six months	10%	40%

Challenges

Several questions demonstrated some specific challenges to be addressed.

Statement	Strongly agree / agree	Comparison - Staff Survey report 2018 for the two CCGs

The CCG is living up to new values and behaviours	56%	Not asked in 2018 survey
The Executives make time to talk to colleagues when they are visiting base locations	40%	Not asked in 2018 Survey

NHS Devon CCG and Plymouth City Council have developed a 'prospectus' for general practice in Plymouth; the aim of which is to list a series of offers to primary care, to assist with practice resilience, and to address some of the challenges and pressures experienced within primary care in Plymouth. It has been developed with a focus on Plymouth as it has some of the most concentrated levels of deprivation and workforce challenges, and the CCG is exploring how such initiatives could be cascaded into other parts of Devon.

5. EU Exit Preparations

The Department of Health and Social Care and NHS England/Improvement continue to work closely together in relation to EU Exit preparations. Both organisations presented the national context of the EU Exit plans to the South West Regional Chief Executives and Accountable Emergency Officer's meeting on 9 September 2019. This meeting was attended by both NHS Devon CCG's Accountable Emergency Officer and Head of Governance.

NHS England articulated that infrastructures are in place to manage the impact of both deal and no deal scenarios and that they will be leading the response on our behalf. In the coming week, our local media teams will be provided with specific communications on the key areas of work listed below*:*

- Continuity of medicines and medical device supply
- Workforce
- Reciprocal healthcare and overseas cost recovery
- Clinical Trial Studies and European Reference Networks (ERNs)
- Data
- Vaccines, blood and organs.

The National team were clear that there will be a national uniformity of communications to the workforce, patients and public and that these will be locally supported by the Regional Communications teams.

The CCG remains joined up with its providers across Devon in providing any regular EU Exit situation reports, as directed, to NHS England/Improvement. As part of the core assurance at this time of year, NHS Organisations Business Continuity Plans are being tested and will continue to form part of our business as usual. Queries or questions regarding the UK's withdrawal from the EU should be addressed to the CCG Communications Team.

6. Key meetings and visits

- I attended the Devon System Long Term Plan workshop, along with a number of

system leaders, where we discussed the requirements of the long term plan, local opportunities and workforce.

- I attended the South West Peninsula Specialised Commissioning roundtable with a number of NHS Chief Executives across Devon to discuss specialised commissioning and the long term plan.
- I chaired the System Performance Group, attended by Chief Operating Officers across Devon and NHS England/NHS Improvement, where we discussed performance across the system with a particular focus on improvement and recovery plans for 52 week waits, diagnostics and urgent care.
- I chaired the Torbay and South Devon NHS Foundation Trust (TSDFT) System Improvement Board, where we discussed improvement programmes for performance and finance.
- I attended the CCG's Annual General Meeting (AGM), where we went through the annual reports for 2018/19 for the two former CCG's, before the merger on 1 April 2019 to become Devon CCG. It was great to be able to broadcast this AGM live on Devon CCG's Facebook page again, following the success last year.
- I chaired the STP Programme Delivery Executive Group, attended by NHS Chief Executives and System Leaders across Devon, where we discussed system performance; system finance report; health inequalities; EU exit preparations, and; the long term plan.

7. Integrated Commissioning Executive meeting

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

Key areas of discussion recently have been:

- Population health management
- Primary care strategy
- Long Term Plan
- Progress on Local Care Partnerships development and strategic commissioning

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GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee
Date of Governing Body: 26th September 2019 **Dates of Committees covered in this report: 19th September 2019** **(Minutes of these committee meetings to be available as an addendum)**
Chair's Name and Title: John Dowell, Director of Finance **Contact Details:**
Reports discussed and assurances received
• Risk Register report • Devon CCG month 5 finance report • STP month 4 finance report • Financial Improvement plan • Long Term Financial plan • GB Quality & Performance report • Proposal for continuation for integrated health and social care in Torbay
Reports received and noted
• **As above** • **Single Source Waivers**
Risk Register Review (changes and areas of concern)
• One risk was agreed for closure • No new risks were added
Committee Decisions
• To approve Devon CCG month 5 finance report for the GB meeting • Approved the procurement policy for clinical healthcare & non-clinical supplies and services
Recommendations for Governing Body

• Recommend the direction of travel for the continuation of the integrated health and social care in Torbay
Recommendations for other Committees
• None
Terms of Reference or other committee effectiveness issues
• None

Management of Conflict of interests:

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GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 26th September 2019 **Date report produced: 19th September 2019**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date:** 19th September 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The report details the financial position to the 31st August 2019 and provides and assessment of the CCG's risk to delivering its planned deficit of £27m.

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

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

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

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

This report sets out the financial performance of the CCG to the end of August 2019 (month 5 management accounts).

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

None.

Key recommendations and actions requested:

The Governing Body is asked to note the month 5 position as at 31st August 2019 and the level of risk to delivery of the CCG's control total.

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

N/A

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

	If Yes, please give details	No

Quality	Safety: Effectiveness: Experience:	
Equality		
Resource and Finance		
Legal		
Engagement and Consultation		
Risk		

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NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 5 – 2019/20

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1. Executive Summary

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

The report details the financial position to the 31st August 2019 and provides and assessment of the CCG's risk to delivering its planned deficit of £27m.

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

Since this initial assessment The Devon System has been through an intensive programme, supported by NHSE & I colleagues, to reach a more acceptable position in relation to financial performance against control total. This has seen a planned improvement in the gross system deficit from £115m to £70m, a distance of £25m from control total, based on significantly increasing the level of ambition in our plan and accelerating the pace of change in the transformation programmes the System is undertaking. This revised plan remains draft while we await NHSE&I's approval.

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

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

Financial Position

This report sets out the financial performance of the CCG to the end of August 2019 (month 5 management accounts).

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

	Planned Deficit £'000	Actual Deficit £'000	Variance to plan £'000
Year to date position	11,250	11,250	0
Year end forecast	27,000	27,000	0

Although the overall year to date (YTD) position balances to the planned deficit of £11.250m, there are several variances to report at Month 5. These are discussed and set out in later sections.

Savings Plan

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

Risk

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

STP Plan

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

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

2. Financial Assurance Dashboard

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

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

- Financial plan
- In Year Financial performance

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

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	11.3	11.3	0.0%	RED
3	Forecast Outturn in year deficit	27.0	27.0	0.0%	RED
4	QIPP - Year To Date Delivery (% achieved)	-22.1	-8.0	36.2%	RED
5	QIPP - Forecast Outturn Delivery	-80.9	-80.0	98.9%	GREEN
6	Running Costs	25.4	22.4	88.2%	GREEN
7	Risk adjustment to deficit (% of allocation)	0.0	39.5	2.3%	RED
8	Cash Position (% drawn down)	41.7%	42.2%	101.3%	AMBER
9	BPPC (% paid - value)	95%	99.1%	104.4%	GREEN

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

3. Detailed Financial Performance

The financial position to the 31st August 2019 by main service heading is as follows:

Month 05 August	DEVON CLINICAL COMMISSIONING GROUP					
	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES						
Acute Services	376,954	377,214	260	904,689	905,040	351
Mental Health Services	84,889	84,816	-73	203,734	203,620	-115
Community Health Services	111,854	111,881	27	268,449	268,555	106
Placements	50,820	51,194	374	121,965	122,002	38
All Other Healthcare	13,475	12,453	-1,022	-1,274	-1,655	-381
Primary Care Services						
Prescribing	80,829	81,326	497	193,990	193,990	1
Other Primary Care	87,193	87,279	86	213,205	213,206	0
Primary Care Subtotal	168,022	168,605	582	407,195	407,196	1
Subtotal	806,014	806,162	148	1,904,759	1,904,758	-1
CORPORATE						
Running Costs	9,346	9,198	-148	22,433	22,434	0
TOTAL COMMISSIONED SERVICES	815,360	815,360	-0	1,927,192	1,927,192	-0
Allocation excl b/fwd position	804,110	815,360	11,250	1,900,192	1,927,192	27,000
2019/20 Surplus/Deficit	11,250	-	11,250	27,000	-	27,000

There are a number of YTD variances to report at Month 5 including an overspend in Primary Care, mainly due to prescribing costs, of £0.582m and £0.374m in Continuing Healthcare. This overspend has mainly been offset using reserves, resulting in the planned YTD deficit of £11.250m. This is discussed and set out in later sections.

When set against our available in year revenue resources of £1,900m for Devon CCG the forecast outturn (FOT) expenditure plan results in an overspend of £27m.

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

3.1 Acute Services

Risk Share Application – Demand and Activity Management

As part of 2019/20 planning the Devon System set an ambition to achieve demand and activity management savings of £25m, with a risk share agreed to support the delivery of this ambition. The intention was firstly to reduce the (up to £15m) growth funded in contract, varying it back out of contract on the basis on which it was funded. The next £10m will be delivered by a combination of demand management and specific schemes/initiatives. Should this £10m not be achieved the risk share agreement requires organisations to manage an element of this risk in their position based on a 70:30 split between the CCG and the four acute providers.

A summary of the quarter one position is shown below, with a range where there are issues for clarification depending on the commissioner / provider view. These results are to be discussed with system directors of finance with a view to establishing the progress and delivery of the targeted reductions/savings relating to acute activity growth and transformation.

Provider	High	Low	Comments
UHP	-£2,459	-£1,058	High includes drugs & devices but excludes blended tariff
RD&E	-£1,607	-£895	High excludes A&E, penalties and unfunded non-elective 19/20 growth
TSD	-£2,200	-£1,100	High includes AMU. Low is based on growth being based on cost not PbR
NDHT	£0	£0	NDHT are showing a £1.2m overspend on contract at month 3
Total	**-£6,266**	**-£3,053**	

In £ millions

The CCG 2019/20 activity planning with providers included comparatively high growth for elective activity, which is designed to maintain sustainable RTT waiting list sizes and to significantly reduce the number of patients waiting over 40 weeks, minimising the risk of 52-week breaches.

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

The sections below show the Month 4 position against total contract plans. The CCG continues to work closely with providers to ensure a joint understanding of activity variances.

RD&E Activity Summary – Month 4

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	3,632	2,973	-659	-18%	10,582	10,186	-396	-4%
Day Case	14,549	14,283	-266	-2%	11,123	11,230	108	1%
Non-Elective	15,658	15,418	-240	-2%	30,052	29,121	-931	-3%
A&E	29,921	29,865	-56	0%	4,077	4,255	178	4%
New Outpatients	43,610	47,409	3,799	9%	5,861	6,015	154	3%
Follow-up Outpatients	73,887	74,315	428	1%	5,148	5,083	-65	-1%
Outpatient Procedures	34,892	32,759	-2,133	-6%	6,020	5,843	-177	-3%
Drugs & Devices					5,325	5,132	-192	-4%
CQUIN					1,047	1,024	-23	-2%
Other					10,173	10,925	752	7%
Total					**89,407**	**88,815**	**-593**	**-1%**

The RDE Acute contract value has been agreed at £268,965k. Overall at Month 4 there is a £593k underspend against plan. There is £1,247k of un-coded activity within the actual position.

The Elective & Day Case activity is 5% below plan equating to an underspend of £288k. The main contributing specialty continues to be Trauma & Orthopaedics with a £267k underspend.
The Non-Elective activity is 2% below plan equating to an underspend of £931k. The main contributing specialty is Paediatrics with an underspend of £323k and Trauma & Orthopaedics with an underspend of £305k.

The A&E activity is 56 below plan with an overspend relating to the casemix (more major cases than planned) of £178k.

Outpatient attendances (first and follow-ups) are 4% over plan with a corresponding overspend of £89k. General Surgery is overspending by £104k with Ophthalmology & Dermatology reducing this with underspends of £159k & £99k respectively.

CQUIN is under plan by £23k.

NDHT Activity Summary – Month 4

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	1,093	1,107	14	1%	3,035	2,533	-502	-17%
Day Case	6,437	6,653	216	3%	3,330	3,528	198	6%
Non-Elective	7,099	7,132	33	0%	12,853	14,411	1,558	12%
A&E	15,065	15,146	81	1%	1,928	1,884	-43	-2%
New Outpatients	13,417	13,834	417	3%	2,228	2,211	-17	-1%
Follow-up Outpatients	29,444	27,124	-2,320	-8%	2,349	2,230	-119	-5%
Outpatient Procedures	11,623	12,722	1,099	9%	1,480	1,580	100	7%
Drugs & Devices					2,371	1,858	-513	-22%
CQUIN					684	700	16	2%
Other					18,408	18,496	88	0%
Total					**48,667**	**49,432**	**765**	**2%**

The NDHT contract value has been agreed at £145.8m (acute and community). Overall at month 4 there is an overspend of £765k, however due to the level of un-coded activity the financial position cannot be validated.

NDHT un-coded activity remains an issue, although this has improved from month 3, with 13% of Daycases, 34% of Inpatients, 36% of A&E and 40% of Non-Electives un-coded at month 4 with an average tariff applied.

Inpatients activity is 1% above plan and Daycase activity is 3% above plan. Clinical Haematology and Gastroenterology remain the lead specialities over performing against plan.

Non-Elective Activity is virtually flat against plan to month 4 although the financial position is an overspend of £1.56m. General Medicine has the highest financial value against plan at £1.3m but due to 45% of general medicine activity un-coded this is subject to change.

A&E is 1% above plan, a reduction from month 3.

First Outpatients is 3% above plan; T&O (£41k) and Clinical Physiology (£57k) have the highest variance against plan. With limited capacity NDHT are prioritising First attendances for these specialties therefore it is likely this variance will continue.

Follow up attendances are showing a large underperformance in general surgery which NDHT are exploring. This nets off an over performance in T&O and Orthoptics.

For Outpatient Procedures ENT, Clinical Physiology and Gynaecology have the largest variance to plan for month 4.

Drugs and Devices is currently showing an underspend of £513k. This is due to the biosimilar savings (Adalimumab) that NDHT and the CCG have agreed.

UHP Activity Summary – Month 4

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	2,185	1,997	-188	-9%	7,397	6,731	-666	-9%
Day Case	10,950	11,461	511	5%	8,045	8,001	-44	-1%
Non-Elective	13,904	13,213	-691	-5%	28,300	27,654	-646	-2%
A&E	28,870	28,534	-336	-1%	4,524	4,372	-152	-3%
New Outpatients	25,504	25,584	80	0%	3,803	3,823	19	1%
Follow-up Outpatients	55,585	53,695	-1,890	-3%	4,489	4,293	-196	-4%
Outpatient Procedures	23,527	26,878	3,351	14%	3,693	3,910	217	6%
Drugs & Devices					5,213	4,994	-219	-4%
CQUIN					852	845	-7	-1%
Other					7,893	8,829	935	12%
Total					**74,210**	**73,452**	**-758**	**-1%**

Expenditure on inpatient elective and day cases is 4.6% behind the financial plan and 2.5% ahead of the activity plan. Half of the year to date financial underperformance has occurred in month 4. The difference between the volume and value variances is due to a different case mix of patients being treated than was expected with overperformance in lower cost specialities such as Endoscopy and Dermatology, and underperformance in higher cost specialities such as Orthopaedics and Cardiology.

Non-Elective activity is behind plan in activity terms and financial terms by 5.0% and 2.3% respectively with an underperformance worth £0.6m. Performance in month 4 was largely on plan, however the underperformance that accumulated is the first 3 months of the year remains.

Accident and Emergency is behind plan by 1.2% or 336 attendances.

An adjustment for the blended payment for emergency care, which is a new risk sharing approach that has been introduced nationally from 2019/20, has been calculated and included within this reporting. The blended tariff means that only 20% of emergency and non-elective over performance is paid for, whilst only 20% of underperformance would be returned to commissioners. Whilst this is a national approach there is scope for local arrangements to supersede this impact, and this needs to be worked through considering the overall STP contracting and risk share approach. As emergency care services (non elective and A&E) are currently under plan, this means that 80% (£1,196k) of the underperformance is being charged back to commissioners.

Outpatient activity is ahead of plan by 1.5% whilst the spend is 0.3% more than had been expected. This variance is driven by UHP seeing more outpatients' procedures and non-face to face contacts and fewer follow ups, than had been expected. First attendances are largely on plan.

Passthrough Drugs and Devices are underspent by 4.2% or £0.2m, which is driven by passthrough drugs underperforming by £0.3m and devices over performing by £0.1m. The large swings in variance in this area are driven by issues with invoicing from homecare providers.

The plan has an adjustment for system savings; this number reflects the differences between the PbR activity plan and the agreed system wide contract value and is worth £3.3m for the whole year, of which £1.1m is reflected at month 4.

Overall, contract reporting illustrates an under performance of £0.8m at the end of month 4, which will increase to £2.0m if the blended tariff adjustment were removed. This underperformance will be different to the value that is calculated under the risk share agreement due to the risk share not covering all contract areas. The value of the risk share will be calculated by JTWG and agreed through the Finance Working Group in accordance with the risk share agreement.

TSD Activity Summary – Month 4

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	1,198	1,101	-97	-8%	4,388	3,910	-478	-11%
Day Case	11,339	12,138	799	7%	7,186	7,755	570	8%
Non-Elective	10,009	8,687	-1,322	-13%	22,093	20,534	-1,560	-7%
A&E	24,176	23,763	-413	-2%	3,624	3,566	-58	-2%
New Outpatients	25,521	24,548	-973	-4%	3,823	3,689	-134	-4%
Follow-up Outpatients	60,172	60,629	457	1%	4,724	4,753	29	1%
Outpatient Procedures	22,776	22,380	-396	-2%	3,423	3,294	-129	-4%
Drugs & Devices					3,748	3,664	-84	-2%
CQUIN					744	744	0	0%
Other					11,169	11,118	-52	0%
Total					**64,922**	**63,026**	**-1,809**	**-3%**

Overall activity is below plan and the overall financial under performance is valued at £1.8m across the acute contract (compared to £2.3m for the previous month).

Of this £1.3m relates to admitted patient care, £0.2m relates to outpatient activity and a further £0.3m underperformance in other areas such as imaging, drugs and maternity.

The largest variation relates to non-elective emergency admissions (£1.5m).

A new unit was introduced in December 2018, called HAAU (High Acuity Ambulatory Unit, or HAAT). Activity in this area has been incorrectly recorded as RDA (Regular Day Attender), which for reporting is linked into Day Case. As a result, the Trust is over-reporting Day Cases and under reporting Non-Electives by approximately 1,000 events with a value of c£0.9m. The Trust have shared a detailed file which is being validated by the CCG. The net income impact is only just over £50k (in the Trusts favour).
As a result of this change, it moves the Day Case activity to below plan, moving from 7% over plan to -2%.

This has not eliminated all the Non-Elective variance but reduced it from 14% below plan to 5% below plan (growth was included at 1.5% for the year). The data will be corrected in time for month 5.

Referrals

Below is a summary by provider of the NHS Devon CCG referrals to consultant led clinics, for month 4 against 2018/19 YTD (TSD and UHP at month 3 due to data quality issues being resolved with the providers).

Provider	Referral Source	2019/20	2018/19 YTD Variance	
NHS Devon CCG Total	GP/Dental	64,273	-107	-0.2%
	Other	34,129	1,272	3.9%
	Total	**98,402**	**1,165**	**1.2%**
Royal Devon & Exeter	GP/Dental	26,731	851	3.3%
	Other	10,847	375	3.6%
	Total	**37,578**	**1,226**	**3.4%**
University Hospitals Plymouth (month 3)	GP/Dental	15,328	840	5.8%
	Other	7,655	-42	-0.5%
	Total	**22,983**	**798**	**3.6%**
Torbay & South Devon FT (month 3)	GP/Dental	10,839	-175	-1.6%
	Other	10,975	312	2.9%
	Total	**21,814**	**137**	**0.6%**
Northern Devon Heathcare	GP/Dental	7,649	-651	-7.8%
	Other	3,512	473	15.6%
	Total	**11,161**	**-178**	**-1.6%**
Other	GP/Dental	3,726	-972	-20.7%
	Other	1,140	154	15.6%
	Total	**4,866**	**-818**	**-14.4%**

The NHS Devon CCG YTD position shows 1.2% growth whilst the rolling 12-month position shows growth of 2.0%. YTD growth is being driven by other referrals which have seen year on year growth of 3.6%, whilst GP & Dental performance is tracking relatively flat at -0.2%.

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

TSDFT: The month 3 referral position is currently 0.6% higher YTD vs last year. Routine referrals YTD have seen growth of 1.0% whilst 2ww referrals have declined -1.0%.
At specialty level ophthalmology (-17.1%) and orthopaedics (-8.1%) are showing the biggest reductions whilst gastroenterology (26.9%) cardiology (17.2%) and gynaecology (9.5%) are showing the highest growth.

NDHT: Month 4 is currently showing a variance of -1.6% YTD, we are working with the trust to investigate Ophthalmology & Cardiology referrals due to different data sources showing opposing direction of performance, there is potential referrals

once reconciled will show a level of growth. Routine referrals have seen a -3.3% fall in referrals YTD whilst 2ww referrals have seen growth of 6.3%.
At speciality level Trauma & Orthopaedics have the biggest referral volume growth (12.6%) followed by Colorectal surgery (16%) and Gynaecology (6.4%)

RDE: Month 4 referral position is 3.4% vs last year. The majority of the overall growth is for routine referrals (3.9%), with 2ww showing marginal growth (1.2%) on 2018/19.
At specialty level the main areas of growth YTD are; General Surgery (14.1%), Dermatology (9.4%) and Trauma & Orthopaedics (5.0%). The largest reductions are colorectal surgery (-28.2%) and Neurology (-12.0%)

Other providers combined have seen a fall in referrals 14.4% as of month 4 YTD.

3.2 Mental Health Services

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

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

At month 5 there is a YTD overspend of £0.070m for IPPs due to LD placements on both Devon & Plymouth Out of Area beds. The position is forecast to be £0.168m overspent at the year end.

Other mental health contracts are showing a YTD underspend of £0.144m, which is a combination of 2018/19 year end accruals and slippage on current year contracts. The position is forecast to be £0.283m underspent at the year end.

3.3 Community Health Services

Community Healthcare Services include contracts with our main providers for community hospital beds and community services as well as children's services, minor injury services and the CCG's investment in the better care fund with our three local authorities. There are no significant variances to report as at M5.

3.4 Placements

Continuing healthcare is overspent by £0.374m at month 5 due to client number reductions being less than anticipated but plans to mitigate this over the coming months are underway.

There is underlying risk that will require robust financial management over the coming months. The key risks relate to the CHC QIPP savings target of £5m that is embedded within the budget where further detailed plans are required to meet the

full challenge and there is inherent risk around the assumption that the number of eligible clients will drop again this year.

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

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

3.5 Primary Care Services

Delegated Primary Care Commissioning

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

As at month 5 we are forecasting a breakeven position across delegated primary medical care. Any areas of risk (that have previously been highlighted to the Primary Care Committee) are being covered from the contingency.

The CCG is working with NHS England to draw up expenditure plans for the GP Forward View allocations received so far during the year.

Primary Care Prescribing

The June data was the first forecast outturn (FOT) for the year however we were advised that due to a delay in receiving the FOT figures they had simply used last years forecast profile to provide an estimate. Therefore, this is not as reliable as we would have hoped. We have reported a YTD overspend for M05 but continued with a breakeven position for year end. This allows for the QIPP yet to be delivered.

Work has taken place on the QIPP plans, with financial amounts allocated against most schemes now and feels like a more reliable forecast. It is currently showing an under achievement of £0.9m by year end. Work will continue to complete this plan and ensure that all schemes are included for M06. The Data group is assisting with this to ensure we are now consistently reporting across all areas and one source is used as appropriate.

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

Other Primary Care Services

Other primary care services include contracts for enhanced GP services, out of hours GP services, home oxygen services and provision for GP IT costs. These are forecast to come in on budget as at M5.

3.6 All Other Healthcare

All Other Healthcare includes contracts for Integrated Urgent Care, hospices, patient transport and other intermediate care services. It also includes reserves and any unallocated savings targets. The variance reported is due to the use of the reserves and the profiling of the QIPP delivery.

3.7 Running Costs

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

The forecast outturn at month 5 is estimated at £22.4m which would be an underspend of £3.0m when compared to the £25.4m allocation received.

3.8 Resource Allocation

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

	NEW Devon CCG	SD & Torbay CCG	Devon CCG
Planned revenue resources	£'000	£'000	£'000
Final allocation after place based pace of change	1,257,424	433,048	1,690,472
Other funding pace of change	2,191	475	2,666
Total recurrent revenue resources	**1,259,615**	**433,523**	**1,693,138**
Recurrent adjustments			2,336
Non recurrent adjustments			17,508
Primary care commissioning			161,805
Running costs allocation			25,405
Total revenue resources			**1,900,192**
Total forecast expenditure			1,927,192
Total revised planned overspend 2019/20			(27,000)

4. QIPP/Systems Savings Plan

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

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

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

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

This means that for the CCG, although the total 2019/20 QIPP savings required is £80.9m, the transformational savings plans (i.e. not contractualised) within this amount to £35.0m. All parties in the system recognise the £35.0m challenge and are committed to developing a detailed risk share between NHS partners to enable all parties to recognise individual contributions to the shared risk of delivery.

Currently a recovery plan is being developed, discussing and establishing the way forward, to provide assurance to the CCG Governing Body that all opportunities are being explored to address the challenge.

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

QIPP Delivery		Plan	Upside Forecast	Upside Risk	Downside Forecast	Downside Risk
Description	**Service Area**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Demand/activity management and transformation programmes	Acute Services	37,500	13,750	23,750	8,000	29,500
Reduction in spend on individual patient placements	Mental Health Services	2,000	1,500	500	1,000	1,000
Joint commissioning	Community Healthcare Services	7,000	4,000	3,000	2000	5,000
Continuing healthcare	Continuing Care Services	5,000	5,000	0	2,000	3,000
Primary care prescribing	Primary Care Services	8,000	8,000	0	4,000	4,000
Allocations/income	Other Programme Services	10,000	10,000	0	5,000	5,000
Further benchmarking opportunities	Other Programme Services	3,896	2,500	1,396	0	3,896
Non-rec opportunities	Other Programme Services	6,000	6,000	0	6,000	0
Procurement/Non-healthcare contract/Admin	Other Programme Services	1,500	1,500	0	1,500	0
Total QIPP		**80,896**	**52,250**	**28,646**	**29,500**	**51,396**

5. Risks

The assessment of financial risk at month 5 is estimated at £39.5m as follows.

Devon CCG		Month 4	Month 5
Risk	**Description**	**£'000**	**£'000**
Acute Services	Latest assessment of the level of risk attached to the activity and transformation programmes being developed with system partners for delivery in 19/20. Monitoring arrangements and an appropriate risk share mechanism are being refined and implemented	27,000	27,000
Mental Health Services	Potential risk of not delivering in full the target set for the reduction in cost of out of area placements.. There is a process for monitoring and managing this area and the arrangements in place	1,000	1,000
Community Healthcare Services	Reassessment of opportunities which were explored and delivered against in 19/20 but at present don't exist for this financial year.	4,000	4,000
Continuing Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arrangements are in place through the Control Centre and this will be proactively managed during the year	3,000	3,000
Primary Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arrangements are in place to monitor delivery but the latest assessment doesn't meet the required target.	2,500	5,500
Primary Care Delegated Commissioning	Initial assessment in advance for full financial due diligence of the potential risks which may materialise in the next two years. This is currently being discussed and developed further with NHS England	1,000	1,000
Other Programme Services	Continuing assessment of opportunities for mitigating against some of the risk which exists in the CCG plan, including non-recurrent solutions and limiting existing exposure to cost pressures	5,000	4,000
Total Risk		**43,500**	**45,500**
Mitigations	**Description**	**£'000**	**£'000**
Acute Services	Potential sources of funding to mitigate opening plan risk being agreed with system partners	-2,000	-2,000
Primary Care Services	Estimate of the potential additional QIPP achievable	0	-2,000
Other Programme Services	Initial reassessment of opening plan risks and potential mitigating solutions	-2,000	-2,000
Total Mitigations		**-4,000**	**-6,000**
Total unmitigated risk		**39,500**	**39,500**

Changes to the risk profile for primary care reflect an updated assessment following review of the month 5 position in this area.

The scale of the unmitigated risk represents a significant challenge to the CCG delivering its plan for 19/20. Work continues to identify mitigations either through acceleration of transformation programmes or through risk sharing mechanisms considered by all partners in the Devon STP with a view to reducing the risk exposure to the CCG.

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 2019 is shown in appendix 1.

6.2 Capital

NHS England have informed the CCG that the bid for the requested £168k of capital, for business as usual projects, was not approved and hence the CCG will need to deal with this accordingly.

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non-NHS Creditors - % of bills paid within target	97.04%	98.97%
NHS Creditors - % of bills paid within target	92.52%	99.23%

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

6.4 Cash

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

7 Recommendations

The Governing Body is requested to:

Note and review the month 5 year to date performance and the forecast year end position including the current risks around delivery of the CCG's control total.

Appendices

Appendix 1: Statement of Financial Position

AS AT 31 AUGUST 2019	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	2,585
Intangible Assets	10
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	2,595
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	4,805
Trade & Other Receivables - Non NHS	24,445
Other Current Assets	-
Cash & Cash Equivalents	4,192
Non-current Assets held for Sale	-
Total Current Assets	33,841
Total Assets	36,436
CURRENT LIABILITIES	
Trade & Other Payables - NHS	- 16,225
Trade & Other Payables - Non NHS	- 108,834
Other Liabilities	- 1,007
Borrowings / Cash in Transit	- 12,044
Provisions	- 231
Total Current Liabilities	- 138,341
Total Assets less Current Liabilities	- 101,905
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 95
Total Non Current Liaibilities	-
Total Assets Employed	- 102,001
FINANCED BY TAXPAYERS EQUITY	
General Fund	102,001
Total Taxpayers' Equity	102,001

Appendix 2: Cash

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

Measure	Month 5
CCGs must operate within their Maximum Cash Drawdown (MCD) *The MCD is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,922.789m for Devon CCG the year.*	42.2% of the MCD has been utilised as at month 5 (41.7% is expected based on a straight-line trajectory at month 5).
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 £5,636 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*

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: 26th September 2019

Dates of Committees covered in this report: 11th September 2019

(Minutes of this meeting are not yet available)

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

Contact Details: nick.ball1@nhs.net

Reports discussed and assurances received

Risk and Assurance Report. The following attachments are included:-

- Assurance Framework (Appendix 1)
- High Level Risks (Appendix 2)
- Standards of Business Conduct Policy (Appendix 3)

- The Audit Committee received and discussed the Assurance Framework and thanked the Board Secretary particularly for the work around risk management and the assurance framework templates. The report further outlined the internal audit recommendations and management responses for audit committee oversight in relation to corporate governance.
- Training for risk co-ordinators and risk owners is taking place during September 2019 and there will be risk training arranged for the Executives and Governing Body members.
- Director of Communications, HR and Workforce was invited to attend to discuss responsible areas of risk from the Assurance Framework – the Audit Committee felt assured by the responses and welcomed Executive attendance at future meetings by invitation of the Audit Chair.

Standards of Business Conduct Policy

- The Audit Committee received a revised policy in light of a national audit of the management of conflicts of interest by NHSE. NHSE identified eight areas where management of conflicts of interest could be improved. This resulted in the publication in February 2019 of the 'Best Practice Update on Conflicts of Interest management. The Committee approved the policy.

Reports received and noted

- Use of Common Seal - The Audit Committee received the annual report in relation to use of the common seal. The contents of the report were noted and accepted by the committee.

- Losses and Special Payments – Clinical Commissioning Groups' (CCG) are required to report any potential losses or special payments to the Audit Committee annually. There were no new items on the registers reported to the Committee in the first 5 months of 2019/20.

Internal Audit Update Report – The report summarised the work of ASW Assurance since the previous Audit Committee meeting in July 2019. The Committee was asked to consider and approve the proposed extensions to deadlines for overdue audit recommendations. The following final audit reports were presented to the committee:

- Review of Clinical Governance Risk Areas
- Equality, Diversity and Inclusion
- Transforming Care Partnership
- Cyber Security
- General Data Protection Regulations

The contents of the Update Report were noted and there were no items for escalation to the GB.

- External Audit Progress report – the paper included a summary of emerging national issues and developments that may be relevant to the Clinical Commissioning Group. The report included a number of challenge questions in respect of emerging issues which the Committee were asked to consider. The contents of the Progress Report were noted and there were no items for escalation to the GB.

Risk Register Review (changes and areas of concern)

Noted that 4 new risks have been added to the risk register:-

Risk 110 – Initial Health Assessments Statutory requirements for Looked after Children.

Risk 111 – Delivery of Control total for 19/20 as a result of the savings target held by the CCG which includes system savings.

Risk 112 – Dementia Diagnosis Rate is being discussed at a commissioning business meeting and will be reported to the Audit Committee at a subsequent date.

Risk 113 - Emergency Planning Resilience and Preparedness (EPRR) Core Standards failure to deliver the CCGs key critical functions in an emergency which will impact on the CCGs statutory obligations.

Committee Decisions

The Audit Committee:

- **Approved the Standards of Business Conduct Policy.**
- **Noted the Use of Common Seal report.**
- **Noted the Losses and special payments report**
- **Noted the Internal Audit Update Report**
- **Noted the External Audit Progress Report**

Recommendations for Governing Body

NA

Recommendations for other Committees

NA
Terms of Reference or other committee effectiveness issues
NA

Management of Conflict of interests:

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

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

Updated 28/08/2019 Corporate Objective	Assurance Framework Ref	Corporate Risk Register mapping Bold text indicates risk pending closure by committee	Initial Risk Score	Updated score on review August 2019	Risk Movement (Trend)	Risk Appetite /Target Score	Assurance Score	Lead Director	Date AF Risk Reviewed	Principle Risks *There is a risk that…….*
We will continue to commission safe, effective and accessible services by:	1	2, 3, 11, 59, 70, **74**, 80, 89, 106, 109	20		⇔	10	8	Sonja Manton & Jo Turl		We do not have sufficient, credible plans to deliver improved performance within agreed timescales
• Being in the top 10% of CCGs by improving performance against core NHS standards	2	49, 102, 104, 38, 110	20		⇔	15	8	Simon Tapley	12/08/2019	The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress.
• Meeting all statutory requirements	3		20		⇔	15	10	Sonja Manton & Jo Turl		The pace of change for roll out of ICM is too slow and therefore does not achieve planned outcomes
• Improving our populations health, their experience of care and the cost-effectiveness	4	42, **44**, 72, 73	20		⇔	15	10	Jo Turl		We do not commission mental health services which meet local need or national expectation
• Increasing the use of technology	5		16	9	⇩	12	11	John Dowell	20/08/2019	We do not develop commissioning plans which incorporate best practice in the use of technology
We will work as a strategic partner in Devon by:	6	**8**, 90, 95	20		⇔	15	11	Simon Tapley	12/08/2019	We do not have full commitment from all system partners to deliver operational system plan so change is not delivered.
• Working as one system to support the delivery of all objectives	7	100	20	15	⇩	15	11	Simon Tapley	12/08/2019	The system does not have robust mechanisms for identifying and responding to emerging risks
• Working more closely with local communities to plan local services	8	107	8		⇔	8	11	Andrew Millward	15/08/2019	Our plans do not reflect the views of patients and the public as there has not been sufficient engagement.
• Developing evidence-based services	9	**15**,17, 20, 24, **45**, 82	16		⇔	8	8	Sonja Manton & Jo Turl		We do not develop evidence-based commissioning plans due to lack of capacity and capability within the CCG
• Empowering, motivating and developing our staff	10		12	8	⇩	4	11	Simon Tapley	12/08/2019	We have not addressed the issues raised in the 2018 staff survey so staff leave or do not perform to their full potential
We will improve the physical and mental health of our population by:	11		16		⇔	8	11	Sonja Manton & Jo Turl		We have not evolved our integrated strategic commissioning arrangements sufficiently to develop plans to deliver improvements in population outcomes
• Integrating and personalising care										
• Addressing issues that cause ill health	12	77, 92	20		⇔	10	8	Sonja Manton & Jo Turl		We have not invested sufficiently in prevention so we do not achieve improvements in population health
• Reducing health inequalities	13	**75**, 79	16		⇔	8	8	Sonja Manton & Jo Turl		We are not targetting our resources at the areas that most need them so health inequalities are exacerbated.
We will make best use of resources by:										
• Using population health management approaches to target resources where they are needed most	13	See AF13	16		⇔	8	8	Sonja Manton & Jo Turl		We are not targetting our resources at the areas that most need them so health inequalities are exacerbated.
• Improving efficiency, productivity and sustainability	2	See AF 2	20		⇔	15	8	Simon Tapley	12/08/2019	The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress
• Achieving financial balance across the whole health and care system in Devon	6	See AF6	20		⇔	15	11	Simon Tapley	12/08/2019	We do not have full commitment from all system partners to deliver operational system plan so change is not delivered.
• Increasing investment in services to meet identified need	14	83, 97, 105, 108	20		⇔	15	8	Jo Turl		There is insufficient workforce capacity and capability in Primary Care (GPs, nurses and pharmacists) to meet demand

Objective: We will commission safe, effective and accessible services.		Director Lead: Sonja Manton and Jo Turl
Risk: AF 1 – We do not have sufficient, credible plans to deliver improved performance within agreed timescales		**Date Last Reviewed:** **Reveiwer:**
Corporate risks	2, 3, 11, 59, 70, 74, 80, 89, 106, 109	
Risk Rating	Impact x likelihood	Reason for current score:
Initial:	**5x4 = 20**	Plans based on potential opportunities but impact is only hypothetical and cannot be tested without delivery
Current:	**5x4 = 20**	
Appetite:	**5x2 = 10**	Rationale for risk appetite:
		Robust plans can be produced to ensure delivery
Controls: (What are we currently doing about this?)		Assurances:
System Operating Plan has been produced and signed off by all partner organisations. Detailed workplans have been agreed and leads have been identified/appointed		PDEG and committees have governance arrangements in place for system working and monitoring performance A&E Delivery Boards, Planned Care Forums and ICM Groups in place in each locality
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**8**
Further Development of LCPs to deliver at locality level Specific pieces of work will be implemented and will demonstrate future deliverability Ongoing review of delivery will result in changes to plans		Gaps in Assurance: (What additional assurances should we seek?) Line of reporting to CCG needs to be strengthened to focus on CCG deliverables which contribute to system plan

Objective: We will commission safe, effective and accessible services. We will make the best use of resources		**Director Lead: Simon Tapley**
Risk: AF2 – The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress		**Date Last Reviewed: 12/08/2019 Reveiwer: Simon Tapley**
Corporate risks	49, 102, 104, 30, 110	
Risk Rating	Impact x likelihood	Reason for current score:
Initial:	**5x4 = 20**	Insufficient capacity for programme management in CCG due to demands of system working
Current:	**5x4 = 20**	
Appetite:	**5x3 = 15**	Rationale for risk appetite:
		CCG needs to ensure robust programme management.
Controls: (What are we currently doing about this?)		Assurances:
Agreed recruitment to increase PMO capacity – Business Case agreed by Exec Team 18/6/19. Monitoring performance of recovery action plans		Quality and Performance reports to GB and Committees largely focus on provider performance
Control Gaps		
Mitigating Actions: (What should we do?)		
Need to establish reporting mechanisms/ formats/content and clear expectations of role of PMO and others in SA dashboard will be developed to clearly set out progress against agreed metrics.		Assurance Score: **8** Gaps in Assurance: (What additional assurances should we seek?) Robust reporting to GB and Committees on: Delivery of Operational Plan Progress with delivery of Corporate Objectives

Objective: We will commission safe, effective and accessible services.		**Director Lead:** **Sonja Manton and Jo Turl**
Risk: AF3 – The pace of change for roll out of ICM is too slow and therefore does not achieve planned objectives		**Date Last Reviewed:** **Reveiwer:**
Corporate risks	19	
Risk Rating	Impact x likelihood	Reason for current score:
Initial:	**5x4 = 20**	Progress with implementation of ICM blueprint has stalled
Current:	**5x4 = 20**	
Appetite:	**5x3 = 15**	Rationale for risk appetite:
		Blueprint has been developed and mechanisms in place for implementation. Systemwide commitment to delivery
Controls: (What are we currently doing about this?)		Assurances:
Blueprint developed and agreed by the system Revised arrangements for ownership, accountability and governance Systemwide approach led by joint SROs in NHS and LA Systemwide resource agreed for implementation Priorities and programmes of work agreed		Reporting to PDEG by programme workstream
Control Gaps		
		Assurance Score:
		10
		Gaps in Assurance: (What additional assurances should we seek?)
Mitigating Actions: (What should we do?)		LCPs to develop workplan and establish regular reporting to PDEG on delivery
Development of Locality Care Partnerships to support implementation Further data analysis required to understand actual vs hypothesised impact and whether this can be better than flat Development work required to increase local system maturity and reduce variation between systems		

Objective: We will commission safe, effective and accessible services.		Director Lead: Jo Turl
Risk: AF4 – We do not commission mental health and learning disability services which meet local need or national expectation		**Date Last Reviewed:** **Reveiwer:**
Corporate risks	42, 44, 72, 73	
Risk Rating	Impact x likelihood	Reason for current score:
Initial:	**5x4 = 20**	Current services to not meet national specification
Current:	**5x4 = 20**	
Appetite:	**5x3 = 15**	Rationale for risk appetite:
		Delivery programme agreed to support system working
Controls: (What are we currently doing about this?)		Assurances:
Mental Health Care Partnership with agreement Work programme (including Out of Area Placements and First response) 2 day mental health conference held Transforming Community Services Group for LD		Exec to Exec meetings with providers Report to NHSE ICE Regular contract meetings with Providers
Control Gaps		
		Assurance Score: **10**
Mitigating Actions: (What should we do?)		Gaps in Assurance: (What additional assurances should we seek?)
System workshop planned for September Review of Learning Disability Beds Work being undertaken to understand and develop the market		Support required from PMO in CCG to improve regular and adhoc reporting arrangements

Objective: We will commission safe, effective and accessible services.		Director Lead: John Dowell
Risk: AF5 – We do not develop commissioning plans which incorporate best practice in the use of technology		**Date Last Reviewed: 20/08/2019** **Reveiwer: John Dowell**
Corporate risks		
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x4 = 16**	This risk is applicable across the STP and closer links with commissioning will be explored to support this area of concern'
Current:	**3 x 3 = 9**	
Appetite:	**4x3 = 12**	**Rationale for risk appetite:**
		Arrangements can be developed that will ensure closer working
Controls: (What are we currently doing about this?)		**Assurances:**
Digital workstream in place and workplan agreed – Reporting into PDEG. System Director – Nick Hopkinson and SRO Suzanne Tracey John McCormick – Clinical Digital Lead – Linked to national programme CCG represented by Jim Goodwin		PDEG AEDB, Planned Care Boards, ICM
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**11**
Increased representation from CCG staff on workstream programme steering group Improve links between digital workstream group and delivery groups such as AEDB, Planned Care Boards and ICM Groups Ensure Digital rep on each LCP to champion use of technology Each commissioning group to identify good practice from outside Devon		**Gaps in Assurance: (What additional assurances should we seek?)** Commissioning plans need to incorporate delivery of required technological changes

Objective: We will work as a strategic partner in Devon We will improve the mental and physical health of the population		Director Lead: Simon Tapley
Risk: AF6 – We do not have full commitment from all system partners to deliver operational system plan so change is not delivered		**Date Last Reviewed: 12/08/2019** **Reveiwer: Simon Tapley**
Corporate risks	8, 90, 95	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**5x4 = 20**	Development work required to support system working arrangements
Current:	**5x4 = 20**	
Appetite:	**5x3 = 15**	**Rationale for risk appetite:**
		System is required to reach ICS status by April 2021.
Controls: (What are we currently doing about this?)		**Assurances:**
System workplan agreed and being managed through system PMO Regular reports from all workstreams and projects to PDEG. STP SRO and Chair appointed Collaborative Board providing oversight of system working and supporting development of relationships.		Progress monitored through Programme Delivery Executive Group(PDEG) and feedback to CCG through AO and other Execs Updates on operational plan to GB Non-Exec Directors aligned to Locality Care Partnerships Investment £2m in prevention
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**11**
		Gaps in Assurance: (What additional assurances should we seek?)
Self assessment against ICS maturity matrix underway ICS Development Plan to be produced and implemented. Development of new Governance Framework in line with national guidance. Implementation of recommendations of PA Consulting review of system working Develop and implement Risk Share agreement		Need to have PDEG performance reports to CCG Finance and Performance Committee Need to develop Non-Executive oversight of system working

Objective: We will work as a strategic partner in Devon		Director Lead: Simon Tapley
Risk: AF7 – The system does not have robust mechanisms for identifying and responding to emerging risks		**Date Last Reviewed: 12/08/2019** **Reveiwer: Simon Tapley**
Corporate risks	100	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**5x4 = 20**	System Risk Register now in place through the STP Directors.
Current:	**5x3 = 15**	
Appetite:	**5x3 = 15**	**Rationale for risk appetite:**
		All statutory organisations have risk management processes in place
Controls: (What are we currently doing about this?)		**Assurances:**
Most workstreams and programmes of work have risks identified and are managing risk log Programme managers meeting reviews risks to individual programmes		Finance working group monitors financial risks SPDG monitors performance and delivery risks Clinical cabinet monitors clinical risks AEDB, Planned Care and ICM Groups also maintain overview of relevant risks
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**11**
System-wide risk and opportunity log being developed for Collaborative Board. This will include risks to system delivery identified by working groups. Links to specific organisational risks will be highlighted.		**Gaps in Assurance: (What additional assurances should we seek?)** ? Prevention Board Need PDEG report to Finance and Performance Committee Need to clarify reporting and management mechanisms for risks identified at local QSGs.

Objective: We will work as a strategic partner in Devon		Director Lead: Andrew Millward
Risk: AF8 – Our plans do not reflect the views of patients and the public as there has not been sufficient engagements		**Date Last Reviewed: 15/08/2019** **Reveiwer: Nick Pearson**
Corporate risks	107	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x2 = 8**	Robust mechanisms in place but wide range of issues and large population size mean that it is difficult to have comprehensive approach
Current:	**4x2 = 8**	
Appetite:	**4x2 = 8**	**Rationale for risk appetite:**
		Risk level will fluctuate with time (e.g. when large or contentious consultation underway) so plan is to maintain risk at current level by actions outlined.
Controls: (What are we currently doing about this?)		**Assurances:**
Increased resource in communications team undertake countywide/large scale work and provide support to local teams on smaller issues. Staff member returned from sickness leave and one new manager now in post. Three staff now in post. Engagement strategy/Plan agreed Engagement Panel meeting on monthly basis. CCG-wide communications strategy written and due to be agreed in September		NHSE Annual Assurance on engagement NED for Patient and Public Engagement Engagement Panel with patient representatives
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**11**
Implement engagement process for LTP Continue to develop all staff within the CCG to increase capacity supporting engagement Citizens panel (1,700 people representative of Devon population) now established and working Continue to support and develop PPGs to deliver their practice role and to increase their involvement in wider engagement initiatives		**Gaps in Assurance: (What additional assurances should we seek?)** Need to agree new arrangements for Engagement Panel reporting/accountability.

Objective: We will work as a strategic partner in Devon		Director Lead: Sonja Manton and Jo Turl
Risk: AF9 – We do not develop evidence-based proposals due to lack of capacity and capability within the CCG		**Date Last Reviewed:** **Reveiwer:**
Corporate risks	15, 17, 20, 24, 45, 82	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x4 = 16**	We do not have sufficient level of expertise in some areas (e.g. digital)
Current:	**4x4 = 16**	
Appetite:	**4x2 = 8**	**Rationale for risk appetite:**
		CCG has identified the need to develop this expertise or identify support from elsewhere
Controls: (What are we currently doing about this?)		**Assurances:**
Some individuals with high levels of knowledge and skills including those linking to national roles		Proposals developed and reviewed by delivery groups and LCPs QEIA process
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**8**
Need to review current levels of skills and experience in commissioning team Develop stronger links with AHSN and establish potential level of support Need horizon scanning mechanisms to translate national examples for applicability in Devon Talent Management Programme and ongoing staff development and PDAR.		**Gaps in Assurance: (What additional assurances should we seek?)**

Objective: We will work as a strategic partner in Devon		Director Lead: Simon Tapley
Risk: AF10 – We have not addressed the issues raised in the 2018 staff survey so staff leave or do not perform to their full potential		**Date Last Reviewed: 12/08/2019** **Reveiwer: Simon Tapley**
Corporate risks		
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4 x 3 = 12**	A lot of work has been undertaken to address staff survey concerns but impact of these changes is unknown
Current:	**4 x 2 = 8**	
Appetite:	**4 x 1 = 4**	**Rationale for risk appetite:**
		It is within the CCGs powers to address many of the issues raised in the staff survey and it is important to maintain key staff
Controls: (What are we currently doing about this?)		**Assurances:**
Each Directorate has reviewed staff survey and agreed actions Redesigned appraisal process Increased staff engagement and listening events Development and implementation of organisational Vision and Values Celebrate You initiative and successful first event		Remuneration and Workforce Committee HR Dashboard to SLT, Execs and Governing Body Quarterly joint meeting of Staff Partnership Forum and Execs
Control Gaps		
		Assurance Score:
		11
Mitigating Actions: (What should we do?)		**Gaps in Assurance: (What additional assurances should we seek?)**
Staff Partnership Forum is focused on addressing the results of the survey and is developing an action plan Implementing quarterly survey to obtain ongoing feedback Develop and implement Talent Management Programme		

Objective: We will improve the mental and physical health of the population		Director Lead: Sonja Manton and Jo Turl
Risk: AF11 – We have not evolved our integrated strategic commissioning arrangements sufficiently to develop plans to deliver improvements in population outcomes		**Date Last Reviewed:** **Reveiwer:**
Corporate risks		
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x4 = 16**	Integrated strategic commissioning is developing and there are examples of good practice but comprehensive framework is not in place
Current:	**4x4 = 16**	
Appetite:	**4x2 = 8**	**Rationale for risk appetite:**
		Arrangements are developing and good relationships in place
Controls: (What are we currently doing about this?)		**Assurances:**
ICE ToR agreed and has met 3 times ICE Workplan agreed Some limited commissioning for outcomes (e.g. ICP procurement) BCF plans in place Some Section 75s in place Several Joint roles appointed and working well Good working relationships between individuals		ICE monitors progress and reports into CCG through AO and other Execs. Papers from ICE shared with Governing Body.
Control Gaps		**Assurance Score:**
		11
		Gaps in Assurance: (What additional assurances should we seek?)
		Need to develop Non-Exec oversight for Integrated Strategic commissioning
Mitigating Actions: (What should we do?)		
Further development and delivery of ICE workplan Developmental time for ICE Need to refresh and embed Outcomes framework		

Objective: We will improve the mental and physical health of the population		Director Lead: Sonja Manton and Jo Turl
Risk: AF12 – We have not invested sufficiently in prevention so we do not achieve improvements in our population health		**Date Last Reviewed:** **Reveiwer:**
Corporate risks	77, 92	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**5x4 = 20**	Low levels of investment in prevention mean that limited progress is being made. Low level of system commitment is making it difficult to address this.
Current:	**5x4 = 20**	
Appetite:	**5x2 = 10**	**Rationale for risk appetite:**
		Prevention is key to ensuring long term and sustainable change in population health
Controls: (What are we currently doing about this?)		**Assurances:**
£2m investment in prevention 40 bids received for this money Prevention workstream co-ordinating wider prevention agenda with projects embedded in other workstreams System SRO appointed Dedicated PMO resource for programme management Significant progress with some projects e.g. Active Devon		PDEG reporting to the CCG through the Accountable Officer and other Executives
Control Gaps		
		Assurance Score:
		8
Mitigating Actions: (What should we do?)		**Gaps in Assurance: (What additional assurances should we seek?)**
Programme needs to be expanded to incorporate all requirements of LTP Need to increase system commitment to prevention to ensure input from all organisations Need to clarify investment for future years to support projects requiring recurrent funding. Ensure that Prevention is regularly on PDEG agendas and sufficient time available for discussion		GB needs improved oversight of prevention programme

Objective: We will improve the mental and physical health of the population We will make the best use of resources		**Director Lead: Sonja Manton and Jo Turl**
Risk: AF13 – We are not targeting our resources at the areas that most need them so health inequalities are exacerbated		**Date Last Reviewed: Reveiwer:**
Corporate risks	75, 79	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x4 = 16**	No agreement in place on the allocation of resources based on population need
Current:	**4x4 = 16**	
Appetite:	**4x2 = 8**	**Rationale for risk appetite:**
		Evidence available to support decision making
Controls: (What are we currently doing about this?)		**Assurances:**
Framework in place for development of Locality Care Partnerships LCPs have developed workplans based on local population health need		Finance and Performance Committee review financial spend and delivery
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**8**
Need to agree process for moving to resource allocation based on health need Need Governing Body decision to accelerate shift of resource to primary and community care. Need to develop CCG and System approach to Population Health Management including access to shared information datasets and developing skills of commissioning staff.		**Gaps in Assurance: (What additional assurances should we seek?)** Mechanisms and information required to monitor spend at locality level not yet developed.

Objective: We will make the best use of resources		Director Lead: Jo Turl
Risk: AF14 – There is insufficient workforce capacity and capability in Primary Care (GPs, nurses and pharmacists) to meet demand		**Date Last Reviewed:** **Reveiwer:**
Corporate risks	83, 97, 105, 108	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**5x4 = 20**	Recognised lack of capacity in several areas impacting on ability to deliver
Current:	**5x4 = 20**	
Appetite:	**5x3 = 15**	**Rationale for risk appetite:**
		Primary Care Networks offer opportunity to develop new ways of working.
Controls: (What are we currently doing about this?)		**Assurances:**
GP Strategy agreed Workforce strategy agreed Locality Workforce Groups GP Provider Collaborative Groups GP Framework associated with long term plan reviewed to identify Primary Care Networks agreed GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments Practice resilience toolkit developed Heat map devised to identify vulnerable GP practices Regular resilience meetings with Devon LMC		Primary Care Commissioning Committee Primary Care Operational Group STP and Workforce Groups Regional Workforce Board
Control Gaps		**Assurance Score:** **8**
		Gaps in Assurance: (What additional assurances should we seek?)
Mitigating Actions: (What should we do?)		
Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. Developing role of Primary Care Networks		

scoring

This score is used to inform the CCG of the degree of reliance they can place on an item of assurance.

1	Does this assurance provide evidence that the controls are achieving the desired outcome?	Yes - proceed to Section 2 No - Do not proceed with this assessment and the score will

2	**Timeliness**		**Score**
2a	If the information is older than 6 months then the adequacy score automatically becomes 0, otherwise proce		
2b	How old is the most recent information on which the Assurance is Within the last month between 1 and 3 months between 4 and 6months		 **3** **2** **1**

3	**Scope of Positive Assurance**	**Score**
3a	Does it provide positive assurance on all aspects of the issue? For example, CCG is fully compliant / achieving the target.	**3**
3b	Does it provide partially positive assurances? For example, compliance in some areas.	**1**

4	**Sufficiency**	**Score**
4a	Is this a key/definitive source of assurance for this area? For example, CQC, formal reports, data.	**3**
4b	Is this one of a number of sources of assurances contributing to an overall picture?	**2**
4c	Is this an indicator of likely achievement of the outcome rather than evidence of actual achievement?	**1**

5	**Basis for Assurance**	**Score**
5a	What is the Assurance based on? Evidence - Audited externally Evidence - audited internally Self-assessment - externally validated Self-assessment - without audit or validation	 **4** **3** **2** **1**

Score 0	No assurance
Score 1 - 7	Weak assurance. Very limited reliance can be placed on this as an indicator.
Score 8 - 10	Moderate assurance. Limited reliance can be placed on this as evidence.
Score 11 - 13	Strong assurance. This evidence can be strongly relied upon.

Risk Assessment Scoring Guidelines

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

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

Assessing the likelihood/probability of risk

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

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

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

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

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

of Risk Appetite and Acceptable Risk Score

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

NHS DEVON CCG
Integrated Risk Report (High Risks Only)

Date produced: 03-09-2019 - 10:47

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners	Assurance Score
2	We will continue to commission safe, effective and accessible services	There is a risk that the 95% of people seen 4hour wait standard in A&E is not met at Torbay and South Devon NHS Trust which may impact on achievement of national standards and patient experience (and risk of handover delays from the ambulance to A and E department - Ambulance Handover issue see Risk 110). (HISTORIC ID: 91)	Revised trajectory agreed. Following CQC letter, revised action plan in place. Monitored through fortnightly urgent care improvement and assurance meetings - CCG attends. Weekly performance metrics produced by trust to show progress against time to initial assessment, time to treatment and frequency of observation. SRG agreed trajectory for improvement on 4 hour wait with trust (combined ED and MIU). STF trajectory agreed. Improvements monitored through TSD flow board and AE delivery board. Weekly performance metrics produced by trust to show progress against time to initial assessment, time to treatment and frequency of observation. Daily monitoring of performance against STF trajectory on daily escalation briefing. Jun 18 - Improvement plan drafted Learning has been gathered from local system hard resets. [Control Gaps] No gaps identified	20 (L=5 x I=4)	Risk Opened: 11/02/2014 Reviewed: 15/08/2019	[11/07/2019] 11.07.19 Have reviewed risk score and increased to 20. Gold calls superseded by weekly exec led assurance and improvement review meetings. , [02/05/2019] April 2019 - Revised processes in Trust to deliver improvement. System leads appointed and three groups (emergency floor, wards and home first) convened to drive change, incorporating recommendations from ECIST diagnostic (Jan 19) and GIRFT (Aug 18). 0.5 WTE performance role funded by CCG in Trust to drive change. , [09/10/2018] Jun 18 - Improvement plan has been drafted with aim of improving performance within the 4 hour wait for ED.Learning has been gathered from local system hard resets. Oct 18 - work continues on this , [04/06/2018] Apr 18 - OPEL 4 declared on 4 occasions (10 days in total) in March 18. Performance was below target at 73% (95% was the national target for March). May 2018 - The Trust held an extra-ordinary meeting of the patient flow board to discuss priorities to "re-set" the local urgent care system., [25/04/2018] Apr 18 - OPEL 4 declared on 4 occasions (10 days in total) in March 18. Performance was below target at 73% (95% was the national target for March).,	Monthly reporting to Commissioning and Finance Committee, Senior Leadership Team and Governing Body in place. Daily reporting to CCG On Call Director and others as part of daily escalation processes. Weekly SIT reps to NHS England Board to board meetings. August 2016 onwards urgent care board becomes A&E delivery board, chaired by Liz Davenport System Lead for UEC. Patient flow Board meeting monthly to discuss issues. [Assurance Gaps] No gaps identified	Executive Lead: Sonja Manton Owner: Christine Branson	8

100	We will work as a strategic partner in Devon	There is a risk that the population of Devon will not receive timely access to 999 emergency ambulance care when needed. The impact of this is upon public and professional confidence in the system; patient experience and safety and CCG reputation. (Previously linked to mirrored risk 101 which is now closed) (HISTORIC ID: Na)	August 2019 - Confirmation that specific Devon call stack information not available (info is made available only as the entire SWASFT footprint). Agreed therefore to increase risk level to 20 (L5 x I4) to coincide with the SWASFT assessment of the risk. Quality Assurance Committee have requested SZ to discuss their concerns about availability of information with SWASFT (SZ) July 2019 - CCG attending for the single item at SWASFT QSG on 8 July - Mark Elster now attending (SZ) June 2019 - The call stacking risk has been reduced by SWASFT to 20. It is now accepted that the system wide* collaboration and application of mitigating actions has decreased the likelihood of call stacking. This will continue to be assessed on a daily basis by SWASFT with regular review by the SWASFT Executive. NB: *System wide = SWASFT footprint. An NHSE/I Quality Surveillance Group meeting has been planned for July where the risk will be discussed further. SZ unable to attend the July QSG as on leave but SPo will attend for this item. An action from the Quality Assurance Committee was for this risk to be reviewed including the scoring. Score reduced to 16 as we know the call stack exists, that is does impact upon response times and could cause significant harm but there is no recent evidence of this (SZ) June 2019 - The call stack risk was discussed in some detail at the May SWASFT QAG. SWASFT are reviewing their trigger points currently, liaising with other ambulance services to see how they manage (and score) the risk - they want to benchmark themselves, but there is a reluctance to share information. The CCG were made aware of a further three deaths that may be attributable to call stacking across the SWASFT footprint (none in Devon). A further system QSG is being planned via NHSE/I. It was agreed that although SWASFT continue to rate this at 25 for the time being, that individual CCGs can rate differently according to their own evaluation of the risk in their area. SZ is satisfied that SWASFT are taking actions to bring this risk down, and are under considerable pressure to do so. In terms of lower level harm arising from call stacking, SZ spoke with Deputy DoN & Chair of the Dorset SWASFT QAG who advises that Dorset are not doing anything in particular around looking at lower level risks. SWASFT produce a regular report on long waits, and we received the most recent reports yesterday. They randomly choose long waits to review according to agreed thresholds. These reports are not indicating harm. However it was recognised that they are only reviewing the patient to the point that they are closed by SWASFT and so this does not account for any harm that might be detected at a later point. We have therefore agreed that some full end to end reviews are needed. The CSU will be planning a programme of end to ends on different themes, this one included. We along with Kernow will be doing end to end on Health Care Practitioner calls (SZ) [Control Gaps] System ownership of risk	20 (L=5 x I=4)	Risk Opened: 21/01/2019 Reviewed: 21/08/2019	[21/01/2019] CCG review of SIRIs/Complaints and Yellow Cards pertaining to the risk June 2019 - the review has take place and action can now be closed (SZ), [21/01/2019] CCG leading on aspects of Joint Commissioner Action Plan June 2019 - this is ongoing and continues (SZ),	May 2019 - the CCG is working closely with this provider in relation to patient safety issues around gaps in service and the different models of care including changes to workforce such as nurse practitioners (SW) April 2019 – Two out of the four EDs have undertaken a deep dive end to end review of handover delays (60 mins+) and the remaining two have been prompted that this is an outstanding action: findings will be reported back to the Devon A&E Delivery Board in May 2019 (SZ) [Assurance Gaps] System ownership of risk	Executive Lead: Lorraine Webber Owner: Sarah Zanoni	11
108	We will make best use of resources	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand and capacity) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system could be affected. This risk replaces risk 09 (SDT) and 68 (NEW Devon) (HISTORIC ID: Na)	GP Strategy STP Workforce Group & Strategy Locality Workforce Groups GP Provider Collaborative Groups Regional Workforce Board 100 day plan in design for Plymouth system Regular review at Primary Care Operational Group Regular review at Primary Care commissioning committee [Control Gaps] Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support In part a lack of evidenced change to new models	20 (L=5 x I=4)	Risk Opened: 29/05/2019 Reviewed: 07/08/2019	[07/08/2019] Feb 19 - The GP framework associated with the long term plan, having been released, is being reviewed for opportunities to further mitigate this risk Apr 19 - Work continues to support practices in working closer together and with wider parts of the system and also building on the skill mix development as outlined in the contract reform GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments 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. ,	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	There is a risk to the CCGs' reputation for underperformance against some key constitutional standards: 52 week waits Diagnostics 62 day cancer standard A and E 4 hour waits The impact of this would be that the CCGs' credibility with regulators and public would be affected, leading to increased levels of scrutiny and assurance of how we are enabling the system to meet these standards, potentially diverting more resources from delivery and attracting external intervention. (HISTORIC ID: Na)	For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. 26/07/2019 - The CCG has a single point of focus and escalation via the head of performance in each locality these heads of performance are responsible foe collating information around referrals, contract performance against the plan and remedial actions to deal with referral growth deviation from contract activity levels and actions to improve performance at trust and system. Monthly reporting at place will now feed into SPG. [Control Gaps] none identified	16 (L=4 x I=4)	Risk Opened: 06/06/2019 Reviewed: 31/07/2019	[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. [Assurance Gaps] none identified	Executive Lead: Sonja Manton Owner: John Finn	
111	We will make best use of resources	There is a risk that the CCG will not be able to deliver its agreed control total for 19/20 as a result of the £80m savings target held by the CCG which includes £45m of system savings primarily directed at mitigating acute activity growth and cost savings as a result of transformation of existing services/practices. (HISTORIC ID: Na)	Contractual review mechanisms have been established to identify and agree activity variations as a result of reduced growth and or service change. A Risk Sharing agreement has been agreed with all local acute providers on how the £45m risk is managed in year. [Control Gaps] A formal PMO led Reporting/challenge mechanism is in the process of being established to capture the risk of the delivery of all savings programmes.	16 (L=4 x I=4)	Risk Opened: 31/07/2019 Reviewed: 28/08/2019		Regular monthly reporting to the Finance Committee/Governing body on the inherent risk in the savings plan. Monthly finance working group meetings with system partners to discuss progress on delivery of the system savings target. [Assurance Gaps] None identified	Executive Lead: John Dowell Owner: Kevin Wheller	
97	We will make best use of resources	There is a risk that the Mayflower procurement will not be successful within the global sum. The impact of this is that there could (a) be no provider, (b) continue with emergency framework or (c) have to top up the contract value. (HISTORIC ID: Na)	Currently going through engagement and development phase of new procurement, which is being linked into the wider Western system services procurement [Control Gaps] None	16 (L=4 x I=4)	Risk Opened: 27/11/2018 Reviewed: 07/08/2019	[07/08/2019] 18 Dec 18 - market engagement sessions held with providers. Ability to identify opportunity and issues to inform procurement process. 29 Jan 19 - Work is being undertaken to look at the ability to align this with the Integrated Care Provider procurement with the aim to mitigate the risk. Apr 19 - work on procurement continues May 2019 – following contract handback from Mannamead surgery, decision to integrate into the Mayflower group and procure as part of a wider contract. Patient engagement includes letter to all patients over 16 and engagement events at the practice. Letters also sent to all registered patients of Mayflower. Interim provider – Access Health Care Ltd - to commence service delivery on 1 July 2019. New Contract due to commence 1 April 2020. 20 Jun 19 - risk reviewed at Primary care operational group. Risk owner to be amended to Siobhan Cambridge. No further update 9 Jul 19 - Mannamead contract change occurred without issue on 1 July. Invitation To Tender imminent for procurement; CCG leading as NHSE have stepped back to an assurance role 7 Aug 19 - Procurement now live for 7+3 APMS contract ,	Joint Operational Group between CCG and NHS England Oversight Group involving Plymouth City Council, CCG and NHS England Groups now stood down as procurement is live and led by CCG. NHSE has an assurance role Governance structure - linking into Integrated Care Provider Lot 2 of ICP procurement [Assurance Gaps] None	Executive Lead: Jo Turl Owner: Siobhan Cambridge	11

102	We will continue to commission safe, effective and accessible services	There is a risk that the number of DPTs overdue RCA Serious Incident (SI) reports might affect the embedding of learning and improvement. The impact of this to the CCG is a lack of assurance that patient safety improvements from incident learning are identified and actioned in a timely way (Previously linked to mirrored risk 103 which is now closed) (HISTORIC ID: Na)	July 2019 - A Deep Dive is planned on DPT Serious Incidents and the ToR are currently being written for the visit. Report from the Deep Dive to go to Quality Assurance Committee (QAC). If NHSI are unable to meet the timescales and attend with Devon CCG the report to be shared with them separately. Devon CCG working on dates with DPT /NHSI and SP to provide a verbal update at the July QAC (SD) June 2019 - Devon CCG & DPT met on 30/05/19 to discuss the current position in relation to the outstanding SI's. DPT have considered not just the immediate ways to address the backlog but also in how to support the team long term, in the standard and detail of completing the reports. This should reduce the amount of time for further information being requested. DPT are looking at delivering training for the RCA team with regard to this and the CCG have offered to support with the training. In addition, the opportunity for real time feedback has been offered by the CCG if DPT have any questions regarding individual reviews. Work has been done to streamline the SI process particularly around S42 investigations so not to duplicate work and to free up time for action implementation. Further work has also involved clinical teams taking responsibility for developing the action plans as a result of investigations rather than the RCA Lead. This means that there is increased ownership by the clinicians, greater opportunity to embed learning and drive to complete the actions. Several actions have been agreed with the CQC to help support the reduction of DPT's overdue SI status to no more than 10 (IL) [Control Gaps] Assurance still lacking at QCiC due to the written report on the management of SI's not being submitted – CCG chasing	15 (L=5 x I=3)	Risk Opened: 25/01/2019 Reviewed: 02/09/2019	[03/06/2019] The CCG will have received the revised S42 reports (currently 17) by Friday 14th June 2019 with the agreed new summary report action plan. , [03/06/2019] CCG to have received all 30 SI's requiring FIR information by Friday 7th June 2019 and for these to be sent onto the original reviewers, [03/06/2019] DPT to send by the 3rd June 2019, the CCG an updated spreadsheet with information on SIs where they have a difference of opinion on ie: DPT report they have been closed, [25/01/2019] Written report around the implementation of improvements including the SI process to be provided to QCIC in February 2019 Rationale for closure: Written report received from DPT that includes the SI process and trajectory and added to the agenda for the next Quality Assurance Meeting (previously QCiC). In addition SP meeting with the DDoN on a monthly basis to track improvements, [25/01/2019] Request to provider to provide a trajectory for reducing overdue numbers. Assurance requested about the quality of 72hr reporting. Provider and CCGs to monitor these. Rationale for closure: Written report from DPT including the trajectory received and on the agenda for the next Quality Assurance Meeting as required by this risk. In addition SP meeting with the DDoN on a monthly basis to track improvement ,	August 2019 - a Deep Dive was undertaken in August 2019 into SI process at DPT. This was jointly undertaken between the CCG, DPT & NHSE/I. A full report will be presented to QAC in September 2019. Whilst some assurance was sought, subsequently recommendations and actions are ongoing and therefore the risk score remains currently. In addition weekly communication with the provider continues in order to seek assurance against the trajectory for improvement (SW) June 2019 - Devon CCG & DPT met on 30/05/19 to discuss the current position in relation to the outstanding SI's. DPT have considered not just the immediate ways to address the backlog but also in how to support the team long term, in the standard and detail in completing the reports. This should reduce the amount of time for further information being requested. DPT are looking at delivering training for the RCA team with regard to this and the CCG have offered to support with the training. In addition, the opportunity for real time feedback has been offered by the CCG if DPT have any questions regarding individual reviews. Work has been done to streamline the SI process particularly around S42 investigations so not to duplicate work and to free up time for action implementation. 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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: Audit Committee 11 September 2019	Date of formal approval Audit Committee 11 September 2019	Review Date:
Date Issued:		Version *2.3 approved*
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
V2.3	12 September 2019	Approved version for circulation and upload to website

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

NHS
Devon
Clinical Commissioning Group

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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).

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 potential fraudulent activity or practice, to report these. CCG staff must inform the Chief Finance Officer or the Anti-Crime Officer Alice Lee, Alicelee1@nhs.net 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 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. 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.

6.5. 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	Individual has a close association with an individual who

consequences of a commissioning decision	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	

6.6. 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)

6.7. 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.

6.8. 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.

6.9. 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.

6.10. 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).

6.11. 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 .

6.12. 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

6.13. 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.

6.14 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.

6.15 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 interests 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 CCGs 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 and Performance 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 bidders conflicts on the register of healthcare procurement decisions, as it may compromise the anonymity during the procurement process. Commissioners should 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 (ie. 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 for the sponsorship of activities and joint working with industry 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 If in any doubt, staff should seek advice from their line manager, the Governance Team or Local Counter Fraud Specialist on 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;
- CCGs 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 t 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 CCGs websites, as this will provide guidance on how to seek advice. Alternatively contact the CCG Prevent Lead: safeadultnotifications.sdtccg@nhs.net Tel:01803 652535

14.2 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
- 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 Northern, Eastern and Western Clinical Commissioning Group (CCG) (including rebate schemes);
- 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
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/).

NHS
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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 acro ss organisations and vice versa

Declaration of Interests (DOI) Flow Chart

Annual Declarations

Annual declaration of interest forms must be completed by:

All CCG employees, including:
- Staff on sessional or short term contracts
- Any students, trainees and apprentices;
- Agency staff and seconded staff

Members of the governing body:

Governing Body committee and sub-committees.

All members of the CCG
Any individual directly involved with the business or decision-making of the CCG. ie GP leads

Register to be reviewed and updated by the Governance Team

Access by committee administrators to DOI SharePoint list to ensure table of DOI for each committee is included in the committee board pack.

Amendments / Changes

New interest to declare

Amend a current declaration

Newly appointed to the CCG

All staff **must** declare any interests.

Declarations of interest should be made as soon as reasonably practicable and by law **within 28 days** after the interest arises (this could include any interest an individual is pursuing)

The declaration of interests form must be completed on appointment

Copy to be placed on personnel file with HR and emailed to the Governance Team

All updates, changes and new staff declaration of interests must be sent to the respective org corporate.sdtccg@nhs.net or D-CCG.Governance@nhs.net for NEW Devon

The register of interest is maintained and updated by the Governance Team.

During a meeting

Interest in an item on the agenda

Is the interest already included in the register?

Have you become aware of a new interest before the meeting?

Declare interest to Chair and during meeting before item discussed

Declare an interest as soon as you are aware

What type of interest do you have?
- Financial interest
- Non-financial interest – professional
- Indirect interest
- Non-financial interest - personal

Chair of the meeting will determine if there is a conflict and the course of action to be taken. The action **MUST** be recorded in the minutes of the meeting and the Governance Team informed of the update/change.

Changes to the recorded declaration of interest to be updated within 28 days

The Governance Team must be informed of new interests or amendments.

Appendix D

NHS
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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 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.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee

Date of Governing Body: 12 September 2019

Dates of Committees covered in this report 12 September 2019

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

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

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

- **Quality Assessment Framework (QAF) – including Flash Reports: Devon Partnership NHS Trust (DPT); Torbay and South Devon NHS Foundation Trust (TSDFT); Children and Family Health Devon; University Hospitals Plymouth NHS Trust (UPHNT); System issues were identified as: Workforce; and Diagnostic Waiting Times**
- QAC noted the key issues outlined in the flash reports - and that quality surveillance continues.
- TSDFT: QAC received assurance that the Patient Safety Quality Team continue to undertake quality surveillance to assure that safe systems are in place within the Emergency Department.
- Children and Family Health Devon: QAC noted partial assurance and requested that further assurance is provided at the October meeting.
- UHP: Where there are waiting lists for neurosurgery, options for patients to have a choice of provider are being explored and QAC were assured by the provider assurance and risk processes that are in place.
- System: Workforce: QAC noted the positive shift in the approaches to addressing the position of a limited workforce in place across Devon, and the work towards achieving the identified requirements across the system. QAC noted that regular assurance on progress is required.
- System: Waiting times for diagnostics pathway: work continues to ensure that the impact from waiting times arising from the diagnostic pathway remains safe.

- **Child Death Review Process**
- QAC received a report on the Child Death Review Process for information. QAC noted the contents of the report, focusing particularly on the statutory requirement in relation to the CCG's involvement in the Child Death Overview Panel (CDOP). Further assurance will be required to support the delivery of the identified actions.

- **Deep Dive into serious incident processes at Devon Partnership NHS Trust (DPT)**
- QAC noted the contents of the report noting the significant improvement in the overall position, and the regular monitoring processes in place. QAC noted that the next stage of the quality improvement proposal outlined by DPT will be reported monthly to QAC.

- **Enhanced Health in Care Homes**
- QAC noted and are assured by the information presented in the report. The committee noted that in some parts of the county this approach is already well embedded and relationships with homes are good, so focus should be targeted at a smaller number of homes where this work is more pressing.

- **Mental Health Gap Analysis**
- QAC noted the contents of the report and are supportive of the recommendations outlined. QAC supported the future format of a Patient Safety Quality (PSQ) paper to contain information about DPT and Livewell Southwest.

- **Translation and Interpretation Services**
- QAC noted the contents of the report and are supportive of the recommendations - including to formally support the Equality Co-operative in achieving these recommendations.

Reports received and noted

- Joint Clinical Executive Group notes of meeting

Risk Register Review (changes and areas of concern)

- QAC received a report that effective risk management processes are in place to identify, assess, manage and mitigate risk and inform of any changes since the last meeting of the QAC 29 August 2019.
- QAC noted that the risk data had been extracted on 27 August 2019
- QAC noted that there were currently 25 risks aligned to QAC. Of those risks, two risks are categorised in the very high category.
- QAC noted that Risk 100 has been reviewed and the risk score increased as requested by NHSE/I and to mirror the SWASFT score.
- QAC noted that Risk 102 - deep dive paper is on the September QAC agenda recommending that the risk levels remain the same score of 15. QAC agreed to keep score the same and are partially assured by the deep dive.
- QAC noted that 1 risk (risk 82) has not been updated in a timely manner. The report noted that this risk requires urgent review, and this has been brought to the attention of the responsible director. QAC declined to close this risk in April 2019. QAC also noted that there are several risks which were last reviewed in July 2019.
- QAC noted that there were no new risks which had been recommended to be added, relevant to this committee.
- QAC noted that there are 5 risks being reviewed by the commissioning team in September and if these risks are recommended for closure, they will be received by the QAC at the October meeting.

Committee Decisions

- None.

Recommendations for Governing Body

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

Recommendations for other Committees
• None
Terms of Reference or other committee effectiveness issues
• None.

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Quality and Performance report				
Date of committee: **Date report produced: 13/09/2019**				
Author (s) Name and Title: **Lorraine Webber – Associate Chief Nursing Officer (South & West) South** **Kelvin Grabham: Associate Director of Business Intelligence** **Karen Helliwell: Senior Information Specialist** **Contact Details: karen.helliwell@nhs.net**		**Name and Title:** **Kelvin Grabham – Associate Director of Business Intelligence** **Lorraine Webber – Associate Chief Nursing Officer (South & West) South** **Contact Details:** **Report Approved by:** **Kelvin Grabham – Associate Director of Business Intelligence** **Date 13/09/2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
For information and assurance				
Executive Summary: This report provides the latest information on key quality and performance indicators including those contained in the NHS Constitution. The report includes as an appendix the Improvement and Assessment Framework (IAF) indicators for the latest quarter.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations				

must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.

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

None

Key recommendations and actions requested:

For information and assurance

Impact on Strategic Objectives

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

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

	If Yes, please give details	No
Quality of Services	For information and assurance	
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.

Governing Body – Quality & Performance Report

September 2019

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Summary

Performance summary

Based predominantly on July 2019 data Devon continues to perform well against the mental health standards, including: IAPT waiting times and recovery and early intervention. Delayed transfers of care remain within target.

However, Devon continues to delivery below local trajectories for many of the key constitutional standards, including: referral to treatment times, diagnostic waits, cancer waiting times and waiting times in A&E departments. Devon are also regional and national outliers for many of these measures.

In order to improve services for patients in Devon the Governing Body agreed in August 2019 to focus on three particular areas of performance: eliminating people waiting longer than 52 weeks for their treatment, access times for diagnostics (as this will also positively impact those who may or do have cancer) and waiting times in A&E.

Referral to treatment times

In July performance against the 18-week standard has decreased from 80.4% to 79.8% against a trajectory of 81.2%, falling under 80% for the first time. There are 225 people waiting over 52 weeks against a trajectory of 146 (up from 199 last month).

At the System Performance Group (SPG) in September, a number of system wide actions and improvements were agreed that will improve the 52 week position:

1. Agreement to immediately implement a central process for managing people waiting more than 52 weeks through Devon Referral Support Services (DRSS). This will mean that all people waiting more than 52 weeks will be managed collectively and we will make best use of existing capacity (NHS and independent sector). This commenced on Monday 16th September and will be monitored weekly at executive level. We estimate this to positively impact performance by approximately 20%.

2. The medical directors have reviewed the protocol for patients who are on an elective pathway but do not wish to receive their treatment in the foreseeable future. We have agreed to implement this for those patients waiting more than a year by the end of October in all Trusts. We estimate that approximately 60 patients will be given the opportunity to postpone treatment and be invited to contact the Trusts directly when they are ready for surgery.

The forecasts for the number of people waiting for longer than 52 weeks will be remodelled and performance against this will be managed monthly through SPG.

Further proposals that are being worked on and will be discussed in October include modelling of total capacity needed from the independent sector on an annual basis in order to agree block arrangements with these providers to provide certainty of capacity and value for money.

Diagnostic waiting times

Performance against the 6-week diagnostic standard improved slightly from 13.9% to 13.4% in July against a trajectory of 6.7% and an England average of 3.8%. Torbay and South Devon FT (TSDFT) remain within their trajectory though still well above the standard, and North Devon Healthcare Trust (NDHT) have now moved significantly closer to their trajectory, but University Hospitals (UHP) and Royal Devon and Exeter (RD&E) remain significantly above.

The main areas of concern remain long waits for MRI, CTs and Endoscopies.

MRI/CT:

RD&E's plans for supporting increased number of patients needing contrast MRI were presented. Access to CT and MRI for all four Trusts is expected to be stabilised. It was therefore felt that our focus and investment for additional capacity needs to be on endoscopy to have most impact on performance for diagnostics and cancer.

Endoscopy:

At SPG in September, it was agreed to invest in additional capacity for endoscopy through:

1. Commissioning additional capacity (£0.5m) from Care UK to provide endoscopy support for UHP. Proposals for this were agreed in September and will be in place during quarter 3.

2. Commissioning additional endoscopy capacity (£1.5m) for RD&E and TSDFT for 6 months. Operational details for this additional capacity are expected to be finalised this month and progressed before next SPG in October.

The revised forecasts of the impact that these interventions will have on the number of people waiting for longer than 6 weeks for diagnostics will be produced in the next month and managed monthly through SPG from implementation of these.

A&E waiting times

Performance against the A&E 4 hour standard remains variable with continual variation in performance by a few percentage points each month and a lack of consistent improvement. Following an overall improvement in July, we have seen an decrease in performance against the 4hr standard from 87.7% to 85.2% against a trajectory of 89% in August. All four providers are now below their trajectories and have felt periods of pressure and heightened escalation over the summer period.

While all areas are focusing on high priority areas of impact, focus at the moment in relation to urgent care is predominantly in Western and Southern Devon.

Western Devon:

At UHP the main problem over the summer period has been a lack of flexibility in staffing in escalation, though the recent recruitment campaign for nursing staff in particular is likely to improve this in the Autumn and in preparation for winter.

The priority areas of focus for UHP are:

- Recruitment to nursing establishment
- Bed configuration and protecting planned care capacity
- Changes to support frailty differently through the Emergency Department (ED)
- Weekend and earlier in the day discharges

Priority areas of focus in the community are:

- The CCG have commissioned additional hours from the Community Crisis Response Team (CCRT), in particular towards the end of the day
- The CCRT will now take direct referrals without the need for a GP assessment
- GPs supporting the top admitting care homes through a Local Enhanced Service (LES) to meet patient needs without needing to admit to ED
- Launch of the Plymouth Primary Care Prospectus with a different offer to practices to support people in the community

These actions will be reported back through the local Accident and Emergency Delivery Board.

Southern Devon:

On a weekly basis, the South Devon and Torbay system continues to have assurance calls to assess operational performance and improvement plans. This continues to focus heavily on actions to improve the experience for people at weekends, and notably the number of weekend discharges.

Following a deep dive into urgent care demand and performance at the local System Improvement Board (SIB) in August, it was agreed to focus on a smaller number of priorities that will have high impact. This will be presented back to the SIB in September.

Areas of focus include:

1. Working with SWAST to put in place alternatives to conveying patients to ED where appropriate (in particular for frailty) and enhanced hospital ambulance liaison. It is expected that this will reduce the number of ambulance conveyances and time that ambulances are unnecessarily held at the hospital.
2. Working with community teams and primary care networks, in particular in Torbay, to put in place an enhanced and resilient community urgent care offer in place to provide a reliable alternative to ED..
3. Same Day Emergency Care – ensuring that the space in the ED remains protected and that sufficient capacity within the hospital is created to resiliently maintain this. We would want to reduce the number of people attending the ED that are admitted to hospital to be closer to national average.
4. Focused re-set of process to ensure timely discharge for those requiring personal care or care home placements in the first instance. Regular reviews of those people who have been in hospital for longer periods of time has shown that this is a particular issue.

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

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

Children & Young People (CYP)

The CCG continues to seek full assurance regarding the new provider's (Children and family Health Devon) quality and safety governance framework. Quality information is not yet fully reported by the new provider, as systems and processes continue to be embedded. A contract review meeting is booked for September 2019, incorporating safeguarding, quality and performance assurance. The CCG has written to the provider with the level of assurance required for September's meeting.

National Cervical Screening:

The CCG have been notified by NHS England that Capita, the current provider of cervical screening services have investigated an administration error that led to emails and letters sent to them being incorrectly processed. A full review found that a small number of women missed an invitation to attend their appointment. Those who did experience delay and who need an invitation for screening have been contacted and will be able to access support from their local GP, who have also been contacted. There is no current evidence that this incident has led to any harm and the advice from Public Health England is that the risk posed by the delay in sending these letters remains low. Changes are now being undertaken in relation to the management of the cervical screening

administration, and the transition to an inhouse service has begun and will be completed in the next few months.

Special Educational Needs & Development (SEND)

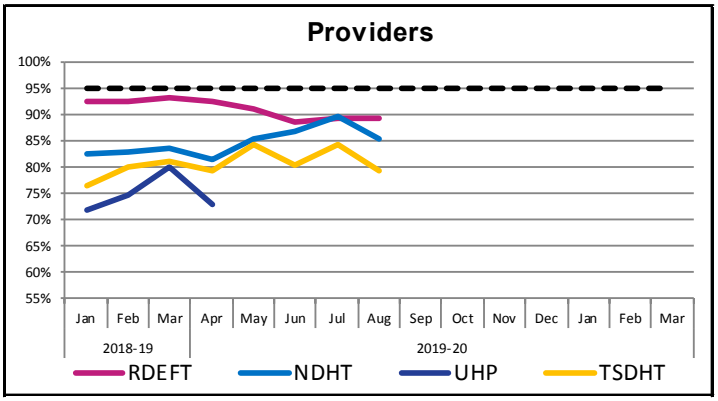
Following the published report in February of the first joint local area Special Educational Needs and Disability (SEND) inspection in Devon, a 'Written Statement of Action' has been submitted and this has now been approved by the Care Quality Commission (CQC) and Ofsted. Progress against the action plan will be monitored through the SEND Improvement Board and the Devon Children & Families Partnership Board.

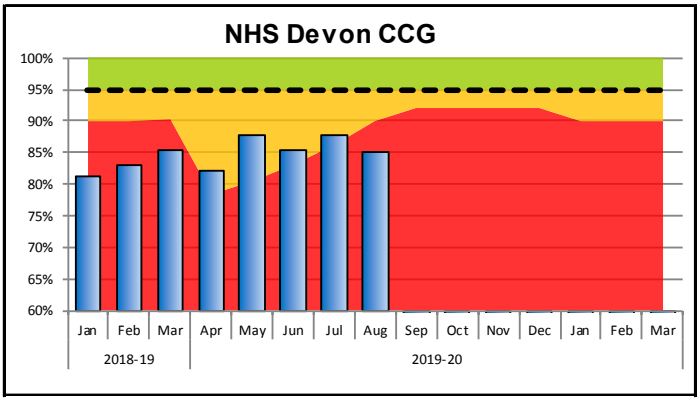
NHS Constitution Performance

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

Trust	Trajectory	August	2019/20
RDEFT	93%	89.0%	90.0%
NDHT	86%	85.4%	85.7%
UHP	86%	N/A	N/A
TSDFT	90%	79.3%	81.5%

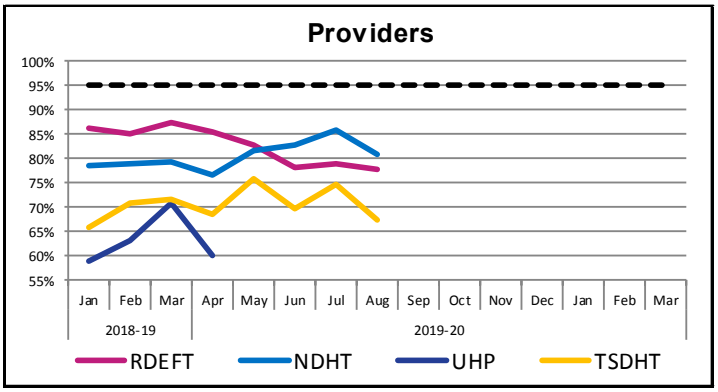
CCG	Trajectory	August	2019/20
NHS Devon	85%	85.2%	85.4%
ENGLAND		87.8%	87.2%

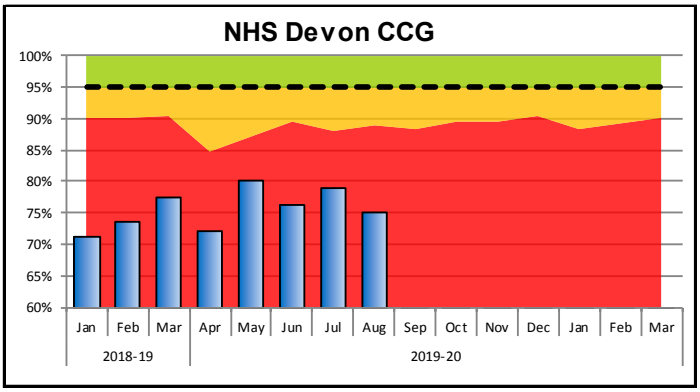




Trust	Trajectory	August	2019/20
RDEFT	93%	77.9%	80.6%
NDHT	86%	81.0%	81.7%
UHP	86%	N/A	N/A
TSDFT	90%	67.4%	71.3%

CCG	Trajectory	August	2019/20
NHS Devon	85%	74.9%	76.2%
ENGLAND		81.3%	80.3%





Performance Commentary

In August the STP 'all types' position was 85.2%, down from 87.7% in July, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. NDHT fell to 85%, RD&E remained at 89% and TSD fell from 84% to 79%.

Quality Commentary and Improvement Actions

The Devon system has continued to experience increased demand impacts within the urgent and emergency care pathways, and this has had significant impact in the South and West localities which have regulatory oversight. The CCG is therefore continuing with additional quality reviews including a rolling programme of observational audits which are being undertaken across all localities.

Information around patient experience, safety and effectiveness of care from this additional surveillance is shared with the providers and informs the local system escalation calls that are in place in these localities.

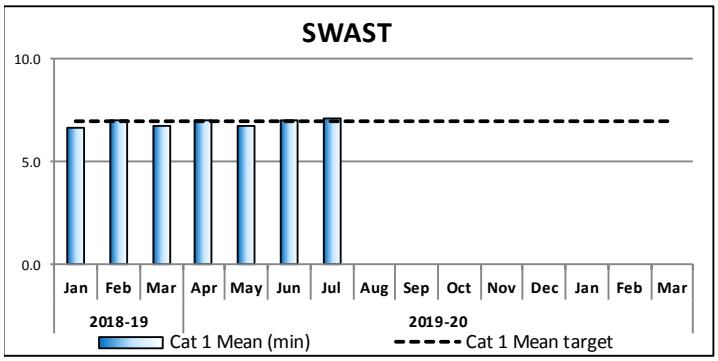
As a CCG, we have been made aware of the temporary reduction in opening hours of Minor Injuries Services within the Southern and Western Localities, with impacts on Totnes and Dawlish in the South & Tavistock in the West. This is as a direct impact of staff availability in order to ensure that safe patient care can be undertaken appropriately and consistently. Impact on patients has been appropriately considered by the providers and Quality, Equality Impact Assessments (QEIAs) have been undertaken and presented to the CCG QEIA Panel.

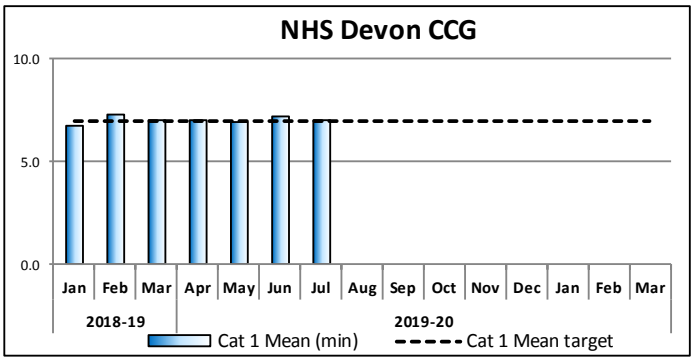
Local communications informing patients of the changes have been put in place, including communication with the Out of Hours Services. Providers will continue to closely monitor outcomes to ensure that any patient safety issues are appropriately reviewed and considered.

A new improvement project in the Western Locality has identified 201 adults (aged 19 and above) who have had 10 or more attendances ED in last year. These individuals have collectively accounted for 2924 attendances at the emergency department,1091 admissions and 3665 days spent in hospital. It has been agreed to focus on and prioritise the top 20 patients and to work within localities and networks to establish an appropriate MDT/lead for each patient. There is recognition that there will need to be different approaches for each patient and a PDSA approach will be used to further develop the improvement project and provide the evidence base.

SWAST Cat 1 Mean response time

Trust	Target	July	2019/20
NHS Devon	7.00	7.00	7.0
SWAST	8.00	7.10	6.9





Performance Commentary

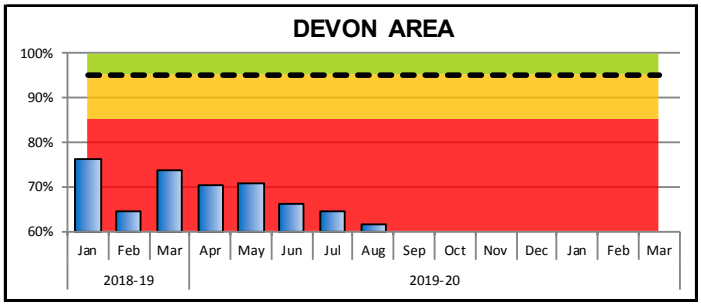
At STP level the 7-minute response time target was met in July.

Quality Commentary and Improvement Actions

The SWASFT call stack risk remains at 20 and mitigating actions continue. This is reflected in the CCGs risk register. This risk is monitored regularly by the SWASFT executive and is reported through the SWASFT Quality Assurance Group chaired by Dorset CCG as coordinating commissioner where it is considered as part of a package of quality indicators. SWASFT continue to monitor for harm caused by delays in getting to patients, and currently report no evidence of serious harm.

NHS 111 answering calls within 60 Seconds

Trust	Target	August	2019/20
DEVON	95%	61.5%	66.7%
ENGLAND	95%	80.5%	84.9%



Performance Commentary

The proportion of calls answered within 60 seconds fell in August to 61.5% from 64.6% in July. Performance remains well below the target of 95%.

Quality Commentary and Improvement Actions

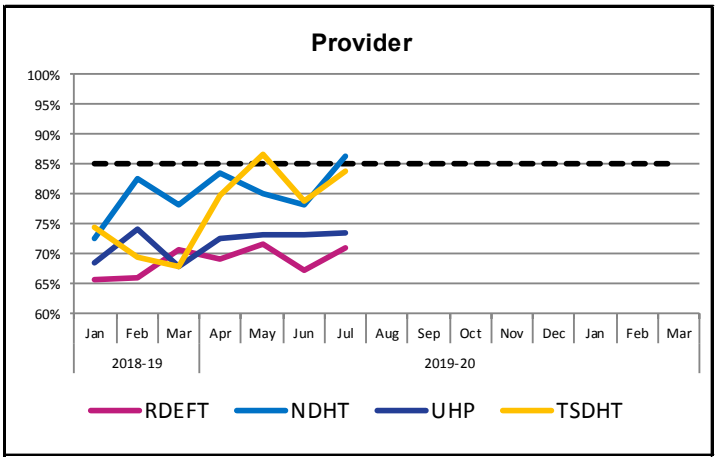
It remains evident that a number of calls are abandoned by patients before answering: it is not clear if this is due to length of wait to be answered or another reason. Collating information and experiences from these patients continues to be challenging as it is not clear if these patients then access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

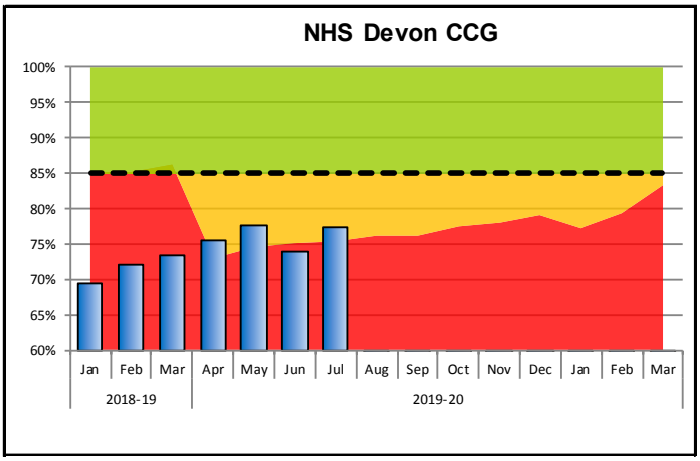
The 111 service is currently run by Vocare on behalf of Devon Doctors Ltd. Devon Doctors and Vocare are currently planning for the contract to return to Devon Doctors from October 2019. The CCG and Devon Doctors are meeting very regularly to manage this process and quality measures are a key part of this transfer process. A clear trajectory for staffing the service is in place, including relevant training and development.

Cancer 62 day Urgent Referral

Trust	Trajectory	July	2019/20
RDEFT	77%	70.9%	69.8%
NDHT	85%	86.3%	82.5%
UHP	70%	73.4%	73.1%
TSDFT	83%	84.0%	82.2%

CCG	Trajectory	July	2019/20
NHS Devon	75%	77.3%	76.1%
ENGLAND	85%	76.7%	76.7%





Performance Commentary

Performance increased at STP level in July from 73.9% to 77.3%. NDHT were the only provider to meet the 85% target at 86.3%, although TSD improved from 78.8% to 84.0% and RD&E rose slightly from 67.2% to 70.9%. UHP remained relatively static at 73.4%. All but RD&E met their improvement trajectory.

NDHT were the only provider to see an increase in the backlog of over 62 day waits in July with good progress being made at RD&E and TSD in particular. TSD and RD&E reduced their over 104 backlogs but there were increases at NDHT and UHP.

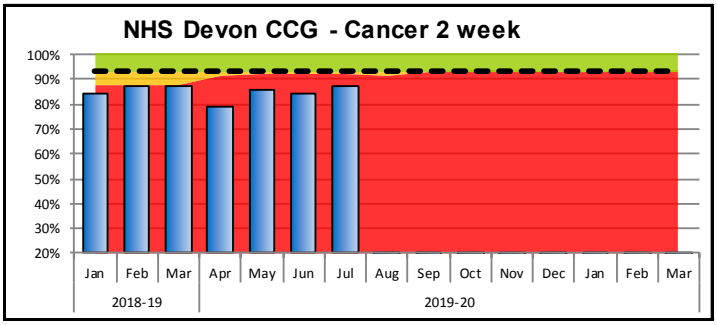
Quality Commentary and Improvement Actions

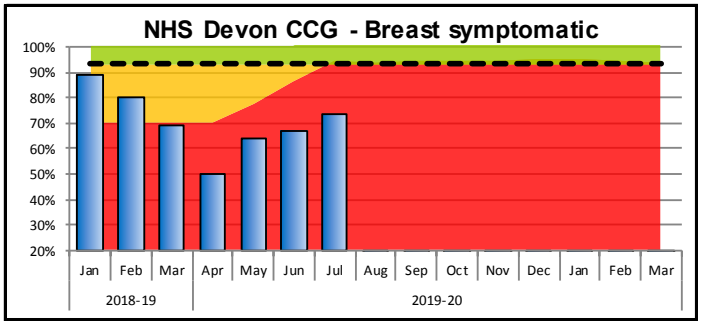
The CCG's strategic plan clearly sets out key areas of work that aim to provide sustainable achievement of the 62-day standard, leading to improved safety and experience for patients. Each provider's improvement plan is overseen by the CCG. There is growing evidence within the system of improved collaboration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

If extended waits are experienced providers have given assurance on the mechanisms by which they maintain patient safety through clinical triage processes, ensuring long waiting patients on cancer pathways are regularly reviewed and communicated with to ensure they remain safe.

Cancer Targets (July-2019)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	87.3%	80.1%	93.8%	94.9%	83.4%
93%	2 week breast	73.5%	75.5%	94.7%	39.1%	98.9%
90%	62 day screening	90.7%	95.8%	100.0%	84.2%	93.8%
85%	62 day consultant	89.8%	90.9%	91.9%	86.5%	76.5%
96%	31 day first	95.7%	94.9%	96.0%	94.2%	97.1%
94%	31 day surgery	96.0%	96.6%	87.5%	92.1%	100.0%
98%	31 day drugs	99.7%	100.0%	97.0%	99.2%	100.0%
94%	31 day radiotherapy	96.0%	95.8%	97.0%	95.3%	95.9%





Performance Commentary

Across the wider range of cancer targets TSD performed well achieving all but two, one of which was the 2ww target, where performance improved from 69.5% to 83.4%. NDHT and RD&E also performed relatively well and there was improvement at UHP who met four targets in July compared to just two in June.

Breast symptomatic performance improved in July with UHP increasing from 8.9% to 39.1% and NDHT moving back above target at 94.7%. RD&E remain under the 93% standard at 75.5% but TSD continue to perform well at 98.9%.

Performance against the main 2ww standard improved from 84.3% to 87.3%. NDHT and UHP continue to perform well and TSD rose from 69.5% to 83.4%, although RD&E fell slightly to 80.1%.

Quality Commentary and Improvement Actions

The CCG continues to seek quality assurance from providers in relation to their actions taken to improve communication with patients and timeliness of patient appointments. All providers acknowledge the impact of delays on patient experience, including increased levels of anxiety within their harm reviews.

There are cancer specific recovery plans in place for each provider. The symptomatic breast pathway has a system-wide plan to improve the performance and harm reviews are being undertaken regularly for those patients having to wait. The aim of these is to set out clear actions to move the Trusts to sustainable achievement of the cancer standards, improving experience for patients requiring cancer care across Devon. These plans now form part of a robust monitoring process supported by NHSI colleagues.

Work with providers and primary care continues to drive improvement. This includes a focus on improving referral pathways where conversion rates are low. Within the Western locality a targeted liaison approach to high referring GP practices is commencing in September.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

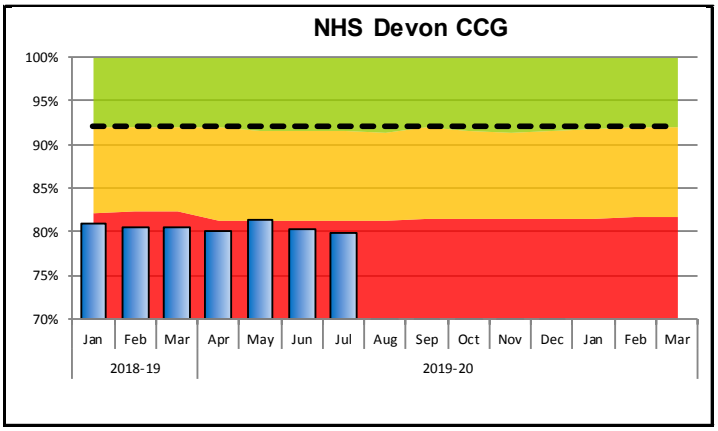
Trust	Trajectory	July	2019/20
RDEFT	82.6%	80.7%	81.5%
NDHT	79.1%	79.2%	79.8%
UHP	77.7%	77.2%	77.0%
TSDFT	81.0%	81.1%	81.3%

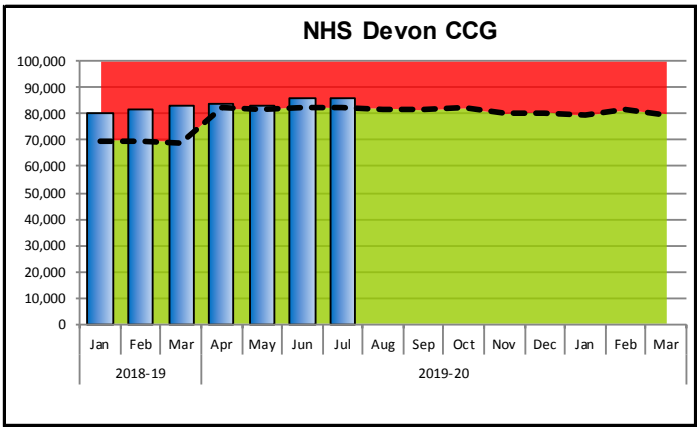
CCG	Trajectory	July	2019/20
NHS Devon	81.2%	79.8%	80.4%
ENGLAND	92.0%	86.3%	86.6%

RTT incomplete waits volume

Trust	Trajectory	July
RDEFT	34,374	35,697
NDHT	11,396	11,641
UHP	28,533	29,702
TSDFT	18,398	19,939

CCG	Trajectory	July
NHS Devon	82,054	85,991





Performance Commentary

The STP level RTT position decreased in July from 80.4% to 79.8%, falling under 80% for the first time. Whilst UHP saw a slight improvement from 77.0% to 77.2% performance fell at RD&E, NDHT and TSD. RD&E reduced from 81.7% to 80.7% whilst the NDHT position fell from 80.7% to 79.2%. TSD dropped slightly from 81.5% to 81.1%. However, TSD and NDHT remain above their improvement trajectory with UHP marginally under and RD&E 2% below plan.

The incomplete waiting list rose by around 200 patients at NDHT but fell at TSD, RD&E and UHP following recent rises. However, all providers remain above their respective waiting list trajectories.

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

Further work to support primary care includes developing advice and guidance and the Devon Referral Support Service (DRSS) has continued to support quality improvements through offers of location choices for patients when booking their appointment.

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

RTT Incomplete Pathways long waiters

40-52 week waits

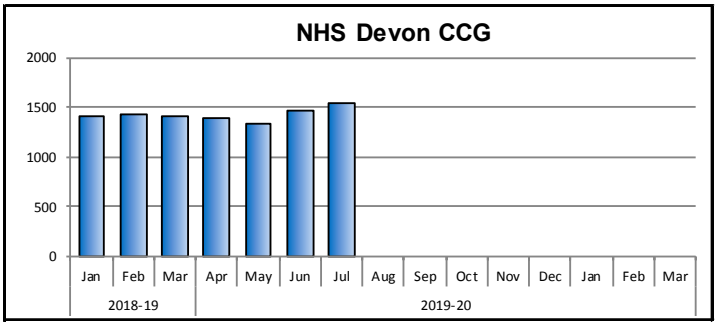
Trust	July	2019/20
RDEFT	586	2257
NDHT	140	477
UHP	705	2711
TSDFT	335	1267

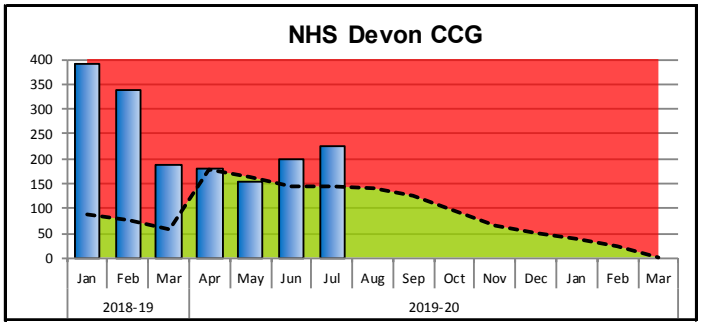
CCG	July	2019/20
NHS Devon	1535	5719

Over 52 week waits

Trust	Trajectory	July	2019/20
RDEFT	0	90	300
NDHT	0	8	43
UHP	43	86	253
TSDFT	120	84	297

CCG	Trajectory	July	2019/20
NHS Devon	146	225	756





Performance Commentary

Over 52 week waits rose in July moving from 199 to 225 at STP level. All providers except NDHT saw increased breaches with TSD increasing from 83 to 86, RD&E rising from 74 to 90 and UHP increasing from 61 to 86. NDHT remained at 8. Only TSD are within their improvement trajectory.

Quality Commentary and Improvement Actions

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

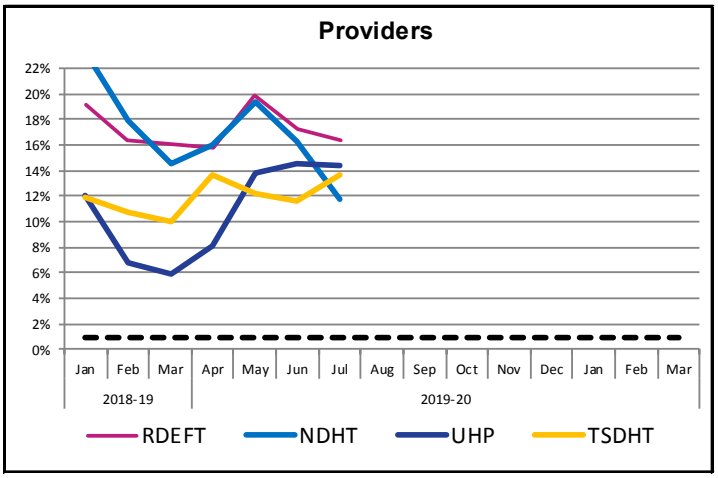
Patient choice continues to impact on this standard and leads to many patients choosing long waits, including 52 week waits. Providers evidence actions to reduce the number of patients waiting for lengthy time periods, for example communicating effectively with patients and encouraging them not to wait for long periods. However, providers and the CCG acknowledge patients have this option and it is essential the patient voice is heard alongside the performance metrics.

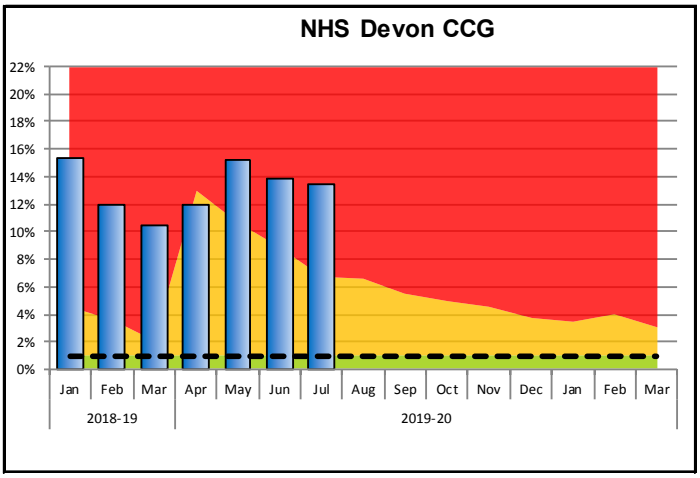
Quality and equality impact assessments continue to be undertaken by providers when planning their activity improvement trajectories. These are reviewed by the CCG Quality, Equality Impact Assessment (QEIA) Panel. These assessments enable consideration of the potential positive or negative impacts to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

Diagnostic 6 week wait

Trust	Trajectory	July	2019/20
RDEFT	3.4%	16.4%	17.4%
NDHT	11.4%	11.8%	15.9%
UHP	5.4%	14.4%	12.8%
TSDFT	10.8%	13.7%	12.8%

CCG	Trajectory	July	2019/20
NHS Devon	6.7%	13.4%	13.6%
ENGLAND	1.0%	3.8%	3.8%





Performance Commentary

The STP position improved slightly from 13.9% to 13.4% in July as a further reduction in breaches at NDHT (moving from 16.3% to 11.8%) and static performance at UHP (14.4%) was balanced out by increased breach levels at RD&E (16.4%) and TSD (13.7%). RD&E and UHP are significantly above improvement trajectories, with NDHT and TSD just over. The majority of breaches continue to be for imaging and endoscopy.

Quality Commentary and Improvement Actions

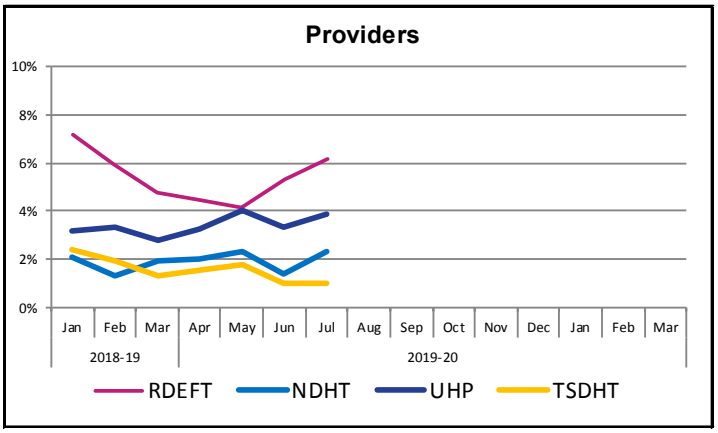
Plans to improve diagnostic pathways to ensure a more local and sustainable position are in place across Devon, with the aim of reducing risks associated with delays as well as patient experience. In the interim, all providers continue to rely heavily on external sourcing for diagnostics but have evidenced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

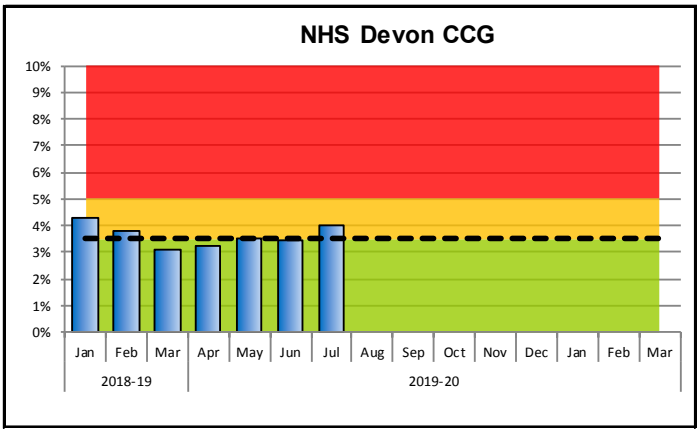
Incidents of diagnostic delays are reported to the CCG through the National Incident Reporting process and full root cause analysis investigations are undertaken. The CCG monitors themes and trends from these and also collates any learning which can be shared across the system. Patient experiences of waiting for diagnostic tests is considered within all Patient Advice & Liaison (PAL's) enquiries and through formal complaints.

Acute Delayed Transfers of care

Trust	Target	July	2019/20
RDEFT	3.50%	6.2%	5.0%
NDHT	3.50%	2.3%	2.0%
UHP	3.50%	3.8%	3.6%
TSDFT	3.50%	1.0%	1.3%

CCG	Target	July	2019/20
NHS Devon	3.50%	4.00%	3.6%





Performance Commentary

In July acute delayed transfers of care (DTOC) remained low at NDHT and TSD but rose at UHP from 3.4% to 3.8% and remained comparatively high at RD&E at 6.2%.

Quality Commentary and Improvement Actions

Progress against performance and quality actions continues to be reviewed through the locality A&E Delivery Boards, with reporting and oversight through the Devon A&E Delivery Board.

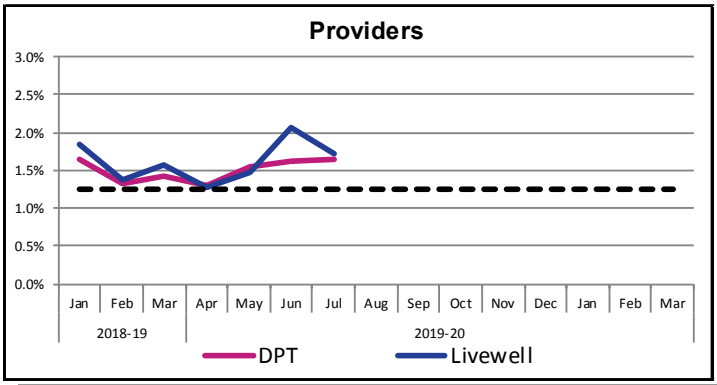
Impact of delayed transfers of care can be seen across the urgent care pathways and the CCG has sight of the position through receipt of the daily situation reports from providers. The patient and system impact of delayed transfers remains a key element of escalation discussions. Partners from across the health and care system participate in escalation discussions to ensure oversight and resolution to challenges in accessing services such as rapid response or domiciliary care that may be delaying timely discharge from hospital.

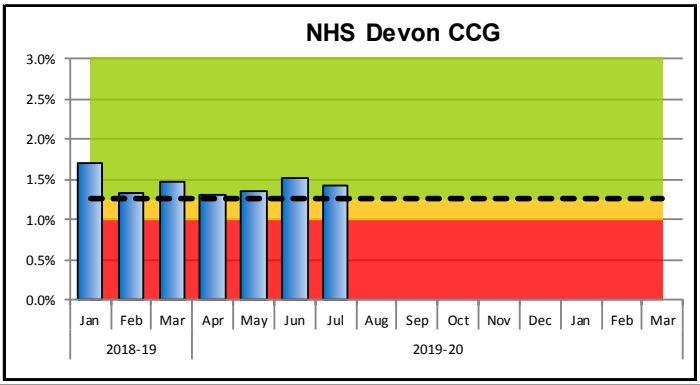
Planning for patients to be discharged during the weekend period has been difficult to successfully achieve in both South and West localities despite significant predictive work. This has adversely impacted on the onward flow of patients and demand/capacity going into the week days. Key issues being addressed are timely preparation of medicines to take out and support for nursing and medical staff in final discharge.

IAPT Monthly Access rate

Trust	Target	July	2019/20
DPT	1.25%	1.6%	6.1%
LIVEWELL	1.25%	1.72%	6.52%

CCG	Target	July	2019/20
NHS Devon	1.25%	1.4%	5.6%





Performance Commentary

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

Quality Commentary and Improvement Actions

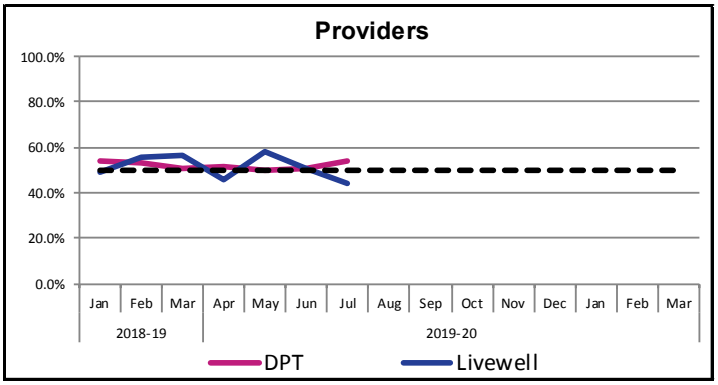
The CCG has reviewed both providers plans for timely patient access to all psychological therapy services and a review paper was presented to the Quality Assurance Committee in September. There is currently variance across Devon in accessing some therapy services. And this potentially compromises patient quality and experience. This may also adversely impact on carers and families.

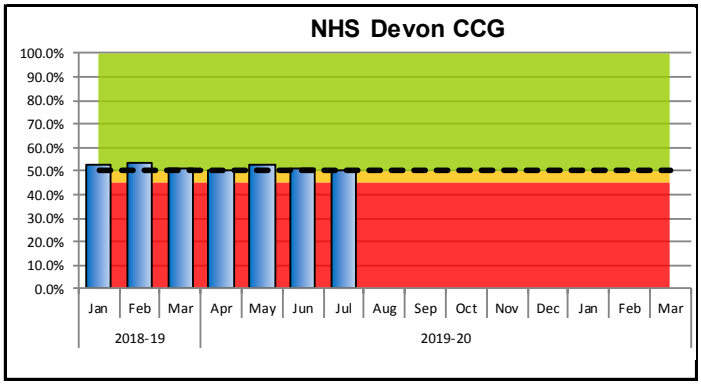
Through the Mental Health Investment Standard, local funding for mental health (excluding learning disabilities
and dementia), will ensure sufficiency of staff with regards to expansion and replacement of therapists. Projection of trainee numbers has been agreed with both DPT and Livewell SW and submitted to Health Education England.

IAPT Recovery rate

Trust	Target	July	2019/20
DPT	50%	54.1%	51.6%
LIVEWELL	50%	43.8%	48.7%

CCG	Target	July	2019/20
NHS Devon	50%	50.0%	51.1%





Performance Commentary

The STP was above the target for IAPT recovery in July, although Livewell performance fell from 50.4% to 43.8%.

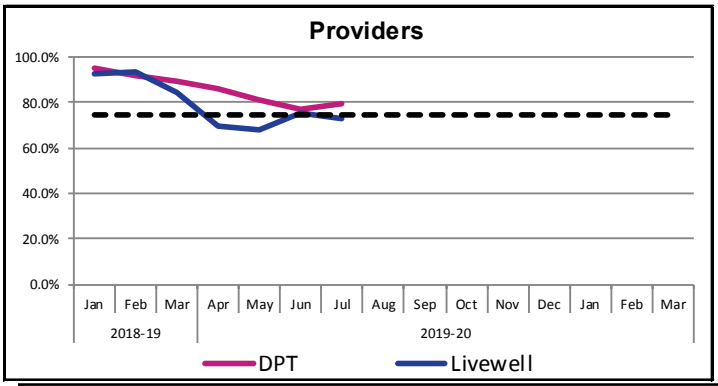
Quality Commentary and Improvement Actions

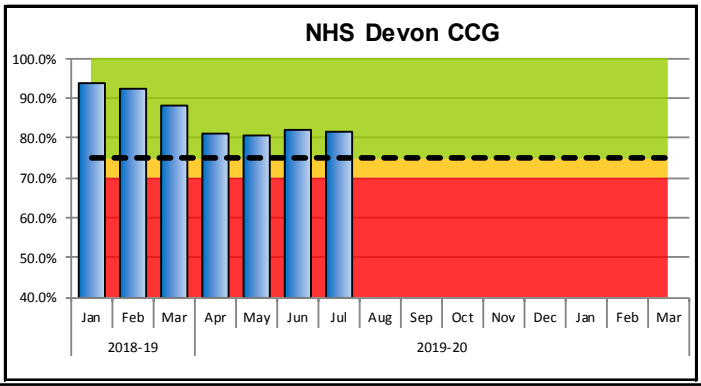
The CCG continues to review all information from provider meetings and other sources to inform the range of indicators within the quality assurance process.

IAPT waiting 6 weeks

Trust	Target	July	2019/20
DPT	75%	79.8%	81.1%
LIVEWELL	75%	73.3%	72.3%

CCG	Target	July	2019/20
NHS Devon	75%	81.6%	81.4%





Performance Commentary

DPT achieved the target in July but Livewell were marginally under the 75% target at 73.3%.

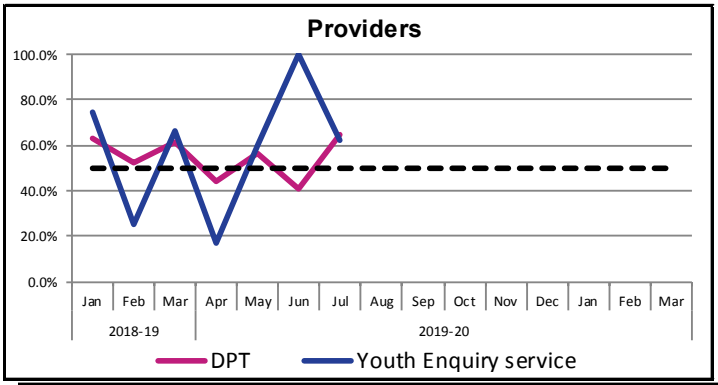
Quality Commentary and Improvement Actions

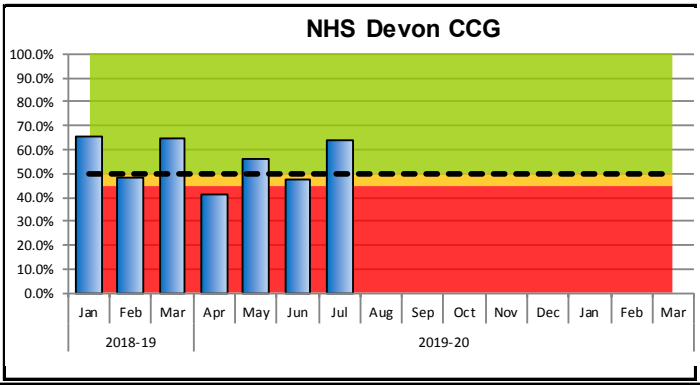
Quality assurance continues through the quality assurance framework process and the CCG is currently reviewing challenges raised by Primary Care for those patients who may not be eligible for Community Mental Health Services but present as too complex for depression and anxiety services. Findings from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

Mental Health Early Intervention

Trust	Target	July	2019/20
DPT	50%	64.7%	51.5%
THE ZONE	50%	62.5%	53.8%

CCG	Target	July	2019/20
NHS Devon	50%	64.0%	52.7%
ENGLAND	50%	76.7%	75.1%





Performance Commentary

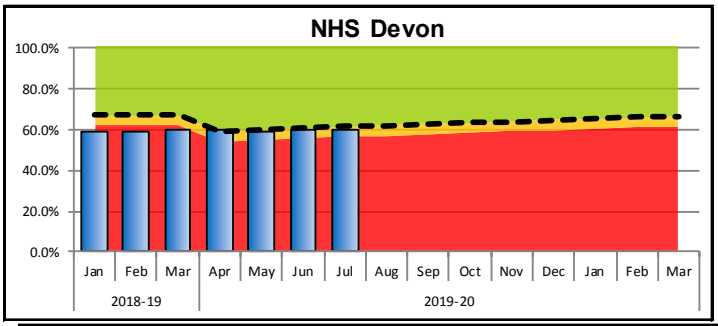
This is a two-part indicator for patients with suspected first episode psychosis or at risk mental state on a completed pathway receiving NICE-recommended care package and allocated to and engaged with an EIP care co-ordinator. Performance rose in July from 47.4% to 64.0%, with both providers achieving the target.

Quality Commentary and Improvement Actions

Providers have continued to demonstrate the positive impact of early intervention services however, challenges in achieving timely access to services for some patients continues. In order to understand the potential quality and experience impacts for waiting patients the CCG is undertaking further review. This aims to identify any potential gaps where patients may be awaiting assessment or allocation of a community mental health care co-ordinator or where they may be deemed too complex for other services or signposting. Findings will be presented to the Quality assurance Committee.

Dementia Diagnosis Rate

CCG	Trajectory	July	2019/20
NHS Devon	61.4%	59.6%	59.6%
ENGLAND	67.0%	68.7%	68.5%



Performance Commentary

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

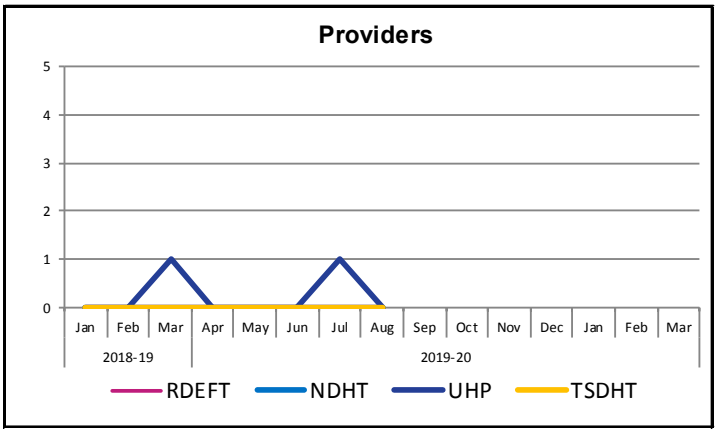
Quality Commentary and Improvement Actions

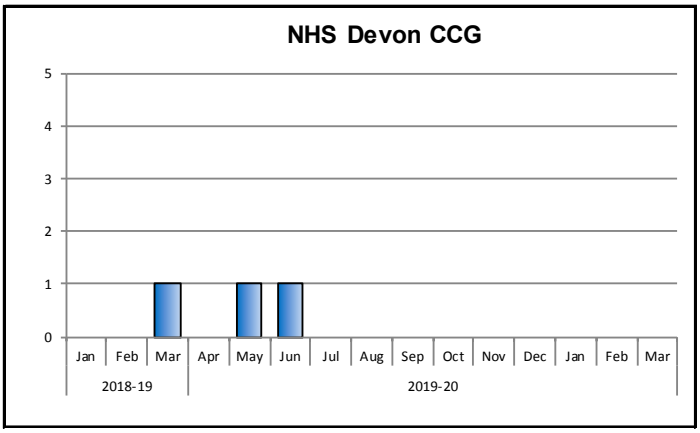
The development of Primary Care Networks and dedicated multi-professional support to each care home will increase professional awareness of early recognition of dementia in these settings. The development of training workstreams as part of the Enhanced Health in Care Home framework may also improve early recognition of dementia and onward referral.

MRSA breaches

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

CCG	Target	August	2019/20
NHS Devon	0	0	2





Performance Commentary

There were no reported cases in August.

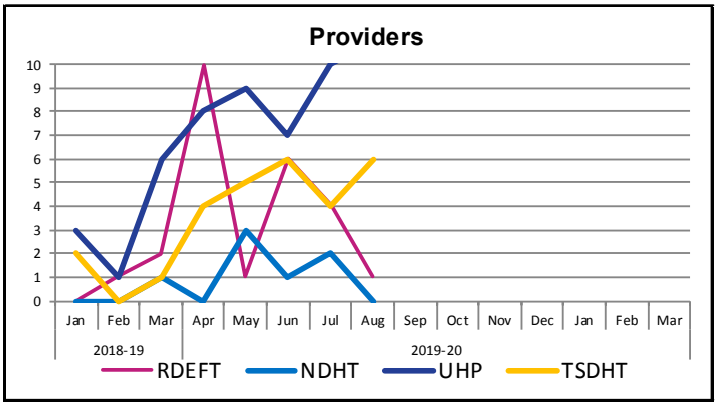
Quality Commentary and Improvement Actions

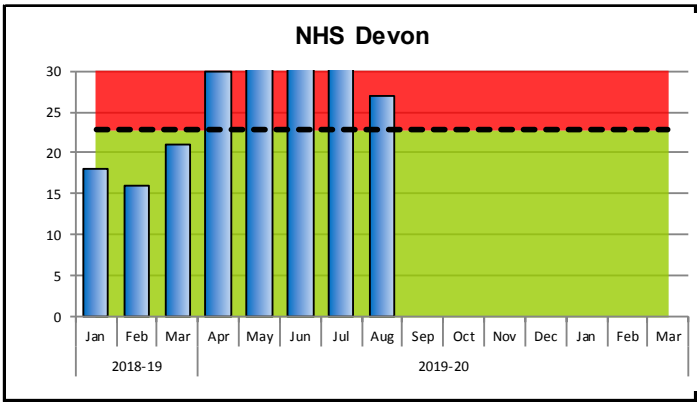
Local reviews of any MRSA case that occurs continue. The case attributed to UHP in July 2019 is currently under review and is the first hospital-acquired case within 2019-20.

C-Diff breaches

Trust	Target	July	2019/20
RDEFT	<31	1	22
NDHT	<9	0	6
UHP	<63	11	45
TSDFT	<36	6	25

CCG	Target	July	2019/20
DEVON STP	<274	27	158





Performance Commentary

There were 18 C-Diff cases acquired within the acute providers and 27 across the STP in July.

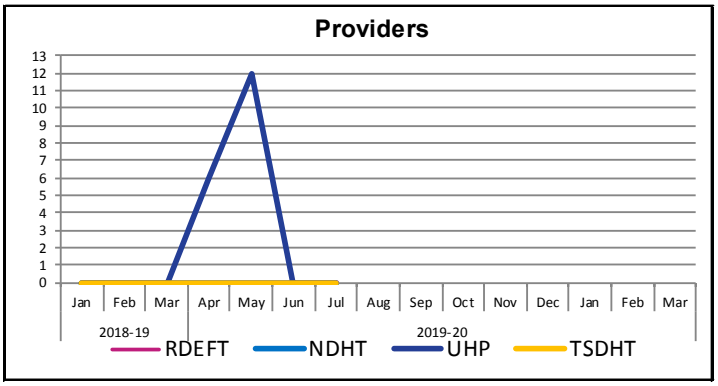
Quality Commentary and Improvement Actions

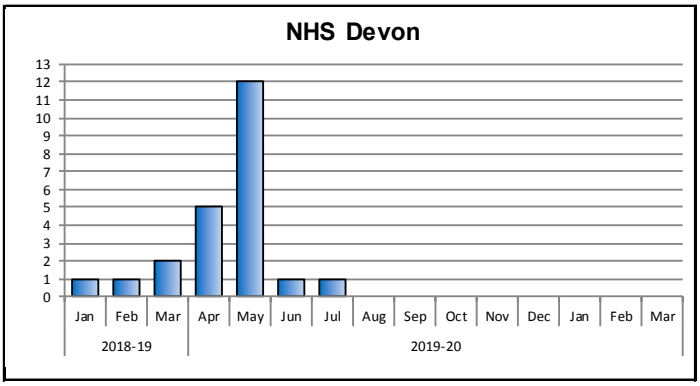
There has been a significant increase in C difficile cases across Devon since April 2019. This is partially due to changes in reporting requirements (community acquired cases <28 days post hospitalisation are now included, an increase of 40% in some areas) but this does not fully explain the increase seen. Historical trends indicate that case numbers will now reduce for the rest of the financial year.

Mixed Sex accommodation breaches

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

CCG	Target	July	2019/20
NHS Devon	0	1	19





Performance Commentary

There were no provider breaches in July although the CCG saw one out of area breach.

Quality Commentary and Improvement Actions

The CCG will continue to seek assurance from the provider organisations that any MSA breaches reported are clinically justifiable. Where it has been indicated that the breach was unnecessary, further assurance from the provider is sought including confirmation of any actions taken to address or lessons learnt as a result.

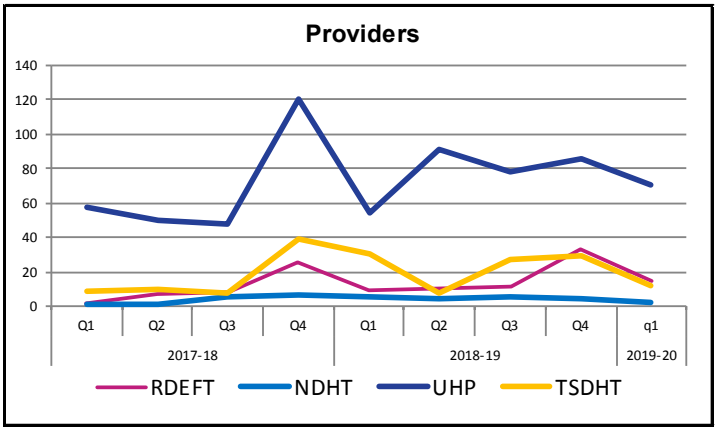
Providers have been asked to submit copies of their Locally Agreed Clinically Appropriate Breach Decision Matrices.

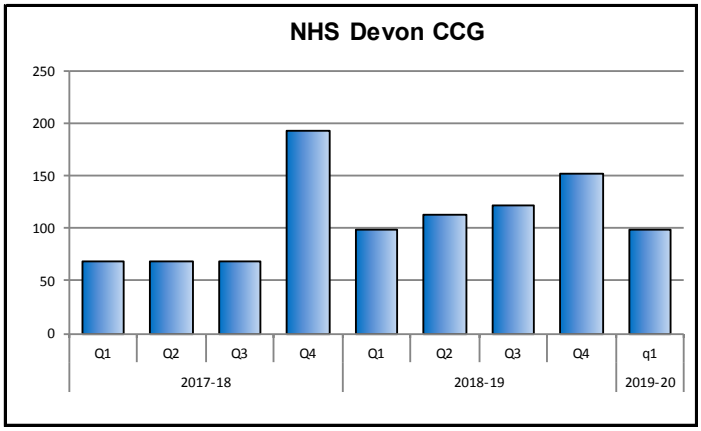
These matrices are currently being reviewed to ensure that the CCG agrees with the decision processes in place and to ensure that clinically appropriate breaches are being adequately considered in relation to both potential patient safety and harm risks and any avoidable impact of patient privacy and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

Cancelled operations not treated with 28 days of cancellation

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

CCG	Target	Q1	2019/20
NHS Devon	0	99	99





Performance Commentary

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

Quality Commentary and Improvement Actions

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

Various complexities are acknowledged for specific complex surgical operations, therefore additional assurance continues to be sought through the planned care forum. This includes reviewing provider processes to ensure collaborative work with partner organisations, planning and on-going communication with patients. This aims to provide assurance that the patient receives care in the most appropriate setting and within the quickest time frame.

NHS Northern Eastern Western Devon

Summary

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

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

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

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

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

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

Summary

Domain	Indicator	Area	Period	England value	Target			99Q: NHS South Devon and Torbay CCG
	999a: Annual assessment	Annual assessment	2018-19				RI	
Better Health	102a: Percentage of children ..	Child obesity	2015-16 to 2017-18	34.2%			30.0%	(32/186)
	103a: Diabetes patients that h..	Diabetes	2017-18	38.7%			36.6%	(184/186)
	103b: People with diabetes di..	Diabetes	2017-18 (2016 cohort)	8.54%			9.30%	(82/186)
	104a: Injuries from falls in peo..	Falls	18-19 Q3	2051			1909	(79/186)
	105b: Personal health budgets	Personalisation and choice	18-19 Q4	75			238	(8/186)
	106a: Inequality in unplanned ..	Health inequalities	18-19 Q2	2109			1832	(68/186)
	107a: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	0.962	0.965	●	0.969	(87/186)
	107b: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	8.71%	10%	●	10.8%	(171/186)
	108a: The proportion of carers..	Carers	2018	0.59	1.000	●	0.68	(108/186)
Better Care	105c: Percentage of deaths wi..	End of life care	2017	7.40%			7.48%	(92/186)
	121a: Provision of high quality..	Provision of high quality care	18-19 Q3				63	(35/186)
	121b: Provision of high quality..	Provision of high quality care	18-19 Q3				72	(3/186)
	121c: Provision of high quality..	Provision of high quality care	18-19 Q3				64	(26/186)
	122a: Cancers diagnosed at e..	Cancer	2017	52.2%			52.2%	(97/186)
	122b: People with urgent GP r..	Cancer	18-19 Q4	77.3%	85%	●	70.0%	(188/186)
	122c: One-year survival from ..	Cancer	2016	72.8%	75%	●	74.8%	(19/186)
	122d: Cancer patient experien..	Cancer	2017				8.0	(13/186)
	123a: Improving Access to Ps..	Mental health	18-19 Q3	51.8%	50%	●	48.0%	(180/186)
	123b: Improving Access to Ps..	Mental health	18-19 Q3	4.48%			2.86%	(191/186)
	123c: People with first episod..	Mental health	2019 03	75.9%	53%	●	66.4%	(179/186)
	123e: Mental health crisis tea..	Mental health	2017-18				0.00%	(114/180)
	123f: Mental health out of are..	Mental health	2019 02	124			889	(186/186)
	123g: Proportion of people on ..	Mental Health	18-19 Q4	30.3%	50%	●	30.6%	(89/186)
	123i: Delivery of the mental he..	Mental Health	18-19 Q4				Green	
	123j: Ensuring the quality of m..	Mental Health	2019 01	Null			0.94	(20/186)
	124a: Reliance on specialist in..	Learning disability	18-19 Q4				40	(49/186)
	124b: Proportion of people wit..	Learning disability	2017-18	51.4%			68.9%	(42/186)
	124c: Completeness of the G..	Learning disability	2017-18	0.49%			0.67%	(20/186)
	125a: Neonatal mortality and ..	Maternity	2016	Null			3.68	(63/194)
	125b: Women's experience of ..	Maternity	2018	82.7			87.2	(19/186)
	125c: Choices in maternity ser..	Maternity	2018	60.4			67.2	(13/186)
	125d: Maternal smoking at del..	Maternity	18-19 Q3	10.5%	6%	●	13.7%	(138/186)
	126a: Estimated diagnosis rat..	Dementia	2019 03	68.7%	67%	●	68.8%	(188/186)
	126b: Dementia care planning..	Dementia	2017-18	77.5%			78.8%	(134/194)
	127b: Emergency admissions ..	Urgent and emergency care	18-19 Q2	2409			1897	(38/186)
	127c: Percentage of patients ..	Urgent and emergency care	2019 03	86.6%	95%	●	81.6%	(141/186)
	127e: Delayed transfers of car..	Urgent and emergency care	2019 03	10.2			9.1	(96/186)
	127f: Population use of hospit..	Urgent and emergency care	18-19 Q2	499			387	(4/186)
	128b: Patient experience of G..	Primary care	2018	83.8%			87.4%	(31/186)
	128c: Primary care access – p..	Primary care	2019 03	99.8%			100.0%	(1/183)
	128d: Primary care workforce	Primary care	2018 09	1.05			1.20	(34/186)
	128e: Count of the total invest..	Primary care	18-19 Q4				Green	
	129a: Patients waiting 18 wee..	Elective access	2019 03	86.7%	92%	●	80.9%	(184/186)
	130a: Achievement of clinical ..	7 day services	2017-18				2	(58/186)
	131a: Percentage of NHS Con..	NHS Continuing Healthcare	18-19 Q4	6.91%	15%	●	0.00%	(1/186)
	132a: Evidence that sepsis aw..	Patient safety	2018				Amber	
	133a: Percentage of patients ..	Diagnostics	2019 03	2.47%	1%	●	10.3%	(181/186)
Sustainability	141b: In-year financial perfor..	Financial sustainability	18-19 Q4				Amber	
	144a: Utilisation of the NHS e-..	Paper-free at the point of care	2019 03	99.8%	100%	●	98.8%	(188/186)
	145a: Expenditure in areas wit..	Demand management	18-19 Q3				Green	
Leadership	162a: Probity and corporate g..	Probity and corporate governa..	18-19 Q4				Fully compliant	
	163a: Staff engagement index	Workforce engagement	2018	3.82			3.83	(41/188)
	163b: Progress against the W..	Workforce engagement	2018	0.14			0.11	(83/188)
	164a: Effectiveness of workin..	CCGs local relationships	2018-19				82.7	(181/186)
	165a: Quality of CCG leaders..	Quality of leadership	18-19 Q4				Amber	
	166a: Compliance with statuto..	Patient and community engag..	2018				Green star	

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

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

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

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

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

Appendix B. Key performance indicators – NHS Devon CCG

FIGURES FOR NHS DEVON CCG

PERFORMANCE MEASURES

INDICATOR	TARGET	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2019/20 YTD
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	>=92%	80.9%	80.6%	80.5%	80.1%	81.3%	80.4%	79.8%									80.6%				80.4%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	391	339	188	179	153	199	225									531				756
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	<=1%	15.3%	11.9%	10.5%	12.0%	15.2%	13.9%	13.4%									13.7%				13.6%
Cancer - percentage seen within 2 weeks - urgent referral to first seen	>=93%	84.4%	87.6%	87.1%	78.8%	85.9%	84.3%	87.3%									83%				84.1%
Breast symptomatic- percentage seen within 2 weeks	>=93%	89.1%	80.0%	69.0%	50.2%	64.3%	66.8%	73.5%									60%				63.5%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	>=85%	69.3%	72.1%	73.5%	75.4%	77.7%	73.9%	77.3%									76%				76.1%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.7%	92.1%	86.7%	95.6%	89.2%	87.2%	90.7%									91%				90.7%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	87.0%	82.6%	85.5%	76.5%	81.1%	83.0%	89.8%									80%				83.1%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	94.5%	93.1%	93.2%	92.8%	95.7%	94.5%	95.7%									94%				94.7%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	88.5%	87.9%	88.4%	93.0%	92.0%	93.7%	96.0%									93%				93.7%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.7%	99.7%	99.7%	99.3%	99.4%	99.7%	99.7%									99%				99.5%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	92.9%	93.7%	91.2%	92.8%	90.2%	91.8%	96.0%									92%				92.8%
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	71.3%	73.7%	77.4%	72.0%	80.3%	76.3%	79.0%									76%				76.2%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	>=95%	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%	87.7%									85%				85.4%
Ambulance Category 1 Mean response Duration (min)	7	6.8	7.3	7.0	7.0	6.9	7.2										7.0				7.0
Ambulance Category 1 90th response Duration (min)	15	12.0	13.1	12.3	13.1	12.5	13.5										13.0				13.0
Ambulance Category 2 Mean response Duration (min)	18	28.5	28.3	27.3	26.0	26.1	26.3										26.1				26.3
Ambulance Category 2 90th response Duration (min)	40	58.7	59.5	56.0	53.7	54.3	54.6										54.2				54.7
Ambulance Category 3 90th response Duration (min)	120	169.7	161.3	156.5	162.4	155.1	158.4										158.6				159.8
Ambulance Category 4 90th response Duration (min)	180	220.2	214.4	200.1	196.4	186.4	197.0										193.3				196.8
Cancelled Operations - Number of patients not treated within 28 days of cancellation	0			152			99										99				99
IAPT Percentage of people entering treatment against the level of need in the general population (Monthly Access rate)	1.25%	2%	1%	1%	1.3%	1.4%	1.5%										4.2%	1.4%			5.6%
IAPT recovery rate - percentage of people who are moving to recovery	50%	53.0%	53.7%	51.4%	50.7%	52.4%	51.4%										51.5%	50.0%			51.1%
IAPT - started treatment with 6 weeks of referral	75%	94.0%	92.3%	88.0%	81.3%	80.4%	82.0%										81.3%	81.6%			81.4%
Mental Health - Percentage of people on CPA who were followed up with in 7 days of discharge	95%	97.7%	87.0%	97.9%	91.1%	98.3%	89.8%										93.5%	93.8%			93.6%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	93.7%	93.4%	93.5%	91.4%	89.0%	86.8%										89.0%	90.4%			89.4%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	65.2%	48.1%	64.7%	40.9%	56.0%	47.4%										48.5%	64.0%			52.7%
Dementia diagnosis rate	62%	59.1%	58.9%	59.6%	59.5%	59.3%	60.0%										59.6%				59.6%

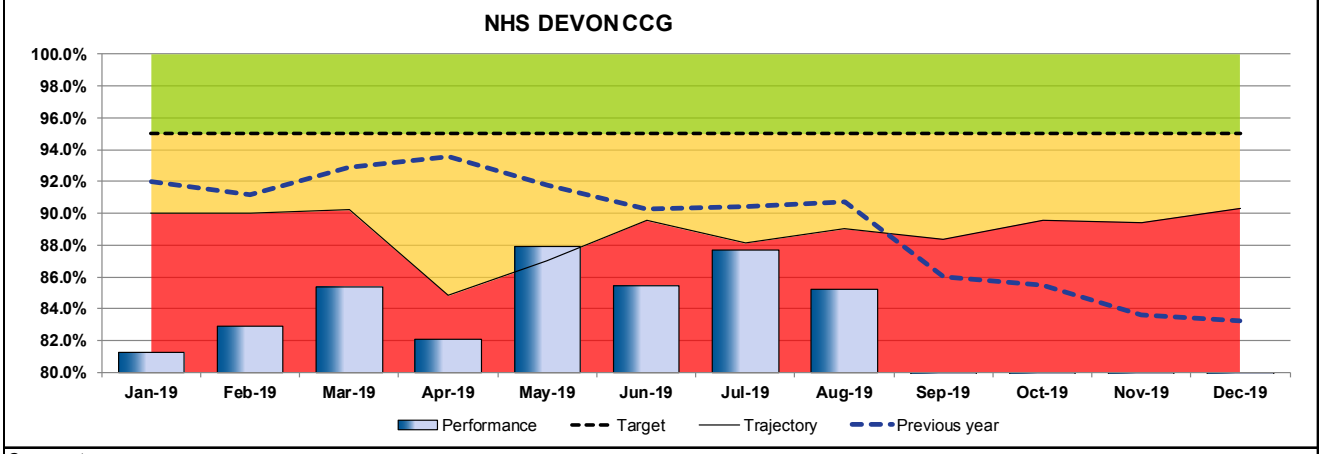
QUALITY MEASURES

INDICATOR	TARGET	Jan-18	Feb-18	Mar-18	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2019/20YTD
MRSA bacteraemia - number of hospital infections	0	0	0	1	0	1	1	0									2				2
Clostridium difficile - number of hospital infections	316	18	16	21	30	35	33	33									158				131
Mixed sex accommodation (MSA) - number of hospital breaches	0	1	1	2	5	12	1										19				18
Delayed transfers of care - patient delays as a percentage of occupied beds (Acute only)	3.5%	4.3%	3.8%	3.1%	3.3%	3.5%	3.4%										5.1%				3.6%
Delayed transfers of care (all) - Percentage of delays per Occupied bed	3.5%	5.3%	4.9%	3.9%	4.2%	4.6%	4.6%										6.7%				4.6%

4 hour waits A&E &MIU

NHS Devon CCG

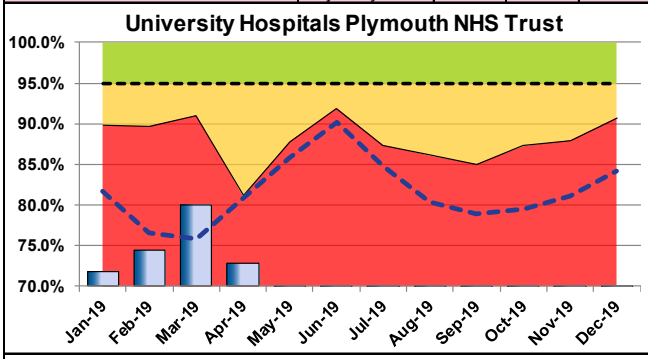
STP footprint	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>95%	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%	87.7%	85.2%				
Trajectory		90.0%	90.0%	90.2%	84.8%	87.0%	89.5%	88.1%	89.0%	88.4%	89.6%	89.4%	90.3%
NHS England		84.4%	84.2%	86.6%	85.1%	88.0%	87.7%	87.8%					

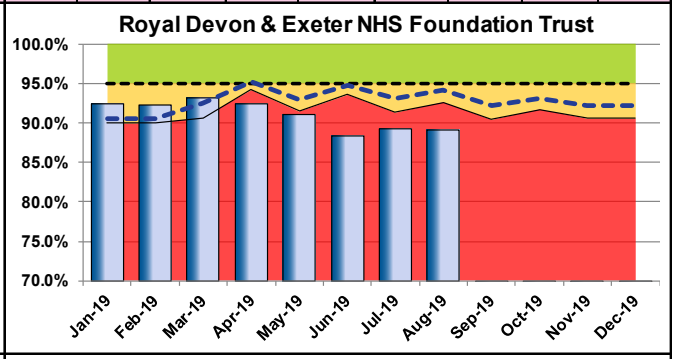


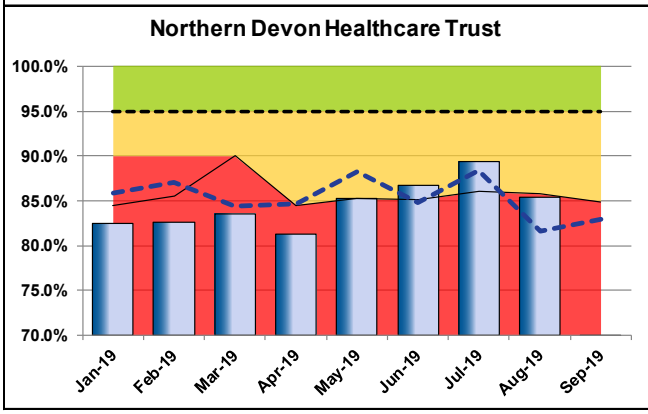
Comment:
Performance continues to be volatile against the A&E 4-hour target. In July the STP position was 87.7%, up from 85.4% in June, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. RD&E performance rose slightly from 88.3% to 89.3%, NDHT improved from 86.8% to 89.4% and TSD also increased from 80.3% to 84.3%.
Early unvalidated August performance shows the STP position falling to 85.4% with NDHT decreasing to 84%, RD&E remaining at 89% and TSD falling to 80%.

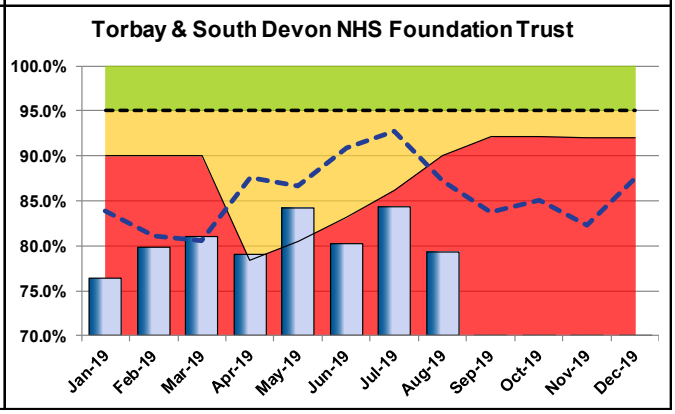
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	71.8%	74.5%	79.9%	72.8%								
	Trajectory	89.8%	89.7%	91.0%	81.1%	87.8%	91.9%	87.4%	86.1%	85.0%	87.3%	88.0%	90.7%
RDEFT	Actual	92.5%	92.2%	93.2%	92.4%	91.1%	88.3%	89.3%	89.0%				
	Trajectory	90.0%	90.0%	90.7%	94.2%	91.5%	93.6%	91.3%	92.6%	90.4%	91.7%	90.6%	90.6%
NDHT	Actual	82.5%	82.7%	83.5%	81.3%	85.2%	86.8%	89.4%	85.4%				
	Trajectory	84.5%	85.5%	90.1%	84.5%	85.2%	85.1%	86.0%	85.8%	84.9%	84.6%	84.4%	84.2%
TSDFT	Actual	76.4%	79.8%	81.0%	79.1%	84.2%	80.3%	84.3%	79.3%				
	Trajectory	90.0%	90.0%	90.0%	78.4%	80.5%	83.1%	86.2%	90.1%	92.1%	92.2%	92.0%	92.0%





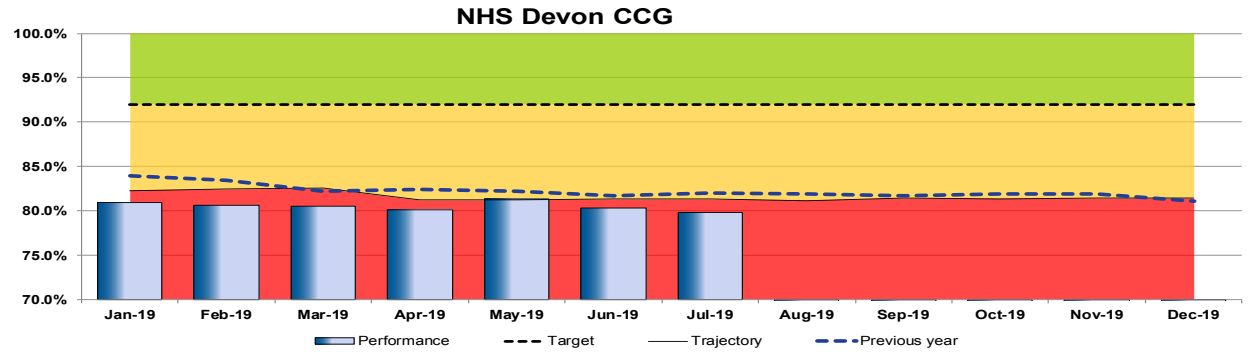




18-week RTT (incomplete pathway)

NHS Devon CCG

NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>92%	80.9%	80.6%	80.5%	80.1%	81.3%	80.4%	79.8%					
Trajectory		82.3%	82.4%	82.5%	81.2%	81.2%	81.3%	81.3%	81.2%	81.4%	81.4%	81.4%	81.4%
NHS England		86.7%	87.0%	86.7%	86.5%	86.9%	86.3%						
RTT total waiting list	78,364	80,089	81,661	82,913	83,546	83,041	85,931	85,991					
Trajectory		75,616	75,353	74,733	82,086	81,536	82,603	82,054	81,730	81,454	82,036	79,922	80,442

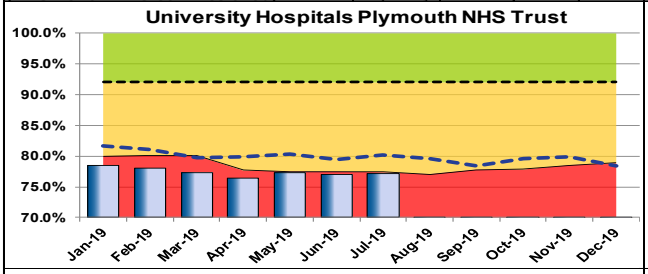


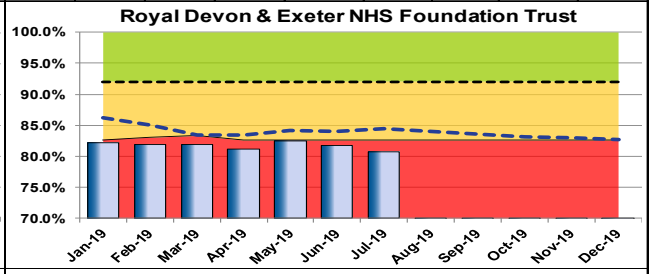
The STP level RTT position decreased in July from 80.4% to 79.8%, falling under 80% for the first time. Whilst UHP saw a slight improvement from 77.0% to 77.2% both RD&E and NDHT performance fell, from 81.7% to 80.7% for RD&E and from 80.7% to 79.7% for NDHT. TSD and NDHT remain above their trajectory with UHP marginally under but RD&E 2% below plan.
The incomplete waiting list rose by around 200 patients at NDHT but fell at both RD&E and UHP following recent rises. However, all providers remain above their respective waiting list trajectories.
Over 52 week waits rose in July moving from 199 to 225 at STP level. All providers except NDHT saw increased breaches with TSD increasing from 83 to 86, RD&E rising from 74 to 89 and UHP increasing from 61 to 86. NDHT remained at 8. Only TSD remain within their trajectory.

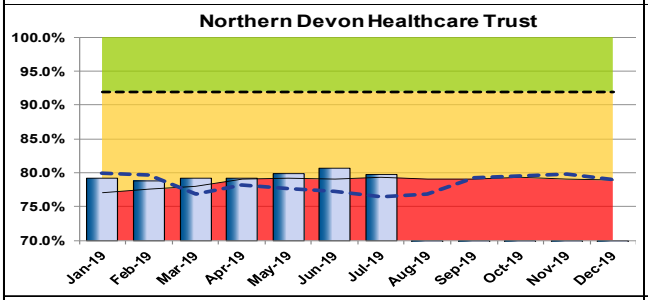
18-week RTT (incomplete pathway).....continued

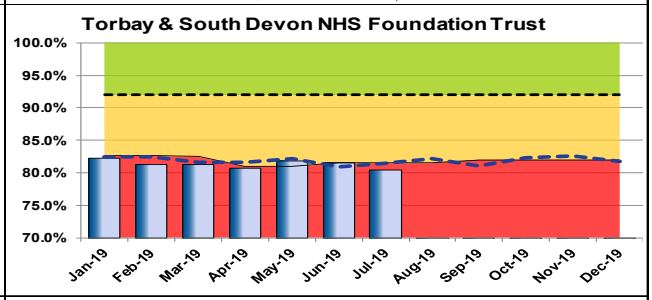
Provider level

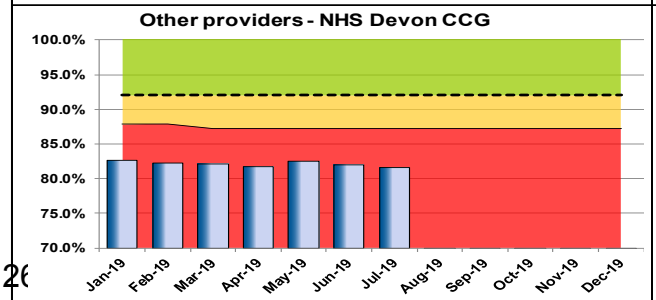
Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	78.4%	78.0%	77.3%	76.4%	77.3%	77.0%	77.2%					
	Trajectory	80.0%	80.0%	80.1%	77.7%	77.5%	77.5%	77.4%	77.0%	77.8%	77.9%	78.5%	78.9%
	Waiting list	27,356	27,872	27,922	28,195	28,611	28,899	29,702					
	Trajectory	25,772	25,725	26,347	28,351	28,476	28,496	28,533	28,730	28,354	28,277	27,927	27,703
RDEFT	Actual	82.2%	82.0%	81.9%	81.1%	82.4%	81.7%	80.7%					
	Trajectory	82.7%	83.0%	83.3%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%
	Waiting list	33,386	33,770	34,262	33,619	35,690	36,355	35,697					
	Trajectory	30,783	30,496	30,178	34,555	33,783	34,857	34,374	33,707	33,992	35,016	33,628	34,374
NDHT	Actual	79.2%	78.9%	79.2%	79.3%	79.9%	80.7%	79.7%					
	Trajectory	77.1%	77.6%	78.0%	79.1%	79.2%	79.1%	79.4%	79.1%	79.1%	79.3%	79.1%	78.9%
	Waiting list	11,790	11,633	11,520	11,385	11,403	11,429	11,641					
	Trajectory	13,439	13,299	13,101	11,797	11,665	11,564	11,396	11,313	11,194	11,044	10,960	10,863
TSDFT	Actual	82.2%	81.3%	81.3%	80.7%	81.9%	81.5%	80.4%					
	Trajectory	82.7%	82.6%	82.5%	81.0%	81.0%	81.5%	81.5%	81.5%	82.0%	82.0%	82.0%	82.0%
	Waiting list	18,430	18,564	19,425	19,016	19,534	19,636	19,939					
	Trajectory	18,282	18,332	18,332	18,567	18,548	18,416	18,398	18,379	18,249	18,231	18,213	18,194
Other providers (NHS Devon CCG commissioned)	Actual	82.7%	82.2%	82.1%	81.7%	82.5%	82.0%	81.6%					
	Trajectory	87.8%	87.9%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%







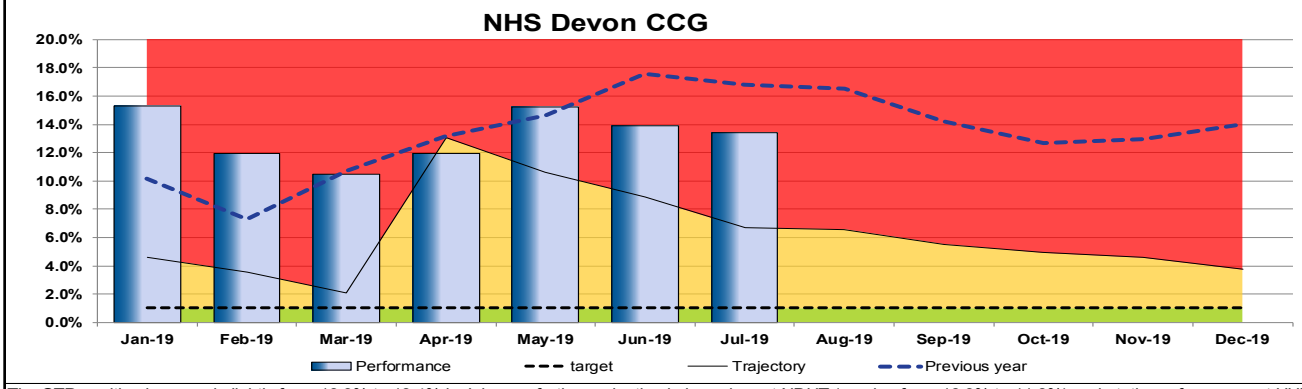




6 Week Diagnostics

NHS Devon CCG

NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>1%	15.3%	11.9%	10.5%	12.0%	15.2%	13.9%	13.4%					
Trajectory		4.6%	3.6%	2.1%	13.0%	10.6%	8.9%	6.7%	6.6%	5.5%	4.9%	4.6%	3.7%
NHS England		3.6%	2.3%	2.5%	3.6%	4.1%	3.8%						

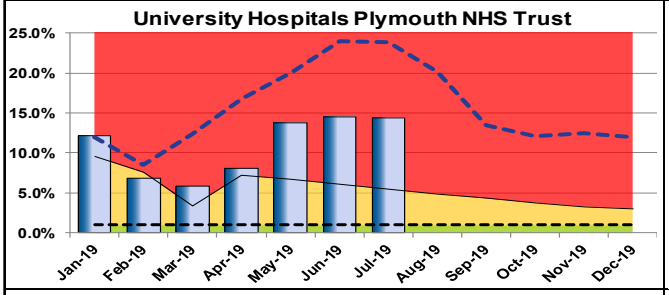


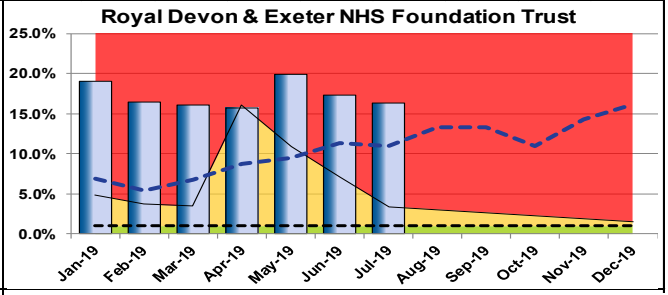
The STP position improved slightly from 13.9% to 13.4% in July as a further reduction in breaches at NDHT (moving from 16.3% to 11.8%) and static performance at UHP (14.4%) was balanced out by increased breach levels at RD&E and TSD. RD&E and UHP are significantly above improvement trajectories, with NDHT and TSD just over. The majority of breaches continue to be for imaging and endoscopy.

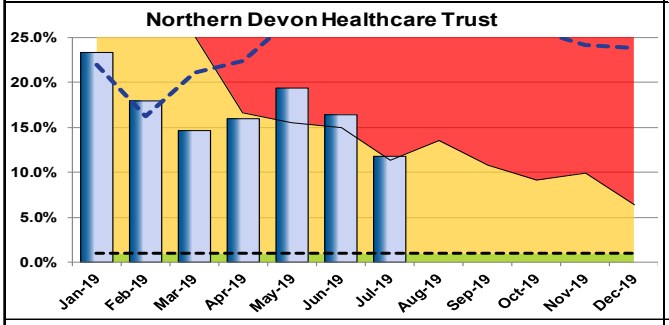
6 Week Diagnostics.....continued

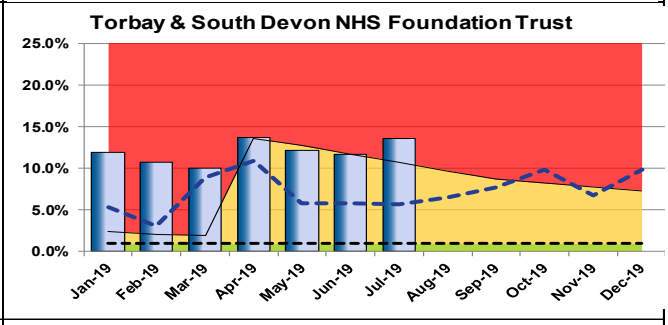
Provider level

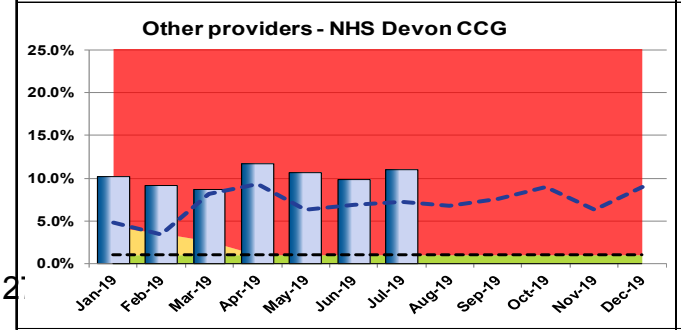
Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	12.1%	6.8%	5.9%	8.1%	13.8%	14.5%	14.4%					
	Trajectory	9.6%	7.5%	3.4%	7.2%	6.7%	6.1%	5.4%	4.9%	4.4%	3.8%	3.3%	3.0%
RDEFT	Actual	19.1%	16.4%	16.1%	15.7%	19.9%	17.3%	16.4%					
	Trajectory	4.9%	3.7%	3.5%	16.1%	11.0%	7.1%	3.4%	3.0%	2.7%	2.3%	1.9%	1.6%
NDHT	Actual	23.3%	17.9%	14.6%	15.9%	19.3%	16.3%	11.8%					
	Trajectory	30.9%	28.3%	25.3%	16.6%	15.5%	15.0%	11.4%	13.5%	10.8%	9.1%	9.9%	6.4%
TSDFT	Actual	12.0%	10.7%	10.0%	13.7%	12.1%	11.7%	13.7%					
	Trajectory	2.4%	2.1%	1.9%	13.7%	12.7%	11.8%	10.8%	9.7%	8.7%	8.3%	7.8%	7.3%
Other providers (NHS Devon CCG commissioned)	Actual	10.2%	9.1%	8.7%	11.7%	10.7%	9.8%	11.0%					
	Trajectory												







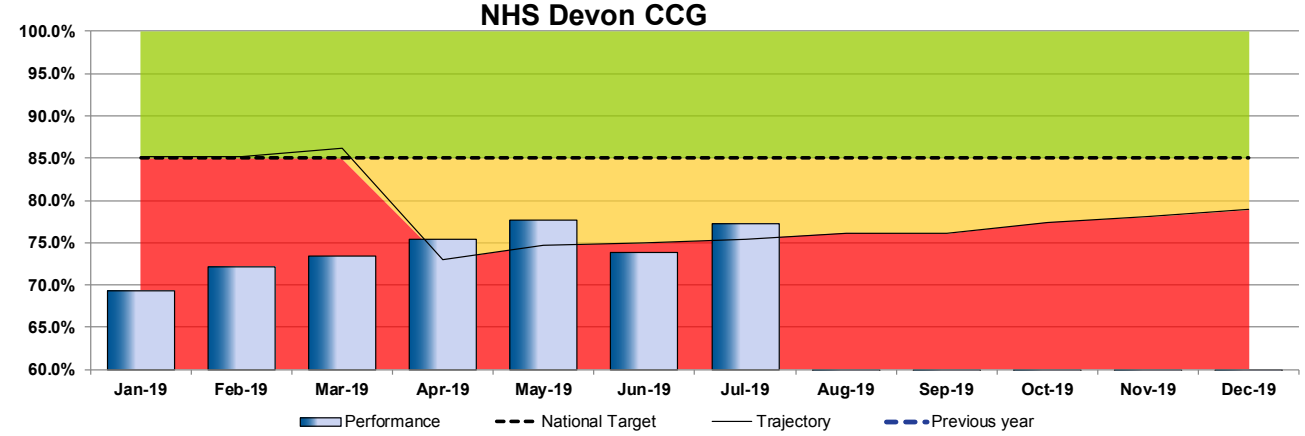




62 day standard Cancer waits

NHS Devon CCG

NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>85%	69.3%	72.1%	73.5%	75.4%	77.7%	73.9%	77.3%					
Trajectory		85.2%	85.2%	86.1%	73.0%	74.7%	74.9%	75.4%	76.1%	76.1%	77.4%	78.1%	78.9%
NHS England		76.2%	76.1%	79.7%	79.4%	77.5%	76.7%						



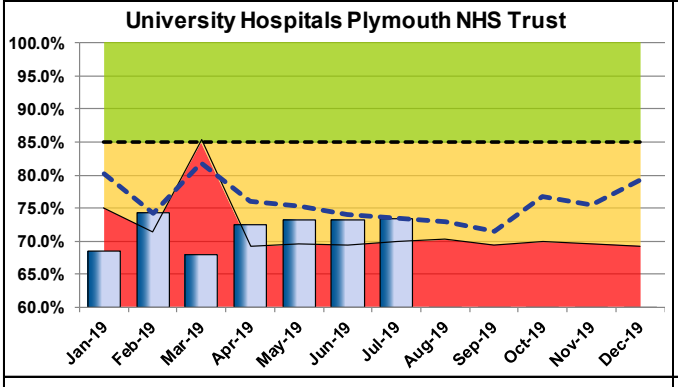
Performance increased at STP level in July from 73.9% to 77.3%. NDHT were the only provider to meet the 85% target at 86.3%, although TSD improved from 78.8% to 84.0% and RD&E rose slightly from 67.2% to 70.9%. UHP remained relatively static at 73.4%. All but RD&E met their trajectory.

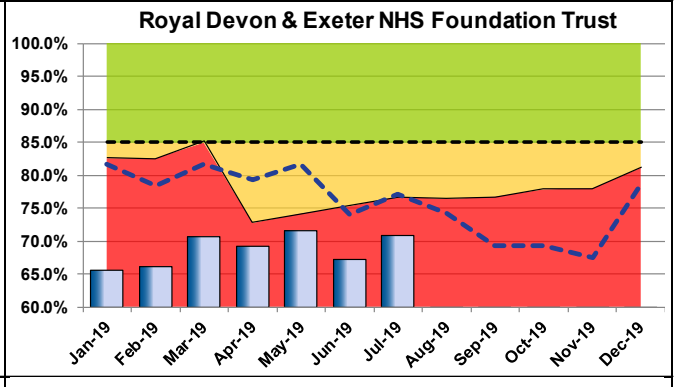
NDHT were the only provider to see an increase in the backlog of over 62 day waits in July with good progress being made at RD&E and TSD in particular. TSD and RD&E reduced their over 104 backlogs but there were increases at NDHT and UHP.

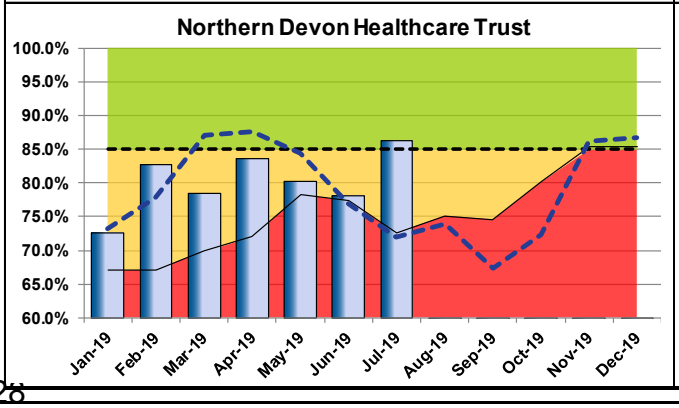
62 day standard Cancer waits……continued

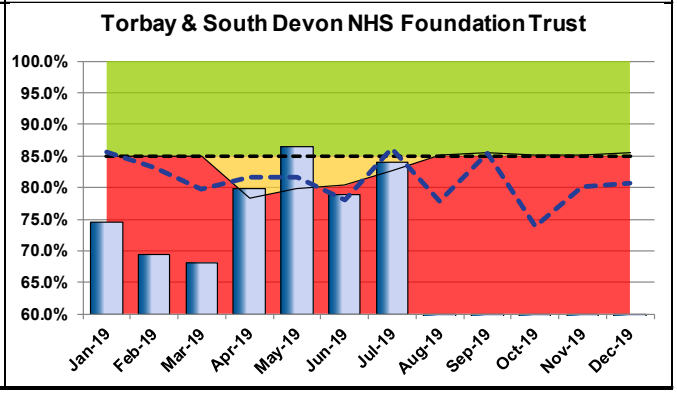
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	68.5%	74.3%	68.0%	72.6%	73.2%	73.2%	73.4%					
	Trajectory	75.0%	71.4%	85.4%	69.2%	69.6%	69.4%	69.9%	70.2%	69.5%	70.0%	69.7%	69.2%
RDEFT	Actual	65.7%	66.1%	70.8%	69.3%	71.6%	67.2%	70.9%					
	Trajectory	82.7%	82.6%	85.2%	72.8%	74.2%	75.4%	76.8%	76.5%	76.7%	77.9%	78.0%	81.2%
NDHT	Actual	72.6%	82.7%	78.4%	83.6%	80.2%	78.1%	86.3%					
	Trajectory	67.0%	67.1%	69.9%	72.0%	78.3%	77.3%	72.6%	75.1%	74.6%	80.2%	85.4%	85.3%
TSDFT	Actual	74.5%	69.4%	68.0%	79.9%	86.5%	78.8%	84.0%					
	Trajectory	85.0%	85.0%	85.0%	78.3%	79.8%	80.4%	82.8%	85.1%	85.5%	85.1%	85.1%	85.5%









NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body:

Dates of Committees covered in this report: 5th September plus ratified minutes from 1st August

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

Chair's Name and Title: Judy Hargadon

Contact Details:, judy.hargadon@nhs.net

Reports discussed and assurances received

- Members of the Committee discussed the following reports:

Finance Report

Finance report for month 4 was presented to Committee.

Workforce Update

Committee members received an update from Paula Knowles on workforce, highlighting activities to attract and retain GPs, nurses and pharmacists. . Key dates for delivery are to be provided to the next meeting of Primary Care Committee.

Estates Strategy Update

Committee members were presented with an update on the Estates Strategy. Members heard that workshops had taken place and practices had been scored on a scale of 1-7 on whether investment in their estate was a priority. Phase 2, PCN workshops to begin in October. Initial results of phase 2 to be reported to Primary Care Committee in November with detailed report in December to feed into the overall STP estates strategy.

PCN Development – Guidance and Update

Committee members received information on PCN development and how guidance for PCNs is being developed. Members discussed the process for assurance and support for PCN development and the key role of leadership development of Clinical Directors.

Patient Survey Results

Members of the Committee heard that patient survey results had been broken down to practice level and were informed that there were trends in the results (with caveats around survey size).

Results will be presented to Quality Committee who will set recommendations.

Primary Care Quality Reporting

Members heard that Primary Care Committee would be receiving a monthly quality report for assurance.

Extended Access – utilisation of underspend

Members received a report detailing how any underspend from extended access would be utilized. Members were happy with the content of the report.

Winter Communications Plan

Members heard detail of from Communications Team on this year's winter communication plan, which is due to be finalized at the next Devon A&E Delivery Board. Following a request from PCC, the Communications Team agreed that self-care messaging should be included in this year's winter plan.

Language and Translation Services

Committee members were informed that Language Empire had been awarded the contract for translation services. Sign Solutions are to be awarded the contract for sign language services with contract due to be signed imminently. All services due to start on 1st October.

Pharmacy First

Members received the Pharmacy First report for information only

Plymouth Prospectus

Members received information relating to the Plymouth Prospectus (copy attached) and wording that had been delivered to Practices in Plymouth, as well as wording that has gone to other Practices across Devon to explain the current focus on Plymouth primary care.. LMC said that wording was satisfactory.

Reports received and noted

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

Primary Care Highlight Delivery Status – Members reviewed the Primary Care Highlight report. Members discussed e-consult and agreed that we need a better understanding of progress to be discussed next month .

Locality Flash Reports – Members noted the locality flash reports. Members agreed to keep the same template for the time being. Deputy Director of Primary Care is now RAG rating all flash reports to ensure consistency.

Contracting Report – Paul Baker presented the contracting report. One CQC report had been received this month with reported a rating of good.

Forward Planner – Members reviewed and noted the Committee forward planner.

Risk Register Review (changes and areas of concern)

- The Risk Register was reviewed by members. No new risks and no proposed movement, closures or new risks this month.

Committee Decisions
• The Committee endorsed decisions made at Primary Care Operational Group
Recommendations for Governing Body
• **None**
Recommendations for other Committees
• **None**
Terms of Reference or other committee effectiveness issues
• **None**

Management of Conflict of interests:

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

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

NHS
Devon
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GOVERNING BODY

Report title: Locality Update Reports				
Date of committee: 26 September 2019 **Date report produced: 16 September 2019**				
Author (s) Name and Title: **Locality Triumvirates**		**Supporting Executive:** **Name and Title: Dr Paul Johnson, Chair** **Contact Details:**		
		Report Approved by: **Name and Title:** Locality Triumvirates **Date 16 September 2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Western and Southern Devon Localities.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				

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

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

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

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

NHS Devon Clinical Commissioning Group

Locality Update Report

Locality:	Northern
Period Covered by Update:	June to August 2019
Locality Clinical Representative:	John Womersley
Locality Executive Lead:	Andrew Millward
Locality Non-Executive Representative:	Charlotte Burrows

Key Achievements and Progress

- **One Northern Devon -** On 30th August the OND membership met for a facilitated development day. The day as very successful, with wide contributions from leaders in Northern Devon representing police, Torridge and North Devon councils, health, education, primary care, public health and communities. The day helped shape direction for the OND group moving forward with their objectives over the coming year, with the multitude of differing priorities across the system.

- Northern Devon **Dementia Pilot** has begun, with the x 4 Barnstaple GP surgeries and the x 3 Bideford Surgeries. Each surgery will have its own designated Dementia Support Worker. This will strengthen an MTD approach to dementia care including an annual review to ensure a holistic review of an individual's health and wellbeing and provide each service user with a personalised assessment and support plan which will be reviewed and added to regularly. We expect to increase the dementia diagnosis rate near to that expected for our population and to increase the number of people, both patients and carers, receiving support.

- **Northern Devon Healthcare Trust** performance continues to improve.

- **RTT** performance continues to improve with >52-week breaches remaining in single figures, and >40 week waiters significantly below the same period last year. **A&E 4 hour wait** performance continues to improve with July performance achieving 89.4% (all types), above the trajectory of 86%. **Diagnostic performance** for July also improved for the second month running at 88.2%, now just very slightly below the trajectory of 88.6%. **DToC** from NDHT remains significantly below the target of 3.5%. **GP referrals** remain stable and within the forecast level for the year.

Primary Care Networks continue to develop, with good CCG support across a number of key areas including winter planning and future PCN investments in physiotherapy and paramedics.

- Strong sustained engagement continues with the **Holsworthy Community Involvement Group** and we are developing cross border collaborative opportunities with Kernow. Outcomes of the group are due in October.

- The Care Quality Commission (CQC) has rated the quality services provided by Northern Devon Healthcare NHS Trust as Requires Improvement overall - following an inspection in May and June 2019.

- While the overall quality rating remains unchanged, inspectors noted clear progress in areas since its previous inspection. The trust is now rated as Good for being caring and effective and is rated as Requires Improvement for being responsive, safe and well-led.

Key Priorities for The Next Three Months

- LCP Development – a meeting of senior representatives from the Northern system are scheduled to meet in October to develop and expand on current thinking around an LCP structure in the locality. More detail on this will be available in next month's report.

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

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

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

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

- Ratifying the Northern Devon **Integrated Care Model** work plan and working on the key priorities: risk stratification and population health management, multi-disciplinary working to review the opportunity to mirror the outcomes achieved by

the Coastal locality, including joint working with the voluntary sector and working with care homes and the care provider market.

- Great emphasis on co-produced data-sets that allow shared emphasis on the correct variances to manage. Better data is needed around Care Home activity so we can better evaluate the effectiveness of our use of Winter Funding monies. This has relevance in the Urgent Care arena.

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

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

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

Issues of Concern or Risk

- NDHT's sensitivity to small changes in demand destabilising ED performance. A wide variation in daily activity and attendance can create challenges for a smaller unit.

- Aside from the ongoing problem with NDHT recording their referrals, the biggest issue NDHT are facing is **Consultant-to-consultant referrals**. They are up 589 (36%) in the first 4 months compared to the first 4 months last year. And up 1170 (42%) over the past 12 months rolling. This may be explained by pathway changes and we are urgently seeking to understand the correct explanation of this growth in activity.

- Despite good Delayed transfer of care (DToc) figures in-patient bed capacity at NDDH can still be a challenge early in the week. This would appear to be due to **weekend discharges** being roughly 50% of admissions.

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

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

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

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

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

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

- Sustainability of investment in diabetes transformation beyond 2019/2020

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

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

- It is proving challenging for our **cross border PCN** to wholly commit to initiatives involving the other three PCNs as some services are commissioned differently in Kernow CCG

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

Support Required from CCG/System or Barriers to Progress

- Early resolution to Community Urgent Care Strategy outcome.

- Increased support from the Business Intelligence team to provide Locality/LCP based reports. This makes local analysis, learning and planning more effective.

- Resourcing multi-disciplinary working, to the same degree as the Coastal model to include GPs and the voluntary sector

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

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Clinical Commissioning Group

Locality update report

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

Key achievements/progress

Integrated care .

The eastern locality delivery group met on September 4th and spent time discussing the STP's anticipated response to the NHS 10 yr plan, it's recognised financial, performance and demographic challenges & it's proposal to systematise integrated working, learning from examples of improved outcomes from elsewhere in the county. Clinical and managerial attendees from primary and secondary care heard presentations from GP leaders from the "coastal" sub locality in south Devon and then spent small group time working in 3 eastern sub localities describing their own MDT models, successes and challenges. The integration of both medical support from GP's as well as mental health provision was recognised and the apparent reduction in non-elective admissions resulting from coastal's integrated care model considered further by eastern's cluster teams. The proposal that additional medical input to integrated cluster teams in east might further help to manage urgent care demand was debated and the locality still considers whether this can best be provided by community geriatricians, GP's or a combination of each.
There were only three of our twelve clinical directors present and it has been recognised that more aligned meeting times and potentially engagement funding may be required to improve the effectiveness of these meetings.
RD+E then presented their community services ambitions & its hoped, going forwards, these ambitions will be less so those of the RD+E, but more of an integrated community provision.

This was followed by presentations from community leaders Kevin Ball (Okehampton), Ian Hall (Axminster) , Heather Penwarden (Honiton) and Karen Nolan (Tiverton) regarding their further community town developments . Offers available through the community voluntary sector were presented and various towns

ambitions & achievements most notable subsequent to the “your future care” , transforming community services decisions, were discussed.
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We are currently reviewing the attendees to be invited to this development group & I am aware we should also be including the children’s services commissioners and providers at further meetings later in the year.

The Eastern locality forum (strategic group ELF) has not met since the August report but is scheduled to meet again in October.

Digital

The 3 GP member forums met again jointly on 18th September to discuss the digital opportunities and challenges for the locality in both primary and secondary care. Presentations were heard regarding, “e” consult, digital first primary care, EPIC, (my care and my chart), digitalisation of Lloyd George records, comprehensive assessment and GP team-net .As further evaluation is awaited after this meeting, this will now be available in October’s locality report.

Winter planning

The eastern system continues planning for winter 19/20 through the A+E board. The eastern winter pressures monies have been identified and bids sought for ideas and projects to support admission avoidance, where clinically appropriate, and earlier facilitation of hospital discharge. Bids have been received from primary care network directors and consideration will be given to these proposals as additional primary care clinically directed opportunities to manage non elective demand over the winter months

Clinical Workforce review

The locality is engaging with the clinical workforce review and expressions of interest in locality roles are expected over the next few weeks. There is currently a significant under provision of “clinical strategic advice” in eastern, however it is hoped this will be further resolved through the workforce review

Primary care

Premises - working through historic outstanding rent reviews

Premises - Minor Improvement Grant for 18/19 complete

Extended Hours - PCNs have reported on their delivery model to provide assurance that the minimum number of hours are being met as per the DES

National Review of Access to General Practice Services template completed on localised data gathering on extended access services

Digital Minor Illness Referral Scheme - Pilot sites in East approved; practices yet to

be approached

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Key priorities for the next three months

Ratifying the ICM work plan and working on the key priorities: risk stratification and population health management, multi-disciplinary working to review the opportunity to mirror the outcomes achieved by the Coastal locality, including joint working with the voluntary sector and working with care homes and the care provider market.

Identifying how the Eastern Locality will develop a collaborative plan for social prescribing to utilise STP prevention monies

Continuing to work closely with the GP PCN's Collaborative Board to deliver these priorities

Recruitment of additional locality strategic clinical advisers, one hopefully from each of the three district GP forum groups.
Several applications have been received for these interim posts however consideration is being given to the proposed clinical workforce review & whether further appointments will in fact be made in the context of this review.

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

Continue preparation for a Governing body (GB) development and "showcase" opportunity for November in E. locality. Considerations are being given perhaps to maybe holding the event at Exeter Racecourse and to maybe encouraging some of our community market town leaders to have an opportunity for a say at this event.

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

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

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

Issues of concern or risk

General & Community

Sustainability of investment in diabetes transformation beyond 2019/2020

The evaluation and sustainability of the Budleigh Hub. Discussions are on-going with Westbank , the Web PCN clinical director and the RD+E re the future of this facility .

The utilisation of community estates in light of the DHSC Guidance for Transfers of NHS Property

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

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

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

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

Remodelling of the urgent care offer in east , better understanding of the minor injuries , walk in centre offer currently and the need for the creation of an urgent care programme board to further describe the best landscape model of community urgent care provision going forwards .

Royal Devon and Exeter Foundation Trust (RDEFT)

Long Waits, Planned Care: There remains a potential risk that standards of quality cannot be met, due to performance issues within certain pathways, including cardiology. There is a concern that patient safety; care effectiveness and patient experience may be being impacted upon and this is being monitored by CCG quality committee

Non-obstetric ultrasound**:** Work to improve data quality within RDEFT diagnostics has revealed a longstanding technical issue with the Trust Patient Administration System (PAS), resulting in patients waiting for ultrasound being excluded from the data set and being recorded as "patient choice".

12 Hour Breaches- Mental Health Patients in the Emergency Department (ED**):** Since July 2018 ED 12-hour breaches have been regularly reported by the provider. A majority of these relate to patients with a mental health condition. There are concerns about the impact of extended waits for both the patient and the whole service/ system.

Urology**:** The Trust has reported delays in some patients having cystoscopies. They have subsequently identified a possible risk to patient safety and experience.

Primary care

Capacity of North and East Team to meet increasing volume and complexity of workload at current pace of change

Risk that some PCNs may not be able to recruit to additional posts

Challenges that have resulted as consequence of PCN formation such as impact on Extended Access provision in Mid Devon

Support required from CCG/system or barriers to progress

Resourcing multi-disciplinary working, to the same degree as the Coastal model to include GPs and the voluntary sector

On-going HR support to engage additional strategic clinical advisors

Primary care commissioning support for greater clarity re working with new PCN's. Flexibility to use any Eastern locality GP engagement monies underspends to support the attendance of primary care clinical directors at eastern locality delivery group meetings.

Further integration of health and social care staff particularly in Exeter. Non elective

admission rates could be much better managed with a more co-located health and social care offer and conversations need to be had with respect to how IT systems can be better linked to enable information sharing more proactively. Need ongoing discussions with CCG estates teams re rationalisation of premises to support better integrated working particularly in Exeter.

Support from comms services to ensure PCN CD's are fully connected with both STP plans, public engagement plans and eastern wider locality stakeholders. Support from CCG to raise the profile of Eastern "digital" engagement event 18th September.

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Locality update report

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

Key achievements/progress

- Launch of Integrated Care Partnership (community, mental health, learning disability and adult social care services) and Mayflower primary medical services procurements
- Primary Care Network Development including engagement between CCG, PCNs, Livewell Southwest and UHP
- Refreshed programme plans in ICM and Urgent Care with good engagement and commitment to implementation
- Digital Accelerator project: GP Practices making progress in plans to rolling out eConsult in stages starting end September
- Soft launch of Plymouth Prospectus on 2 September and plans to launch formally at GP Forum on 1 October.
- Contributing to Devon Long Term Plan.
- Information Sharing session run by STP Digital and Western GP – resetting the aim and preparing for programme of development – well attended

Key priorities for the next three months

- Trajectories and metrics for Livewell's ICM and Urgent Care delivery in 19/20
- Primary Care Networks including early development of enhanced primary care teams (MDTs) and alignment of existing social prescribing programme and resources with Devon-wide approach and PCN engagement
- Integrated Care Partnership and Mayflower Procurement
- Integrated Care Model (5 priority programmes: Primary and community integration; multi-morbidity including LTC, frailty and dementia; population health management; wellbeing hubs; enhanced health in care homes)
- Implementation of demand plans through AEDB
- Population health management (Devon-wide and local projects)
- System pharmacy support offer to PCNs – CCG, LSW and UHP Pharmacy leads have met with PCNs to discuss offer. Support and integrated working with individual PCNs to be established.
- Engagement between ICM and Digital workstreams to progress shared use of clinical information systems across primary/community in particular (kick off meeting)
- Roll out of pilot eConsult Beacon hub as part of Digital Accelerator programme.

Issues of concern or risk

- Emergency Department performance
- Operational Plan delivery to achieve financial efficiencies
- 52 Week waits (currently above trajectory)
- Symptomatic breast performance has reduced due to increased demand and has not recovered in line with trajectory
- Diagnostic waits
- Primary Care Provision
- Improved Access sustainability
- Pharmacy Workforce capacity
- Population health management
- Beacon rollout of eConsult : Autumn/Winter timing will need monitoring for potential adverse impact.

Support required from CCG/system or barriers to progress

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

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Locality update report

Locality:	Southern
Period covered by update:	September 2019
Locality clinical representative:	Dr David Greenwell Dr Matthew Fox
Locality executive lead:	Dr Sonja Manton
Locality non-executive representative:	Judy Hargadon

Key achievements/progress

Integrated Care Model - Health and Wellbeing Centres

- Teignmouth: Meeting with NHS England on 17 September to discuss modernising health and care services in Teignmouth and Dawlish, following conditional approval by Teignbridge District Council for the purchase of the Brunswick Street site in Teignmouth by Torbay and South Devon NHS Foundation Trust.
- Dartmouth: CCG and trust colleagues attended a communications workshop with local stakeholders on 27 August. Attendees included MP Sarah Wollaston, local councillors, GPs, PPG, League of Friends, Dartmouth Caring and Dartmouth Area Healthcare Action Group. The purpose of the meeting was to present and discuss information connected with the project and begin work on a communications strategy to support the opening of the new Health and Wellbeing Centre near the park and ride. A number of actions were agreed and are now being carried out.

Integrated Care Model - Personal Care Sufficiency

- We have further developed work with Devon County Council and the Trust to fund alternative personal care provision, we have been able to secure further capacity in addition to that reported last month.

TSDFT performance

- The deep dive into A&E performance was presented to the System Improvement Board in August. Four key target areas have been identified for focus, with leads from across the system involved to work up action plans to address those key issues.
- Additional support for TSDFT in view of ECIST recommendations and findings – commissioning managers have been aligned to work on key projects with them.

Winter Funding

- A&E Delivery Board and locality care partnership delivery group jointly agreed proposals for use of winter funding for Torbay and South Devon.

Quality

- Patient Safety and Quality leads are continuing to work with the providers to highlight areas of concern from Yellow cards and work is ongoing to address these issues.
- Parity in physical health and mental health care for in patients in both general and mental health bed-based settings has been a focus. Further partnership work is underway focussing on access to tissue viability and end of life care specialist support for mental health in-patients.

Key priorities for the next three months

ICM

- Progress plans for development of health and wellbeing centre in Teignmouth, informed by meeting with NHSE on 17th September
- Complete design phase for Dartmouth Health and Wellbeing Centre, ahead of planning proposal early in 2020.
- Refresh and improve stakeholder engagement in Dartmouth in the lead up to the opening of the new centre.
- Monitor and evaluate the new personal care provision for end of life clients with a view to inform future commissioning intentions for the longer term.

Long Term Conditions (LTCs)

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

TSDFT performance

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

Integrated Urgent Care Services

- We continue to develop the South model for community urgent care services, including on-going development of Newton Abbot MIU as a designated urgent treatment centre.

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

Quality

- Topics for future Quality Surveillance Group discussions: Quality assurance across domiciliary care and supported living services, and patient experience across the local health and care system.

Issues of concern or risk

- TSDFT Performance and financial position. Despite some signs of improvement in weekend performance, this continues to be an issue and heightened governance arrangements remain in place.
- Personal care capacity and resilience continues to be a concern across Devon. Additional agency capacity has been secured and we will continue to explore how to make this a viable and sustainable option.
- The short-term change to current MIU provision in Dawlish and Totnes is ongoing. A progress report went to CCG executives in early September, and we continue to ensure actions are on track to deliver expected outcomes.

Support required from CCG/system or barriers to progress

- Likely that TSDFT performance will continue to require exec-level focus and assurance, in partnership with NHSEI.
- Progressing the developments for modernising health and care services in Teignmouth will require additional capacity and resources including at executive level.