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

MS Teams (refer to formal calendar invitation for joining details)

27 August 2020 14:00 - 27 August 2020 17:00

AGENDA

#	Description	Owner	Time
1	Patient Experience Presentation	Non-Exec Lay Member Public and Patient Involvement	14:00
2	Welcome and Apologies Verbal	Chair	14:15
3	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 13 Augu... 5	Chair	14:20
4	Minutes of last meeting Paper 1 Draft PUBLIC GB minutes 30.07.2020 v2 pjcd.do... 11	Chair	14:25
5	Chair's Report Paper Chairs Report August 20 final v2.docx 23	Vice Chair/ Chair of Audit	14:30
6	Accountable Officer's Report Paper 1 Cover sheet template (002) AO Report Public Au... 25 2 AO Report Public August 2020.docx 27	Accountable Officer	14:35
7	PROGRAMMES OF WORK		14:45
7.10	Devon System COVID-19 Response Paper GB good news 27082020.docx 29	Associate Director of Commissioning - Northern	

#	Description	Owner	Time
7.20	Modernising Health and Care Services in Teignmouth and Dawlish Paper Cover Sheet GB August 2020cd.docx 37 NHS Devon CCG Governing Body Report Aug 202... 39	Director of Commissioning - Western	
7.30	Devon Integrated Care System (ICS) Lead/Accountable Officer (AO) Devon CCG - recruitment process approval Paper GB_ICS Lead CCG AO recruitment_Report (v2 G... 45	Chair of Remuneration and Strategic Workforce Committee	
7.40	BREAK		15:30
8	FINANCE, PERFORMANCE AND QUALITY		15:40
8.10	Month 4 Finance Report Paper 1 FPC_Report_FPC_Month 4_DRAFT_2020-21 (G... 53 2 FPC_Report_FPC_Month 4_DRAFT_2020-21 (G... 57	Finance Director	
8.20	Performance and Quality Report Paper NHS Devon CCG - Governing Body Performance F... 75	Chief Operating Officer/ Chief Nurse	
9	GOVERNANCE		16:00
9.10	Governing Body Effectiveness Paper Governing Body effectiveness report 2020.docx 99	Board Secretary	
10	COMMITTEE CHAIR'S REPORTS		16:10
10.10	Commissioning Committee including update from first meeting and chair's report Paper August GB - Commissioning Committee Report 13.... 111	Director of Commissioning - Western/ GP clinical representative	

#	Description		Owner	Time
10.20	Finance Committee Paper [P] Finance Committee Chair Report 20 August 2020 v...	113	Chair of Finance Committee	
10.30	Primary Care Committee Paper [P] 1 Committee Chair Report - Public PCC - August 2...	119	Chair of Primary Care Committee	
10.40	Quality Assurance Committee Paper [P] QAC Part 1 Chair Report August 2020 v2.docx	121	Chair of Quality Assurance Committee	
11	LOCALITY UPDATES			16:30
11.10	Northern, Eastern, Southern and Western Paper [P] 0 Locality Updates Cover Sheet.docx [P] 1 Northern Locality Report August 2020 V2cd.docx [P] 2 Locality Update Report - Eastern August 2020cd.... [P] 3 NHS Devon CCG WL Update Report - August 20... [P] 4 NHS Devon CCG - South Locality Update Report...	135 137 141 145 147	Locality Triumvirate	

Declaration of Interests Register - NHS Devon Clinical Commissioning Group Governing Body
Report Generated by the Governance Team on 13 August 2020

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Allcorn	Darryn	CCG and System Chief Nursing Officer Shared role with Phillip King to 20 June 2020 Caldicott Guardian	Member of Governing Body Member of Quality Assurance Committee Senior Leadership Team (SLT) CCG Executive Team Meeting Member of Devon JCEG Commissioning Committee (CC DOI)	Honorary Associate Professor University of Exeter Seconded to NDHT		11/05/2020		09/07/2020	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Appleby	Gaynor	Non Executive Lay Member (Allied Health Professional)	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee Member of Remuneration and Workforce Committee	CQC Specialist Advisor Therapy Lead for Health and Social Care for North Devon		01/11/2019		05/05/2020	Non Financial	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Atherton	Glynis	Non Executive Lay Member- Quality Geographical remit - Eastern	Member of Governing Body Member Quality Assurance Committee (Chair) Member Primary Care Commissioning Committee Member of Remuneration and Workforce Committee (Chair)	Consultancy for FORCE cancer charity – not CCG funded but has a relationship with RD&E hospital Trustee for St. Margaret's Hospice, Somerset Volunteer for Hospiscare, Exeter – helping at events and proof reading applications to charitable trusts Volunteer for University of Exeter – mentoring students Member of the Labour party		14/05/2019		21/05/2019	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geographical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 , Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		10/05/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Blackford	Derek	Deputy Chief Finance Officer	Attendee of Audit Committee (Deputy for CFO) Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Member of Vacancy Control Panel	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Non Executive Lay Member - Patient and Public Involvement Geographical remit - Northern	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Member Primary Care Commissioning Committee (PCCC)	Self-Employment business consultant from September 2019 Associate for Research In Practice Feb 2020 Associate for Research In Practice Supplier/Associate for SWAHSN (Feb 2020) Within my role as SWAHSN associate will be part of their project team which is supporting the Think 111 project Associate for Devon Communities Together		04/04/2019		04/08/2020	Financial/Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt	Partner is employed by Livewell Southwest in position of influence	26/09/2017		15/10/2018	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Coles	Anna	Director of Integrated Commissioning Seconded to CCG to Associate Director of Commissioning (Western)	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019		12/03/2019				Plymouth City Council
	Davis	Alison	Associate Non-Executive Lay Member	Attendee Governing Body	Plymouth City Council – Foster panel Chair Torbay Council- Foster panel Chair Pathway Care Fostering- Ashburton- Independent Reviewing Officer University of Exeter – student mentor Somerset County Council- casual employee		19/10/2019		19/10/2019	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015				Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Doble	Clare	Head of Governance Deputy Caldicott Guardian	Attendee of Audit Committee Quality Assurance Committee Primary Care Committee Governing Body (ad hoc)	Member o Taunton & Somerset NHS Foundation Trust Godmother to member of governance team's daughter	Partner on secondment to CCG Business Intelligence Team	22/08/2017	20/07/2020	Non-Financial Personal Interest	Indirect/Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Member of Primary Care Commissioning Committee (PCCC) Strategic Commissioning Programme Board Commissioning Committee (CC DOI)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	19/06/2018	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body A & E Delivery Board (SD&T)	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher GP Locality Clinical Director Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	28/07/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay and South Devon NHS Foundation Trust
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration and Workforce Committee(Non exec rem) Member of Devon JCEG	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	08/11/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Hargadon	Judy	Non Executive Lay Member - Primary Care and Prevention Geograhical remit - Southern	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) (Chair) Member of Remuneration and Workforce Committee		Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	10/03/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Harris	Penny	Management Consultant	Attendee of Governing Body Senior Leadership Team (SLT) Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Finance and Perfomance Committee Strategic Commissioning Programme Board Commissioning Committee (CC DOI) R&T System Management Group	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training Director of Kerr Mediation ltd - working alongside LMC law taking on primary care mediations commissioned by the LMC.		23/07/2019	04/08/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	KERR Darnley Ltd
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body (Chair) Member of Remuneration and Workforce Committee Transition Sub Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	GP Partner, Cricketfield Surgery (ceased December 2019) Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Clinical Chair NHS Devon CCG 1 March 2017 Church Warden Holy Trinity Church Spouse works in emergency department at RDE and for Exeter Medical School Primary Care Network - Templar Care Network		21/08/2015	04/10/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

Dr	Kennedy	Nick	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 Member of Devon JCEG Commissioning Committee (CC DOI) R&T System Management Group	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of Data safety monitoring committee (DSMC), The GAP study (safety of gabapentin) United Hospitals Bristol Member of national Independent Funding Request Panel NHS England Non-Executive Director GO-OP, GO-OP is a Multistakeholder Co-operative Society (Somerset Rules), registered under the Co-operative and Community Benefit Societies Acts. GO-OPGO-OP will be the UK's first co-operatively owned and run Train Operating Company Introduced PPE supplier (Orthofix International) to Devon CCG. Company part owned by my cousin Non-Executive Director of a start up limited company called LinkExec, an online business aimed at promoting start up businesses and investors. April 2020		26/09/2017	11/08/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Member of Integrated Commissioning Executive (ICE) Attendee Remuneration and Workforce Committee Attendee of Audit Committee Member Strategic Commissioning Programme Board Commissioning Committee (CC DOI)	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Lees	Sarah	Representative of Director of Public Health for Plymouth City Council	Member of Governing Body (Deputy) Member of Primary Care Commissioning Committee (PCCC)	School Governor, College Road Primary School, Plymouth	Husband is an employee of Livewell Southwest	10/11/2017		Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Manton	Sonja	Director of Strategy Interim Director of Commissioning. Northern, Eastern and South Devon and Torbay	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Transition Sub Committee Senior Leadership Team (SLT) Member of Quality Assurance Committee Attendee Audit Committee Member of Devon JCEG	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit from 1st Nov 2018	03/04/2017	09/10/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Governing Body Clinical Lead – Western Locality Chair of Western Primary Care Partnership	Member of Governing Body Member of Quality Assurance Committee Clinical Cabinet QEIA Panel STP Collaborative Board Remuneration and Workforce Committee (Non exec rem) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG)	Elected member, South West Regional Council of BMA Occasional Locum (self-employed) at Access Health Ltd Plymouth. GP Appraiser (NHS England) Working at Church View Surgery as self-employed sessional GP Elected to the Medical managers Committee of the BMA from September 2019	Partner is Medical Secretary and Board member of Devon LMC Partner is GP Partner, Church View Surgery, Plymstock Partner is Clinical Director of Mewstone Primary care Network(PCN)	26/09/2017	25/09/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Director of Communications and HR functions NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	04/03/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Pearson	Virginia	Chief Officer for Communities, Public Health, Environment and Prosperity/Director of Public Health, Devon County Council System Director of Population Health and Wellbeing, Devon STP	Co-opted Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Member of Integrated Commissioning Executive (ICE) Strategic Commissioning Programme Board	Member, STP Directors Group Member, STP Programme Delivery Executive Group Member, Devon Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Association of Directors of Public Health Member, British Medical Association Honorary Clinical Professor, University of Exeter College of Medicine and Health		02/02/2017	22/04/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council

Pearson	Nick	Head of Communications and engagement	Senior Leadership Team (SLT) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for Director of Communications)	Member of the Labour Party Member of the Exeter City Supporters Trust	Spouse is owner of Pearson Creative	13/01/2017	14/08/2019	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. Will not be commissioned by employee	NHS Devon CCG
Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee of Quality Assurance Committee Attendee of Finance and Performance Committee Attendee of Audit Committee Attendee of Remuneration and Workforce Committee Attendee of Commissioning Committee (CC DOI) Attendee of Primary Care Commissioning Commitee CCG Executive Team Meeting Senior Leadership Team (SLT) Working with Industry and Sponsorship Group R&T System Management Group	No interests declared		22/03/2019	10/08/2020				NHS Devon CCG
Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Attendee of Remuneration and Workforce Committee Strategic Commissioning Programme Board	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	07/09/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Tetley	Piers	Associate Director of HR and OD	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel CCG R&T Project Team meeting	No interests declared			16/10/2018				NHS Devon CCG
Thompson	Sarah	Interim Chief Operating Officer	Member Governing Body Member of Senior Leadership Team (SLT) Member of Integrated Commissioning Executive (ICE) Commissioning Committee (CC DOI)	Managing Director SF Thompson Consulting Limited (Not trading) Volunteer for Redbourn Care Group and the Redbourn Community Volunteers in response to the COVID-19 pandemic		22/01/2020	21/04/2020	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Turl	Jo	Director of Commissioning - Western	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Quality Assurance Committee	No interests declared		13/08/2015	03/09/2019	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee (Chair)	Co-opted Councillor on Budleigh Salterton Town Council (Independent Member – non-political)	Son employed by Care Quality Commission as an Information Analyst	16/10/2019	26/11/2019	Indirect interest		Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

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

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting
DRAFT minutes held in PUBLIC

Date: 30 July 2020 Time: 13:30 – 16:10

Location: Via Microsoft Office Teams

Item	Discussion	*Action*	
1	**Welcome and Apologies** PJ, chair welcomed everyone to the meeting, and noted that although no members of the public were observing live, the meeting was being recorded and would be available to the general public through the CCGs website. PJ reminded the members the use of language that can be understood by the public to demonstrate the values we have as a CCG. There were no questions submitted in advance of this meeting. Apologies were noted as detailed below. • ST • SMC • RH		
2	**Register of Interest (ROI)** The members reviewed the ROI there were no changes to the register. As an associate of South West Academic Health Science Network (AHSN) CB declared a conflict of interest around Think 111 national programme. **The Governing Body received and noted the ROI and conflict of interest declared.**		
3	**Minutes of the last meeting** PJ led a page by page review of the minutes of the meeting held on 18 June 2020 and it was agreed these were a true and accurate record of the meeting. **Open action log** **Action 1 – excess deaths compared to other parts of the UK.** VP provided an update and noted for the winter period of 19/20 death rates were lower in Devon and this was partly due to the mild weather and impact of the flu vaccine. We have since undertaken further analysis with support from clinical coders from the Royal Devon and Exeter Hospital (RDE) to look how death rates changed from the beginning of this year to the peak of the virus. The peak in Devon was less than, although higher than expected but death rates compared to the previous 5 years was not too bad and reverted to normal death rates following the peak. PJ referred to data that Public Health had analysed and offered to circulate this to the Governing Body. This action was formally closed.		

	ACTION 1 **Excess deaths data analysed by Public Health to be circulated to the Governing Body for information. Post meeting update this was circulated to Governing Body, action closed.**		
4	**Patient experience** CB welcomed Kevin Dixon (KD) from Healthwatch and highlighted that he had been given an opportunity to experience and be involved in the development of the engagement process for the Devon Ethical Framework. KD explained that he was a volunteer, carer and chair of Healthwatch Torbay and gave an account of his involvement in the engagement, co-design and co-delivery of engagement using technology to engage people from across the county and rural locations. He was pleased to say that progress had been made in empowering patients to ensure their voice is heard. Vina Flores (VF), joined to share her experience. Vina is involved with Hikmat Devon a Community Interest Company who enable and support minority ethnic communities in Devon. VF talked through her experience and noted that the consultation was helpful and that it was a privilege for voices to be heard. Often there is a language barrier where people don't always ask for help and there is some learning to take forward to improve the hearing of voices of non-UK nationals that are part of the community. She explained that engagement is important and Hikmat offer online activities and engagement to reduce isolation and build confidence. JH wondered how good the CCG is letting people know what happens following consultation and KD responded that this needs further development, and this could be improved by using social media more. VF noted that Hikmat inform clients what is happening on a regular basis through phone calls and 'what's app'. JWo queried the low response rate from Devon Voices panel for the Ethical Framework consultation which was disappointing. AM replied that it was important to recognise that panel members would be interested in different topics and the engagement went beyond the panel with the support from KD and VF to reach as many other people and he agreed that more work needs to be undertaken with diverse communities to get a wider range of views. SK wondered how he could modernise engagement with patients in his practice and VF felt that word of mouth and signposting them to Hikmat would be a small step towards this. JW wondered if people in the communities had missed meeting people in person during the pandemic and it was acknowledged there is need to get the right balance to meet people's needs. Technology has helped towards different opportunities, but not the solution as face to face engagement can be easier in a larger setting. PJ thanked KD and VF for sharing their experience which has been hugely valuable. *Vina Flores left the meeting.*		
5	**Devon Ethical Framework**		

Jo Turl and John Finn joined the meeting part way through this item.

SL was delighted to present the paper and personally thanked PJ and the CCG for deciding that it was important that the system in Devon had an ethical framework and the courage to do the public engagement work that had been undertaken.

The first task was for the Devon Ethical Group to bring commonality and fill in gaps where there was no national guidance available, so clinician and patients have the guidance expected and need. It was identified early on that a common ethical approach across the system was needed.

SL referred to the ethical framework and guidance for allocation and withdrawal of critical care and mentioned the legal advice received by the CCG last month. She described how Devon Virtual Voice panel were involved in public engagement and three convened separate focus groups with representatives from people who feel the guidance would apply to their situation.

- Black Asian Minority Ethnic (BAME) communities
- People with disabilities
- Older people

SL felt that through this engagement we have received valuable reflections and comments for improvements and we now have a common approach. This has been tested through public scrutiny and the independent representatives sitting on the ethical reference group feel this is cutting edge and that other organisations nationally could benefit from the Devon approach.

JH wondered if there was any reluctance in the system and objections to the framework and SL did not get the sense there was. SL confirmed the ethical guidance is consistent with guidance for local authorities and there was representation from local authority including adult social care on the ethical reference group. PJ acknowledged that alignment had been achieved with such a complex issue and this was positive.

The guidance and framework have been developed to support decision making and includes procedures for escalation if the system becomes overwhelmed and ethical support would need to be available 24/7 at hospital level and at reference group level if required.

SL confirmed that each individual Trust Board will receive and consider the recommendations in the same way as the CCG and then this will become an existing document.

SL felt that as the Devon Ethical Reference Group is an advisory group that it would be more appropriate for individual organisations to monitor the framework through their own ethical committees how this is to be adopted. PH reiterated that every provider does have an individual responsibility for ethical committee and dissemination and ensuring and that it was important that we don't cross over onto their responsibilities.

It was agreed as a commissioner and as part of our responsibilities that we do need to think about how we support primary care to act within the framework. We recognise that primary care are independent providers, but we do know that they want to work collaboratively as a system, and we will discuss how we can support them with the Local Medical Committee (LMC) and Primary Care Committee.

	SL referred to an area of work that regional ethics committee is looking at to address the issues of prioritisation and this work sets out the difficult decisions to be made around allocations of treatment and she offered to share this with the Governing Body when completed. **The Governing Body:** **a) Unanimously approved the Devon Ethical Framework (Appendix A) for use in this organisation.** **b) Unanimously approved the Devon guidance on allocation and withdrawal of treatment (Appendix B) for use in this organisation.** **c) Noted the Public Engagement Report (Appendix C).** **d) Noted the Recommendations adopted by the Devon Ethical Reference Group following Public Engagement (Appendix D) and which have been reflected in the Ethical Framework and Guidance.** **e) Noted that once the Framework and Guidance documents have been approved by all organisations, Devon CCG Communications & Engagement Team will work with provider teams to produce common patient-facing materials working with groups and individuals identified during their Public Engagement.** SL took the opportunity to personally acknowledged and thank Adam Carrick as secretary to the reference group and for his work and contribution in the development of the Ethical Framework. *Kevin Dixon and Nellie Guttman left the meeting*.		
6	**Chair's Report** There was nothing to add to the report, however PJ thanked ST for the way he has led the CCG through Covid and the way he supported his executive team over the challenges we have faced during the past few months. **The Governing Body received and noted the contents of the Chair's report.**		
7	**Accountable Officer's Report** JD presented this report in the absence of ST and summarised the CCGs latest update on our response to Covid, stating that we are stepping down our incident management response in a controlled and phased approach as we move towards business as usual. We are keeping an eye on the environment we are working in and we can stand up our response if required. Nightingale Exeter has been completed and handed over to RDE as the host organisation and is being used in the short term as a diagnostic centre to provide us with capacity around diagnostics but will continue to remain a key part of our surge capacity if needed for that purpose. We are working closely with the team around the return to office-base working in August/ and September and all the necessary safety measures will be put in place to support this. 111 first is an initiative looking at optimal flows for urgent care and directing people to the appropriate setting for care, Philippa Slinger, Devon STP CEO Lead is leading on this on behalf of the system.		

Integrated care partnership work continues to ensure we have a smooth transition for the rest of the year and the winter period, and we are reconsidering integrated care and working with providers for opportunities.

JF, associate director joined the meeting and talked through the Restoration and Transformation planning report as part of phase 2 of the response to the pandemic.

He highlighted the three aims of the report and noted that the CCG was working at pace in planning for phase 3 of the response.

JF referred to the letter received at the end of April from NHS England and the actions required for phase 2 which included 43 objectives focused on several areas including urgent and routine care, women and children and mental health. These objectives were to be completed by a set time frame of the 12 June. JF was pleased to report the delivery of actions was achieved by the timeframe.

To support the delivery of actions teams and groups were used that were operating as business as usual rather than set up new and kept governance as requested.

JF highlighted areas of success learning and impact such as:

- Utilisation of the independent sector and this capacity is still critical to phase 3
- Strengthened capacity of out of hours service include 111
- Discharge services excelled
- Transformation changes how healthcare was delivered including non face to face primary care appointments
- Set up system restoration group across STP, including senior health and social care members – whole system approach
- Devon Referral Support Service (DRSS) 70% back to where classed as normal referrals, low starting point from Mid-April and phase 3 will need to respond to low referral rates
- 52 Weeks quadrupled
- Good robust process put in place to understand waiting lists and providers are operating through categorisation lists
- Urgent care has recovered from pre-Covid levels
- Focusing on mental health services
- Introduced service change process which has now been reversed using Quality Equality Impact Assessment (QEIA) and reported weekly through to the executive team

JF noted that the CCG has not received the Phase 3 letter from NHS England and in the absence of the letter guidance has been received from the regional team around planning principles focused on single winter plan and he assured the Governing Body the processes around winter planning are in an advanced position than this time last year.

SK wondered if there was any insight into the financial impact of phase 3 and the implications of costs such as poorer outcomes for patients not being seen face to face. JF responded that the cost base of services will need quantifying and understanding as to what that means around outpatient work and plans for next year. It was acknowledged that outcomes for patients and access to diagnostics has had an impact and this is a prime focus for the CCG to increase capacity.

	JH highlighted that it was important to recognise the massive amount of work and energy that is already being undertaken by the executives in advance of direction from NHS England and that we need to continue planning and use our own initiative in these processes. On behalf of the Governing Body, PJ thank JF and the team for their work. *John Finn left the meeting.* **The Governing Body received and noted the contents of the Accountable Officer's report and the update on restoration and transformation.**		
8	**Month 3 Financial Report** This report detailed the financial position to end of June 2020 and JD reminded the Governing Body we are currently working within the temporary emergency financial framework that has been put in place by NHSE/I whilst responding to the pandemic. All costs will be covered whilst operating within this framework and this has been formally extended to the end of August. JD referred to page 99 section 3 and the expenditure directly relating to Covid and other services not directly to Covid. It shows at the end of month 3 £18.5m costs directly relate to Covid with £11.6m of that having been reimbursed. We are still working through assurance process NHSE/I around the gap of reimbursed costs. JD noted that the forecast included in the table is for the end July. JD directed the members to page 105 which detailed the Covid related expenditure for the Nightingale Exeter and the faster hospital discharge programme which has been a key system response to Covid. Section 6 detailed the risks and JD declared that uncertainty was the biggest risk around allocation for the population and we are working to understand the forecast expenditure and what this will look like. Once we have confirmation of the allocation this will enable us to make comparison. JD highlighted primary care prescribing which is an area of concern and there is more to be done in this area to understand and we remain in open dialogue with NHS E. JT provided an update on primary care prescribing programmes and the restart of the quality, innovation, productivity and prevention programme (QIPP) on 1 September 2020. We are also reviewing the primary care strategy and how we can further support general practice. GAth pointed out that the paper appeared to show there had been an increase in running costs. JD explained the rate of expenditure which had not increased, and we have seen a reduction in variance. GT wondered about the savings plan and the original budget of £22.6m which has been set aside during Covid. JD confirmed it was the intention to stand up elements QIPP again and we will be reassessing each element of the plan to see what is reasonable and deliverable within context and remainder of the year. NB congratulated JD on the outstanding performance in terms of creditor payments within the 30-day timescale, especially in the current environment and this will have made the difference as to whether business have survived or not.		

	The Governing Body received, reviewed and discuss the month 3 year to date performance and the forecast four-month position including the current risks.		
	Quality and Performance Report DA took the quality element of the report as read but brought the following points to the attention of the Governing Body. • Working to shift quality view to understand impacts on quality • Supporting providers regarding 111 impacts • Open dialogue with Quality Surveillance Group, NHS England and Care Quality Commission (CQC) to better understand the potential of harm • Risk stratification links to forward view • Delay in investigations reviewing the learning • Joint working on good practice to improve care home performance STh referred to the performance report which was for April and May and is underpinned with the restoration and transformation recovery work. She reaffirmed that during our response period we are in a better national position against compliance for diagnostics, Emergency Department (ED) and cancer waiting times. However, 18-week performance has fallen behind the national position. Looking forward we have received new guidance to step back up reporting arrangements. The CCG has not waited for new guidance we have pre-empted and agreed a local approach around health inequalities to make real impact and change going forward. PJ commented that where historically we have been below average in performance, but we have been recognised regionally and nationally for the ability to have used the independent sector and there has been some good work both from commissioners and providers in using opportunities to optimise demand coming through. **The Governing Body received and noted the contents of the quality and performance report for April and May.**		
9	**NHS Devon CCG Constitution and supporting Governance Handbook amendments** GS introduced this paper and reminded the Governing Body that amendments to the constitution were approved at the Governing Body back in January 2020. Following feedback from NHSE/I there are some minor amendments outlined in the paper and GS drew attention to the timescales for the development of the next version of the constitution which will commence in September. List member practices in document appears to be formatting issue make sure corrected before published on our website or sent to GP Practice members. JH referred to the Remuneration and Workforce Committee Terms of Reference (ToR) and proposed changes to the Primary Care Commissioning Committee (PCCC) as result of internal audit report. For the PCCC we can update the ToR as a working arrangement, and we will update the constitution at the next iteration. There was discussion around the agreed membership for the Remuneration and Workforce Committee and this would be clarified outside of the meeting and revisited and reviewed by the members of this committee.		

	GAth queried why the Quality Committee and Finance Committee ToRs were not included in the constitution and this was because the constitution only requires statutory committees to be included, but the ToRs for these committees have been included the governance handbook. **The Governing Body:** • **Approved the amendments requested by NHSE following their review during Q4 2019/20 as outlined in section 2 of this report.** • **Agreed to the circulation of the constitution, once formal approval received from NHSE, to its member practice representatives with a covering letter from the Chair, senior officers of the CCG, and ensure that the formatted constitution and the supporting governance handbook is made publicly available on its website.** • **approved in principal the timeline for the next review of the constitution and inform the CCGs member practice representatives of rationale for this approach** *Suzi Leather left the meeting.*		
10	**Remuneration and Workforce Committee Chair's Report** GT noted there was nothing further to add to this report. He thanked GAth for chairing the committee for the last twelve months and extended thanks to the executive team for their leadership during our response to the pandemic. GT referred to the Devon ICS Lead role and handed over to the chair. PJ set the context of the role and the arrangements that are currently in place. The paper set out the recommendations regarding the nature of the Devon ICS Lead role and next steps in the permanent appointment of this role including the design of the role and the appointment process for it. PJ noted that the benefits for the organisation and system of the combined role, which NHS E have stipulated was articulated in the paper. **The Governing Body:** • **supported and approved the combination roles of ICS Lead with the Accountable Officer of the CCG** • **supported and approved the establishment of a system coordination group to oversee the development of the ICS Chief Executive role (incorporating the CCG AO) job description, person specification and appointment process** • **supported and approved on completion of the development of a robust appointment process, approval will be sought from the Remuneration and Workforce Committee and, thence, Governing Body ahead of advertisement launch and this may be done electronically due to timings, and formally ratified at the next scheduled formal Governing Body** **The Governing Body noted and received the contents of the Remuneration and Workforce Chair's Report**		
11	**Finance Committee Chair's Report** **There was nothing to add to the report. GT informed the members that the finance** committee had been reluctant to close risks and that a couple of risk had been added to the register one of which was around the temporary financial arrangements.		

	The finance committee received a separate report about the interim financial framework and compared to the CCG's original budget set we are receiving more funds than anticipated. Whilst this was good news, monthly we are spending more than the rate of expenditure, and some modelling around potential in year projection savings. **The Governing Body received and noted the contents of the Finance Committee Chairs Report.**		
12	**Audit Committee Chair's Report.** There was nothing further to add to this report. GS referred to the recommendations in the report and drew attention to the Risk Management Framework Policy which is the overarching framework for managing risks which has been updated around strengthening our risk management and be clear on training requirements. **The Governing Body received and noted the contents of the Audit Committee Chair's Report.** **The Governing Body approved the Risk Management Framework Policy.**		
13	**Primary Care Committee** JH highlighted one activity that the primary care team undertook when moving into the transformation approach. An exercise was undertaken to understand the needs of practices and in doing this we used general practice and governing body expertise and JH thanked them for their contribution. And from this piece of work we need to rethink how we support practices needs post Covid. **The Governing Body received and noted the contents of the Primary Care Committee Chair's Report.**		
14	**Quality Assurance Committee** GAth drew attention to the development of a task and finish group and the development of a strategy and workplan. This was not just for the Quality Assurance Committee but also for the quality team. **The Governing Body received and noted the contents of the Quality Assurance Committee Chair's Report.**		
15	**Locality Update Reports** The chair remarked that the locality reports were excellent. <u>Northern Locality</u> The report was taken as read. JWo felt there was change fatigue and desired for certainty around the function, structure and responsibility of and integrated care partnership to allow individuals to manage and deliver change. JW asked about the suicide prevention plan and are the resources in place to support the standing back up of this service. JWo confirmed that he will be meeting with the CEO of Devon Partnership Trust discuss this and how we manage the wider mental health strategy. <u>Eastern Locality</u> The report was taken as read.		

	SK supported the view around strategic direction and the eastern locality is focusing how best to deliver outcomes for patients and the system. A developmental day is being arranged for September to understand the pressures in primary care. <u>Western Locality</u> NB did not propose to go through the report in detail but highlighted the following: 1. Success of connectivity during Covid and weekly systemwide video conferencing 2. Focus on investigating whether we can use fair shares funding and how to use this to substantiate some of the changes during Covid for sustainability 3. Workforce issues – voluntary sector and impact of Covid 4. Resilience of Plymstock GP practices following on from Barton contract which has not been completely resolved 5. Progression of ICP bringing forward to December to ease pressure in system over the winter period – will be challenging <u>Southern Locality</u> DG noted that the report covered recovery and restoration plan and highlighted the way we improve the way we look after chronic conditions. Key priorities going forward include winter planning, diagnostics and elective care. Newton Abbot is part of the population health pilot and we are waiting to see the outcomes. PH explained the concept around the care coordination concept which is a pilot for directing people to community services through a variety of models.		
16	**Any other business** There was none raised. The chair thanked everyone for a good productive day.		
17	The meeting closed at 16:10		

Attendees (attended** / apologies [A])	
Name and initials	*Title and organisation*
Alison Davis (AD) **	Associate Non-Executive Director, Devon CCG
Andrew Millward (AM) **	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Darryn Allcorn (DA) **	Chief Nurse, NHS Devon CCG
David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Gaynor Appleby (GApp) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT) **	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG

James Wooldridge (JW) **		Associate Non-Executive Director, Devon CCG
John Dowell (JD) **		Chief Finance Officer, Devon CCG
John Womersley – Dr (Jwo) **		Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **		Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **		Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF) A (in absence of DG)		Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **		Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **		Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) **Chair** **		Clinical Chair, Devon CCG
Penny Harris – (PH) **		Director, Devon CCG
Philip King (PK) **		Interim Chief Nurse
Ruth Harrell – Dr (RH) A		Director of Public Health, Plymouth City Council
Sarah Thompson (STh) **		Chief Operating Officer, Devon CCG
Simon Kerr – Dr (SK) **		Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc) A		Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST) A		Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **		Interim Director of Commissioning – North, East and South, Devon CCG
Virginia Pearson – Dr (VP) **		Director of Public Health, Devon County Council
In Attendance		
Nikki Coombes (NC) ** **Minute Taker**		Executive Assistant, Devon CCG
Dame Suzi Leather (SL) **Item 4&5**		Independent Chair – Devon STP
Nellie Guttman (NG) **Item 4&5**		Senior Strategic Engagement Manager, Devon CCG
Kevin Dixon (KD) **Item 4&5**		Healthwatch Torbay
Vina Flores **item 4**		Hikmat Devon, Community Interest Company (CiC)
John Finn (JF) **item 7**		Associate Director of Commissioning, Northern and Planned Care and Cancer, Devon CCG
Minutes approved	Date:	Signed by chair:

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY – CHAIRS REPORT

1. Clinical Chair – invitation to join future Governing Body meeting

Dr Paul Johnson recently met with Andrew Girhder, Clinical Chair, NHS Bath and North East Somerset, Swindon and Wiltshire (BNSSW) Clinical Commissioning Group (CCG) who is keen to learn and has expressed an interest in sitting in and observing a future NHS Devon CCG meeting, both public and private. Dr Paul Johnson has extended an invitation for Andrew to our meeting in October and I am sure you will give Andrew a warm welcome. Dr Paul Johnson has also requested to observe NHS BNSSW Governing Body in November and he will feedback his experience in a future chair's report.

2. Appointment of System Chief Executive and Accountable Officer of NHS Devon CCG

Further to the discussions that were held in July, Dr Paul Johnson has now set up the working group to agree the appointment process for the above post. The group met and has now appointed GatenbySanderson to support the CCG through the process. The group membership consists of:

- Dr Paul Johnson, Clinical Chair, NHS Devon CCG (Chair of the group)
- Richard Crompton, Chair, University Hospitals Plymouth
- Dame Suzi Leather, Independent Chair, Devon STP
- Elizabeth O'Mahony, South West Regional Director, NHS England
- Graham Turner, Non-Executive Director/ Chair of Remuneration and Strategic Workforce Committee, NHS Devon CCG

Nick Ball
Vice Chair/ Chair of Audit
17 August 2020

NHS
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GOVERNING BODY MEETING

Report title: Accountable Officer's Report				
Date of committee: 27 August 2020 **Date report produced: 14 August 2020**				
Author (s) Name and Title: Simon Tapley, Accountable Officer Molly Bishop, Executive Assistant to Accountable Officer		**Supporting Executive:** **Name and Title:** Simon Tapley, Accountable Officer **Report Approved by:** **Name and Title:** Simon Tapley, Accountable Officer **Date** 18 August 2020		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				

Executive Summary:
This report contains updates on:

- CCG response to COVID-19
- Restoration and transformation – Phase 3
- Senior Leadership Team

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

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

N/A

Key recommendations and actions requested:

This report is for information only.

Impact on Strategic Objectives

We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
N/A
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality	Safety: Effectiveness: Experience:	✓
Equality		✓
Resource and Finance		✓
Legal		✓
Engagement and Consultation		✓
Risk		✓

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

NHS
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Clinical Commissioning Group

Accountable Officer's Report

1. CCG Response to COVID-19

Returning to CCG offices

In response to national guidance, the CCG has adopted to a new way of working and changed its infrastructure appropriately to enable staff to work from home. A CCG recovery group was set up to consider the actions from this guidance and has subsequently implemented a number of operational processes to protect employees and others from the risk of coronavirus infection. These include:

- COVID-19 site specific risk assessments with adaptions to ensure offices are COVID-19 safe in line with guidance. All five CCG sites have received approval that they are 'COVID-19 safe' by our external Health & Safety advisor.
- CCG Covid-19 guidance for employees to keep safe in the workplace during COVID-19, along with provisions for health and wellbeing.
- Homeworking/Workstation guidance and checklist.
- Cleaning protocol and checklist developed in line with guidance.
- COVID-19 outbreak protocol for CCG.

Meetings have taken place with all staff to discuss their views and requirements for returning to our offices. In addition, individual risk assessments have been undertaken for those within Extremely Vulnerable and Vulnerable Groups, including those living with someone or in a 'support bubble' within these groups.

A recent announcement from the government stated that staff should go back to work if they can from 1 August 2020. As such, myself and our executive team have agreed recommendations to ensure workplaces are now 'COVID-19 secure'. From 1 September 2020, our message to staff is to work from home if they can, balanced against the needs of individual's mental health and wellbeing. We have set out the following principles to our staff:

- It is important those in vulnerable groups continue to work from home
- Workers in critical roles for the organisation, that cannot be performed remotely, should continue to work from the office. This will include a requirement for the appropriate ratio of first aiders/fire warden per site, depending on occupancy
- Workers in critical roles which might be performed remotely, but who are unable to work from home due to personal circumstances or the unavailability of equipment, can work from the office
- Individuals who have asked to be prioritised for a return to the workplace can be considered, based on their individual circumstances, e.g. to support health and wellbeing, in discussion with their manager

- Agile working will continue to be supported.

Each directorate will be allocated desks at sites to cater for those staff who want to work in the office, and we have issued a guidance document to all our staff to support our new way of working.

2. Devon System COVID-19 Phase 3 Response

We received the letter from NHS England and NHS Improvement, setting out key actions and measures for phase 3 of the NHS response to COVID-19, on 31 July 2020. It contains key priorities for the NHS from August, which includes a shared focus on:

- Accelerating the return to near-normal levels of non-COVID-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter
- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID-19 spikes locally and possibly nationally.
- Doing the above in a way that takes account of lessons learned during the first COVID-19 peak; locks in beneficial changes; and explicitly tackles fundamental challenges

As we have moved into phase 3 of our response to COVID-19, it is important we recognise the transformational work by our staff and take learning from phase 1 and 2. We are taking a number of steps to restore services whilst maintaining a focus on benchmarking of costs and performance recovery. There is a paper included as a separate item for the Governing Body this month, which sets out our approach to phase 3 and a reflection on our successes in further detail.

3. CCG Senior Leadership Team

As we have had time to reflect on the last 12 months and in particular the opportunity to learn from our response through the COVID-19 pandemic, we are now seeking to make some evolutionary changes to the current structure and portfolios for senior leadership team. This is intended to embed learning and promote matrix working to enhance our operational capabilities and efficiency as a CCG. We have issued a 'seeking your views' document to our senior leadership team and will take into consideration any feedback received on these proposals.

NHS
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NHS DEVON GOVERNING BODY - PUBLIC

Report title: Devon System COVID-19 Response				
Date of committee: 27th August 2020 **Date report produced:** 19th August 2020				
Author (s) Name and Title: Alison Wilkinson – Deputy Chief Operating Officer Nicola Bonas - Deputy Head of CCG and System Communications and Engagement		**Supporting Executive:** **Name and Title:** Simon Tapley – Accountable Officer **Report Approved by:** **Name and Title:** Simon Tapley – Accountable Officer **Date:** 19th August 2020		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of this paper is to build on the paper presented to the Governing Body on 30 July 2020 regarding Restoration and Transformation planning, focusing on more areas of good practice and innovative work undertaken during the COVID-19 pandemic response.				
Management of Conflict of interests: **Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.**				
Committees that have previously discussed/agreed the report and outcomes:				
None				
Key recommendations and actions requested:				
Members of the Governing body are asked to note the contents of this report.				

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

Devon System COVID-19 Response

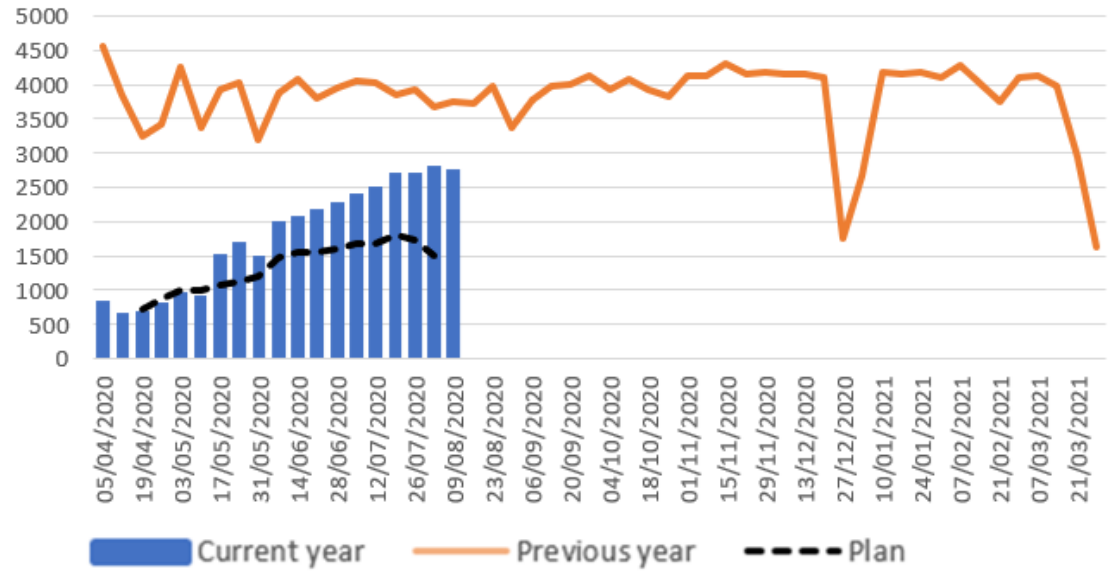
Introduction

The purpose of this paper is to build on the paper presented to the Governing Body on 30 July 2020 regarding Restoration and Transformation planning, focusing on more areas of good practice and innovative work undertaken during the COVID-19 pandemic response.

There is much to celebrate in the way organisations within the Devon system have worked together as a single system team through the COVID-19 response, showing commitment and flexibility in working to deliver the best for our local population.

Activity and Performance

In terms of activity, the South West recommenced elective activity faster than any other region and, within the South West, Devon has consistently over-achieved against Phase 2 plans for elective inpatient and day case activity. In the latest two weeks (ending 2nd and 9th August 2020), system information shows that STP elective activity levels were at 76% and 73.7% of 2019/20 levels - against a national Phase 3 ambition of 70% in August. This puts the system in a good position to achieve the 80% aim in September. The graph below shows the combined elective inpatient and day case weekly activity against planned levels and 2019/20 activity:



The Devon system has maintained performance against key Cancer targets throughout the COVID-19 pandemic response, improving both 62-day and two week wait performance between February and June, despite the significant reduction in capacity. As of June 2020, the CCG met the two week wait 93% target, achieving 93.07%, which is also higher than the England average of 92.5%. Whilst in relation to the 62 day urgent referral to treatment standard Devon did not achieve the target

of 85% in June, again we exceeded the England average of 75.2%, with performance of 76.74%. This can be attributed in some part to the way in which Devon used available Independent Sector capacity and it has been recognised that Devon has led the way in maximising capacity available in the independent sector to provide additional space and services to support cancer and priority surgery.

Importantly, Devon has lost the fewest beds of any system in the South West due to infection control, losing just 5% of beds, compared to an average for the region of 10%.

In terms of COVID-19 infection rates, Devon has 157.9 cases per 100,000 (lowest ranked in SW and second lowest out of 150 or so upper tier/unitary authorities nationally). The South West is still the lowest region at 247.3 cases per 100,000 which compares to 490.0 per 100,000 nationally.

Phase 2 recovery – highlights

- Greater use of digital technology and innovative solutions to care and wellbeing services, including significant increase in virtual outpatient and general practice appointments. Before the outbreak, around 80 per cent of GP appointments were carried out face-to-face – now it is the opposite, with about 90 per cent of patients seen first online.

- Local patients are embracing new technology, with more than 13,000 video consultations in Devon between April and May 2020 - among the highest of any area in the country

- Nightingale Hospital Exeter is now providing safe and fast diagnostic testing for the peninsula for a range of conditions: CT scanning services commenced last month and nearly 200 patients have so far been seen. Ultrasound services started week commencing 10/8/20 and 100 patients have been scanned so far. It is anticipated that 2,000 ultrasound scans will be undertaken in the next 12 weeks, which will clear the non-obstetric ultrasound backlog. Almost 100 echocardiography tests have been completed since the service started last week.

- The CCG has continued to work closely with care homes and out of hospital providers, alongside local authority colleagues. A regular webinar has provided information and shared experiences on key topics. These have been planned using feedback from the care sector. We recently published a set of system agreed principles for health and care professionals visiting care homes. The AHSN is working with us to support the rollout of RESTORE2, a digital tool which will enable care homes and primary care to have early identification of deteriorating individuals. Infection, prevention and control training has been offered to all care homes across Devon and continues with domiciliary and supported living providers included.

- In a pioneering approach to target groups who are digitally excluded, an informative newspaper was delivered to more than 300,000 homes across Devon as an essential guide to services and next steps in the continuing efforts

against COVID-19. The publication was jointly commissioned by NHS Devon Clinical Commissioning Group, Devon and Cornwall Police and Crime Commissioner's Office and Devon County Council - https://edition.pagesuite-professional.co.uk/html5/reader/production/default.aspx?pubname=&pubid=705c1249-f093-49ed-acf5-acefd9935afb (*use this link to view the paper*)

- The need for stringent infection prevention and control (IPC) measures had a significant impact on diagnostic activity as we moved into Phase 2, doubling the time taken for CT, MRI and non-obstetric ultrasound scans (NOUS) from 15 minutes to 30 minutes, halving productivity. As the weeks have progressed, teams have worked to improve productivity whilst maintaining the same strict infection control processes and have reduced the time per scan to 20 minutes, aiming to return to 15 minute slots shortly. Given the significant constraints on diagnostic capacity in Devon, this is an important development.

- Throughout the COVID-19 pandemic response DRSS has continued to provide referral management services, albeit contingency based, and since February 2020 has processed **99,261** routine, urgent and 2WW referrals.

- Additionally, DRSS has supported the system in several ways;

  - Contacted over **1,500** local businesses and companies and collected over **55,000** assorted items of PPE equipment and clothing
  - Supported Devon Doctors by speaking to over **37,000** patients waiting on the Devon Dental Waiting list
  - Supported **10** GP Practices with shielding support, having made **2,000** outbound patient calls and receiving **200** inbound calls
  - Co-ordinated around **2,300** antibody tests referrals (CCG staff and GP practices - approx. 17 000 staff eligible for antibody testing within Devon/East Cornwall).

- Launch of the first Ethical Framework and Guidance on the treatment of critically ill patients in a future pandemic like Coronavirus. The CCG linked up remotely with local community members as well as key professional groups to agree vital guidance for frontline clinicians, patients and their families and carers in a pandemic situation where health systems are at risk of being overwhelmed.

Phase 3 - what is happening now?

Some of the steps we are taking to restore services include:

- Identifying the most clinically urgent cancer patients for surgery, including use of the independent sector.
- Reviewing all surgery lists, prioritising patients and reintroducing surgery and outpatients' services incrementally.
- GP referrals to hospitals beginning to return to pre-pandemic levels over time, while continuing to focus on high-risk patients.

- Continue to maintain increased community services capacity to support discharges, support care homes and predominantly support young patients and those patients with respiratory conditions or learning disabilities. Also ensuring that appropriate services and support is in place for those people who have been in hospital with COVID-19 and are now in recovery.
- Seeking to understand the potential mental health impact of the pandemic, providing ongoing support for high risk and urgent patients. Preparing for possible longer-term increases in demand for mental health services
- Continued segregation of infected and non-infected patients across all services
- Enhanced discharge planning to ensure timely, safe and appropriate discharges
- Further support to care homes including identifying a clinical lead for each care home and setting up weekly virtual 'care home round' of residents needing clinical support and medication reviews
- Enhanced psychological support for all NHS staff who need it
- Putting in place mechanisms to ensure closer working between the NHS, local communities and partners to increase the scale and pace of progress in reducing health inequalities.
- GP practices are starting to address the backlog of childhood immunisations and cervical screening, as well as flu planning through their Primary Care Network (PCN)

Things to consider

We will keep a constant check on the development of the pandemic locally and be guided by the Local Outbreak Boards, we will remain fully prepared to go back to full COVID-19 provision if this is required, in line with national and regional guidance. As we restore our services, we need to ensure that:

- We protect the long-term welfare of our staff to be able to treat the numbers of extra patients. Our staff have been absolutely fantastic in their response to the pandemic and affected in many different ways by COVID-19. We must support our staff to recover before we take too many steps forward in recovering our services.
- Our stocks of Personal Protective Equipment (PPE) are able to match service provision to ensure services can commence and continue safely to protect staff and patients
- We want to support patients to continue to use services in a different way. The latest, August, data shows reductions of more than 14% in our accident and emergency departments' A&E attendances compared to last year's volumes, amounting to 56,000 fewer attendances. And while some of this may have been patients who perhaps might have been best to come to A&E but were deterred, we expect also that many patients with minor injuries or illness decided not to attend A&E and either used an alternative service or self-care, which is a message we have been trying to send to the public for many years.
- We start to understand the greater impact of the pandemic on the population, both for routine care and where there might be the potential for greater

complications due to patients being treated later than would normally have happened.

- We understand the knock-on implications for different sectors and services within health and social care, not least the secondary impact of operations on primary and community care services.

Conclusion

The Governing Body is asked to note the contents of this report.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Modernising Health and Care Services in Teignmouth and Dawlish				
Date of committee: 27 August 2020 **Date report produced: 14 August 2020**				
Author (s) Name and Title: Jenny Turner, Head of Integrated care **Contact Details: jenny.turner3@nhs.net**		**Supporting Executive: Jo Turl** **Name and Title: Director of Commissioning** **Contact Details:** **Report Approved by: Jo Turl** **Name and Title: Director of Commissioning** **Date: 14 August 2020**		
Public or Private (Governing Body only):	**Public**	**x**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The purpose of this paper is to update the Governing Body on plans to progress the Coastal Consultation (approved by the Governing Body in February 2020), as follows:

- 01 September – 26 October 2020 eight-week consultation
- 26 October – 29 November 2020 analysis and evaluation
- 17 December 2020 – Meeting of Devon CCG's Governing Body for decision

NHS Devon Devon Clinical Commissioning Group (CCG) needs to progress the consultation in the Coastal locality, Modernising health and care services in the Teignmouth and Dawlish area. The consultation was approved by the CCG's Governing Body in February 2020. It was due to launch in March 2020 but was postponed due to the COVID-19 pandemic. It has been kept under review since then.

The public consultation will run from 01 September 2020 to 26 October 2020. The consultation process has been adapted and will be a remote consultation process utilising postal hard copy, online platforms and telephone clinics. The documentation has been updated to reflect the new format and delivery of healthcare services during the pandemic.

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:

Executives

Key recommendations and actions requested:

The Governing Body is asked to note:

- **The format for remote consultation using the consultation channels as outlined in section 6**
- **The consultation meeting dates and timeline**

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

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

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

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

NHS Devon Clinical Commissioning Group

Report to NHS Devon Clinical Commissioning Group Governing Body

August 2020

Modernising health and care services in Teignmouth and Dawlish Area

1 Purpose

The purpose of this paper is to update the Governing Body on plans to progress the Coastal Consultation (approved by the Governing Body in February 2020), as follows:

- 01 September – 26 October 2020 eight-week consultation
- 26 October – 29 November 2020 analysis and evaluation
- 17 December 2020 – Meeting of Devon CCG's Governing Body for decision

2 Recommendation

The Governing Body is asked to note:

- The format for remote consultation using the consultation channels as outlined in section 6
- The consultation meeting dates and timeline

3 Introduction

NHS Devon Devon Clinical Commissioning Group (CCG) needs to progress the consultation in the Coastal locality, Modernising health and care services in the Teignmouth and Dawlish area. The consultation was approved by the CCG's Governing Body in February 2020. It was due to launch in March 2020 but was postponed due to the COVID-19 pandemic. It has been kept under review since then.

The terms of the agreement reached for the purchase of the land for the new health and wellbeing centre between landowner, Teignbridge District Council, and purchaser, Torbay and South Devon NHS Foundation Trust, stipulated that work had to start on site in October 2020.

The original consultation timeline was designed to enable this to be achieved. Due to COVID-19, the timescale for the health and wellbeing development has been delayed which has put the start date back to January 2021.

The NHS is actively restoring services and as part of this as well as enabling the timeframe for the health and wellbeing centre, the CCG is progressing with the consultation from 1 September 2020.

4 Background

NHS Devon CCG and the health community have worked with GPs, stakeholders and local people to develop a vision for health and wellbeing services in Teignmouth.

The potential of various options to achieve the vision has been assessed over the past months with a view to moving towards a proposal for public consultation. The proposal was approved by the CCG's Governing Body in February and the consultation originally scheduled for March 2020, but all plans were put on hold due to the COVID-19 pandemic, which not only required all the CCG's resources but made the holding of a consultation seem inappropriate during the lockdown phase.

Our intention is to enable a range of health and wellbeing services to be located together in a new Health and Wellbeing Centre on Brunswick Street, including Teignmouth's biggest GP practice, Channel View Medical Group, the health and wellbeing team, the voluntary sector, and potentially pharmacy.

The centre would allow the safe flow of staff and patients around the building, enabling social distancing. Designated space for GPs to train new doctors would be available – which is not the case at present – and we would expect the current difficulties that GPs have in attracting new partner doctors to be eased because the new recruits would not be asked to take on liability for premises which fall below modern standards. A light, airy and more fit for purpose environment would provide an improved experience for local people and our staff alike.

The local NHS has been looking at what the Health and Wellbeing Centre could mean for the community clinics, specialist outpatient services and day case procedures currently provided at Teignmouth Community Hospital. Informed by engagement with local people, the CCG is of the view that all these services should be kept within Teignmouth and Dawlish.

The proposals are:

a) Move the most frequently used community clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre

- This includes podiatry, physiotherapy and audiology. Because they are closely related to audiology, specialist ear nose and throat services would also move to the new centre.
- Overall, these clinics make up 73% of all the outpatient appointments currently held in Teignmouth, at the community hospital. And 91% of these clinics are used by local people, living within the Dawlish, Teignmouth and surrounding areas

b) Move specialist outpatient clinics, except ear nose and throat clinics, from Teignmouth Community Hospital to Dawlish Community Hospital, four miles away

- These are the specialist clinics, 23 in number, that are less frequently used at Teignmouth Community Hospital, making up only 27% of total appointments there.
- They are currently used by people from all over South Devon and Torbay as well as those from Teignmouth and Dawlish. 70% of people using them come from outside the Dawlish and Teignmouth area.

c) Move day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital

- This service includes minor procedures that require a specific treatment room.
- 86% of those using them come from outside the Dawlish and Teignmouth area, with more than half from Torbay.
- Journey times for many patients would increase, by up to four miles.

d) Continue with a model of community-based intermediate care, reversing the decision to establish 12 rehabilitation beds at Teignmouth Community Hospital

- After investment in community teams, we can now treat four times as many patients in their own homes as we could on a ward at Teignmouth Community Hospital.
- With the Nightingale Hospital established in Exeter, current analysis shows the 12 beds would not be needed for patients with COVID-19.
- The South West Clinical Senate, in a review, concluded that it was clear the 12 rehabilitation beds were not now needed.

If the proposal is approved after consultation, Teignmouth Community Hospital would no longer be needed for NHS services by Torbay and South Devon NHS Foundation Trust, which would be likely to sell the building.

5 Pre-consultation engagement

As part of the planning for the public consultation starting on 1 September the CCG has briefed the following:

- NHS England who have approved our approach and support the timelines.
- The Consultation Institute who have reviewed our documentation and our approach to consultation.
- Local MPs and other key stakeholders.
- Devon Overview and Scrutiny Committee

A pre-consultation promotion of the process started on 18 August with stakeholders being able to visit the website to register as an interested stakeholder and receive regular updates, express an interest in attending an on-line meeting or to invite us to meet remotely with community group to discuss the proposal **www.devonccg.nhs.uk/teignmouth-and-dawlish**

6 Consultation Format

Because COVID-19 is still present in the community, the consultation will be conducted differently.

- The full consultation document will be delivered to people 16,000 households in the Teignmouth and Dawlish area (EX7 and TQ14 postcodes), with a leaflet delivered to the 133,000 households in the rest of South Devon and Torbay
- Meetings will be held online, with opportunities to ask questions and air views, as follows:
  - Friday, 11 September 2.30pm – 4pm
  - Thursday 17 September 10.30am -12noon
  - Wednesday 23 September 6pm -7.30pm
  - Tuesday 29 September 3pm – 4.30pm
  - Monday 5 October 11.30am – 1pm
  - Saturday 17 October 11am – 12.30pm
- We will actively seek remote meetings with a wide range of community groups. With the support of Healthwatch we will target hard to reach groups identified in the equality impact assessment. We will seek to attend existing online meetings or offer the facility to hold an online meeting.
- We will offer the opportunity for people to book a telephone conversation for those who do not have online access.
- A questionnaire will be available via the website and as part of the consultation document with a freepost address.
- We will repeat the approach taken in engagement and in previous consultations where we will establish dedicated email contacts, as well as providing for written and other electronic correspondence. All correspondence will be logged as part of the consultation period and a speedy response will be given to all correspondence where queries are raised.
- Questions, requests for more information etc throughout the consultation will be managed by the CCG response team.
- The consultation document, detailed supporting information and questionnaire will be available at **www.devonccg.nhs.uk/teignmouth-and-dawlish**

7 Role of Healthwatch

Healthwatch Devon, Plymouth and Torbay will support and oversee the consultation. They will be responsible for:

- Hosting the on-line survey and receiving postal survey responses and inputting.
- Hosting the 'front of house' email and telephone queries and responding where possible with a freephone telephone number staffed 10am-4pm Monday to Friday.
- Sending out copies of the consultation document on request.
- Liaising with the CCG response team where support is required for response.
- Taking notes at all meetings
- Arranging meetings and feedback from targeted hard to reach groups

- Analysing feedback from meetings and survey
- Producing the final report

8 Impact of COVID-19

The COVID-19 pandemic has meant that the health and social care system has had to deliver services in different ways, and we need to understand the emerging impact of delivering services in the future to ensure the proposed model of care in Teignmouth and Dawlish remains fit for purpose. This includes the need for bed capacity for future COVID-19 surge capacity, the delivery of rehabilitation services, primary care services outpatient services and day case procedures.

8.1 Demand for hospital beds during future COVID-19 surge

Demand modelling for a second wave of COVID-19 has been undertaken by the Devon CCG's Business Information team. The modelling for beds with mechanically ventilated or non-invasive ventilation oxygen (MV/O+) and those with normal oxygen (o) is based on the assumption that a second wave would be similar in size to the first wave, in line with current estimates. A number of assumptions are made in relation to the Government's appetite for risk.

The modelling shows that across the Devon and Cornwall system, with NHS Nightingale Hospital Exeter, in place, 77 beds MV/O+ beds will be available with demand for 73 beds and 315 O beds will available with demand for 286 beds. Therefore, there is enough bed capacity to meet expected future surge demand.

At the beginning of the pandemic Torbay and South Devon NHS Foundation Trust undertook a planning exercise on how their community hospital bed capacity could be expanded to support increased numbers of patients needing hospital care but not requiring MV/O+ or O beds. The exercise identified Dawlish, Brixham and Totnes community hospitals as suitable for additional beds with an additional 18 beds available in the first phase and another 6 available if demand continued to increase. These beds were not required during the pandemic but are still available should the system experience a surge in demand over the winter.

It was concluded that the 12 rehabilitation beds at Teignmouth community hospital would not be required or considered suitable to provide care for patients requiring MV/O+ and O beds. Teignmouth community hospital was not considered suitable as part of the plan to expand the number of community hospital beds as the wards are not suitable to provide safe nursing during a pandemic, the access to the wards does not support caring for patients with only one entrance point and that there were other options that were more economically viable with shorter timescales for implementation.

8.2 Delivery of Rehabilitation Services

During COVID-19 patients have been discharged from hospital along nationally defined pathways:
- Pathway 0 includes discharges home with no additional support in place.
- Pathway 1 is for people who can go home with additional support.
- Pathway 2 is for people who need a short term bedded placement.
- Pathway 3 is for people who are experiencing life changing circumstances.

From April to July 1,120 discharges were made from the TSDFT hospitals along pathways 1-3 via the discharge hub based at Torbay Hospital. Of these 77% have were through Pathway 1, 8% of discharges through Pathway 2 and 15% though Pathway 3. Care Homes have been able to meet the needs of Pathway 2 short term placements.

8.3 Delivery of Primary Care and Community Services

Digital technology has been instrumental in the delivery of primary care services during the pandemic. In the Coastal Primary Care Network, 2,191 e-consultations were delivered between 2 March and 2 August 2020 showing a steady increase during the pandemic. The number of video consultations undertaken May – July was 466. This model of care will continue. Patients will still need to be seen face to face by clinicians but the number will be less than pre-March. The new health and wellbeing centre will have fully functioning digital technology allowing delivery of this emerging model of primary care.

During the pandemic Teignmouth Community Hospital was used to run the Primary Care COVID hub for the locality. The hub was intended for patients who are suspected to have COVID-19 and need a clinical assessment to supplement telephone triage/video assessment or patients with potential dual diagnosis. As outpatient clinics had been suspended, the GPs were able to use the outpatient department at Teignmouth Community hospital where it was possible to isolate the area from other parts of the building and not disrupt other activities. From 23 March – 30 June the hub saw 208 patients.

The community team continued to be based at Teignmouth Community Hospital and their focus during the pandemic was on the co-ordination of care in people's own homes including care homes. Staff from across the Trust were deployed into the team to support the community response resulting in an increased capacity to manage elevated referral numbers alongside the community led testing that was taking place. The team has been involved in supporting care homes with management of outbreaks, COVID-19 testing and supporting discharge from hospital as well as urgent intervention to prevent hospital admission, where safe to do so. The team has worked closely with local GPs and voluntary sector.

8.4 Delivery of Outpatients

Outpatient services had to be delivered differently during the COVID-19 pandemic with the use of telephone consultation and digital technology. The emerging impact on the model of care indicates that there will continue to be a move away from face to face appointments with specialists where this can be done remotely.

Whilst during the pandemic many face-to-face outpatient clinics were suspended, these services are being restored from now and will be fully reinstated at the latest during September.

8.5 Delivery of Day Case Procedures

Some day case procedures continued during the pandemic especially for those patients on cancer pathways of care. Other procedures were suspended and are currently being reinstated.

8.6 The new Health and Wellbeing Centre

The layout of the new health and wellbeing centre has been reviewed by the GPs and TSDFT in light of the requirements placed on the delivery of health services by the COVID-19 pandemic in terms of social distancing and infection control. The fact that the building has 2 entrances, is spread over a number of floors, has a number of patient waiting areas and has 2 staircases and 2 lifts allows for safe flow around the building and separation of patients and staff to ensure social distancing and delivery of different types of care in different areas of the building.

9 Post consultation evaluation

After the close of the consultation Healthwatch will analyse the feedback, identify any alternative proposals suggested during the consultation and produce a final report. There will be an evaluation process involving local stakeholders to assess any alternative ideas and proposals.

A final report with recommendations will be submitted for consideration to the CCG Governing Body in December.

10 Conclusion and Recommendations

The public consultation will run from 1 September 2020 to 26 October 2020. The consultation process has been adapted and will be a remote consultation process utilising postal hard copy, online platforms and telephone clinics. The documentation has been updated to reflect the new format and delivery of healthcare services during the pandemic.

The Governing Body is asked to note:

- The format for remote consultation using the consultation channels as outlined in section 6
- The consultation meeting dates and timeline

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Devon Integrated Care System Lead and Devon CCG Accountable Officer recruitment process				
Date of committee: 27th August 2020 **Date report produced: 21st August 2020**				
Author (s) Name and Title: • Piers Tetley, Associate Director • Samantha Tribble, HR Manager **Contact Details:** samanthatribble@nhs.net		**Supporting Executive Name and Title:** Paul Johnson, Clinical Chair NHS Devon CCG Graham Turner, Non Executive Director (Finance and Remuneration) **Contact Details:** paul.johnson4@nhs.net **Report Approved by: Graham Turner** **Name and Title:** Non Executive Director (Finance and Remuneration) **Date:** 21.08.20		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

On 30th July 2020, the Governing Body received a paper regarding the role of Devon Integrated Care System (ICS) Lead and Devon CCG Accountable Officer (AO). Approval was received to combine the roles of ICS Lead with the Accountable Officer of the CCG and to establish a system coordination group to oversee the development of a robust appointment process for this role (including the creation of a job description and person specification).

This working group (the "STP Recruitment Working Group") has since progressed the development of the appointment process and has appointed GatenbySanderson to support the process.

This paper requests approval to progress with the draft appointment process (including draft job description, person specification and remuneration package).

With regards to the remuneration package associated with this post, it is recognised that in order to attract and retain the required calibre of candidate with the requisite knowledge, skills and experience to fulfil the requirements of this role, a competitive salary is required. This paper therefore provides the proposed remuneration negotiation parameters for this role and the associated rationale for this.

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:

- **Recommendation 1:** Approval of appointment process approach and timetable outlined in section 2.
- **Recommendation 2:** Delegate the CCG Clinical Chair and Chair of Remuneration and Workforce Committee to sign off the final version of the Job Description and Person Specification and appointmen process.
- **Recommendation 3:** Approval of the salary negotiation parameters of between £175,000 and £215,000 per annum pro rata.

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

Devon Integrated Care System Lead and Devon CCG Accountable Officer recruitment

1. Introduction

1.1. On 30th July 2020, the Governing Body received a paper regarding the role of Devon Integrated Care System (ICS) Lead and Devon CCG Accountable Officer (AO). Approval was received to combine the roles of ICS Lead with the Accountable Officer of the CCG and to establish a system coordination group to oversee the development of a robust appointment process for this role (including the creation of a job description and person specification).

1.2. This working group (the "STP Recruitment Working Group") comprises Dr Paul Johnson (CCG Chair – group chair), Dame Suzi Leather (Independent Chair of the STP), Elizabeth O'Mahony (Regional Director NHSE/I) Graham Turner (CCG Non Executive Chair of Remuneration and Strategic Workforce Committee and Finance Committee) and Richard Crompton (Chair of University Hospitals Plymouth), has since met to progress the development of the appointment process.

1.3. A key action undertaken was the review of a number of recruitment companies experienced in supporting organisations to attract very senior appointments. Following a selection process, Gatenby Sanderson was selected as the most appropriate company to support our system in this process.

1.4. In collaboration with GatenbySanderson, a draft appointment process and timetable has been created. Both a draft job description and person specification are in the process of being developed but at the time of this report these are not available for inclusion, as they continue to be shaped further through a wide stakeholder engagement as part of the process, to which members of the Governing Body have contributed.

1.5. With regards to the remuneration package associated with this post, it is recognised that in order to attract and retain the required calibre of candidate with the requisite knowledge, skills and experience to fulfil the requirements of this role, a competitive salary is required. This paper therefore provides the proposed remuneration negotiation parameters for this role and the associated rationale for this.

2. Appointment process (including job description and person specification)

2.1. In order to successfully recruit to this post, it is vitally important that we develop a robust and thorough appointment process that captures and reflects stakeholder input and provides an attractive offer to candidates.

2.2. Under the direction of the STP Recruitment Working Group, GatenbySanderson will lead on the following next steps which include:

Stakeholder engagement: This will include one-to-one meetings with key leaders within the system (organisation chief executives and chairs, local authority chief executives and leaders and system medical directors for secondary and primary care) and the CCG (members of the executive team, clinicians and non-executive Governing Body members). Also included is a wider online questionnaire to gain intelligence and views from wider groups including organisation staff, population representatives and the voluntary sector, some 400 individuals in total. This stakeholder engagement will be used to inform the development of the application pack, job description and the preferred personal attributes that the planned executive profiling will aim to elicit.

Development of the application pack and selection process: This pack will be in the format of an interactive online resource as well as a downloadable pack. This will include key information about the area, the system, the challenges and opportunities presented by the role, including job description and person specification, shaped by the STP Recruitment Working Group and the stakeholder engagement.

Supporting the selection process:

The selection process will be robust and include consideration of longlisting, preliminary interviews, shortlisting, psychometric assessment and an assessment event, which is intended to include:

- Interview panel (the current Working Group plus a local authority chief executive);
- a CCG Panel including Executives, Clinicians, and Non-Executives;
- a panel including Provider CEOs;
- a panel including Local Authority leaders and CEOs;
- a panel made up of patient and public representatives

2.3. The aforementioned draft job description and person specification will continue to be developed over the coming days and it is requested that the Governing Body delegates the CCG Chair and the Chair of the Remuneration and Strategic Workforce Committee to sign off the final version of these documents, with Working Group colleagues. This final sign off will be following an extensive stakeholder engagement process as outlined above.

2.4. A summary of the timetable of next steps is shown below and Governing Body is asked to recognise that this will be subject to potential further change as the process continues to be shaped:

Activity	**Date**
Individual key stakeholder engagement and wider engagement survey	August - September
Search commences and post advertised	Mid-September – Early October
Formal closing date for receipt of applications	October
Sift of applications sent	Late October
Longlisting of applications	October - November
Preliminary interviews by GS	October - November
Interview reports sent	October - November
Shortlist meeting	October - November
Assessment / Referencing	October - November
Final panel interview	October - November

Recommendation 1: Approval of appointment process approach and timetable outlined in section 2.

Recommendation 2: Delegate the CCG Chair and the Chair of the Remuneration and Strategic Workforce Committee to sign off the final version of the Job Description, Person Specification and appointment process. This final sign off will be following an extensive stakeholder engagement process as outlined above.

3. Remuneration

3.1. In order to attract and retain the required calibre of candidate with the requisite knowledge, skills and experience to fulfil the requirements of this role, a competitive salary is required.

3.2. In determining the appropriate salary for the role of ICS lead and Devon CCG AO, the following points were considered:

- The level of accountability, responsibility and influence is significant and the salary should recognise the business criticality of the role in terms of delivering NHS and partner priorities. The role will provide strong and effective leadership and inspiring vision to enable innovation in developing future organisational form, the implementation of the strategic commissioning function and in the development of the Devon Partnership towards a fully mature ICS. The role will also provide AO leadership to NHS Devon CCG.
- Consideration has been given to NHS England's guidance entitled *'Clinical commissioning group guidance on senior appointments, including accountable officer'* and NHS Commissioning Board's guidance entitled *'Clinical Commissioning Groups: Remuneration guidance for Chief Officers (where the senior manager also undertakes the accountable officer role) and Chief Finance Officers'.* However, as this guidance is focused on CCG AO appointments and as this new role is also a STP lead role (which includes the CCG AO), guidance has been sought on recent market comparators from headhunting agents.
- Benchmarking of Chief Executive salaries across Devon STP Provider organisations indicates annual salaries of up to £195,000. It is important, based on the requirements of the role, that this role is comparable with other system leaders.
- Finally, specific advice has been sought from NHSE/I in regard to salary parameters. NHSE/I confirmed that the appropriate salary parameters for a Devon STP lead (including CCG AO) are a minimum of £145k, mid value of £180k and maximum £215k.

3.3. Following consideration of all contributing factors outlined above, it is recommended by the Working Group that salary negotiation parameters of between £175,000.00 and £215,000.00 per annum pro rata (37.5 full time equivalent hours) are approved. Actual salary will subsequently be determined depending on the candidate's previous experience and capabilities. The pay variance is attributable to the significance of the role and responsibilities and allows scope for negotiation.

Recommendation 3: Approval of salary negotiation parameters of between £175,000 and £215,000 per annum pro rata.

3.4. It is important to note that the remit of this role delivers value for money in recognising its duties are presently delivered by two separate post holders i.e. an Accountable Officer for the CCG and an STP Chief Executive Officer.

3.5. The CCG is subject to the same remuneration controls as NHS Trusts and NHS Foundations Trusts in regards to VSM salaries exceeding £150,000 per annum. Any salary exceeding this amount requires business case submission to NHSE/I for approval through the Minister of State for Health. Due to the proposed timeline and in recognition that this approval can take a number of weeks to be received, an initial business case is being submitted in line with the proposed negotiation parameters outlined in section 3, subject to Governing Body approval.

3.6. For the purposes of recruitment, it is intended that the salary will be described as '*Very Senior Manager – competitive'*, ahead of formal approval being received.

4. Recommendations

- **Recommendation 1:** Approval of appointment process approach and timetable outlined in section 2.
- **Recommendation 2:** Delegate the CCG Chair and the Chair of the Remuneration and Strategic Workforce Committee to sign off the final version of the Job Description, Person Specification and appointment process. This final sign off will be following an extensive stakeholder engagement process as outlined above.
- **Recommendation 3:** Approval of salary negotiation parameters of between £175,000 and £215,000 per annum pro rata.

Appendix 1: GatenbySanderson support to the appointment process

GatenbySanderson have provided the following overview of the support they will provide:

Defining the role

Initially will conduct 121 briefings with key stakeholders (systems partners and leader, the CCG exec) in addition to an online tool to gather wider stakeholder opinion on what success will look like in the role. These involve identifying behaviours that are key to success, as well as gathering opinions from stakeholders on their expectations. The final report combines all stakeholder responses, so we can explore with you where there is consensus, and areas that require further consider consideration. We have a deep understanding of the core skills and behaviours that make for a good CEO, and we appoint one CEO per week on average within the public sector. This knowledge allows us to work with you to refine what you are looking for and support you in understanding what will be necessary to make a success of the post.

Having these conversations early in the recruitment process ensures that all of us, both at GatenbySanderson and on your panel and wider stakeholders, have a clear vision of what the successful appointee should look like. Gaining a three-dimensional picture of the role means we can anticipate and respond to detailed and often nuanced candidate queries, often relating to an organisation and the system as a place to work and the weight and influence of the roles. We can then all use this to guide us at each stage of the selection process.

Working with the Appointments Committee we will also put together a compelling microsite and candidate pack.

Securing the right candidates

We will use a combination of search and advertising (probably HSJ, Guardian and social media) to raise awareness about the post, although 90% of the shortlist are likely to come from search. The Appointments Committee will receive a regularly weekly update on our progress.

Longlisting

The selection process begins when we assess each of the applications received on your behalf. This sifting process assesses how well candidates' applications fulfil the recruitment criteria outlined in the person specification, as agreed with you at the beginning of the assignment. We are very clear that the panel makes the decisions and we are here to help as advisers. Our approach to handling any internal candidates involves treating them in a consistent way to those that are external - however there is a sensitivity to be shown here. We are very experienced at handling these situations.

Preliminary interviews

Interviews will be a thorough, searching, yet fair and open assessment, probing candidates' commitment and motivation to work for the organisation and seeking tangible evidence and outcomes of achievement and delivery that have made a difference. We will use the information gathered at the briefing stage, and through the online tool, to ensure the interviews are targeted in the specific organisational context and focused on the behaviours that are key to success in role.

We will talk through each candidate's career history ensuring that we are confident about what they will have claimed to have achieved in their written application. We will also explore their salary expectations so that there is some clarity about their expectations should they be offered the role, we check out risks such as whether they are comfortable with the location (and relocation if appropriate) and whether they are involved in any other recruitment processes.

You will receive a comprehensive report on each candidate with a recommendation as to who should be invited to a final panel interview. We would recommend a shortlisting meeting to talk through the outcome of the interviews and define a shortlist.

Shortlisting

Once the Appointments Committee has agreed who should be selected to go through to the final panel interview, we give successful candidates thorough feedback to ensure they are well prepared for final panel interview and unsuccessful candidates will be given full feedback to ensure they understand the reasons behind the decision.

We take thorough references from two referees for every shortlisted candidate and ensure these are available prior to final panel (although we recommend as best practice that these are only consulted at deliberation point). Should any issues for concern or further exploration arise at this stage, we raise it with our clients immediately and can provide support exploring the issues in more depth.

Psychometrics

Candidate will undertake psychometric testing and will be interviewed by a psychologist; a report will be provided for the panel for on the key competencies of the role.

Final panel interview

We work with you to help shape the structure of the final panel interviews and draw up the interview timetable, book the candidates in and provide them with any information and support they need to prepare for their meeting with you. We will provide final interview briefing packs for Panel members, including specimen questions if needed. We will also advise on how you involve wider stakeholders in a range of presentation and engagement sessions.

A briefing from the profiling assessor can also be arranged at the beginning of the final panel day. This session will aid to bring the candidate reports to life and to answer any questions you may have on the candidates' profiles, ahead of the final interview.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 27th August 2020 **Date report produced: 19th August 2020**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date:** 19th August 2020		
Public or Private (Governing Body only):	**Public**	√**COVID**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

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

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

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

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

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

On the above basis the CCG has received an allocation of £696.2m, including £14.3m for COVID19 related expenditure, for the period to 31st July 2020 together with an expectation that budgets are set within the parameters stipulated by the NHSE Model.

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

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

NHS England has confirmed that, to support restoration, and enable continued collaborative working, the current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. Whilst this is being finalised the current report covers the period to the 31st July only.

Management of Conflict of interests:

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

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

None.

Key recommendations and actions requested:

The Governing Body is requested to:

Consider, review and discuss the month 4 year to date performance including the current risks.

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

N/A

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

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

NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 4 – 2020/21

Contents

Appendices

1. Executive Summary

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On the above basis the CCG has received an allocation of £696.2m, including £26.1m that provides funding for the overspend to the end of June including COVID19 related expenditure.

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

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

NHS England has confirmed that, to support restoration, and enable continued collaborative working, the current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. Whilst this is being finalised the current report covers the period to the 31st July only.

Financial Position

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

July 2020 (Month 4)	Budget £'000	Actual £'000	Variance £'000	Additional Allocation £000	Revised Variance £'000
Year to date position	696,156	702,243	6,087	-6,087	0

The variance against the original allocation to the end of July is £32.2m of which £26.1m has currently been reimbursed. The variance mainly arises from additional costs linked to the COVID19 pandemic £23.9m. These costs are detailed in section 4.

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

Savings Plan

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

Risk

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

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

STP Plan

The STP planning process was put on hold in March. As mentioned above, NHSE has confirmed that the current financial arrangements for CCGs and Trusts will be extended to cover August and September 2020.The CCG and STP partners will be addressing the next steps through the restoration and recovery programme and its response to the financial regime post 30th September once the detail is published.

2. Financial Assurance Dashboard

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

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

- Financial plan
- In Year Financial performance

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

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	13.5	6.1	45.2%	GREEN
3	Forecast Outturn deficit to 31st July	13.5	6.1	45.2%	GREEN
4	Running Costs	7.2	7.3	101.4%	RED
5	Risk adjustment to deficit (% of allocation)	0.0	0.0	0.0%	GREEN
6	Cash Position (% drawn down)	33.3%	40.5%	121.6%	RED
7	BPPC (% paid - value)	95.0%	99.6%	104.8%	GREEN

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

3. Detailed Financial Performance

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

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 JULY 2020 Month 04 July	DEVON CLINICAL COMMISSIONING GROUP Year To Date Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES					
Acute Services	303,533	302,056	0	302,057	-1,477
Mental Health Services	70,936	70,736	548	71,284	348
Community Health Services	99,869	92,629	11,064	103,693	3,824
Placements	44,339	42,891	1,595	44,486	147
All Other Healthcare	20,193	14,701	3,580	18,280	-1,912
Primary Care Services					
Prescribing	74,387	74,548	2,392	76,940	2,553
Delegated Commissioning	56,661	57,311	-	57,311	651
Other Primary Care	20,098	16,627	4,290	20,918	819
Primary Care Subtotal	151,146	148,487	6,682	155,169	4,023
Commissioned Services Subtotal	690,016	671,499	23,470	694,969	4,953
CORPORATE					
Running Costs	6,141	6,893	382	7,275	1,134
EARMARKED RESERVES AND CONTINGENCIES					
Earmarked Reserves	-	-	-	-	-
Contingency	-	-	-	-	-
Other Reserves	-	-	-	-	-
Reserves Subtotal					
TOTAL COMMISSIONED SERVICES	696,157	678,392	23,852	702,244	6,087

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

3.1 Acute Services

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

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

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

The underspend of £1.5m at Month 4 relates mainly to the reduction of Non-contract activity compared to the budget set.

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

3.2 Mental Health Services

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

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

At month 4 there is an overspend of £0.4m for all mental health services and is driven mainly by the temporary budget setting process when compared to actual commitments. The largest of which relates to Learning Disability and s117 placements where the budget compared to commitments and other pressure presents a £0.3m adverse variance at Month 4.

3.3 Community Health Services

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

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

Much of the year to date overspend of £3.8m relates to COVID19 costs detailed in section 4, however £0.3m relates to the NHS budget model not reflecting the BCF uplifts agreed.

3.4 Placements

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

This area in total is overspent by £0.1m at Month 4. This is largely as a result of exceptional costs during the current pandemic (uplifts to market rates) and variance between NHSE/I budget setting model verses local plan but offset by client number reductions and additional budget received from NHSE/I for COVID19 costs and 19/20 FNC uplift.

The following table provides an analysis of the forecast variance.

Placements FOT Variance	
Variance Type	**£m**
Additional Covid related costs e.g. fee uplifts	1.6
Additional Budget for Covid costs M1 to 3	-0.9
Budget variances (NHSE/I model vs local plan) & profiling	1.0
Non delivery of QIPP savings plan	0.8
Cost reduction due to client number movements (partly Covid related)	-2.8
FNC Uplift over and above plan assumption	1.0
Additional Budget for 1920 FNC Uplift	-0.6
Total	0.1

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

Specifically, several investments have been necessary to support the care market and ensure efficient flow across the health and care system. At the same time NHSE

have implemented new discharge guidance which affects the traditional flow and reporting of costs in the placement's arena.

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

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

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

3.5 All Other Healthcare

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

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

3.6 Primary Care Services

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

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

Prescribing

The Month 4 prescribing figure is reported as a £2.5m overspend. This has improved with the NHSE budget changes now made for M03 YTD position and resolved some of our pressures. The No Cheaper Stock Obtainable (NCSO) have increased this month worsening the position. The official PMD forecasting report will be available in M05 but currently forecasts are based on last year's activity.

Delegated Commissioning

The month 4 delegated commissioning figure is reported as a £0.7m overspend reflecting the recurrent commitments and pressures anticipated in 20/21.

Other Primary Care

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

3.7 Running Costs

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

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

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

The CCG's allocation for 2020-21 was set to reduce from £25.4m last year to £22.4m for this financial year but as part of the framework set for this period to 31st July this has been revised. The CCG is reporting expenditure for the 4 months at £7.3m, of which £0.4m are specific short-term costs in relation to COVID19.

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

3.8 Resource Allocation

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

Planned revenue resources	£'000
Allocation after place based pace of change	1,759,720
Primary care commissioning	170,193
Running costs allocation	22,411
Recurrent adjustments	-1,768
COVID19 non-recurrent allocation	14,312
Non recurrent adjustments (Months 5 to 12)	-1,268,712
Total revenue resources to month 4	**696,156**

The resources include non recurrent COVID19 allocations totalling £14.3m, but excludes the assumed additional allocation to cover the overspend position reported. The high level parameters under which the allocation was set are as follows:

Plan modelled as follows:

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

4. COVID19 Specific Costs

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

The CCG has incurred costs of £23.9m to date and whilst commitments are reducing we are anticipating additional COVID costs of £3.2m relating to PPE within the next 3 months.

COVID 19 Commitment Analysis	**YTD** £m
Nightingale Hospital	2.2
CHC - Market Enhancements	2.1
Prescribing	2.4
Primary Care	4.3
PPE, Staffing and other costs	2.3
	13.3
Hospital Discharge	
Devon CCG	0.4
Devon Council	7.0
Plymouth Council	2.0
Livewell Southwest (Social Care)	1.2
	10.6
Total	23.9

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

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

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

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

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

5. Risks

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

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

6. Other Financial Information

6.1 Statement of Financial Position

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

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

6.2 Capital

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

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non NHS Creditors - % of bills paid within target	99.44%	99.82%
NHS Creditors - % of bills paid within target	97.30%	99.52%

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

6.4 Cash

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

7 Recommendations

The Governing Body is requested to:

Consider, review and discuss the month 4 year to date including the current risks.

Appendices

Appendix 1: Statement of Financial Position

AS AT 31 JULY 2020	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	1,880
Intangible Assets	3
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	1,883
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	6,828
Trade & Other Receivables - Non NHS	35,604
Other Current Assets	-
Cash & Cash Equivalents	1,432
Non-current Assets held for Sale	-
Total Current Assets	44,264
Total Assets	46,147
CURRENT LIABILITIES	
Trade & Other Payables - NHS	96,527
Trade & Other Payables - Non NHS	- 149,271
Other Liabilities	- 1,020
Borrowings / Cash in Transit	- 4,686
Provisions	-
Total Current Liabilities	- 58,450
Total Assets less Current Liabilities	- 12,303
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 89
Total Non Current Liaibilities	-
Total Assets Employed	- 12,391
FINANCED BY TAXPAYERS EQUITY	
General Fund	12,391
Total Taxpayers' Equity	12,391

Appendix 2: Cash

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

Measure	Month 4
CCGs must operate within their expected annual cash drawdown requirement. *The expected annual cash drawdown requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,997.205m for Devon CCG the year.*	40.5% of the MCD has been utilised as at month 4 (33.3% is expected based on a straight-line trajectory at month 4). Over utilisation is due to the requirement by NHS England to pay Providers one month's block payment in advance.
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £9,643 for July.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

Appendix 3: Operating Expenditure

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 JULY 2020 Month 04 July	DEVON CLINICAL COMMISSIONING GROUP Year To Date Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's
ACUTE CARE					
NHS Royal Devon & Exeter Foundation Trust	92,104	92,104	-	92,104	-0
NHS University Hospitals Plymouth NHS Trust	76,121	76,121	-	76,121	0
NHS Northern Devon Healthcare Trust	40,294	40,294	-	40,294	0
NHS South Devon Healthcare Foundation Trust	67,419	67,419	-	67,419	-0
NHS Taunton and Somerset	3,218	3,218	-	3,218	0
NHS South Western Ambulance Trust	16,832	16,832	-	16,832	0
Independent Sector	475	373	-	373	-102
Other Acute	7,071	5,696	0	5,696	-1,375
Subtotal	303,533	302,056	0	302,057	-1,477
PLACEMENTS					
Continuing Healthcare	39,697	38,325	1,320	39,645	-52
Funded Nursing Care	4,223	4,182	276	4,458	234
Individual Patient Placements	418	384	-	384	-35
Subtotal	44,339	42,891	1,595	44,486	147
COMMUNITY & NON ACUTE					
Livewell Southwest	17,697	16,110	2,060	18,170	473
Royal Devon and Exeter Community	19,578	19,578	-	19,578	-0
Northern Devon Healthcare Community	10,204	10,204	-	10,204	-0
South Devon Healthcare Community	23,503	23,503	-	23,503	-
Children and Families Health Devon	3,875	3,878	-	3,878	3
MIU Contracts	279	285	-	285	6
Plymouth Integrated Fund	4,652	3,118	1,992	5,110	457
Better Care Fund_Devon CC	14,831	10,556	7,012	17,568	2,737
Better Care Fund Torbay	1,012	1,098	-	1,098	86
Other Community Services	4,237	4,299	-0	4,299	62
Subtotal	99,869	92,629	11,064	103,693	3,824
MENTAL HEALTH SERVICES					
Devon Partnership NHS Trust	43,314	43,314	-	43,314	-0
Livewell MH Services	12,819	12,819	-	12,819	-0
Children and Families Health Devon	3,525	3,525	-	3,525	-
Individual Patient Placements	9,218	9,056	458	9,514	296
Other Mental Health	2,061	2,022	90	2,112	51
Subtotal	70,936	70,736	548	71,284	348

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 JULY 2020 Month 04 July	DEVON CLINICAL COMMISSIONING GROUP Year To Date				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)
OTHER COMMISSIONED SERVICES					
NHS 111	1,216	1,216	-	1,216	-0
Integrated Urgent Care Service	184	184	-	184	0
Hospices	2,667	2,772	16	2,788	121
Patient Transport Services	2,868	2,798	124	2,922	54
All Other Commisionned Services	13,258	7,731	3,440	11,171	-2,087
Subtotal	20,193	14,701	3,580	18,280	-1,912
PRIMARY CARE					
Prescribing	74,387	74,548	2,392	76,940	2,553
Enhanced Services	4,904	4,978	-	4,978	74
Delegated Commissioning	56,661	57,311	-	57,311	651
GP Out Of Hours	4,887	4,573	380	4,953	66
Other Primary Care	10,308	7,076	3,910	10,987	678
Subtotal	151,146	148,487	6,682	155,169	4,023
TOTAL COMMISSIONED SERVICES	690,016	671,499	23,470	694,969	4,953
RUNNING COSTS					
Pay	4,618	5,373	291	5,664	1,046
Non Pay	1,555	1,567	91	1,658	103
Income	-32	-47	-	-47	-15
Subtotal	6,141	6,893	382	7,275	1,134
EARMARKED RESERVES AND CONTINGENCIES					
Earmarked Reserves					
Contingency					
Other Reserves	-	-	-	-	-
Subtotal	-	-	-	-	-
NET TOTAL OPERATING COSTS	696,157	678,392	23,852	702,244	6,087
CCG Control Total	-696,157	-678,392	-23,852	-702,244	-6,087
2020/21 Surplus/Defecit	-	-	-	-	- 0

NHS Devon Clinical Commissioning Group

NHS DEVON GOVERNING BODY - PUBLIC

Report title: Performance and Quality Report				
Date of committee: 27th August 2020 **Date report produced:** 13th August 2020				
Author (s) Name and Title: Sarah F Thompson – Interim Chief Operating Officer Lorraine Webber – Associate Chief Nursing Officer & Deputy Caldicott Guardian Alison Wilkinson – Deputy Chief Operating Officer Kelvin Grabham – Associate Director of Business Intelligence		**Supporting Executive:** **Name and Title:** Sarah F Thompson – Interim Chief Operating Officer **Report Approved by:** **Name and Title:** Sarah F Thompson – Interim Chief Operating Officer Darryn Allcorn – Chief Nursing Officer Philip King – Interim Chief Nursing Officer **Date:** 13th August 2020		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The purpose of the paper is three-fold:

- To present the 1st April 2020 to 30th June 2020 (month 3) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.
- To present the quality, nursing and safety performance position for the period 1st April to 30th June 2020.
- To provide members with an update on the latest published national guidance on performance dated 31 July 2020, for the period 1st August 2020 to 31st March 2021.

Management of Conflict of interests: **Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.**
Committees that have previously discussed/agreed the report and outcomes:
Finance and Performance Committee Joint Finance and Performance and Quality Assurance Committee
Key recommendations and actions requested:
Members of the Governing body are asked: • To agree the 1st April 2020 to 30th June 2020 (month 3) Constitutional Standards performance position; • To agree the 1st April 2020 to 30th June 2020 (month 3) quality and safety performance position; • To note the publication of new national guidance on performance for the period 1st August 2020 to 31st March 2021 and the action being taken to ensure we can monitor against the requirements.
Impact on Strategic Objectives
(Delete as applicable) **We will continue to commission safe, effective and accessible services** **We will work as a strategic partner in Devon** **We will improve the physical and mental health of our population** **We will make best use of our resources**
Reference to other documents or accompanying papers:
Appendix 1 - Performance Report
Does this report have implications in any of the areas highlighted below?

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

Equality (staff or public)		√
Resource and Finance		√
Legal		√
Engagement and Consultation		√
Risk	Reputational risk due to non-achievement of trajectories	

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

NHS Devon CCG
GOVERNING BODY (PUBLIC)
27th August 2020

Performance and Quality Report

1. Introduction

This paper builds on the last performance paper presented to the Governing Body on 30th July 2020. The purpose of the paper is three-fold:

- To present the 1st April 2020 to 30th June 2020 (month 3) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.

- To present the quality**,** nursing and safety performance position for the period 1st April to 30th June 2020.

- To provide members with an update on the latest published national guidance on performance dated 31st July 2020, for the period 1st August 2020 to 31st March 2021.

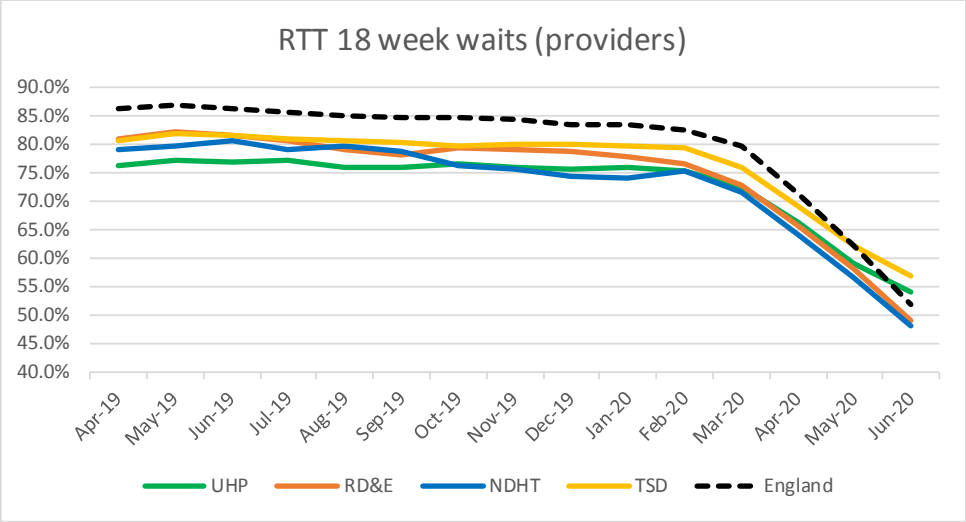
2. Constitutional Standards Performance from 1st June to 30th June 2020

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

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

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

Referrals to Treatment (RTT) Waiting Times
June validated data shows a further fall in RTT 18 week performance, from 59.3% to 52.5% at STP level, compared to the target of 92% and national performance of 52%.



Waiting lists have risen slightly across most of the county, the exception being at the Royal Devon and Exeter NHS Foundation Trust (RD&E). The table below shows the RTT waiting list movement between May and June by provider:

	RD&E	NDHT	UHP	TSD
May	30910	11435	25626	20059
June	30777	11611	25734	21968
Variance	**-133**	**176**	**108**	**1909**

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

	RD&E	NDHT	UHP	TSD
May	494	131	411	192
June	836	366	620	344
Variance	**342**	**235**	**209**	**152**

Diagnostic Waiting Times
Diagnostic waiting times have also been significantly affected by the COVID-19 pandemic.

All providers except Northern Devon Healthcare NHS Trust (NDHT) saw an improvement in June, with University Hospital Plymouth NHS Trust (UHP)

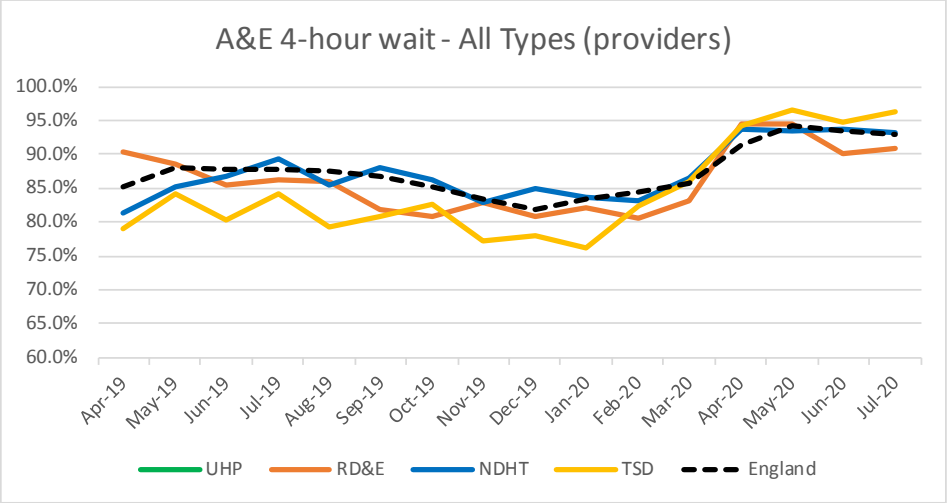
performance rising to 62.5%, Torbay and South Devon NHS Foundation Trust (TSD) 58.7% and the Royal Devon and Exeter NHS Foundation Trust (RD&E) at 43%.

The table below shows the percentage of patients seen within 6 weeks, as compared to the national 99% target, and the movement between May and June. The STP position of 50.9% remains well below the 99% target and is slightly worse than the England position of 52.2%.

	RD&E	NDHT	UHP	TSD
May	36.70%	42.40%	53.60%	45.80%
June	43.00%	41.60%	62.50%	58.70%
Variance	**6.3%**	**-0.8%**	**8.9%**	**12.9%**

A&E Waiting Times

Performance against the A&E 4-hour wait target improved as a lower number of patients presented in emergency departments from late March and into April. Overall attendance volumes continued to increase in July but remain below expected levels. July performance was 93.7% for all types and 91.8% for type 1 attendances, slightly up on the June position and below the 95% national target. The England position was 93% for all types.



111 Performance

The proportion of calls answered within 60 seconds fell from 67.3% in June to 57.8% in July. Performance remains well below the target of 95% and continues to be the lowest in the South West. Actions being taken by the CCG to address this include:

1. The CCG agreed additional investment of c £800k (full year effect) in August to bring 111 call handler capacity in line with the national benchmark, which will enable the

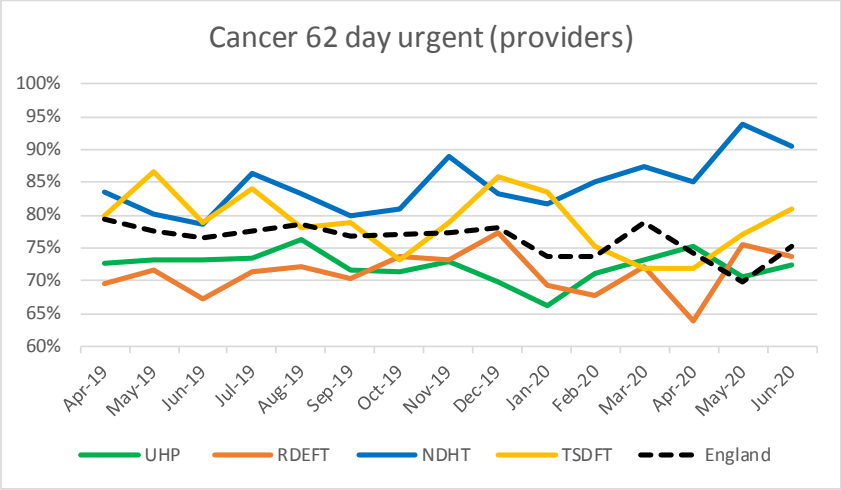
provider to achieve the targets. The call handlers should be trained and in place by October 2020.

2. We are working with and supporting Devon Doctors very closely on their performance improvement plan, with weekly meetings to review and monitor progress.
3. The Think 111 programme has a demand/capacity workstream, with initial objectives which are linked to ensuring that the 111 service has enough capacity to deal with additional demand when we launch the campaign.

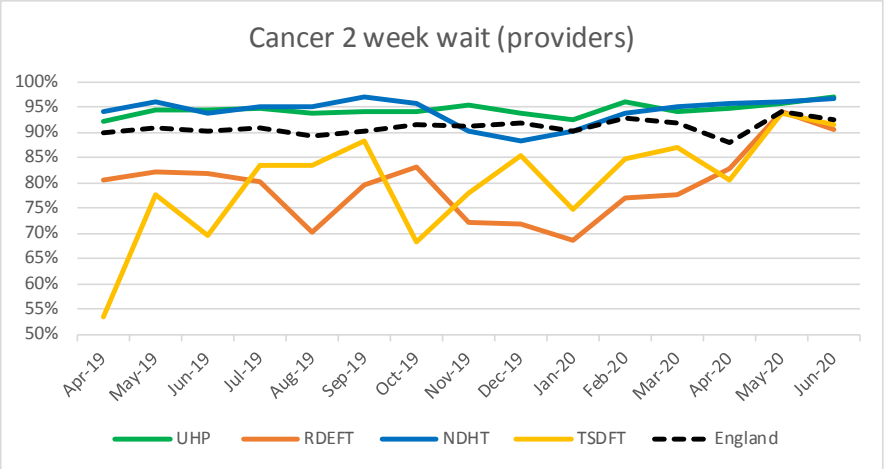
Cancer Waiting Times

Performance against the cancer waiting times standards remained relatively stable through the initial COVID-19 period.

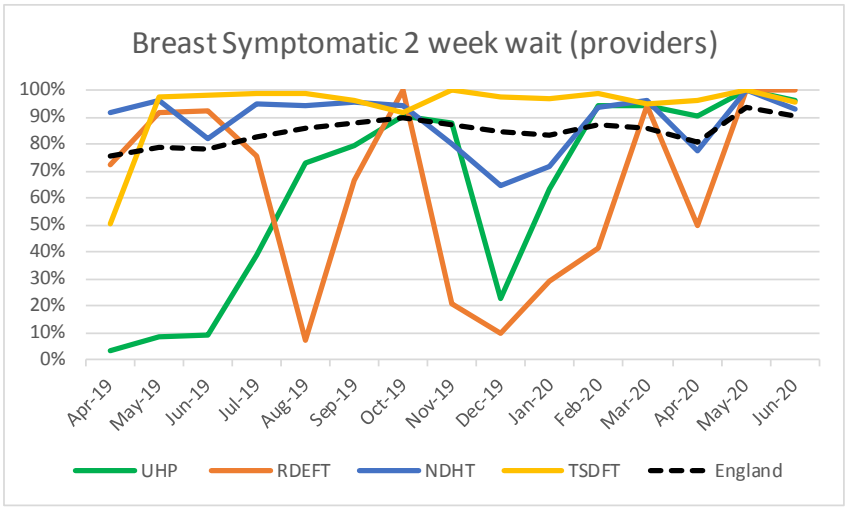
In June there was a further increase in performance against the cancer 62 day urgent standard, with the STP position rising from 74.9% to 76.7%. However, NDHT continued to be the only provider achieving the 85% target, at 90.4%. UHP improved from 70.6% to 72.5%, whilst RD&E & TSD fell slightly, to 73.8% and 75.5% respectively.



Performance against the main two week wait standard remains just above target at 93.07% in June. NDHT & UHP both achieved the target, at 96.6% and 96.9% respectively. However, RD&E's performance fell from 94.2% to 90.7% and TSD fell slightly from 93.6% to 91.4%.



Breast symptomatic performance continues to be above target in June, at 95.6%. NDHT was the only provider not to achieve the target, but this was due to small numbers.



3. Nursing, Quality and Safety Performance for the period 1st April to 30th June 2020 (month 3)

Urgent & Emergency Care

Two decision to admit 12-hour breaches were reported in July, compared with eight reports during the same period in 2019, one through RD&E and one UHP, with no reported evidence of harm through either review. The RD&E breach included a 25 hour wait in ED for a patient in mental health crisis. Considerable time was lost (228 hours) to ambulance handover delays across Devon in July. There has been no reported adverse impact or

physical harm in relation to delays (either to the patient in the ambulance or patients still waiting for an ambulance), but it is likely to have impacted on patient experience.

Significant pressure on the 111 service with increased call volumes during July (compared to June, but below forecast volumes). Call abandonment rate remains unacceptably high at 16.87% (against a target of less than 5%) with only 57.77% (against a target of 95%) calls being answered within the target time of 60 seconds. This poor call answering position may lead to poor patient experience, although complaints to the service remain low.

Planned Care & Diagnostics

Pre COVID-19 escalated quality issues have been exacerbated by the pandemic, including long waits. The CCG is seeking assurance from each provider, including the independent sector, to ensure system working for patients on planned care waiting lists. With excellent examples of innovation, providers are now being asked to share, learn, adopt and develop new models of working to drive improved safety and experience; restoring, but transforming services is key to stepping up and transforming moving forward. Impact of recovery and transformed service changes are being supported through the Quality and Equality Impact Assessment (QEIA) process; concise QEIAs continue to be submitted by providers that must demonstrate they are considering the safety, effectiveness, equality and system impact of service decision making.

Never events reported continue to indicate a variance in the application of safety check processes between procedures undertaken in theatre and non-theatre sites. There is on-going assurance being sought from providers to ensure the National Safety Standards for Invasive Procedures (NatSSIPs) and the use of Local Safety Standards for Invasive Procedures (LocSSIPs) in the four acute hospitals in Devon are progressed and adhered to. An update report is planned for August Quality Assurance Committee.

Mental Health (MH) – Delays in serious incident reporting continue within Devon Partnership Trust (DPT). Executive level discussions and CCG quality support is on-going. The Trust has provided assurance through improvement plans and trajectories, but significant sustained improvement is required and will continue to be monitored.

Across the system, work is underway to understand the impact on mental health services and patients (adults, children and young people) as a result of COVID-19. This will help inform service planning moving forward, both in the immediate and long term.

Primary Care

Key improvement areas that support quality surveillance and assurance across primary care moving forwards are being developed by the CCG. This includes improvement actions following the Internal Audit Primary Care Quality Assurance Audit. In addition, the CCG is

looking to learn from examples of challenged primary care practices. Both methods will support the CCG's aim to provide responsive plans for oversight and early supportive interventions.

With more patients being seen virtually by hospitals, a shift in the workload to primary care including phlebotomy is being experienced. The CCG are working to support primary care and other providers in the short term to resolve this and are facilitating providers to meet and plan how best services like phlebotomy and other tests can potentially be delivered closer to home for patients in the longer term.

Care Home & Home Care Support

The Care Home & Home Care Cell led by the CCG with membership from three Devon Local Authorities and CQC, continues to provide significant resource and support to community and social care settings and partners. There are challenges for care homes as visitor numbers increase and a set of Principles for Visiting Health & Care Professionals has been developed in line with national guidance, by statutory partner organisations across Devon and feedback from care providers has influenced this.

Testing regimes and local outbreak management plans are supported by the CCG and responsive decision making across the system is undertaken when required to promote safety within care homes and ensure infection prevention measures are in place to protect residents and staff.

A care home digitalisation survey undertaken to establish current levels of technology in use across this sector has provided a benchmark that will guide additional support requirements. 312 care homes responded to the survey (61%) and key findings are:

- Wifi is available in all but two of the homes that responded but not always available in each room of the building;
- Digital communication through video calls is in good use for contact between residents and families (93%), GP practices (79%), community health & social care teams (60%) but less used to communicate with hospitals (39%), discharge teams (24%) and hospices (14%);
- 6 homes reported not having use of any digital equipment (tablet, laptop, smart phone) for use by residents or staff, while the majority of homes have at least 1 tablet for use;
- A patient safety collaborative programme 'improving health in care homes' using RESTORE 2™ has been piloted in Torbay and East Devon by the Academic Health Science Network (AHSN). RESTORE2™ is a physical deterioration and escalation tool for care/nursing homes based on nationally recognised methodologies. CCG and system partners are committed to the roll out of the offer further and the AHSN have

developed training and support packages and is linked with the care home & home care cell in order to progress the use of RESTORE2.

Nursing and Quality Functional Performance from 1st April 2020

Quality Equality Impact Assessments (QEIAs)

Concise QEIAs continue to be submitted by providers looking to change or step up services. These are demonstrating that providers are properly considering impacts of their decision making, one example is to the lip-reading community who will be significantly affected by mask wearing. Clear mask procurement to support these individuals is recommended.

Continuing Health Care (CHC)

CHC assessments should recommence on 1 September 2020 as set out in the '***Implementing Phase 3 of the NHS Response to the COVID-19 Pandemic***' document published on 7 August. In preparation all outstanding CHC referrals that have been deferred since the start of the emergency period on 19 March 2020. The CCG anticipate there will be in excess of 600 new cases waiting for assessment and are considering options to progress these.

NHSEI are planning to recruit and train a central bank of registered nurses to support individual CCGs with additional assessors and in addition to this the CCG is considering a number of local options to enhance delivery. These include a wider call to the NHS community providers to support the CHC Team with additional resources and the development of a 'Trusted Assessor' model for longer term implementation.

Safety Systems & Patient Experience

The national step down on the patient complaints process requirements made in March 2020 was discontinued from July with complaints services returning to normal. The CCG has maintained the function throughout the pandemic and continues to support providers. One member of the PACT team remains redeployed to support the response to the pandemic.

In July the CCG have received 175 cases of patient and staff feedback; 112 of which were health care professional feedback via the CCG's Yellow Card system with a clear theme relating to workload shift from acute providers to primary care. Four formal complaints with no particular trends or themes identified were received during July.

In July the CCG were notified of 31 Serious Incidents (SIs) and one Never Event. One SI is potentially linked to COVID-19.

Influenza Planning & Support Programme 2020/21

There are a number of potential challenges that will impact on this year's influenza (flu) programme across the patient/public and front-line healthcare worker vaccine programme. The CCG flu planning and support group has met for the first time and terms of reference have agreed to support providers across Devon in the planning and delivery of this national programme. The group has Local Medical Committee, Local Pharmaceutical Committee and primary care representation. An updated DHSC/PHE flu planning letter has been published, including details of expanded eligibility and advice on delivering the programme during the pandemic. This will be carefully considered at the next meeting of the group to further inform our plans to help optimise uptake in Devon this year.

LeDer Programme

The CCG is required to ensure the application of the LeDer programme across the Devon system, overseen by a steering group, through commissioning of reviews and co-ordinating system wide activity. The aim of the programme is to drive improvement in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities in this population, through mortality case review. A revision to the steering group terms of reference is underway to support a more collaborative system approach to the programme with an improved level of oversight on programme activity and outcomes. NHSE/I have supported all CCGs with additional funds to increase reviewer capacity for a short-term period. There are currently 26 reviews awaiting allocation across Devon.

4. CCG Performance Reporting from 1st August 2020 to 31st March 2021

The letter entitled ***Third Phase Response to COVID-19*** dated 31st July details the following:

"*As acute COVID-19 pressures were beginning to reduce, we wrote to you on 29th April to outline agreed measures for the second phase, restarting urgent services. Now in this Phase Three letter we:*

- *update you on the latest COVID-19 national alert level;*
- *set out priorities for the rest of 2020/21; and*
- *outline financial arrangements heading into Autumn as agreed with Government."*

It sets out an inclusive approach going forward as follows:

"Following discussion with patients' groups, national clinical and stakeholder organisations, and feedback from our seven regional 'virtual' frontline leadership meetings last week, we are setting out NHS priorities for this third phase. Our shared focus is on:

A. *Accelerating the return to near-normal levels of non-COVID-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter*

B. *Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID-19 spikes locally and possibly nationally.*

C. *Doing the above in a way that takes account of lessons learned during the first COVID-19 peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention."*

Objectives to support the approach include:

- *"Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021.*
- *Recover the maximum elective activity possible between now and winter.*
- *Restore service delivery in primary care and community services.*
- *Expand and improve mental health services and services for people with learning disability and/or autism.*
- *Preparation for winter alongside possible COVID-19 resurgence.*
- *Doing the above in a way that takes account of lessons learned during the first COVID-19 peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention."*

In terms of elective activity, the letter looks to balance the need to be ambitious with a deliverable performance level. The requirements for NHS acute providers are:

- In September, achieve at least 80% of last year's activity for overnight electives and outpatient/day case procedures, rising to 80% in October;
- At least 90% of last year's levels of MRI/CT and endoscopy activity, with an ambition to reach 100% by October;
- 100% of last year's first and follow-up outpatient attendances (delivered face to face or virtually) from September, aiming for 90% in August.

The CCG is looking at potential pinch points in capacity that could result from these elective performance requirements. Furthermore, there is an expectation that elective waiting lists

and performance will be managed at a system as well as trust level. And the letter emphasises that clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients.

As part of the Devon system restoration process, providers submit weekly information to the CCG Business Intelligence team and this will allow the CCG to monitor the requirements of the letter. These indicators will be included in future Governing Body reports.

5. Recommendations to Members

Members of the Governing Body are asked:

- To agree the 1st April 2020 to 30th June 2020 (month 3) Constitutional Standards performance position;
- To agree the 1st April 2020 to 30th June 2020 (month 3) quality and safety performance position;
- To note the publication of new national guidance on performance for the period 1st August 2020 to 31st March 2021 and the action being taken to ensure we can monitor against the requirements.

Appendix 1

Governing Body – Performance Report

August 2020

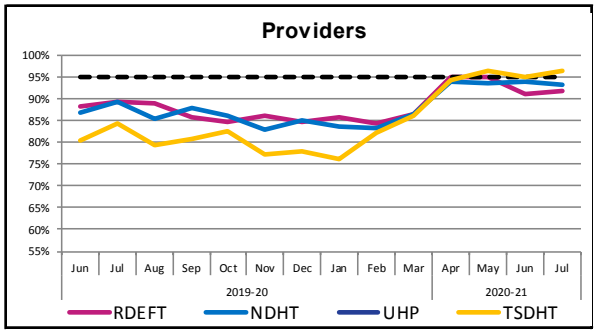
Performance and Quality indicators

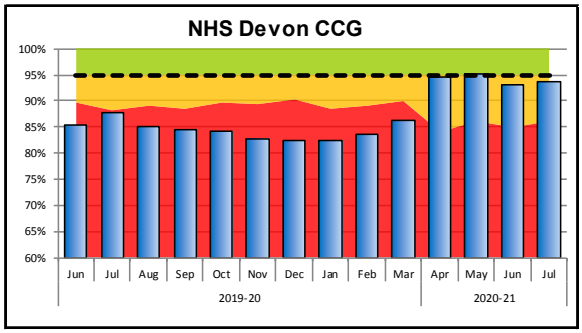
A&E Performance - Percentage of patients waiting less than 4 hours.

All types (including MIU and WiC)

Trust	Trajectory	July	2020/21
RDEFT	86%	91.8%	92.9%
NDHT	88%	93.2%	93.5%
UHP	N/A	N/A	N/A
TSDFT	85%	96.3%	95.6%

CCG	Trajectory	July	2020/21
NHS Devon	95%	93.7%	94.0%
ENGLAND		93.0%	93.2%

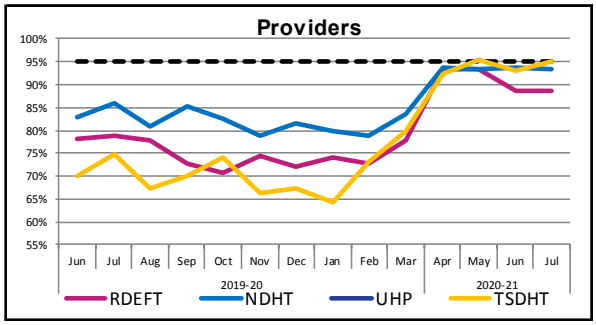


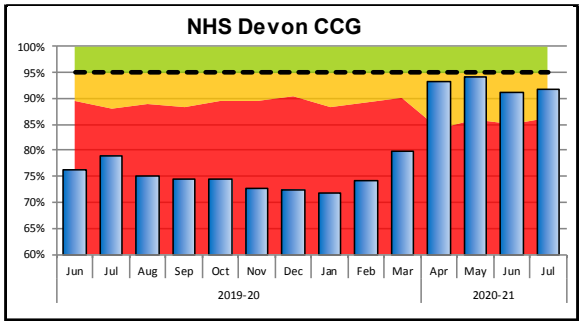


Type 1 A&E only

Trust	Trajectory	July	2020/21
RDEFT	86%	88.5%	90.6%
NDHT	88%	93.2%	93.5%
UHP	N/A	N/A	N/A
TSDFT	85%	94.9%	94.1%

CCG	Trajectory	July	2020/21
NHS Devon	95%	91.8%	92.5%
ENGLAND		90.2%	90.7%





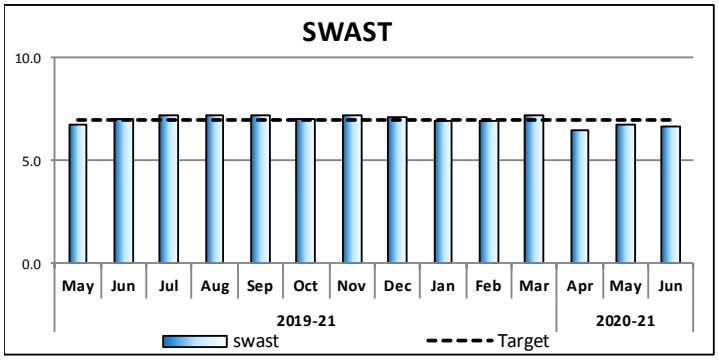
Performance Commentary

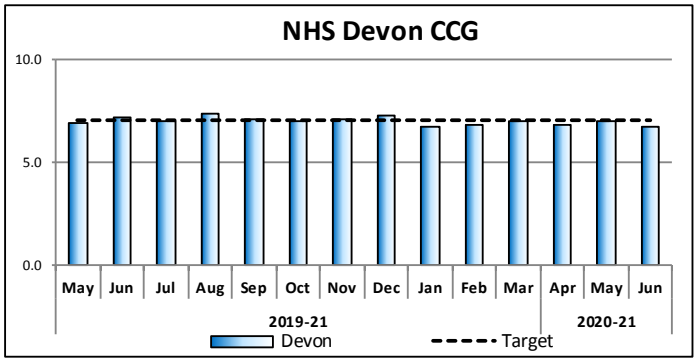
Performance fell back slightly in June but remains comparatively good against the A&E 4-hour target across all providers.

The July STP 'all types' position was 93.7%, slightly up from 93% in June and falling under the national 95% target. TSD continued to see the highest level of performance at 96.3%, with NDHT at 93.2% and RD&E falling to 91.8%. Type 1 performance also remained relatively good at 91.8%, compared to the England position of 90.2%.

SWAST Cat 1 Mean response time

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



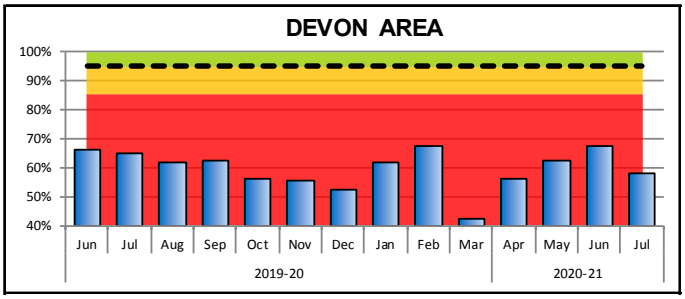


Performance Commentary

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

NHS 111 answering calls within 60 Seconds

Trust	Target	July	2020-21
DEVON	95%	57.8%	60.7%
ENGLAND	95%	91.0%	83.7%



Performance Commentary

The proportion of calls answered within 60 seconds fell from 67.3% in June to 57.8% in July and performance remains well below the target of 95% and continues to be the lowest in the South West.

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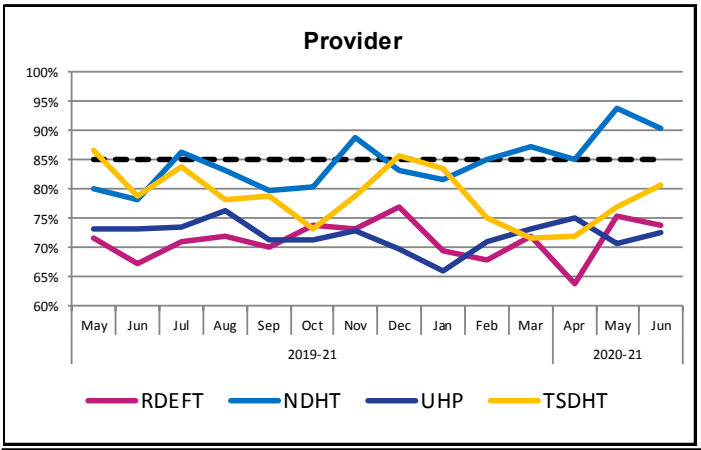
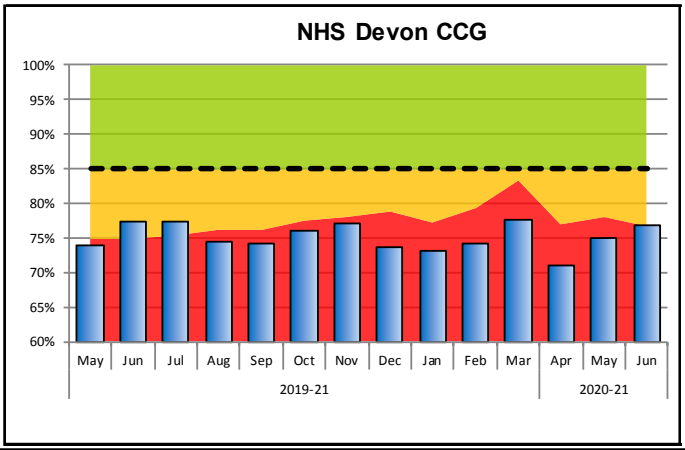
Cancer 62 day Urgent Referral

Trust	Trajectory	June	2020/21
RDEFT	71.3%	73.8%	70.6%
NDHT	84.4%	90.4%	89.4%
UHP	73.4%	72.5%	72.9%
TSDFT	85.2%	80.9%	76.1%

CCG	Trajectory	June	2020/21
NHS Devon	77%	76.7%	74.1%
ENGLAND	85%	75.2%	73.3%



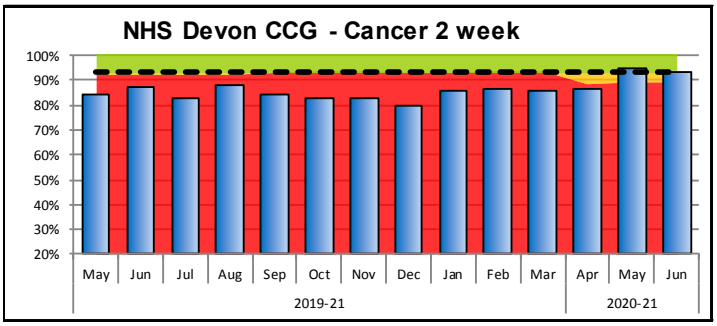


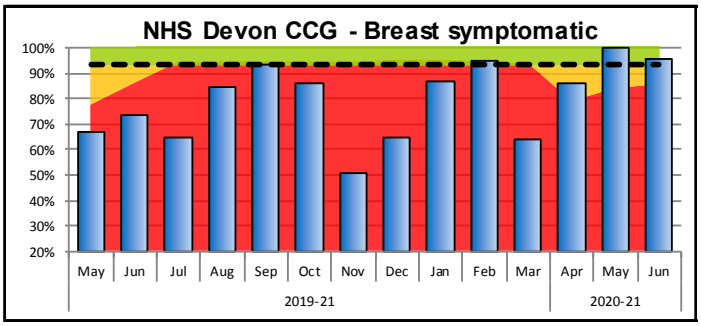
Performance Commentary

There was a further increase in performance in June with the STP position rising from 74.9% to 76.7%. However, NDHT continued to be the only provider achieving the 85% target at 90.4%. RD&E fell from 75.5% to 73.8%, TSD deceased from 77.1% to 75.5% but UHP improved from 70.6% to 72.5%. Whilst the STP underperformed against target it remains above the national position of 75.2%.

Cancer Targets (June-2020)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	93.1%	90.7%	96.6%	96.9%	91.4%
93%	2 week breast	95.6%	100.0%	92.9%	96.3%	95.3%
90%	62 day screening	57.1%	0.0%		66.7%	66.7%
85%	62 day consultant	87.3%	86.5%	92.3%	81.8%	33.3%
96%	31 day first	97.9%	94.5%	100.0%	99.0%	100.0%
94%	31 day surgery	85.5%	76.0%	88.9%	90.0%	100.0%
98%	31 day drugs	100.0%	100.0%	100.0%	100.0%	100.0%
94%	31 day radiotherapy	96.7%	97.2%		93.5%	100.0%





Performance Commentary

June showed an similar level of performance to May against the majority of cancer targets with TSD achieving five of eight measures, RDEFT and UHP achieving four out of eight and NDHT meeting four of the six applicable to them. At STP level only the 62 day screening and 31 day surgery targets were not achieved.

Performance against both the main 2ww standard and the 2ww breast symptomatic measure remained above target with strong performance at UHP in particular.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

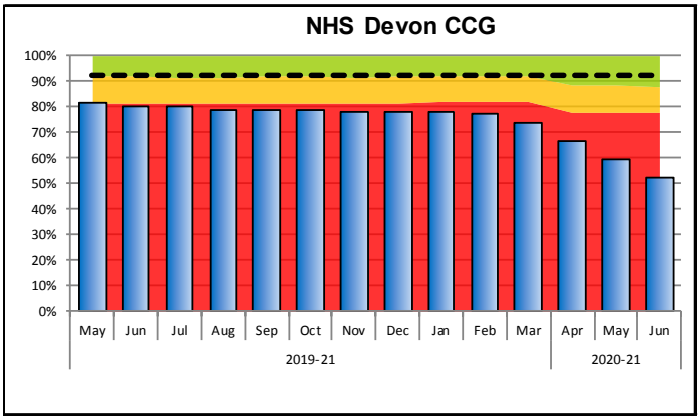
Trust	Trajectory	June	2020/21
RDEFT	76.7%	49.2%	57.8%
NDHT	74.6%	48.3%	56.3%
UHP	76.0%	54.1%	60.0%
TSDFT	79.5%	57.0%	62.6%

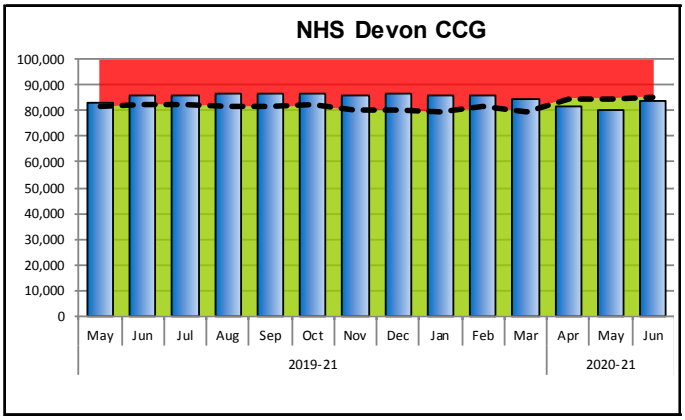
CCG	Trajectory	June	2020/21
NHS Devon	77.4%	52.5%	59.4%
ENGLAND	92.0%	52.0%	61.9%

RTT incomplete waits volume

Trust	Trajectory	June
RDEFT	34,857	30,777
NDHT	11,564	11,611
UHP	28,496	25,734
TSDFT	18,416	21,968

CCG	Trajectory	June
NHS Devon	82,603	83,549





Performance Commentary

The STP level RTT position continued to fall in June from 59.3% to 52.5% compared to the target of 92% and national performance of 52%. All providers saw a worsening position with UHP performance decreasing to 54.2%, RD&E at 49.2%, NDHT at 48.3% and TSD at 57%. All providers are under target and performance is expected to continue to decline when August data is released.

RTT Incomplete Pathways long waiters

40-52 week waits

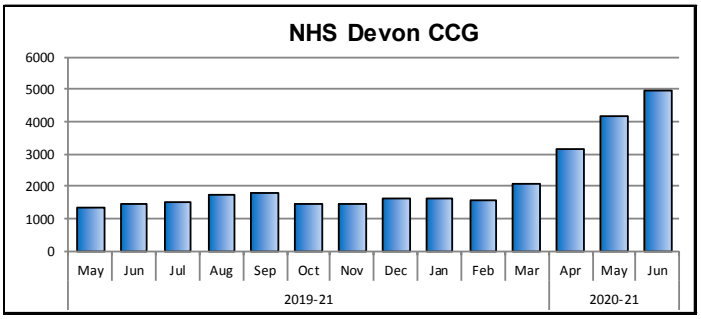
Trust	June	2020/21
RDEFT	1995	4873
NDHT	953	2383
UHP	1509	4088
TSDFT	1002	2337

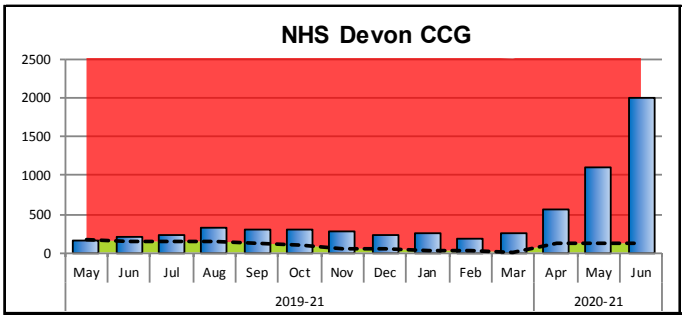
CCG	June	2020/21
NHS Devon	4956	12322

Over 52 week waits

Trust	Trajectory	June	2020/21
RDEFT	5	836	1583
NDHT	0	366	538
UHP	46	620	1262
TSDFT	110	344	629

CCG	Trajectory	June	2020/21
NHS Devon	143	2006	3667





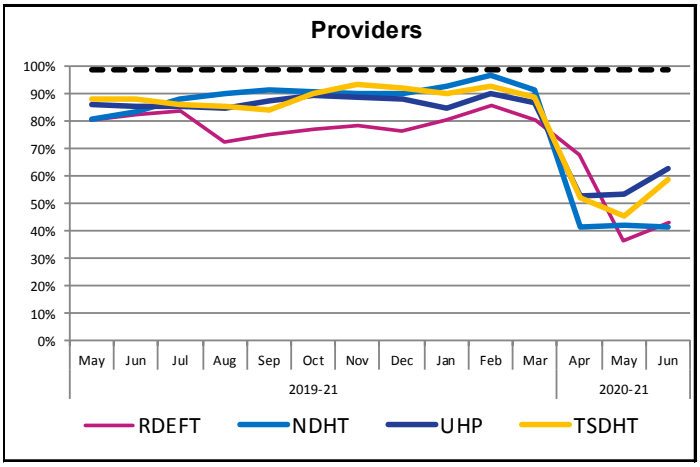
Performance Commentary

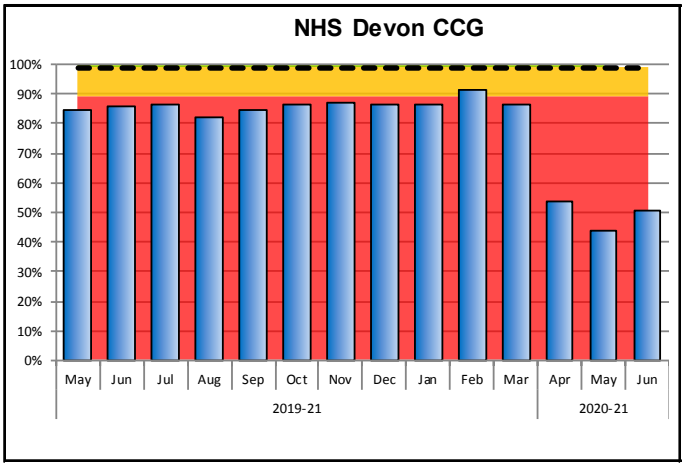
Over 52-week waits have continued to rise. There were 1107 people waiting over 52 weeks in May and this has risen to 2006 in June. All providers have seen an increase in breaches with RD&E rising to 836 (from 494), UHP at 620 (411), TSD at 344 (192) and NDHT at 366 (131). July is expected to show a further increase.

Diagnostic Seen within 6 weeks

Trust	Trajectory	June	2020/21
RDEFT	92.9%	43.0%	52.1%
NDHT	85.0%	41.6%	58.2%
UHP	93.9%	62.5%	43.4%
TSDFT	88.2%	58.7%	47.2%

CCG	Trajectory	June	2020/21
NHS Devon	91.1%	50.9%	49.4%
ENGLAND	99.0%	52.2%	46.4%





Performance Commentary

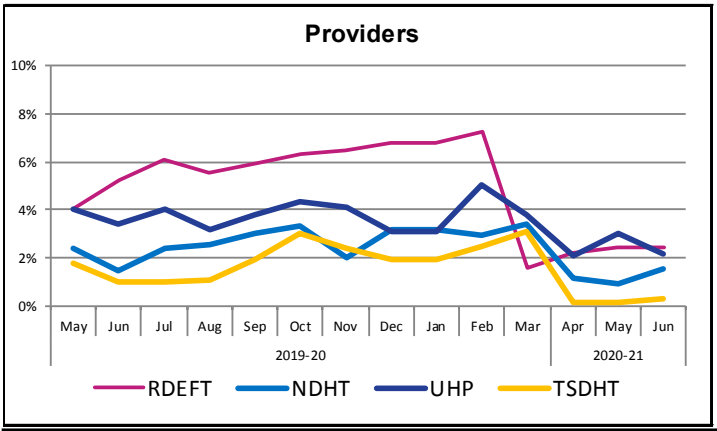
The STP position improved in June as test volumes increased, with 50.9% of patients being seen within the 6 weeks target compared to a national threshold of 99% and an England position of 52.2%.

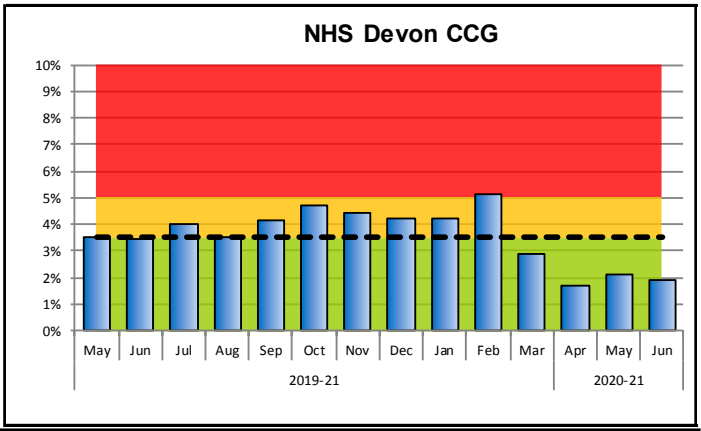
All providers except NDHT saw an improvement with UHP performance rising from 53.6% in May to 62.5% in June, TSD moving from 45.8% to 58.9%, RD&E increasing from 36.7% to 43% but NDHT falling slightly from 42.4% to 41.6%.

Acute Delayed Transfers of care

Trust	Target	June	2020/21
RDEFT	3.50%	2.4%	2.3%
NDHT	3.50%	1.5%	1.2%
UHP	3.50%	2.2%	2.4%
TSDFT	3.50%	0.3%	0.2%

CCG	Target	June	2020/21
NHS Devon	3.50%	1.90%	1.9%





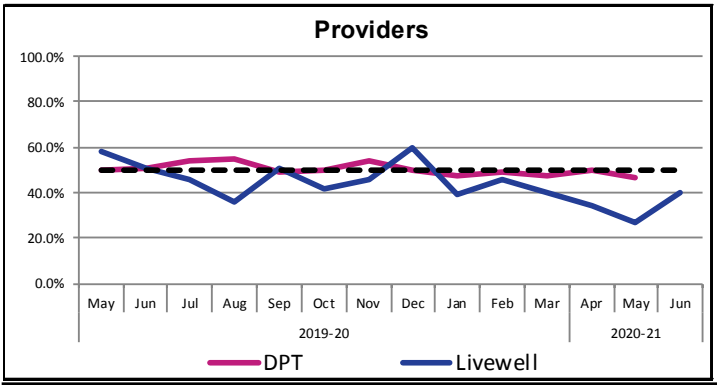
Performance Commentary

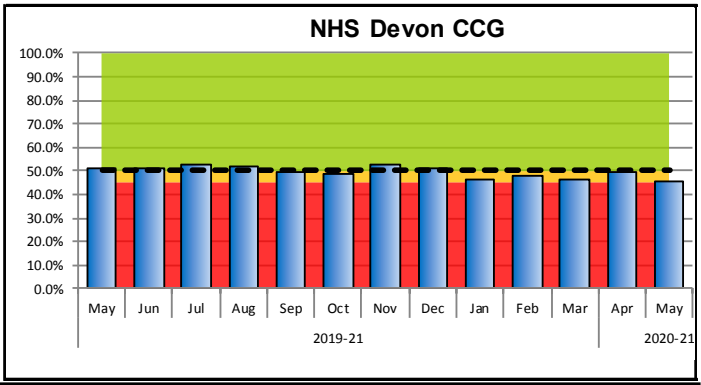
In June acute delayed transfers of care (DTOC) continued to be below the 3.5% target at 1.90%. All providers were within target.

IAPT Recovery rate

Trust	Target	May	2020/21
DPT	50%	46.4%	48.1%
LIVEWELL	50%	40.2%	35.0%

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





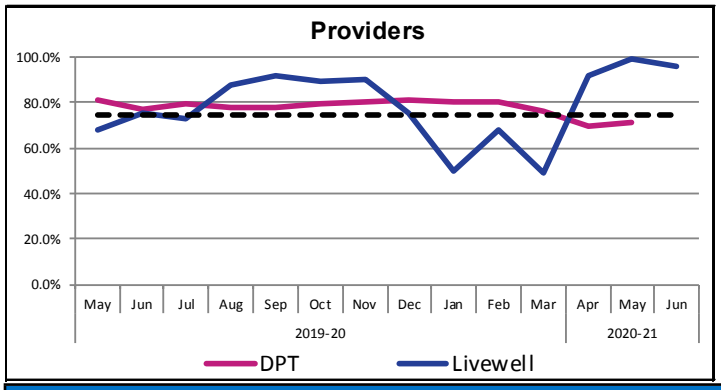
Performance Commentary

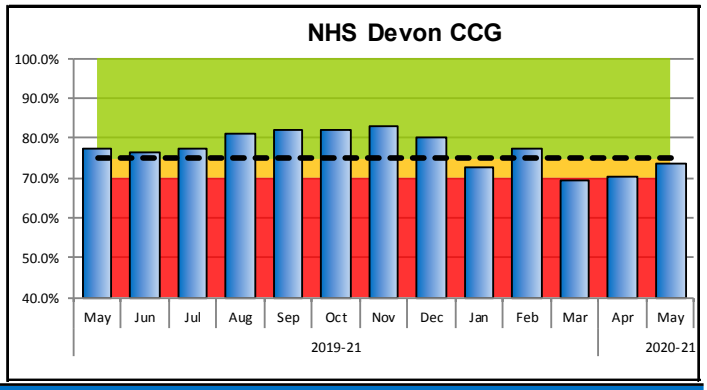
May IAPT recovery data shows performance continuing to be under the 50% target at 45.1% for the STP. DPT fell to 46.4% and Livewell continue to perform lower at 40.2%.

IAPT waiting 6 weeks

Trust	Target	May	2020/21
DPT	75%	70.9%	70.1%
LIVEWELL	75%	96.4%	96.7%

CCG	Target	May	2020/21
NHS Devon	75%	73.6%	72.1%



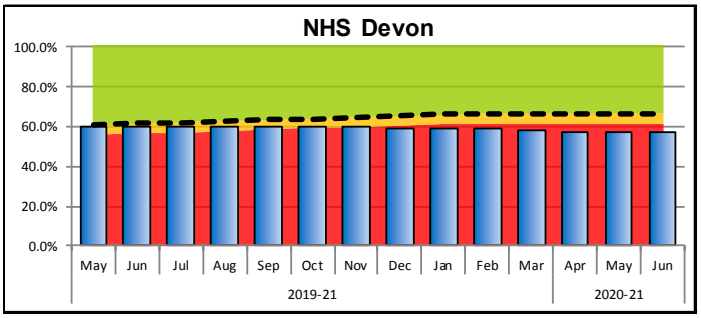


Performance Commentary

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

Dementia Diagnosis Rate

CCG	Trajectory	July	2020/21
NHS Devon	59.4%	59.5%	59.5%
ENGLAND	67.0%	63.2%	64.2%



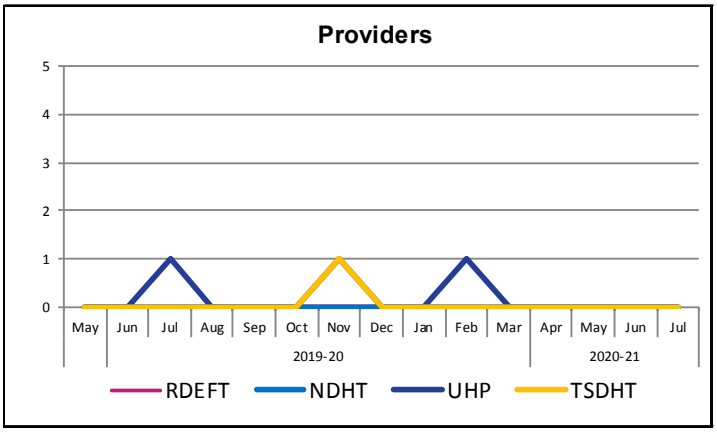
Performance Commentary

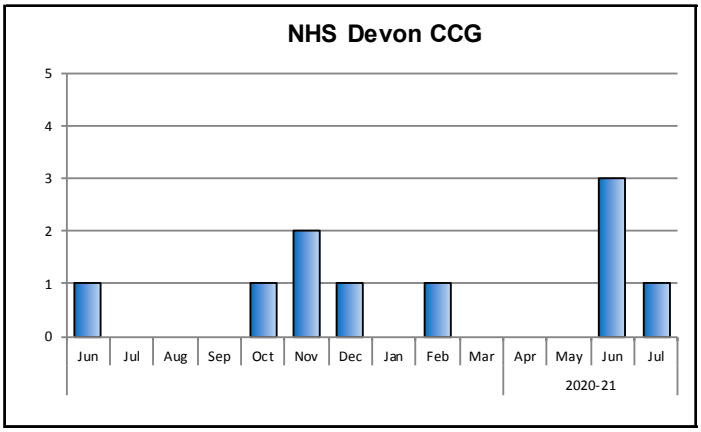
STP level performance remained static in July and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (41.2%), Mid Devon (49.8%) and Plymouth (55%). Conversely Exeter is at (68.7%), Torbay (52.7%) and East Devon at (61.8%).

MRSA breaches

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

CCG	Target	July	2020/21
NHS Devon	0	4	4





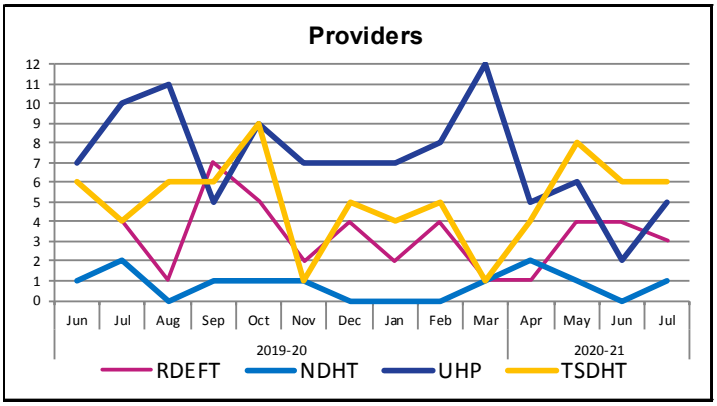
Performance Commentary

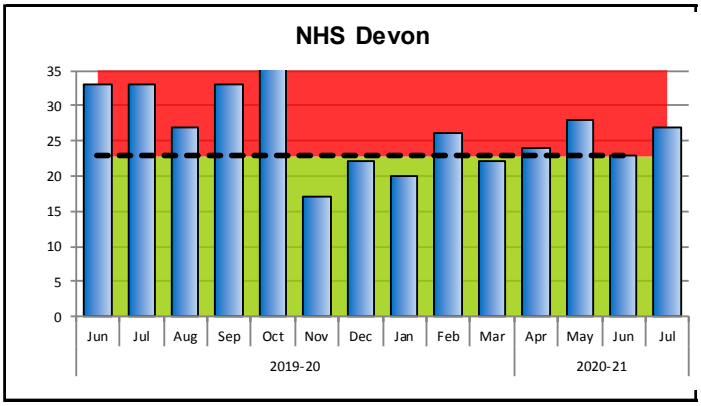
There were four reported cases of MRSA in July for the CCG but all were for out of area providers.

C-Diff breaches

Trust	Target	July	2020/21
RDEFT	<31	3	12
NDHT	<9	1	4
UHP	<63	5	18
TSDFT	<36	6	24

CCG	Target	July	2020/21
DEVON STP	<274	24	102





Performance Commentary

There were 15 C-Diff cases acquired within the Devon acute providers and 24 across the STP in July.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Governing Body Effectiveness report				
Date of committee: 27 August 2020 **Date report produced: 10 February 2020 & 13 August 2020**				
Author (s) Name and Title: **Lauren Bird, Compliance and Governance Officer** **Nikki Coombes, Senior Executive Assistant** **Contact Details: lauren.bird8@nhs.net** **ncoombes@nhs.net**		**Supporting Executive:** **Name and Title: Ginny Snaith, Board Secretary** **Contact Details: g.snaith@nhs.net** **Report Approved by:** **Name and Title:** **Date 14 August 2020**		
Public or Private (Governing Body only):	**Public**		**Private**	✓
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of this paper is to present the findings of the review of effectiveness of the Governing Body, which was undertaken using an electronic questionnaire, and to summarise the effectiveness review process.				
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:				
Not applicable				
Key recommendations and actions requested:				

Recommendation 1 – A Governing Body development session to be held to discuss the Integrated Care system and its governance, as well as Governing Body membership roles and behaviours, in particular with regard to challenge and scrutiny.

Recommendation 2 – Action logs to be reviewed to ensure clarity of action owners and feedback on progress/resolution.

Recommendation 3 – All papers must be reviewed and approved by the Executive Lead prior to submission to ensure that there is an executive summary which clearly articulates the content of the report, the actions required of the Governing Body, and that detail is succinct but sufficient enough to inform governing body members.

Recommendation 4 – The level of and process for membership and public engagement and consultation is reviewed at a Governing Body development session to ensure that the CCG is seeking adequate feedback from its membership and population.

Recommendation 5 – The GB forward planner is reviewed to ensure that items and agendas are appropriate and not duplicated. Consideration also needs to be taken regarding item length, order and likely discussion time to ensure items on the agendas are given sufficient time and timings realistic and manageable.

Recommendation 6 – Regular breaks would be welcome to ensure comfort during long Governing Body sessions and the agenda should be planned to accommodate this

Recommendation 7 – Executives must be encouraged to ensure that papers are submitted by the planned deadline for Governing Body to ensure one version of the pack is circulated to Governing Body members. Where it is recognised that there will be a late paper, in line with constitution, the Chairs approval will be sought and GB members informed.

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:

Not applicable

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.

Governing Body Effectiveness Report

1. Executive Summary

1.1 Effective committee meetings are a key part of an effective governance structure and provide evidence that the CCG Code of Governance principles are being met. This is particularly important to ensure that governance arrangements are robust and undertaking such a review of effectiveness provides further assurance to the CCG members as it progresses through the five-year forward view and the components of the NHS England assurance framework.

1.2 The main function of the Governing Body is to ensure that Devon CCG has arrangements in place to exercise all of their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance.

The Governing Body is responsible for:

- Assurance, including audit and remuneration
- Assuring the decision-making arrangements
- Oversight of arrangements for dealing with conflict of interest
- Agreeing the vision and strategy
- Formal approval of commissioning plans on behalf of the CCGs
- Oversight of performance
- Providing assurance of strategic risks

All other duties are delegated to the Sub-Committees of the Governing Body.

1.3 The purpose of this paper is to present the findings of the review of effectiveness of the Governing Body, which was undertaken using an electronic questionnaire, and to summarise the effectiveness review process. This report is further supported by the monthly effectiveness reviews undertaken following each Governing Body Session for 20/21 and findings are presented at the end of this paper.

1.4 The Governing Body will receive reports of the effectiveness of all of its sub-committees via Chair's reports.

2. Purpose of report

2.1 The CCG has undertaken a review of its governing body effectiveness using the NHS clinical commissioning groups code of governance and HFMA audit committee handbook as best practice guides and using the following principles:

- The need for committees to be clear about their roles in strengthening the governance arrangements of the CCG and support the Governing Body in the achievement of their CCG's strategic objectives, as well as acknowledging their own committee objectives outlined in the terms of reference;

- The requirement for a committee structure that strengthens the role of the Governing Body in strategic decision making and supports the role of non-executive directors / Lay Members in appropriately challenging the executive management.
- Maximising the value of the input from non-executive directors / lay members, given their limited time commitment
- Supporting the Governing Body in fulfilling their roles, given the nature and content of the committee's agenda.

2.2 The current governance for the CCGs is provided through properly constituted Governing Body established in accordance with the CCGs constitutions. The Governing Body has the following approved committees:

- Audit Committee
- Finance and Performance Committee
- Quality Assurance Committee
- Remuneration and Workforce Committee
- Primary Care Commissioning Committee

Effectiveness reviews have been presented through each Chairs report for 19/20 to the Governing Body.

2.3 The principles set out in the NHS clinical commissioning groups' code of governance together with the HFMA audit committee handbook were used as the basis of the review of committee effectiveness. A desktop review of the cycle of business and terms of reference of the quality committee has been undertaken by Governance. The review has been broken down into the following subsections, known as themes:

- Governing Body agenda
- Governing Body board papers
- Committee focus
- Committee effectiveness
- Behaviours, dynamics and atmosphere

2.4 Reporting arrangements and cycle of business have also been reviewed to ensure that this is adequate and meets constitutional requirements.

3. Key Findings

3.1 The effectiveness review was issued to all GB members and 7 responses have been received. This comprises of 4 Non-executive Directors /Lay Members, 2 clinical members and 1 attendee.

3.2 The table attached as appendix 1 summarises the responses received.

3.3 The key findings from the responses have been collated into general themes, the comments relating to each theme are as follows:

Theme 1 – Governing Body Agenda

It was largely agreed that The GB agenda is clear, manageable within the time frame and well balanced across relevant issues. The following comments were received:

- *It varies so much based on quality of the paper, nature of presentation, time of day. Need to resolve best way to do GB performance management of big contracts with overspends.*
- *Main issue is time allocated to some agenda items does not represent the time we take. Can we be more accurate in forecasting issues that might need some discussion. Having said that the Chair usually allows time, but it is at the expense of other items.*
- *Mostly clear though sometime history /context of certain items could do with some scene setting (especially with new members). Seems to be little time spent on prevention as a topic compared to other topics*
- *Agendas and paperwork are both lengthy. We could look at splitting agendas by items for decision, discussion and information. Larger strategic items might be better place at the top of the agenda - sometimes we get to these as people run out of steam.*

It was also largely agreed that the Chair actively ensures that each agenda item is given appropriate time, discussion focus remains strategic and centred around forming decisions and items are sufficiently explored. It was commented that this is a challenging task given the agenda and is well managed, there are times when items are not given the sufficient time needed, but this is always a balancing act which the chair navigates well.

Theme 2 – Governing Body Board papers

There was some disagreement regarding whether Board papers are of an appropriate length / level and produced to defined standards ensuring quality and consistency and provide assurance. The following comments were received:

- *Some papers are but many papers do not cover the key evidence and financial information we need, especially in development session.*
- *They are often too lengthy and too much supporting information*
- *There is the opportunity for some papers to be shorter - this is not always the case sometimes detail is needed , but other times reports could be tightened up to focus on the specific and strategic. Papers are of a good standard but would benefit from more visuals, or report that are presentations (these reports tend to be more focused)*
- *Board papers are very lengthy. Authors should be encouraged to pull out the key strategic issues. It sometimes feels like we are buried with information.*

It was agreed that Board papers are circulated in sufficient time to allow for full preparation. However, one respondent stated that this is not always the case with other Committee's papers.

Theme 3 – Committee Focus

The majority of respondents agreed that The Governing Body has agreed the strategic objectives for the CCG. One member queried if these objectives are under timely

review. Another commented that they were sure that this must be the case, but it does not always feel so.

It was largely agreed that the Governing Body has agreed its commissioning intentions for the year.

It was also mostly agreed that the Governing Body discussions are strategically focused and are high level, forward focused and explore new areas/perspectives. However, it was commented that there is still quite a lot of day to day issues discussed and that further discussions required around the 'difficult decisions' get mentioned but not actively discussed

There was some disagreement regarding whether as the organisation has changed and evolved, members are clear on the role of the Governing Body within the evolving role of an Integrated Care System (ICS). The following comments were received:

- *I have some clarity, though this is a changing picture and I believe will be clearer as the ICS governance is firmed up*
- *Though ICS not yet formed, there is probably more clarity to come around how the different governance will work in practice; but feel I am as clear as I can be currently*
- *Not entirely clear*

Theme 4 – Committee Effectiveness

There was some disagreement that discussions lead to clearly identifiable decisions, with responsibility assigned for taking any actions forward where appropriate. The following comments were received:

- *This is not always clear*
- *Usually, not always*
- *We could be clearer occasionally on who is going out of the room to do something as a result of decisions, what and when there might be feedback.*

It was agreed that the Governing Body is clear about the authority it has with its committees. However, one respondent stated that while this is mostly the case there have been some issues recently about full GB not being happy re a decision from one subcommittee.

It was also agreed that The Chair encourages input and perspective from all governing body members. Decisions are made on the collective exploration of issues and agreed by all members (where this is possible and does not create a timely ‘stalemate’ situation).

There was some disagreement that Committee Chairs reports summarise decisions made and offer adequate assurance and achieve visibility of key issues and progress. The following comments were received:

- *Not sure we are fully there yet*

- *Feels more month-specific (which useful) so I would not see it as key decisions report . Often seem to be more about monthly activity/key strategic meetings/events*
- *Difficult to say - they are usually "taken as read" at the end of a long and tiring meeting.*

Theme 5 – Behaviours, dynamics and atmosphere
It was agreed that Governing Body members declare any interests at the beginning of the meeting or where an agenda item may require declaration.

There was some disagreement whether the roles of all governing body members are clear, agreed and specified. It was stated that it would help to have a session to clarify these.

All respondents felt that the role of clinical members provides the appropriate level of clinical expertise and clinical representation on the GB, with one member noting that they were particularly impressed by this.

Respondents mostly felt that the role of the Executives provides the appropriate level of technical expertise and knowledge required to support the function of the GB. However, one member stated that they were concerned that we get a lot of plans, but these don't always seem to then get implemented.

All respondents felt that the role of the lay members support independent scrutiny and challenge. It was commented that Current lay members have demonstrated a good level of challenge and I'd want to see this continue. Clinical members could be more challenging.

There was some disagreement that the CCG understands the views of the public and service users. The following comments were received:
- *While there is some good work, looking at how to understand and engage the public/patients this seems to sit mostly within engagement /PALS. Still a lot of traditional focus on detailed feedback surveys that characterise formal consultations to meet standards. would be a positive move to look at how all areas of CCG work think creatively around how to understand and involve those using services. For example, not consulting on the service changes (once they are worked up), engaging patients early on so they are involved in the design of the options.*
- *Not sure. Apart from the odd "patient experience" input, I think sometimes we may need to remind ourselves of the patient perspective.*

There was also some disagreement regarding whether meetings are held in a convenient location of appropriate size and sufficiently catered for. The following comments were received:
- *Usually not always , some venues have been cramped , layout of table is very important*

- *Unfortunately, our locations do not always lend themselves well to a more sustainable green travel plan approach. We are very car dependent.*
- *I welcome the move to different locations*

3.4 With regard to the CCG values, the responses were largely positive with the average score being 3.7. For all scores relating to CCG values, please see appendix 1.

3.5 Additional comments from governing body members to note are:

- *In a good corporate Board or Governing Body both Execs and NEDs should feel able to constructively challenge and scrutinise. I am not yet clear if all Execs feel confident enough to do that.*
- *There is a need for Execs and NEDs to form a "Unitary Board" (or GB in our case) where constructive challenge is not seen as the preserve of the NEDs. NEDs, in turn, are not there simply to referee a game being played by Execs - NEDs too need to share fully in collective responsibility.*
- *Thank you for the opportunity to comment. This really helps to demonstrate an open and transparent culture. It is still early days for me, but I feel that the GB would benefit from some "away day" time, without the pressure of a business agenda and with the opportunity for team building, strategic discussion and horizon scanning.*

Effectiveness of Governing Body meetings held remotely 20/21

Although this report covers the effectiveness of our Governing Body meetings held during 19/20, we felt it would be beneficial to include key findings from our meetings that have been delivered remotely during our response to the pandemic during 20/21. We have been able to capture this data through the survey links that are circulated following each meeting.

Key Findings

The effectiveness review was issued to all Governing Body members and an average of 8 anonymous responses have been received for the period of April to July 2020.

The key findings from the responses have been collated into general themes, the comments relating to each theme are as follows:

1. **How effective overall was the Governing Body day**?
    1. For the three-month period the average score was 8 out of 10 with 10 being most effective.

2. **What do you think was the best thing of the meeting?**
    1. Microsoft Teams works well and is effective for asking questions and seeing everyone
    2. Focused and balanced discussions on key topics
    3. Virtual meetings allow for everyone to have a chance to participate
    4. Well chaired
    5. Development sessions have allowed good level of debate

3. **What do your think was the worst thing about the meeting?**
    1. Length of day
    2. Duplication of agenda items in public and private
    3. Sitting down for long periods and tiredness – more breaks required
    4. Not being able to have face to face conversations with fellow members during breaks
    5. Constant refreshing of supporting papers
4. **What three things could be done to make the next meeting more effective?**
    1. Ensure agenda not overloaded
    2. Ensure items have sufficient time for discussion
    3. Reduce amount of discussion in private to only those things that cannot be done in the public meeting
    4. Focus on strategic issues
    5. Time management
    6. Actions to be made clear
5. **Materials and papers provided?**
    1. Generally of a good standard
    2. Lots of updates means duplication of reading
    3. Summaries are helpful
    4. Helpful when papers are updated that changes are indicated
6. **The timings of the day?**
    1. Tendency for meetings to overrun
    2. More breaks to be built in
    3. Feeling meetings are rushed towards the close of the day
7. **Your opportunity to contribute**
    1. Good chairing
    2. Hand up feature in Microsoft Teams makes it easier to contribute
    3. Amount of agenda items on occasion stifles discussion
    4. Very good

4. Recommendations

4.1 The Chair of the Governing Body is requested to note the following:

- The feedback from members was in the main very positive, with a clear sense of leadership from the Chair of the Governing Body
- The response to the 19/20 survey included 7 replies, which may not be representative of the views of the whole membership regarding Governing Body effectiveness.
- One of the main themes running throughout the survey concerned the content and length/size of papers.
- All members agreed that Governing Body members declare any interests at the beginning of the meeting or where an agenda item may require declaration
- In relation to the remote feedback of GB meetings held remotely, this was in the main positive

<u>Recommendation1</u> – A Governing Body development session to be held to discuss the Integrated Care system and its governance, as well as Governing Body membership roles and behaviours, in particular with regard to challenge and scrutiny.

<u>Recommendation 2</u> – Action logs to be reviewed to ensure clarity of action owners and feedback on progress/resolution.

<u>Recommendation 3</u> – All papers must be reviewed and approved by the Executive Lead prior to submission to ensure that there is an executive summary which clearly articulates the content of the report, the actions required of the Governing Body, and that detail is succinct but sufficient enough to inform governing body members.

<u>Recommendation 4</u> – The level of and process for membership and public engagement and consultation is reviewed at a Governing Body development session to ensure that the CCG is seeking adequate feedback from its membership and population.

<u>Recommendation 5</u> – The GB forward planner is reviewed to ensure that items and agendas are appropriate and not duplicated. Consideration also needs to be taken regarding item length, order and likely discussion time to ensure items on the agendas are given sufficient time and timings realistic and manageable.

<u>Recommendation 6</u> – Regular breaks would be welcome to ensure comfort during long Governing Body sessions and the agenda should be planned to accommodate this

<u>Recommendation 7</u> – Executives must be encouraged to ensure that papers are submitted by the planned deadline for Governing Body to ensure one version of the pack is circulated to Governing Body members. Where it is recognised that there will be a late paper, in line with constitution, the Chairs approval will be sought and GB members informed.

The Governing Body is asked to note the results of the review and that relevant actions included will be taken forward. The next effectiveness review of the governing body will be undertaken in January 2021 ahead of the annual report co-ordination in March 2021.

Report author and job title: Lauren Bird, Compliance and Governance Officer and Nikki Coombes, Senior Executive Assistant

Executive Lead: Ginny Snaith

Job Title: Board Secretary

Appendix 1 - Full list of responses

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
The GB agenda is clear, manageable within the timeframe and well balanced across relevant issues.	1	4	2	0	0
Governing Body members declare any interests at the beginning of the meeting or where an agenda item may require declaration	5	2	0	0	0
The Chair actively ensures that each agenda item is given appropriate time, discussion focus remains strategic and centred around forming decisions and items are sufficiently explored	2	4	1	0	0
Board papers are of an appropriate length and produced to defined standards ensuring quality and consistency	0	4	0	3	0
Board papers are circulated in sufficient time to allow for full preparation	3	4	0	0	0
The Governing Body has agreed the strategic objectives for the CCG	0	6	1	0	0
The Governing Body has agreed its commissioning intentions for the year	0	4	3	0	0
The Governing Body discussions are strategically focused. They are high level, forward focused and explore new areas/perspectives	1	5	1	0	0
Discussions lead to clearly identifiable decisions, with responsibility assigned for taking any actions forward where appropriate	1	4	1	1	0
The roles of all governing body members are clear, agreed and specified.	0	5	1	1	0
The Chair encourages input and perspective from all governing body members. Decisions are made on the collective exploration of issues and agreed by all members (where this is possible and does not create a timely 'stalemate' situation).	2	5	0	0	0
The Governing Body is clear about the authority it has with its executive committees	2	5	0	0	0
Committee Chairs reports summarise decisions made and offer adequate assurance and achieve visibility of key issues and progress	2	2	2	1	0
I feel the role of clinical members provides the appropriate level of clinical expertise representation on the GB.	2	5	0	0	0
I feel the role of the Executives provides the appropriate level of technical expertise and knowledge required to support the function of the GB.	1	5	1	0	0
I feel the role of the lay members support independent scrutiny and challenge.	4	3	0	0	0
Meetings are held in a convenient location of appropriate size and sufficiently catered for.	1	6	0	0	0
I feel that the CCG understands the views of the public and service users.	0	5	2	0	0
As the organisation has changed and evolved, I am clear on our role as a GB within the evolving role of an Integrated Care System (ICS).	0	3	2	2	0

Which of the values do you feel the GB demonstrates on a scale of 0 – 5 (0 = not meeting value)	**0**	**1**	**2**	**3**	**4**	**5**
One team	0	0	1	3	3	0
Quality in everything we do	0	0	0	2	5	0
Respect for all	0	0	0	0	7	0
Everyone is a leader	0	0	0	2	5	0

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Commissioning Committee

Date of Governing Body: Thursday 27 August 2020

Dates of Committees covered in this report: Thursday 13 August 2020

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

Chair's Name and Title: Dr Claire Hooper, Strategic Clinical Advisor (Urgent Care)

Presented by Dr Simon Kerr, Governing Body Clinical Representative

Contact Details: claire.hooper2@nhs.net / simon.kerr@nhs.net

Reports discussed and assurances received

Commissioning Checklist

- The Committee were provided with a Commissioning Checklist which will be used at future Committees to ensure that papers presented have been through the appropriate stages and to confirm relevant engagement has taken place.

Commissioning Objectives: In and Out of Hospital

- The Committee were updated on the proposed In Hospital and Out of Hospital Portfolio changes and were sighted on the workplans and timescales.

Local Plan for Recovery and Restoration

- An update was provided on the Local Plan for Recovery and Restoration. The response to Phase 3 is required by 21 September 2020.

Diagnostics Update

- The Committee received an update on the diagnostic position. The planned care team are looking to accommodate as many patients as possible that are currently on the waiting list prior to the end of September.

Winter plan – with reference and alignment to Operating Plan

- Information was provided on the latest iteration of the Winter Plan. It was noted that the Winter Plan will be brought back to the next committee.

Think 111 Overview of Programme and Commissioning Input

- An overview of the Think 111 Programme was provided to the Committee. It was noted that a decision may be required in a future meeting regarding additional funding and plans for the future of the contract.

Reports received and noted
Ambulance Commissioning Strategy • The Committee **noted** the Ambulance Commissioning Strategy. Further reviews and comments were sought following the committee to take to the next Joint Ambulance Committee meeting.
Risk Register Review Updates
• The Committee **agreed** to close Risk ID 42 and Risk ID 03. • The Committee **requested** for Risk ID 121 to be re-reviewed ahead of next meeting. • A further review of the Commissioning Risk Register will take place ahead of the next Commissioning Committee.
Committee Decisions
• The Committee **accepted** the recommendation made by CPC of Prasterone for the treatment of vulvar and vaginal atrophy. • The Committee **accepted** the recommendation made by CPC of Ospemifene for the treatment of vulvar and vaginal atrophy. • The Committee **agreed** to the extension of the evaluation in service for Prostatic artery emoblisation (PAE) for the treatment of benign prostatic hyperplasia.
Items of concern to be escalated to the Governing Body
• **None**
Recommendations for Governing Body
• **None**
Recommendations for other Committees
• **None**
Terms of Reference or other committee effectiveness issues
• Terms of Reference were shared with the Committee, further changes were required and will be taken to the next Committee for recommendation of Governing Body approval.

Management of Conflict of interests:

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

NHS
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GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 27 August 2020

Dates of Committees covered in this report 20 August 2020

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

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

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- **Risk Register Reports – see Risk Register review below.**
- **Quality & Performance Report – the Committee received information on key quality and performance indicators for the period 1 April to 30 June 2020, including those contained in the NHS Constitution. The report had previously been considered at a joint Committee meeting with the Quality Assurance Committee. The following areas were highlighted: -**
    - **Referral to treatment times - a further fall in RTT 18 week performance from 59.3% to 52.5% at STP level compared to the target of 92% and national performance of 52%. Long wait patients continued to increase, with over 52 week waits rising quickly at all providers in June.**
    - **Diagnostic waiting times have been significantly affected by the Covid-19 pandemic. The STP position of 50.9% remains well below the 99% target and is slightly worse than the England position of 52.2%.**
    - **A&E waiting times - performance against the A&E 4- hour wait target improved as overall attendance volumes fell in April and, although they have been increasing during May, June and July, remain below expected levels. July performance was 93.7% for all types and 91.8% for type 1 attendances, slightly up on the June position and below the 95% national target. The England position was 93%.**
    - **Performance against the Cancer Waiting Times standards remained relatively stable through the initial Covid-19 period and has further improved in June. The STP position against the 62-day standard rose from 74.9% to 76.7%. NDHT continued to be the only provider achieving the 85% target.**
    - **Urgent & Emergency Care – Continued significant pressure on the 111 service with**

increased call volumes during July (but below forecast volumes). There remained significant levels of call abandonment – 16.87% against a target of less than 5%. The Committee asked for the pressures on the 111 service to be added to the Corporate Risk Register.

- **Mental Health (MH) – Delays in serious incident reporting continue within Devon Partnership Trust (DPT). Significant sustained improvement is required.**
- **Care Home Support Model - The Care Home & Home Care Cell led by the CCG with membership from three Devon Local Authorities and CQC, continues to provide significant resource and support to community and social care settings and partners.**
- **Influenza Planning & Support Programme 2020/21 - There are a number of potential challenges that will impact on this year's influenza (flu) programme across the patient/public and front-line healthcare worker vaccine programme.**
- **CCG Performance Reporting from 1 August to 30 March 2021 - The letter entitled *Third Phase Response to COVID-19* dated 31st July has now been published. The Committee noted that providers submit weekly information to the CCG Business Intelligence team and this will allow the CCG to monitor the requirements of the letter. These indicators will be included in future Finance and Performance Committee reports.**

Reports received and noted

- **STP Monthly Finance Report – the paper was presented for information to the Committee, outlining the position at Month 2.**
  - **All providers receive block contract payments from commissioners including specialist. The current regime gives providers a top up payment where their plan shows a deficit position to bring each provider to breakeven.**
  - **A true up payment is also received by providers where there is an adverse variance to the planned position. Devon CCG will also receive a top-up payment where expenditure is greater than the April – July allocation.**
  - **Additional expenditure for COVID-19 is covered through the top-up and true-up payments.**
  - ***As at month 2 the Devon system required a true-up payment of £33m to break even after any top-up payments. The forecast for the first four months of the year requires £73.2m of true-up.***
  - ***Total costs for COVID-19 for M1&M2 are £39.2m***
  - ***Year to date overspend on bank of £0.8m is offset by an underspend on agency of £1.5m.***
  - ***Only Devon Partnership Trust is above plan on agency spend for both YTD and Forecast.***
- **The Committee received a presentation on the Financial Framework Post Covid-19 Emergency Update. Following Month 6, systems will be issued with funding envelopes, within which providers and CCGs must achieve financial balance.**

Risk Register Review (changes and areas of concern)

- **There have been no changes to risk scores and no risks were recommended for closure.**
- **Following discussion, the Committee agreed the addition of three new risks: -**
    - **Risk 124 - There is a risk that the CCG will not be able to deliver its agreed control total of break even for the second 6 months of 2020-2021 as a result of the required savings to stay within the pre-Covid rate of expenditure on which the revised NHSE allocation is based. This total may also be affected by a lack of funding for non-Covid related overspends and increased costs of service provision due to ongoing of impact of Covid in some cases**
    - **Risk 125 - There is a risk that there is a possibility that some of the excess COVID19 costs over and above the budget set are not funded by NHSE through the top up process leading to an inability to deliver against the temporary financial regime for the period to 31st July 2020. Whilst we have funding to cover the CCG's first two months of COVID19 costs, it is not guaranteed that this arrangement will continue. The impact of this is that the CCG will not be able to deliver against the temporary financial regime for the period to 31st July. If COVID19 costs are not funded beyond the first 2 months, ongoing costs will have a negative impact on the CCG's overall financial position**
    - **A new risk regarding the pressures on the 111 service.**
- **The Committee noted: -**
    - **The closure of the COVID risk register**
    - **The transfer of some risks from Quality Assurance Committee to the Commissioning Committee.**

Committee Decisions

- **Devon CCG Monthly Finance Report - the report reminded the Committee of the draft budget previously agreed (a deficit position of £47.8m with a savings requirement of £22.6m). This draft budget had not received approval by NHSE, who had instead put in place a temporary financial regime for the period 1 April to 31 July 2020, with an expectation that CCGs will break even during this time. Variance against plan will be reviewed, with a retrospective allocation being made if considered reasonable. The Committee noted that the temporary arrangement had been extended to cover August and September and that the Phase 3 planning guidance includes provision that CHC assessments should be re-commenced for new placements from the 1st September with reviews of those placements made between 19th March and 31st August to be undertaken. It is not yet possible to predict the financial consequences going forwards.**
    - **The Committee reiterated its view that early actions to scope the deliverability of savings for the remainder of the year are needed.**
- **The Committee received a report on Commissioning for Contracts ending in 2021, which indicated that there is an opportunity to address a number of issues: -**
    - **There is often a lack of information describing the services that are currently being delivered and so the CCG is unable to confirm the services being purchased are those it requires, thereby failing to meet the core CCG duty to commission services that best meet**

the needs of patients and are effective.

- **There is an inadequate demonstration of the value for money, as the current payment has not been evaluated.**
- **The risk of challenge – this may have legal and / or reputational implications leading to financial and other resource pressures. The risk of this happening increases with the value of the contract and whether it has previously been procured. Services valued at over the EU threshold (£615,278 for the life of the contract) pose a greater risk of challenge being successful. The value of multiple small contracts may be aggregated together is there is a reasonable case to see them as elements of a service that could be considered as a single service. (An example of this could be if there were 4 MIUs, each with a value of 200k then it could be argued that the value should be seen as 800k)**
- **While it has been acceptable to cite PCR 32.2.c**
  - ***'Insofar as is strictly necessary where, for reasons of extreme urgency brought about by events unforeseeable by the contracting authority, the time limits for the open or restricted procedures or competitive procedures with negotiation cannot be complied with'***
  - **This would not be a robust defence for the CCG other than where there is extreme urgency and as we move toward COVID becoming part of BAU this clause will no longer be applicable. It is not felt that this clause would be applicable for contracts ending in 2021.**
- **In many cases there is no clear CCG strategy for future service delivery models, e.g. primary providers / ICP type provision or multiple providers individually commissioned and managed by the CCG that can be demonstrated to have been evaluated and are reasonably considered to best meet the needs of patients and secure best value for money.**

- **The Committee agreed the following recommendations and it was requested that a further recommendation be added for a future report to be presented at this committee for assurance purposes only regarding the issues raised in the report and highlighted above: -**

  - **In order to develop a robust workplan to ensure a thorough commissioning review of need and the development of service models that will meet the needs of our population, considering inequalities and COVID related measures, it is proposed to issue short term direct awards for (a) community urgent care until Sept 2022, (b) mental health providers until March 2022. In order to mitigate risk of challenge in both cases a robust project plan must be agreed and then closely managed to ensure the outlined timescales and objectives are achieved.**

  - **Make immediate decision about the way forward for community based elective services such that all contractual changes and procurements that may be required can start immediately (i.e. no later than September 2020) in order that all are completed prior to April 2021, the start date of new services.**

  - **Ask the Commissioning Committee to identify named lead and develop and implement project plan for the commissioning review and reprocurement as required for elective community services in line with contract end dates.**

  - **Undertake primary care procurements as and when required.**

  - **Monitor progress of the commissioning review (and procurements as required) through the Commissioning Committee.**

- **The Committee received a Updated Terms of Reference were agreed, which had essentially been**

a "tidy up" of the previous version, which had been produced on the merger of the two previous CCG Finance Committees. It was agreed to add the Chief Operating Officer to the Committee and to increase the number of Non Executive Directors from 2 to 3.

Recommendations for Governing Body
• **That the revised Terms of Reference be approved.**
Recommendations for other Committees
• **The attention of the Commissioning Committee is drawn to the report on Commissioning for Contracts ending in 2021, mentioned above.**
Terms of Reference or other committee effectiveness issues
• **As noted above, updated and amended Terms of Reference were agreed.**

Management of Conflict of interests:

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

NHS
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GOVERNING BODY

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

Date of Governing Body: 27 August 2020

Date of Committee covered in this report: 06 August 2020 (Minutes of this committee meetings to be available as an addendum)

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Reports discussed and assurances received:

Members of the Committee discussed the following reports:

Commissioning:

Update reports and Locality Highlight reports The Committee reviewed the contents of the Primary Care highlight and flash reports for July 2020 including priorities both delivered and in progress for COVID -19 and Business as usual in all locality areas.

PCOG report The Primary Care Operational Group meeting report highlighting recommendations approved in:

- Coleridge and Sid Valley Boundary Change.
- GP Retainer Scheme
- Pembroke Surgery Parking Permit Reimbursement

The PCN Development fund update report. The committee was presented with an update on the progress of the Primary Care Development Fund (2019/20) for Primary Care Networks (PCNs) across Devon, including a breakdown of spend to date, outstanding spend and plans for onward review and monitoring.

Reports received and noted:

The Committee noted:

LMC negotiations report: the key outcomes of formal negotiations undertaken with the Devon Local Medical Committee (LMC) for the committee meetings held on 26 June and 24 July 2020.

Restoration and Transformation report: The report highlighted the actions completed to date and some known areas of focus that will be ongoing into the next phase of transformation and restoration work.

The Finance report: It was reported that the temporary finance regime (C19 budget) has been extended to the end of September. Spending has been successfully reimbursed by NHSE until the end of June.
Risk Register Review (changes and areas of concern)
The Risk Register was reviewed by the Committee, 2 areas of risk have been revised and declared reduced. 1 new risk has been added from the COVID risk register – regarding transfer of services. No Risks have been closed
Committee Decisions
None
Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
Final Internal Audit Report: regarding Primary Care Quality Assurance, ToRs for PCCC & PCOG The committee reviewed relevant sections of the current ToR for both PCCC and PCOG and approved a course of action to deal with the audit's recommendations: 1. The change of the word 'external' for 'internal' to describe the audit 2. Terms of reference can be approved by PCCC 'in principle' and will then form part of the wider approval process. 3. All but one of the recommendations made in the Quality Assurance Audit have been completed. The last to be completed by 14/08/2020 4. Both PCOG and PCCC ToR have been amended to reflect both sets of recommendations.

Management of Conflict of interests:

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 27 August 2020

Dates of Committees covered in this report: 20 August 2020

Chair's Name and Title: Charlotte Burrows Non-Executive Director
Lay Member (Patient & Public Involvement)

Contact Details: charlotte.burrows@nhs.net

Reports discussed and assurances received

The Committee received updated reports as detailed below

Reports received and noted

Quality Assurance Framework Situation - Background, Assessment Recommendation (SBARS) points for escalation

University Plymouth Hospital NHS Trust - Whilst the CCG attend the Trust's Governance Committee and is observing evidence of planned long-term solutions to current issues, until sustained improvement is seen, these issues remain escalated. These include, increasing number of serious incident investigations becoming overdue, Emergency Department performance and patients experiencing long waits, persistent 12-hour breaches and poor patient experience.
Children Family Health Devon- Challenges remain with Children Family Health Devon (CFHD) particularly in leadership and organisational governance processes. Structure does not appear to be in place as previously described and assurances have been requested through informal contract and quality discussions. Updates have been requested of the provider within the next 8 weeks and progress will continue to be reported through Quality Assurance Committee. The CCG also remains cognisant that providers with current challenges are responsible for the overall leadership of CFHD (Torbay and South Devon NHS Foundation Trust) and the provision of Child and Adolescent Mental Health Services (CAHMS) within Children Families HD (Devon Partnership Trust).

- Collaborative liaison meetings between CCG and CFHD are in place, and restoration and transformation of services has commenced within the organisation including pathway and process mapping.
- In line with national guidance CFHD continue to report the required performance and quality data during the pandemic.

Royal Devon and Exeter NHS Foundation Trust (RDEFT) Quality, experience and risk colleagues at RDEFT continue to meet monthly with CCG Nursing and Quality Directorate colleagues to discuss incidents and safety queries. The provider is able to demonstrate robust incident management processes and that investigations

continued during the pandemic response. Key learning from incident events planned for spring 2020 are on hold pending suitable organisational service recovery. Experience data is being captured to report to the Trust board and CCG quality colleagues have invited the provider to share the COVID-19 experience stories and their learning from these with Quality Committee.

Devon Referral Support Services - Devon Referral Support Services (DRSS) continues to manage a number of specialist processes across the CCG and support the restoration and transformation response to COVID-19. The DRSS team have provided exceptional support during the Covid-19 and aided the CCG in multiple ways. They support primary care practices to deliver quality care for patients, provide information to the system, work with other providers and support new initiatives such as antibody testing clinics.

System Service Specific Issues

- **Elective and Planned Care**
  Pre COVID-19 escalated quality issues have been exacerbated by the pandemic, including long waits. The CCG is seeking assurance from each provider, including the independent sector, to ensure System working for patients on planned care waiting lists. With excellent examples of innovation, providers are now being asked to share, learn, adopt and develop new models of working to drive improved safety and experience; restoring, but transforming services is key to stepping up and transforming moving forward. Impact of changes, be they stepping up or transforming in some way, are being supported through the CCG Quality and Equality Impact Assessment (QEIA) process; concise QEIAs continue to be submitted by providers that must demonstrate they are considering the impact of decision making.
- **Community Care**
  The Care Home & Home Care Cell led by the CCG with membership from three Devon Local Authorities and Care Quality Commission, continues to provide significant resource and support to community and social care settings and partners. There are challenges for care homes as visitor numbers increase and a set of Principles for Visiting Health & Care Professionals has been developed in line with national guidance, by statutory partner organisations across Devon, and feedback from care providers has influenced this. Testing regimes and local outbreak management plans are supported by the CCG and responsive decision making across the system is undertaken when required to promote safety within care homes and ensure infection prevention measures are in place to protect residents and staff.

  A care home digitalisation survey has been undertaken to establish current levels of technology in use across this sector and has provided a benchmark that will guide additional support requirements. 312 care homes responded to the survey (61%) and key findings are:

  - WIFI is available in all but two of the homes that responded, but not always available in each room of the building
  - Digital communication through video calls is in good use for contact between resident and families (93%), GP practices (79%), community health and social care teams (60%), but used less to communicate with hospitals (39%), discharge teams (24%) and hospices (14%).
  - Six homes reported not having use of any digital equipment (tablet, laptop, smart phone) for use by residents or staff while the majority of homes have at least 1 tablet for use.

  A patient safety collaborative programme ‘improving health in care homes’ using RESTORE 2™ has been piloted in Torbay and East Devon by the Academic Health Science Network (AHSN). RESTORE2™ is a physical deterioration and escalation tool for care/nursing homes based on nationally recognised methodologies. CCG and system partners are committed to the roll out of the offer further. The AHSN have developed training and support packages and is linked with the care home & home care cell in order to progress the use of RESTORE2.

- **Primary Care**
  Key improvement areas that support quality surveillance and assurance across primary care moving forwards are being developed by the CCG. This includes improvement actions following the Internal Audit Primary Care Quality Assurance Audit. In addition, the CCG is looking to learn from examples of

challenged primary care practices. Both methods will support the CCG's aim to provide responsive plans for oversight and early supportive interventions.

With more patients being seen virtually by acute providers, the shift in the work to primary care includes phlebotomy. The CCG are working to support primary care and other providers in the short term to resolve this, but the CCG are facilitating providers to meet and plan how best services like phlebotomy and other tests can potentially be delivered closer to home for patients in longer term.

- **Children & Young People (CYP)**
  The contract for an Early Intervention Self Harm pilot in a Torbay school was awarded in March 2020 to the Children's Society. Following a small pause, contract mobilisation commenced and services have been delivered to a smaller cohort of pupils than initially anticipated using various digital offers and enhancements. The relationship between the school and the provider is working well although the provider outlined the difficulty in starting an organic relationship over media platforms is difficult, especially for some young people; virtual adaptations and service options work for some young people, but some prefer face to face. Standard operation procedures and guidelines are in place and will be shared with the CCG this month. Staff have been communicated with and informed of frequent adjustments to practice. The service expects a high number of referrals and engagement during the summer months.

- **Urgent Care**
  Considerable time was lost (228 hours) to ambulance handover delays across Devon in July. There has been no reported harm in relation to delays either to the patient in the ambulance / or patients still waiting for an ambulance, but it is likely to have impacted on patient experience.

  Significant pressure on the 111 service with increased call volumes has been reported during July (compared to June, but below forecast volumes). Call abandonment rate remains unacceptably high at 16.87% with only 57.77% calls being answered within the target time of 60 seconds. This call answering position may lead to poor patient experience, although complaints to the service remain low.

CCG Functions

- **Continuing Healthcare (CHC) -** The CCG has been informed via the 'phase three' letter (as described above) that CHC assessments should recommence on 1 September 2020. As such, the teams are cleansing all outstanding referrals that have been deferred since the start of the emergency period on 19 March 2020. The CCG anticipate there will be in excess of 600 new cases on the backlog waiting list for assessment and therefore have been considering options to progress them.

  NHS England Improvement Board (NHSEI) are planning to recruit and train a central bank of registered nurses to support individual CCGs with additional assessors and in addition to this the CCG is considering a number of local options to enhance delivery. These include a wider call to the NHS community providers to support the CHC Team with additional resources and the development of a 'Trusted Assessor' model for longer term implementation. The CCG also plan to retain the 'Returner Nurses' to support the process moving forward.

- **Safeguarding Adults -** The Safeguarding Adults team have continued normal working through the COVID-19 pandemic. Initially there was a reduction in Safeguarding Adults referrals, but during June and July this has returned to normal limits, but with an increase in whole service safeguarding across Devon. The Safeguarding Adults team are working with the extended team to provide support and supervision to all main health providers across Devon. All Trusts are experiencing difficulties achieving safeguarding training but are working to provide virtual solutions now the COVID-19 response is reducing. A report has recently been provided to NHSEI regarding 'Prevent' training.

  There has been a whole service Safeguarding Adults Strategy meeting in relation to a series of Section 42 referrals for a DPT unit. The designated nurses have been chairing the Section 42 meetings to ensure

independence in the safeguarding process. Though this did not meet threshold for whole service safeguarding, it was agreed DPT will have an overarching action plan from the themes, learning and findings of the investigations and these which will be shared with the Local Authority and monitored by the CCG.

- **Safeguarding Children -** Referrals for children into the Multi Agency Safeguarding Hubs (MASH) initially saw a reduction, but as Covid-19 'lockdown' progressed, a significant increase in anonymous referrals from members of the public was seen. This created a different approach for reviewing the situation as there was decreased face to face contact and non-attendance at school. The Safeguarding Partnerships have all considered the impact of hidden children and expecting a further increase in referrals when children return to school. Additionally, Reports that incidents of domestic abuse and neglect are increasing with the police having to use Protection Powers more frequently to ensure children are safe, these incidences have also been linked to drug and alcohol use.

  The CCG Safeguarding Team has worked cohesively with health providers, creating and facilitating a supportive network with weekly calls during COVID-19. This in turn has led to increasing supervision and working together to safeguard across all health communities. This appears to have successfully increased communication and transparency between partners.

  Workforce issues have improved within the Safeguarding Team; the Designated nurses within the Children's team are all in post, a Named Nurse for Primary Care started with the CCG in July alongside the newly appointed Primary Care Safeguarding Nurse. However, recruiting into Doctor posts remain difficult and currently there are vacancies in the Children and Primary Care Team. A review is in place to understand the risk and to focus on a solution.

- **Patient Experience -** The national step down on the patient complaints process requirements made in March 2020 was discontinued from July 2020, with complaints services returning to normal. The CCG has maintained the function throughout the COVID-19 pandemic and continues to support providers.

  In July the CCG have received 175 cases of patient and staff feedback; 112 of which were health care professional feedback via the CCGs Yellow Card system with a clear theme relating to workload shift from acute providers to primary care. Four formal complaints with no particular trends or themes identified were received during July.

  The theme of shift of workload from secondary to primary care continues to be raised via Yellow Card, particularly in the Eastern and Western Localities. The two acute providers are aware of these issues and are addressing them. Devon LMC asked GPs to submit reports of inappropriate workload shift directly to providers and not via the CCG's Yellow Card system. The LMC said that this was because Yellow Card is ineffective for this issue, as GPs are not receiving individual responses. However, the Yellow Card exists to capture themes and trends and where a trend is recognised (such as workload shift) the CCG rely on the acute provider to review these themes and provide an update. However, the CCG recognises there are some areas for improvement, particularly in reporting of themes and trends from Yellow Card. Due to the COVID-19 pandemic, this has been put on hold, but this is planned for the coming months.

- **Safety Systems -** In July the CCG were notified of 31 Serious Incidents (SIs) and one Never Event. Any potential or actual impact of COVID-19 is captured on the CCG reviewer template. The aim of this change is to contribute to the overarching CCG measuring of the impact of the pandemic on patients, for example national guidance recommendations to temporarily step-down services.

- **LeDeR -** The LeDeR programme is prioritising deaths from Covid-19 as directed by NHSE. In order to do so and review existing cases the CCG have agreed the procurement of additional workforce; band 6 reviewers. This will significantly improve the LeDeR backlog position and ensure a timely review of COVID-19 cases for families and staff. As these contracts are temporary, to address the immediate challenge, the CCG Chief Nurse has written to all provider Director of Nurses requesting named reviewers per organisation to be drawn upon going forward. This will ensure a sustainable number of

reviewers across the system. NHSE have released the national annual report and finding from a case review of the first reported COVID-19 cases which will be shared at the September Steering Group. National findings appear to reflect our local data and findings.

- **Infection, Prevention & Control -** Currently Devon benchmarks on the lowest quartile of MRSA blood stream infection case rates nationally, the second quartile of MSSA blood stream infection case rates nationally and the second quartile of E. coli bacteremia case rates nationally. All four acute providers breached the national targets for Clostridium difficile infection in 2019/20. This was an expected outcome of the changes to reporting and has been echoed nationally; the new category of community-onset healthcare-associated cases have contributed significantly to the increase in reported cases, comprising approximately two in five cases

Devon System National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) Update
This report aims to provide an update on the progression of the Devon-wide adoption of National Safety Standards for Invasive Procedures (NatSSIPs) and the use of Local Safety Standards for Invasive Procedures (LocSSIPs) in the four acute hospitals in Devon; North Devon Healthcare NHS Trust (NDHT), Royal Devon and Exeter NHS Foundation Trust (RD&E), Torbay and South Devon NHS Foundation Trust (TSDFT) and University Hospitals Plymouth NHS Trust (UHP).

A previous update paper was brought to QAC in March 2020 regarding the implementation and sharing of NatSSIP and LocSSIP's across our four acute providers as well as a forward plan. The planned meeting in April 2020 was stood down due to COVID 19. In June 2020 the CCG requested updates from each organisation reminding them of their commitment to this work, particularly as elective procedures are resuming. Due to COVID 19 very little progress has been made either internally or indeed in sharing documents with each other however the CCG has been assured commitment continues in this workstream.

In terms of numbers there have been 10 Never Events reported to the CCG since 1st July 2019 this is a reduction of 4 compared to the previous year (01/07/2018-30/06/2019). In the last year 7 of these events have been reported by UHP. Each Never Event is reported as a Serious Incident and has a Root Cause Analysis investigation completed. There is no other particular pattern in terms of speciality or location except that the incidents generally occur in minor theatres / interventions.

Enhanced Surveillance of the Additional Support Unit (ASU) run by Devon Partnership Trust (DPT)
This is an adult 6 bed unit for those with a learning disability and mental health diagnosis who are in acute crisis and cannot be supported in the community at that time. Patients are from Devon and Cornwall. Following completion of whole service safeguarding process at the end of 2019, it was agreed between NHS Devon Clinical Commissioning Group (CCG), Local Authority and DPT that a period of enhanced surveillance would be appropriate to ensure actions undertaken and embedded within the unit. Following a 6-month stock take meeting in August 2020 between CCG and DPT it has been agreed that the enhanced surveillance process could be stepped down.

Update on re-establishing the Devon Quality Surveillance Group

The Devon Quality Surveillance Group (QSG) met on the 21 July 2020. Darryn Allcorn has submitted the outline of the scope and principles in the re-establishment of the QSG. Appendix 1.

The principles of a QSG have been established through the National Quality Board (NQB) which includes partners:

- Department of Health and Social Care
- Public Health England
- NHS England and NHS Improvement
- Care Quality Commission

- National Institute of Care Excellence

As a system it is a mandated requirement to have a QSG in order to promote quality improvement with providers, commissioners and service users. The QSG will meet again in September and the agenda will focus on three sections

- QSG soft intelligence with regulators (private)
- Organisational development creating a collaborative environment (public)
- Mental health rapid learning session (public)

The Committee agreed to support the continued development of the Devon Quality Surveillance Group.

Risk Register Review Updates

Quality Risk & Assurance Report including Risk Register:
Please see below with regards to Risk Register Review (changes and pertinent areas).
Data extracted for this report on the 4 August 2020, NHS Devon CCG has 28 open risks on the corporate risk register.

- There are four risks pending closure reporting to the Commissioning Committee.
- There are 10 risks reporting to the Quality Assurance Committee.
- There have been no new risks added to the Corporate risk register reporting to this committee.
- There has not been any not risk score movement in this reporting period.
- There are no risks recommended for closure at this committee.
- The COVID 19 Risk Register - the Executive team have decided to stand the register down & the risks will either be transferred over to the Corporate Risk Register or the new Directorate/Team risk register for ongoing review & management.

Committee Decisions

- No specific decisions required.

Items of concern to be escalated to the Governing Body

- None

Recommendations for Governing Body

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

Recommendations for other Committees

- None

Terms of Reference or other committee effectiveness issues

- None

Management of Conflict of interests:

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the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.

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Appendix 1

NHS Devon Clinical Commissioning Group

QUALITY ASSURANCE COMMITTEE

Report title: Update on re-establishing the Devon Quality Surveillance Group					
Date of committee: 20 August 2020 **Date report produced: 8 August 2020**					
Author (s) Name and Title: Darryn Allcorn Chief Nursing Officer **Contact Details:** darryn.allcorn@nhs.net			**Supporting Executive:** **Name and Title: Darryn Allcorn** **System Chief Nursing Officer** **Contact Details:** darryn.allcorn@nhs.net **Report Approved by:** **Name and Title:**		
Public or Private (Governing Body only):			**Public**	x	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**		**Information** x
Does this report place individuals at the centre?			**Yes**	x	**No**

Executive Summary:

There is a statutory requirement under the guidance of the National Quality Board to hold a Quality Surveillance Group.

A system conversation supported by NHSE has been undertaken to establish the focus and benefits of a Quality Surveillance Group and a consensus has been achieved, the Devon system will chair the meeting with a focus on system learning for improvement and learning from good practice.

There is also agreement that the group will hold a part one and part two to enable system soft intelligence to be discussed with regulators to enhance the open session.

In order to develop a culture of openness and transparency further development work with the group will be undertaken. This paper details the agreements achieved to date.

The Quality Assurance Committee (QAC) will receive a regular report from the Quality Surveillance Group and the QAC can task the Quality Surveillance Group to undertake deep dives into systems areas of quality.

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 purpose of the paper is to update the Quality Assurance Committee on progress in reestablishing the Quality Surveillance Group

Reference to other documents or accompanying papers:

Have the legal implications been considered?

Yes, through revised positioning of the Quality Surveillance Group will meet the requirements of the National Quality Board.

Equality Impact Assessment:

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

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

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

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

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients,

contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

Report Title: Update on re-establishing the Devon Quality Surveillance Group

1. Position statement

- The Devon Quality Surveillance Group (QSG) met on the 21 July 2020 and the following were discussed and agreed.
- The principles of a QSG have been established through the National Quality Board (NQB) which includes partners:
    - Department of Health and Social Care
    - Public Health England
    - NHS England and NHS Improvement
    - Care Quality Commission
    - National Institute of Care Excellence
- As a system it is a mandated requirement to have a QSG in order to promote quality improvement with providers, commissioners and service users.
- Following discussions at Quality Assurance Committee and Quality Surveillance Group there is now an agreed model of quality as depicted below:

- System priorities for quality have been agreed as and prioritised as:
    1. Setting direction and priorities
    2. Safeguarding quality
    3. Bringing clarity to quality
    4. Recognising and sharing quality
    5. Measuring and publishing quality
    6. Staying ahead and horizon scanning
    7. Building capability
- The group identified that the following key words would support a good model for the QSG

- The following principles were agreed by the attendees
    1. Person-centred
    2. High trust
    3. Inclusive
    4. Challenge
    5. Action-orientated
    6. Well informed
    7. Comprehensive
- Importantly there was consensus that the QSG adds value and not another layer of bureaucracy hence its agreed positioning within the system governance
- The scope of QSG has also been agreed although there is some additional work to be undertaken to ensure this is inclusive of the Devon system
    - Consider the quality of services including:
    - Public, private, not for profit and third sector providers
    - Primary care including general practice, dental, optometry and pharmacy
    - Community services
    - Secondary and tertiary services
    - Mental health
    - Health and justice
    - Military health and veterans
    - Specialised services
- Enablers to create a safe environment for collaboration have been identified as

- The group also explored learning from COVID and what practice they would like to see continue through the QSG

- System priorities for group learning were identified as

- The QSG will meet again in September and the agenda will focus on three sections
  - QSG soft intelligence with regulators (private)
  - Organisational development creating a collaborative environment (public)
  - Mental Health rapid learning session (public)

2. Recommendations:

The committee are asked to support the following:

- The Quality Assurance Committee should support the continued development of the Devon Quality Surveillance Group as detailed above.

NHS
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GOVERNING BODY

Report title: Locality Update Reports				
Date of committee: 27 August 2020 **Date report produced: 17 August 2020**				
Author (s) Name and Title: **Locality Triumvirates**		**Supporting Executive:** **Name and Title: Nick Ball, Vice Chair/Audit Chair** **Contact Details:**		
		Report Approved by: **Name and Title:** Locality Triumvirates **Date 17 August 2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Southern and Western Devon Localities.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				
Impact on Strategic Objectives				

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

Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality of Services		
Health Inequalities		
Equality (staff or public)		
Resource and Finance		
Legal		
Engagement and Consultation		
Risk		

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NHS
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Locality update report

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

Key achievements/progress

- **Stratton & Holsworthy.** Following the suspension of the Holsworthy Community Involvement Group's (HCIG) activity over the past 4 months, contact with the group's membership has now been re-established with the aim of progressing the HCIG's 28 recommendations published back in February. The 28 recommendations will shortly be circulated to organisations previously identified by the group. A review of the utilisation of the temporary bedded capacity in the Holsworthy and district area (Stratton Community Hospital and Deer Park Care residential home), both prior to and during the COVID-19 incident, has now been re-established between the locality team and North Devon Healthcare Trust (NDHT), with a report due for completion by the end of September 2020.

- Inaugural meeting of the **Northern Integrated Delivery Group.** On Tuesday 4th August 2020 the inaugural meeting of the Northern Integrated Delivery Group (IDG) was held, with a wide range of representation from the northern health 'system' in attendance. The aim of this first meeting was to provide a general overview the current key system pressures, with presentations on urgent, planned and out-of-hospital care. The meeting also received a presentation on Population Health Management. Further discussion is now underway to determine how best to structure the other locality working groups that will deliver the prioritised actions that emerge from the IDG discussions. Some members feel that the volume of work requires the IDG to be a relatively high-level strategic group that directs locality/operational commissioning and performance monitoring. Developmental discussions are continuing around this as well as the focus of two subgroups; options of planned and unplanned care verses Out of Hospital and In Hospital top the list.

- **Discharge Planning.** Following the intense locality focus on discharge and out-of-hospital (OOH) planning over the past four months, overseen through the CCG's Discharge and OOH Cell, the locality has now moved back to a more 'business as usual' approach to supporting the NDHT with discharge planning. This more localised approach still involves daily analysis of discharge and occupancy numbers at the NDHT, supported by twice-weekly calls with the NDHT and a weekly system meeting across the CCG localities. The locality is confident this current level of oversight and assurance would enable rapid escalation of issues should the need arise.

- The Locality has just completed the formal consultation aspect of our **accommodation review**. Several potential properties are under consideration.

- Over the past month a small group of the northern locality team has been reviewing the pre-COVID-19 workstreams against the ICM programme and have started to incorporate these areas of work into both the emerging locality priorities and some of the key outcomes of the recent capacity planning modelling. The aim is to rapidly develop a set of high-priority actions, that will deliver maximum impact, in the areas that the northern locality deems the highest priority. This work is clinically led and will provide an informed view for the emerging Northern Integrated Delivery Group meetings.

- There are ongoing conversations around the siting of further hot hubs in the Northern Locality.

- Wellbeing seminars and other events run within the CCG are proving popular and effective in keeping people feeling connected and supported. Our thanks goes to all those involved in these events.

Key priorities for the next three months

- Both primary and secondary care are looking at how **virtual clinics** and revised ways of working can be embedded as we return to a more usual way of working with the easing of lockdown. This involves increased use of digital technology and a cross organisational rebalancing of where and how services are delivered.

- **Urgent Care Demand** in the NDHT Emergency Department reduced by 60-70% in the early weeks of the pandemic lockdown in line with other localities across the STP. During June and July this demand has steadily increased and is back to pre-pandemic levels. Some initial feedback is being received that changes in seeing patients across the system as a result of COVID-19 have resulted in an uplift in attendance to the Emergency Department with

ambulatory non-ED conditions. This is being monitored by the Trust and will be followed up within a Northern Devon system meeting if required. We will be working to progress the community urgent care redesign work in line with the required time frame to support the contract finish dates and include all the COVID-19 lessons learnt. Work closely with locality partners to as much as possible ensure that all NDHT elective bed capacity is ring fenced and not required to respond to escalating urgent care/non-elective demand.

- **Phase 3 of the Out-of-Hospital Capacity Plan.** Completion of Phase 3 of the localities out-of-hospital capacity plan is due for completion by the end of August, and work is well underway to meet this deadline. Phase 3 predominantly now focuses on a joint review between NDHT, the CCG and Devon County Council (DCC) on the demand and capacity requirements heading into winter, with the additional impact of a likely resurgence of COVID-19 demand (at whatever level) being taken into consideration. The Locality will seek to maintain the discharge performance gains achieved as a result of the revised discharge guidance. The locality is working closely with the eastern locality to ensure continuity with our approach.

- We need to make sure that plans for a **Northern Local Care Partnership** continue to be developed. Hopefully the joint system working we have seen over the past 3 months will enable us to set this up with added enthusiasm.

- We need to better understand how the lockdown and the present easing of restrictions has affected the mental health of the Northern Devon population. This needs to be not only about the sense of isolation felt during lockdown but also the present anxieties around population movement, the economic effects on our communities and the support available to people to make sure that there is financial and medical support available to help with mental health concerns and overall wellbeing. **One Northern Devon** is working with DWP and the South West Academic Health Science Network on a pilot aimed at tackling inequalities.

- **Winter Planning** has commenced within the locality with NDHT leading on the work. This will be a significant service delivery challenge this year as planning is required to manage demand from seasonal flu, potential CV19 second wave, ring fenced elective beds unable to be used for emergency admissions and increased non-elective demand as a result of delayed elective investigations during the pandemic response. We are seeking the reopening of Bideford and Ilfracombe MIU's in time to support winter demand.

Issues of concern or risk

- There are continuing concerns around a shift in workload from secondary care to primary care, such as phlebotomy, because of the increase in virtual appointments happening in secondary care and other new pathways of care. Conversations continue between the CCG, Primary Care, the LMC and Secondary Care to try and see how the patient journey can be more effectively managed in these new circumstances; the aim being to prevent patients having to travel to NDHT unnecessarily as a follow on from their outpatient appointment.

- The CCG Quality Team have seen, reported and proposed reducing the risk for NDHT through Quality Assurance Committee; NDHT's collaborative working relationship with Royal Devon and Exeter Foundation Trust (RDEFT) has seen significant improvement in leadership, governance and other processes.

- Community Services continue to see an increase in workload. District Nursing Team capacity is stretched due to some staff being temporarily unavailable and Care Packages are being closely monitored as we seek to ensure that people can access the care they need at home.

- The planning for a second wave of COVID-19 in the Northern Locality continues as we do not have access to the Hub facility developed as part of our initial response.

- Workforce burnout and '**Change Fatigue'** is a real risk. Extensions of new ways of working have created fatigue in the system workforce and we need to look at how we can work differently but in a sustainable manner. The scope and pace of change in the delivery of care are a challenge for some.

- There is a concern in the Locality that the large influx of visitors to the area is putting an increased strain on resources. We continue to track this as a Locality and our four PCNs find the daily Situation Report (Sitrep) very reassuring as an early warning system for the re-emergence of COVID-19 in our area.

Support required from CCG/system or barriers to progress

- The locality is progressing with the development of a Local Care Partnership (LCP). This process would be expedited by formal agreement on the intended governance structure for the central components of Devon Integrated Care System and the anticipated functions expected from each LCP.

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Locality update report

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

Key achievements/progress

- The Eastern system has begun Winter planning, with a working group set up including primary and secondary care, mental health and commissioners to compile a comprehensive list of schemes for 20/21.

- The COVID-19 national discharge standards remain a focus for the CCG Discharge and Out of Hospital Cell, now meeting on a once weekly basis to reflect the steady occupancy figures seen in the local Trust. We are continuing to monitor the day to day management of discharges and to work closely with the RD&E teams to initiate system wide response at times of high demand that previously would only have been initiated as higher Operations Pressure Escalation Level (OPEL) status were reached in the hospital.

- Work continues on the Eastern locality out of hospital demand and capacity plan. This plan will set out how these services will ensure delivery during the coming winter period, embedding the Discharge to Assess Guidance within Trust process as per the recent Phase 3 letter, and developing sufficiency within the local care market.

- The Eastern System Tactical Call is evolving into a long term delivery group for the Eastern System and to that end a half-day workshop has been set up for 10th September where partners will agree how this delivery group will function and what role it will play in the Eastern Local Care Partnership.

- Discussions initiated by the clinical team at the RD&E to understand how to provide a COVID-19 safe Emergency Department and service by

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

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

Key priorities for the next three months

- Support the Devon-wide development of Think 111 First and Emergency Department demand management.
- Produce an out of hospital demand and capacity plan which is evidence based and in line with system priorities.
- Establishing longer-term clinical leadership for each care home and continuing to shape the response to care home resilience plans.
- East system winter planning to include modelling of COVID-19 demand in addition to wider winter demand on services.
- Further develop the hospital discharge partnership to continue reducing in hospital length of stays
- Specify and commission leg ulcer services in response to practices notice to cease services previously provided under the Leg Ulcer Local Enhanced Service (LES) as part of a Devon-wide review of services.
- Early Supported Discharge for stroke patients across the whole of east to reduce the length of stay for this specific patient group.
- Strengthening the role and acuity capacity of community urgent care sites to develop them into viable alternatives for patients to attend other than an emergency department and therefore less likely to result in a patient admission.
- Continuing to strengthen the role and function of the discharge teams within the RD&E to promote reduced lengths of stay and Discharge to Assess as the primary discharge model, in particular the patients waiting 7+ and 14+ days.
- A review of the role and capacity of the Urgent Community Response Team to improve further the already strong performance in regard to admission avoidance and early support discharge.

Issues of concern or risk

No issues of concern to raise this month.

Support required from CCG/system or barriers to progress

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

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Locality update report

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

Key achievements/progress

- Integrated Care Partnership (ICP) Team mobilised, specification and outcomes framework revised and with preferred bidder for review. Due Diligence approach developed and additional capacity aligned to support this.
- Effective and positive engagement continues with partners including United Hospitals Plymouth (UHP), Livewell South West, Local Authorities, and Primary Care Network Clinical Directors through various channels including a weekly system video-conference. This forum will support with system winter planning.
- Agreement on use of, and funding for COVID-19 Hot Hubs resolved and scope being developed to support winter planning
- Flu plan developed, use of large venues provided by Plymouth City Council (PCC) being considered as part of response

Key priorities for the next three months

- Continuing the Integrated Care Partnership procurement, due diligence process, NHSE/I Checkpoint 2 assurance preparation and completion including development of draft contract
- Development of Western Locality profile.
- The nationally procured NHS use of Independent Sector providers is changing and it will be essential to ensure that we continue to use this to the maximum benefit to ensure access to elective care across the system.
- Ensuring benefits reaped from escalation and rapid transformation are locked into local system.
- Development of programmes to utilise the Fair Shares funding.
- Continued use of the community wide capacity planning to support the system to be prepared for winter, restoration of elective capacity and any further COVID surge.
- Ensuring providers remain focussed on agreed demand and occupancy reduction

plans.
- Support to ECIST who will be working with the system to reduce ambulance conveyances through improved community service access.
- Progress Primary Care Network (PCN) development in delivery of the Direct Enhanced Services (DES) including alignment of PCNs with care homes as part of the Enhanced Health for Care Homes framework
- Balancing urgent care demand with need to increase elective capacity, Intensive Care Unit (ICU) capacity and consistent access to the Major Trauma Unit.
- Support system approach to the delivery of primary care flu vaccinations

Issues of concern or risk

- Staffing capacity across the commissioning team to manage conflicting priorities at pace.
- COVID-19 – system-wide risks including to patients due to non-availability of services and healthcare and social care staff and wellbeing (various mitigations being actioned and will be considered and acted upon through Restoration and Transformation process)
- Workforce capacity – nursing, domiciliary care, pharmacy, voluntary sector (being managed during COVID-19 escalation, will require review and mitigation through Restoration and Transformation process)
- Community capacity for future COVID-19 peaks in activity needs to be understood as a priority, both in terms of demand and the impact of restarting routine work.
- Urgent care occupancy levels at UHP impacting on elective restart. (not related to discharge for western locality, but Cornish processes, internal processes over the seven days in UHP and high levels of front door demand.
- Focus on admission avoidance priorities and impact of demand from ambulance conveyances.

Support required from CCG/system or barriers to progress

- Progression of ICP at pace to achieve system benefits for winter, it is anticipated that this arrangement will facilitate improved flow whilst releasing commissioning capacity currently heavily deployed in facilitation and intervention between existing providers. This will require focussed activity and careful negotiation and additional resources are being mobilised.

NHS Devon Clinical Commissioning Group

Locality update report

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

Key achievements/progress

Local Care Partnership (LCP) development: effective and positive engagement continues with partners via a weekly Teams meeting. The concept for the LCP was discussed at our South Locality Recovery Huddle which has a comprehensive membership across the system in South. This weekly huddle will continue as part of the LCP development for the South.
Out of hospital services demand and capacity planning: a process-mapping exercise undertaken with partners to inform phase 3 of the demand and capacity plan.
Phase 3 planning: Gap analysis underway to be informed by demand and capacity planning.
Winter planning: engagement with partners to create a comprehensive reflection of what went well last winter and during COVID-19 and what they think should be avoided for the coming winter. Agreement reached for a process to develop a winter plan including CCG, both Devon and Torbay Councils, TSDFT, primary care and the voluntary sector.
Bed capacity: Reached agreement with TSDFT to keep occupancy sub 80% in the acute hospital to allow 10% for stepping elective activity back up and sub 90% in the community hospitals with daily monitoring in place. TSDFT successfully repatriated its children's and oncology wards back to the district general hospital from Newton Abbot. As a result the stroke ward has returned to Newton Abbot and the community hospital capacity increased by 30 beds.
Public Consultation: the public consultation approved by the Governing Body in February was put on hold during the pandemic. The consultation will now take place from 1 September for 8 weeks. A consultation cell has been set up to support the process and is planning for a remote consultation process and undertaking pre-consultation engagement.
Voluntary, Community and Social Enterprise Sector (VCSE): A focussed piece of work is underway to co-design with the VCSE pathways out of hospital and those that support urgent care management. A health and wellbeing coordinator has been recruited by Teignbridge CVS in collaboration with TSDFT and will start at the discharge hub and on the wards this month. In Torbay the success of the COVID-19 Helpline has enabled a Health and Wellbeing Partnership to develop.

Torbay and South Devon Frailty Partnership Group: newly established Torbay and South Devon Frailty Partnership Group met at the beginning of August recognising that no single entity can meet all the needs of our frail population and that to improve health, wellbeing and independence a whole system approach and commitment is required to achieve our strategic aims.
Enhanced Health in Care Homes: agreement reached with PCNs regarding the alignment of care homes.
Primary care: Two of our PCNs stretch from the South into the Western locality. This means that we have four more practices in our population footprint: South Brent, Modbury, Norton Brook in Kingsbridge and Redfern in Salcombe. This presents challenges as their community and acute service providers come from Western. At the request of the South Hams PCNs we facilitated support to work through with the practices on how best to work effectively across their geography and two systems. The PCNs have unanimously agreed to join management up with South Dartmoor and Totnes with Jamila Groves as the CD for both networks. This will provide links across both networks that span boundaries and provide a strong voice for primary care in the area.
Joint Clinical Effectiveness Group (JCEG): This group in South has re-started and is now chaired by Morven Leggott, a medical director at TSDFT. The group discussed how it will work and align with Devon JCEG, as well as how information should get to the Formulary quickly and in the best way.

Key priorities for the next three months

Locality Care Partnership: the first LCP meetings will take place in September, using the vehicle of the Locality Recovery Huddle as a basis to build from. From this a structure for delivering the urgent care, out of hospital care and primary care programmes will be developed.
Public Consultation: The consultation will be held remotely utilising on-line platforms and telephone clinics and is being supported by Healthwatch from 1 September to 26 October.
Demand and capacity plan: finalise actions to inform winter planning and Phase 3 plan.
Winter planning: informed by the demand and capacity plan, a plan will be developed for winter and future surge and planning for flu vaccination will continue.
Phase 3: gap analysis to be completed and action plan developed. A process mapping session for connection with the VCSE part of pathways is being planned for September
South locality profile: will be developed based on work started in January
Enhanced health in care homes framework: stocktake of the framework and identification of gaps for development.
Frailty: set up of sub-groups and governance under the Frailty Partnership Group and develop a comprehensive integrated frailty pathway and strategy.
Population health management: Newton Abbot PCN is taking part in the Population Health Management pilot, supported by a very multidisciplinary approach including district council, DPT, TSDFT and the voluntary and community sector. Workshops start in September.
Urgent Community Care: develop plans for community place-based teams to provide an enhanced urgent community care offer to avoid ED attendance. As part of this the locality planning a “care coordination concept” pilot, supported by the Emergency Care Intensive Support Team (ECIST), in conjunction with SWASFT and TSDFT. It will enable access to community alternatives for the ambulance service via the hub and to crews on scene.
Urgent treatment centres/minor injury units: use of Newton Abbot Urgent Treatment centre and Dawlish and Totnes to be reviewed.

Voluntary, community and social enterprise sector (VCSE): To co-design a mechanism for the VCSE sector (particularly in Torbay) to receive referrals for short term response to enable discharge and avoid ED attendance/admission where appropriate.
Primary Care: We will be working with Jamila Groves and the networks to support PCN DES delivery. This will also help consolidate the South footprint to include the South Hams and South Brent practices to the wider system.
Long-term Conditions: The first post-COVID-19 meeting of the local Diabetes Improvement Group is being arranged for the beginning of September. A steering group is being established for CVD along with connections from the South to the South West Cardiac Network.

Issues of concern or risk

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

Support required from CCG/system or barriers to progress