NHS Devon Clinical Commissioning Group
Governing Body Public

Committee Suites, County Hall, Topsham Road, Exeter, EX2 4QD

27 June 2019 13:00 - 27 June 2019 17:15

AGENDA

#	Description	Owner	Time
1	Welcome and Apologies Verbal	Chairman	13:00
2	Patient Experience Story - End of Life Care	Lay Member - Patient and Public Involvement	13:05
3	Register of Interests Paper DOI Governing Body 13 June 2019.pdf 7	Chairman	13:25
4	Minutes and action log of the meeting held on 23 May 2019 Paper 1 Draft minutes held in public 23.05.2019 v1 nc.doc... 11 2 Master Action Log - Public GB v1 nc.xlsx 19	Chairman	13:30
5	Chairman's Report Paper 1. Chairs Cover Sheet.docx 21 Chairs Report V2.docx 23	Chairman	13:35
6	Interim Accountable Officer's Report Verbal 1. Interim AO Report Public COVER sheet June 20... 27 2 Interim AO Report Public Devon CCG June 2019.... 29 Appendix 1 GB Op plan 2020-21 v8.docx 33 Appendix 2 - LTP AO slides June 18.pptx 43 Appendix 3 - ICE workplan v2.xlsx 47 Appendix 4 - ICE ToR (v5).docx 49	Interim Accountable Officer	13:45
7	QUALITY AND PERFORMANCE UPDATE		

#	Description		Owner	Time
7.10	Quality Committee Report		Chair Quality Committee	13:55
	1. QAC report. April 2019 Final.docx	55		
	2 QAC May19 Committee Chair Report Approved.d...	59		
	3 QAC June19 Committee Chair Report Part 1 Fina...	63		
7.20	Quality and Performance Report		Chief Nursing Officer/Dir of Commissioning	
	02 Quality and Performance cover sheet.docx	67		
	Quality and performance report June.docx	69		
8	GOVERNANCE AND ASSURANCE			
8.10	Governing Body Committee Effectiveness		Board Secretary	14:30
	Paper			
	Committee Effectiveness Report Front Cover Sheet...	95		
	Full Committee effectiveness report 2019 v2 CD am...	97		
8.20	Revised Emergency Preparedness, Prevention and Response Framework (EPPR)		Board Secretary	14:45
	Paper			
	1 GB report - EPRR cover sheet.docx	105		
	Devon CCG EPRR Framework DRAFT 0.1 2019-06...	107		
8.30	BREAK			15:00
9	DELIVERY			
9.10	Integrated Care Provider Procurement		Associate Director of Commissioning - Western	15:15
	Paper			
	201906019 GB Approval paper version 17.docx	119		
9.20	Peninsula Clinical Services Strategy (PCSS)		Director of Commissioning	15:30
	Paper			
	Cover Sheet_PCSS initiation paper board_GB appr...	139		
	Peninsula Services Strategy initiation paper board_...	143		
9.30	PA Consulting Report		Interim Accountable Officer	15:45
	Verbal			

#	Description		Owner	Time
9.40	Operational Plan 19/20 Paper [P] 2019_20 operating plan GB Cover sheet.docx [P] STP - CCG Op Plan Report 13.6.2019.docx	 155 159	Director of Finance/ Director of Commissioning	16:00
10	INFORMATION			
10.10	Finance and Performance Committee Chairs Report Paper [P] GB Committee Chair Report - Finance Performanc...	 165	Lay Member - Finance	16:30
10.20	Month 2 Finance and Activity Report Paper [P] 1 FPC_Report_GB_Month 2_FINAL_2019-20 (GB... [P] 2 FPC_Report_GB_Month 2_FINAL_2019-20 (GB...	 167 171	Director of Finance	16:35
10.30	Locality Updates (Eastern, Northern, Southern and Western) Paper [P] 0. Locality Reports - front cover sheet.docx [P] Eastern locality GB board report for June 19_.docx [P] Locality update report- Southern - June 2019 v2.do... [P] Northern Locality Report V5.docx [P] WL Update Report for June 2019 GB - new format....	 187 189 193 195 199	Locality Clinical Lead Representatives	16:40
10.40	Primary Care Committee Chairs Report Paper [P] Committee Chair Report - Public PCC June 19.doc...	 201	Lay Member - Primary Care	17:00
11	Close of Meeting Verbal		Chairman	

Declaration of Interests Register - Governing Body extracted 13 June 2019

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date interest from	Date interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Atherton	Glynis	Lay Member - Quality	Member Governing Body Member Quality & Assurance Committee (Chair) Member Primary Care Commissioning Committee Member of Remuneration Committee (REMCOM)	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		NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Director - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG	Member of Governing Body (Vice Chair) Member of Audit and Assurance Committee (Chair) Member of Finance and Performance Committee Member of Remuneration Committee (REMCOM) 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 and Assurance Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member Governing Body (Deputy for CFO)	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Lay Member - Patient and Public Involvement	Member of Governing Body Member of Quality and Assurance Committee Member of Remuneration Committee (REMCOM) Attendee Primary Care Commissioning Committee (PCCC) non voting	I am chair of the Devon Maternity Voices Partnership (MVP) a collective of parents (and parents to be) and organisations who support maternity services (health professionals, charities, Healthwatch, non-health professionals) working together to review and contribute to the development of local maternity care across Devon. Devon CCG provide funding to the MVP		04/04/2019		09/04/2019	General Interest	Direct	Resigned as Chair from the Devon Maternity Voices Partnership. (formally leaves July 2019) Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group Member Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt	Partner is employed by Livewell Southwest in position of influence	26/09/2017		15/10/2018	Non-Financial Personal Interest	Direct		NHS Devon CCG
	Coles	Anna	Director of Integrated Commissioning Seconded to CCG to Associate Director of Commissioning (Western)	Senior Leadership Team (SLT) Member Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019		12/03/2019				Plymouth City Council
	Collingwood-Burke	Lorna	Chief Nursing Officer and Caldicott Guardian - for NHS Devon CCG Interim Deputy Chief Officer NHS Devon CCG	Member of Governing Body Member of Quality Assurance Committee Member of Audit and Assurance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team QEIA Panel Senior Leadership Team (SLT)	Chief Nursing Officer for both NEW Devon and SD&T CCGs School Governor Ashleigh C 0f E School, Barnstaple and chair of the resources committee Member of and Nurse Lead for the national board for NHS Clinical Commissioners Chair of the Nurse Forum for NHS Clinical Commissioners Director role for DELT	Spouse is: GP Principal Wallingbrook Health Group - primary medical services (PMS) contract holder (ended 30/04/2018). Prescribed Specialised Advisory Group (PSSAG), Department of Health Member of Devon Health and Wellbeing Board GP Locum Devon Performers List from 01/05/2018	1 August 2017 - Joint post with NHS Devon CCG & New Devon CCG		17/04/2019	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015					Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council

	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Senior Leadership Team (SLT) Attendee Audit and Assurance Committee Member of Primary Care Commissioning Committee (PCCC)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	19/06/2018	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body	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 Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	28/03/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration Committee (REMCOM) (Non exec rem)	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	08/11/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Hargadon	Judy	Lay Member - Primary Care and Prevention	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) Chair Member of Remuneration Committee (REMCOM)	Independent Member on Council of University of Exeter NED on Board of Restorative Solutions CIC Ltd	Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	20/05/2019	Financial / Personal	Direct		NHS Devon CCG
Dr	Harrell	Ruth	Director of Public Health Plymouth City Council	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Member of NEW Devon CCG Governing Body		26/10/2016	26/10/2016	Non-Financial Personal Interest	Direct		NHS Devon CCG
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body (Chair) Member of Remuneration Committee (REMCOM) Transition Sub Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	GP Partner, Cricketfield Surgery Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Clinical Chair NHS Devon CCG 1 March 2017 Church Warden Holy Trinity Church Spouse works in emergency department at RDE and for Exeter Medical School Primary Care Network - Templar Care Network		21/08/2015	04/10/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kennedy	Nick	Secondary Care Doctor	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration Committee (REMCOM) Member of Primary Care Commissioning Committee (PCCC) QEIA Panel Member of Audit Committee	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer Partner, Staplegrove Anaesthetists LLP, Taunton Partner Blackdown Orthopaedic and Spinal Services, Taunton Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of Data safety monitoring committee (DSMC), The GAP study (safety of gabapentin) United Hospitals Bristol Member of national Independent Funding Request Panel NHS England		26/09/2017	06/10/2018	Financial / Personal	Direct		NHS Devon CCG
Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Member of Integrated Commissioning Executive (ICE) Attendee Remuneration Committee (REMCOM) Attendee of Audit and Assurance Committee	Chair of East Devon GP Members Forum Partner Coleridge Medical Centre Undertakes DDOC shifts 5. Shareholder in Devon Doctors Ltd Shareholder in Devon Health Member of East Devon Health Practice part of the East Devon Federation (March 2018) Chair of East Devon Members forum. Chair Eastern Locality Delivery Group Primary Care Network - Honiton/Ottery/Sid Valley (HOSMS)	Spouse works for Social Services	14/02/2017	13/05/2019	Financial / Personal	Direct		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		NHS Devon CCG

	Mackness	Brian	Non Executive Director, Finance and Commerce	Member of Governing Body Member of Audit and Assurance Committee Member of Finance and Performance Committee (Chair) Member of Remuneration Committee (REMCOM) Transition Sub Committee	Trustee and honorary secretary of ABBFEST, a community festival which makes grants to organisations which may include those providing health and social care. Member, County Organising Committee and County Publicity Officer, national gardens scheme which makes grants to inter alia, national charities working in the field of health and social care. Member, Parochial Church Council, St Mary' Abbotskerswell. The local Church may provide voluntary support and aid in the social care field. Chairman of patient group at Kingskerswell and Ipplepen Surgery,		July 2015	28/03/2019	Non-Financial Personal Interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Manton	Sonja	Interim Director of Commissioning	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Joint Staff Partnership Transition Sub Committee Senior Leadership Team (SLT) Member of Quality and Assurance Committee Attendee Audit and Assurance Committee	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit from 1st Nov 2018	03/04/2017	09/10/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Governing Body Clinical Lead – Western Locality Chair of Western Primary Care Partnership	Member of Governing Body Member of Quality Assurance Committee Clinical Cabinet QEIA Panel STP Collaborative Board Remuneration Committee (REMCOM) (Non exec rem) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group	Elected member, South West Regional Council of BMA Sessional GP (self-employed) at Access Health Ltd Plymouth. GP Appraiser (NHS England)	Partner is Medical Secretary and Board member of Devon LMC Partner is GP Partner, Church View Surgery, Plymstock	26/09/2017	18/12/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Director of Communications and HR functions NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit and Assurance Committee	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University.		19/06/2018	26/02/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Pearson	Nick	Head of Communications	Senior Leadership Team (SLT) Primary Care Operational Group Member Governing Body (Deputy for Director of Communications)	Member of the Labour Party Member of the Exeter City Supporters Trust		13/01/2017	04/04/2018	Non-Financial Personal Interest	Direct		NHS Devon CCG
Dr	Pearson	Virginia	Director of Public Health, Devon County Council Co-opted member of Governing Body	Member of Governing Body Member of Quality and Assurance Committee Member of Primary Care Commissioning Committee	Member, Devon Health and Wellbeing Board Member, Exeter Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Devon Safeguarding Children Board Attends Governing Body of Devon CCG Council Member, Association of Director of Public Health Member, British Medical Association		02/02/2017	02/02/2017	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council
	Polak	Tracey	Public Health Consultant (Devon Council) Honorary Clinical Associate Professor – University of Exeter Medical School	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group	Honorary contract with Exeter University	Spouse: Deputy Chief Nursing Officer, Devon CCG	24/10/2017	21/01/2019	Indirect interest	Indirect		NHS Devon CCG
	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee Audit and Assurance Committee CCG Executive Team Senior Leadership Team Member	No interests declared		22/03/2019	09/04/2019				NHS Devon CCG
	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Senior Leadership Team (SLT) Attendee Audit and Assurance Committee Attendee of Remuneration Committee (REMCOM)	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	07/09/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	STP Director of HR	Attendee of Remuneration Committee (REMCOM) Joint Staff Partnership Senior Leadership Team (SLT) Attendee Governing Body/Member Governing Body (Deputy for Director of Communications)	No interests declared			16/10/2018				NHS Devon CCG

	Turl	Jo	Director of Commissioning - Western	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) Member of Governing Body Attendee Audit and Assurance Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC)	No interests declared		13/08/2015	06/06/2019				NHS Devon CCG
	Webber	Lorraine	Associate Chief Nursing Officer (South & West).	Member of Quality Assurance Committee A & E Delivery Board QEIA Panel Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Member Governing Body (Deputy)	No interests declared		14/03/2017	29/08/2018				NHS Devon CCG
	Wheller	Kevin	Locality Chief Finance Officer (Northern & Eastern)	Attendee of Audit and Assurance Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member Governing Body (Deputy for CFO)		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		NHS Devon CCG
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit and Assurance Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration Committee (REMCOM) (Non exec rem)	General Practitioner at Coombe Coastal Practice in Ilfracombe (ended 10/09/2017) Member of Royal College of General Practitioners Director of One Ilfracombe Our Place Programme Chair of One Northern Devon		14/02/2017	31/01/2019	Non-Financial Interest Professional	Direct	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 held in Public –DRAFT Minutes

Date: 23 May 2019 Time: 14:00

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

Item	Discussion	*Action*	
1	**Welcome and apologies:** PJ, Chair welcomed everyone to the meeting and introduced James Peskett from PA consulting who are undertaking a review of the system leadership in Devon. The following apologies were noted: LCB – Lorraine Webber deputy VP – Tracey Polak, deputy DG – Dr Matt Fox, deputy AM – Piers Tetley, deputy JH and CD		
2	**Patient Experience – Charlotte's Story** CB Non-Executive/ Lay Member with an interest in patient and public involvement has agreed to lead and keep a focus on our patient experience stories that are shared at our Governing Body meetings. CB introduced 'Charlotte's Story' whereby she shared her experiences of being involved in the Better Births in Devon engagement project for maternity services in Devon. CB explained the engagement that was undertaken with mums and dads which included going out and about to visit them in the community. CB detailed her involvement with the Local Maternity Service (LMS) who are working with the Maternity Voice Partnership (MVP) to help with our learning on how we engage with our population and listen to their experiences. The MVP is independent to the CCG and is chaired by a service user and comprises of representatives from service users, midwifes and health professionals. Engagement is continuing including launch events to assist in the co-production of service models and MF suggested that an update on LMS and MVP should be included in a future GP update. **ACTION 1: NC to liaise with the communications team to include an update on LMS and MVP in the next GP update. Post meeting update action completed and recommended for closure.** **The Governing Body welcomed the opportunity to listen to 'Charlotte's Story' and how these experiences can help with our engagement with the public.**		

3	**Register of Interest** PJ directed the members to register of interest and it was noted that there some adjustments to be made including the formatting and inaccuracies to several declarations. The Governing Body were reminded of their proactive duty to inform the governance team of any changes to their conflicts of interests. **The Governing Body received and noted the register of interest.**		
4	**Minutes and action log** Subject to minor amendment to page 14 and page 16 the minutes of the last meeting held on 25 April were agreed as a true and accurate record of the meeting.		
5	**Chairs Report** PJ introduced this report and did not propose to go through in detail, however he did draw attention to the place based Non-Executive/ Lay Member and Executive Directors that have now been agreed and assigned to our four localities. **The Governing Body received and noted the Chair's Report.**		

6	**Interim Accountable Officers Report**
	ST referred to the review of the Devon Health and Social Care System led by PA consulting which is in its final stages. The final report is awaited but emerging themes include:
	
	• Key lines of enquiry (KLOEs) – these will be further detailed in the final report
	• Improvements to consider:
	  o Credibility
	  o Clearer design working arrangements
	  o Implementation value
	• Positive points:
	  o Triumvirate – Executive Directors/ Leads
	  o CCG launch day and values positively received
	  o Examples of leadership
	• System Wide
	  o How we have different conversations to enable a clearer vision
	  o Accountable Officer and STP Senior Responsible Officer (SRO) – roles will be brought together in future
	
	The final report including an action plan will be presented to the Governing Body in June.
	
	Feedback around the table:
	• Primary Care Networks – do we need to increase our engagement. Executive response agreed that we will develop an action plan to support Primary Care Networks including CCG visibility and acknowledged that this will be adapted for different stakeholders.
	• PJ suggested using Patient Participation Groups (PPGs) and the strength of using this network to engage with our public, and BM echoed this as a current chair of a PPG.
	
	The Governing Body received and noted the Interim Accountable Officers Report.		

7	**Finance and Performance Committee Chair's Report** There was nothing further to add to the report included in the board pack, however BM did draw attention to the Finance and Performance Committee Terms of Reference (ToRs) whereby we are working to these in their present form but acknowledged these may need to be adapted as the arrangements for placed based are confirmed. NB chaired the May Finance and Performance Committee and reported that as we had achieved our financial target for 18/19 a substantive amount of time was allocated for discussions about the 19/20 plan. **The Governing Body received and noted the Finance and Performance Committee's Chairs Report.**		
8	**Monthly Finance and Activity Report** JD noted there was nothing further to add to the enclosed report, however he was pleased to report that for year end month 12 for 18/19 the auditors have given an unqualified opinion as expected. SK queried the conditions attached to the Commissioner Sustainability Fund (CSF). JD replied that that was agreement of a long-term milestone-based recovery plan against the cumulative debt and once we are back to a positive surplus each year we will pay off the cumulative debt but that no time frame has been specified for this. On behalf of the Governing Body ST congratulated JD and the wider team on their achievements as a couple of years ago the thought of returning to a balanced position was imaginary and it is a testament to their hard work that we have reached this place. It was noted that the annual report will be published in June and formally presented at our AGM in September. **The Governing Body noted the month 12 financial position and the level of risk to deliver the CCGs control totals.**	q	
9	**Risk Management Framework** Coinciding with the merger of the CCGs an internal audit review was undertaken, although a satisfactory rating was given there were several recommendations for improvement and these were detailed in the executive summary of this report, but GS drew attention to the following: • Robust reporting of risks • Corporate Objectives nearing the stages of completion which will help improve the effectiveness of the assurance framework • Senior Leadership Team – to receive more up to date information to help support and shape agenda's • Risk Management – training programme • How do we manage risk in the system – this will be incorporated in the STP governance arrangements GA referred to the table on page 73 and the review of risks at governance level and suggested that GB oversight should be included in the governance level of risk that will be reviewed to strengthen assurance. **The Governing Body received noted and approved the Risk Management Framework.**		

10	**Integrated Commissioning Executive (ICE) Terms of Reference (ToRs)** ST presented referred to the executive summary of the report and noted that the ToRs were for the Governing Body's information rather than approval. The purpose of this meeting is for a joint mechanism in aligning strategy planning with our local authority colleagues and will also give us an opportunity to focus on driving the system toward a strategic nature. Shared decision making would be undertaken by senior responsible officers who already have delegated authority to act in agreement within a framework for each organisation. CB felt it would be useful see future ICE reports and ST agreed for the minutes of these meetings and workplan to be included in the addendum pack of Governing Body papers. ST mentioned that it would be beneficial to invite voluntary sector representatives to future meetings at relevant points as it is important to have different views at the right time. Following discussions, it was agreed that section 3.1 responsibilities bullet point two should be amended to: • Supporting the delivery of the Operating Plan 2019/20 and supporting the development of a long-term plan for the wider Devon **The Governing Body received and noted the ICE ToRs.**		
11	**Audit Committee Report** NB presented this report and declared for the record that the head of internal audit opinion was reviewed at the Audit Committee held earlier in the day and approved. NB highlighted two recommendations to bring to the Governing Body's attention a minor change to the Audit Committee ToRs and that the Better Care Fund should be an agenda item for discussion at a Governing Body Development session. **ACTION 2:** **NC to add Better Care Fund (BCF) to Governing Body forward planner for 19/20.** **Post meeting update this action is recommended for closure.** **The Governing Body received and noted the Audit Committee Chairs Report.**		
12	**Quality and Performance Report** SM referred to the report in the pack which was based on validated data of the month of March 2019 for both CCGs prior to the merge. SM drew attention to the following: • Delayed Transfers of Care (DTOC) – improvements are continuing to be seen around performance and we have met our target for the STP • A&E performance is slowly making progress and continues to fluctuate in some areas in particular the Western and Southern Localities. The CCG are participating in the regular gold command calls. SM noted that performance for the other indicators remain static and next months quality and performance report should be aligned to the single CCG.		

	LW reported that A&E is continuing with quality surveillance checks until improvements remain sustained and highlighted there will be checks through lived patient experience and PJ suggested for LW to link with CB for a future patient story. ST declared a conflict of interest in that his step son is a quality surveillance checker. SK mentioned the standards for Mental Health IAPT/ recovery and access rates as the current waiting times are increasing and asked where this issue is being discussed. It was suggested for the Quality Committee to make space at a future meeting to review and then feedback to the Governing Body. **ACTION 3:** **Governing Body to receive an update on waiting times for Mental Health IAPT/ recovery and access rates.** NK raised SWAST response times and that nationally we are rated as a risk of 25 and queried the impact this has had on patients. LW confirmed that this is being discussed as part of our quality surveillance meetings with NHS England and we are reviewing this as a system and we are working with our delivery boards. Data analysis is underway on delays of 60 minutes or more and we are awaiting the outcome report. JWo welcomed the rotation focus on the Governing Body agenda for quality and performance and financial performance in moving forward. **The Governing Body received and noted the quality and performance report.**		
13	**Locality Updates** **Southern** MF presented this report and drew attention to the opening of the new Friends Centre in Brixham and PJ confirmed that he will be going to visit this centre soon and encouraged other Governing Body members to as well. MF noted that progress is being made with Local Care Partnership (LCP) delivery group. *Dr Matthew Fox left the meeting.* **Eastern** SK was pleased to report that due to community conversations Okehampton is making progress and Budleigh Community Hub may be showed cased later this year when there is a locality focus session as part of the Governing Body meeting. One of the key achievements over the past month has been engagement with our members and we are continuing to work with Eastern A&E delivery board. SK did indicate that support was needed for the infrastructure in working with the wider health partnership and that there were concerns around the gap in provision for patients requiring mental health support and cardiology waiting times in the East. **Northern** JWo talked about the positives in the North including: • Collaborative system • Different conversations		

	• Clinicians mood is different • Reaching out to the community – clinicians from the acute trust JWo touched on the One Northern Devon and the benefits of this initiative and highlighted the risk around urgent care and the workforce challenges. **Western** SMc referred to key priorities and the Primary Care Networks (PCNs) and how best to work together. Support required to ensure social prescribing is aligned whilst retaining our workforce experts and making sure that no one work in isolation. Concerns have been raised around mental health and patients falling through gaps in services. There will be an opportunity in the integrated care partnership to commission in a different way that meets the needs of our population. JT confirmed that there will be some joint work with commissioners and providers through the Local Medical Committee (LMC) to get an understanding of current issues. Mental health investment monies will help towards improving communities and strengthen what community services should look like. ST mentioned that our locality representation is now placed based to ensure our commissioning reflects the needs of our local population and suggested that the triumvirate of executives and clinical representatives consider how they would like to present the locality reports at future Governing Body meetings. BM felt as digital is a priority for NHS England that it would be useful to include this on a future agenda for the Governing Body and suggested that a presentation on interoperability would be informative. **ACTION 4:** **NC to add digital interoperability to the Governing Body 19/20 forward planner. Post meeting update action completed and recommended for closure.** **The Governing Body received and noted the contents of the Locality Reports.**		
14	**Primary Care Committee Chair's Report** NK presented this report and there was nothing further to add, however JWo did note that although as a CCG we do not commissioning dentistry services the presentation that was recently delivered by NHS England was interesting. **The Governing Body received and noted the contents of the Primary Care Committee Chair's Report**		
15	**Close of Meeting** The Chair closed this meeting and informed the members that a survey would be circulated to the Governing Body to gain feedback to support the continued improvement and effectiveness of our meetings. **The meeting closed at 15.20pm.**		

Attendees (attended** / apologies [A])	
Name and initials	*Title and organisation*
Andrew Millward (AM) [A]	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Brian Mackness (BM) **	Non-Executive Director/ Lay Member – Devon CCG
Caroline Dimond – Dr (CD) [A]	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Dr Matt Fox (MF)**	Clinical Representative, Southern Locality, Devon CCG
David Greenwell – Dr (DG) [A]	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Glynnis Atherton (GA) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Womersley – Dr (JWo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Transformation, Devon CCG
Judith Hargadon (JH) [A]	Non-Executive Director/ Lay Member – Primary Care
Lorna Collingwood-Burke (LCB) [A]	Chief Nursing Officer, Devon CCG
Lorraine Webber (LW) **	Deputy Director of Quality Assurance and Improvement, 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
Piers Tetley (PT) **	Associate Director of HR, Devon CCG
Ruth Harrell – Dr (RH) **	Director of Public Health, Plymouth City Council
Shelagh McCormick- Dr (SMc) **	Clinical Lead Representative, Western Locality, Devon CCG
Tracey Polak (TP) **	Assistant Director Public Health, Devon County Council
Simon Kerr – Dr (SK) **	Clinical Lead Representative, Eastern Locality, Devon CCG
Simon Tapley (ST) **	Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **	Director of Commissioning, Devon CCG
Virginia Pearson – Dr (VP) [A]	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) **	Executive Assistant, Devon CCG
James Peskett (JP) **	PA Consulting
Alex Cameron (AC)**	Media and Publications Manager, Devon CCG
Minutes approved | Date:	Signed by chair:

NHS Devon Clinical Commissioning Group

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertakenYes/No confirmation if all actions		This will be the lead or person to whom the action was	Confirmation that committee that raised the action is content the action	Confirmation if action complete
1	23/05/2019	NC to liaise with the communications team to include an update on LMS and MVP in the next GP update.	27-Jun-19	Nikki Coombes	Post meeting update action completed and recommended for closure.				**FOR CLOSURE**
2	23/05/2019	NC to add Better Care Fund (BCF) to Governing Body forward planner for 19/20.	27-Jun-19	Nikki Coombes	Post meeting update this action is recommended for closure.				**FOR CLOSURE**
3	23/05/2019	Governing Body to receive an update on waiting times for Mental Health IAPT/ recovery and access rates.	TBC	Lorna Collingwood-Burke/ Lorraine Webber					**OPEN**
4	23/05/2019	NC to add digital interoperability to the Governing Body 19/20 forward planner.	27-Jun-19	Nikki Coombes	Post meeting update action completed and recommended for closure.				**FOR CLOSURE**

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GOVERNING BODY

Report title: Chairs Report				
Date of committee: 27 June 2019 **Date report produced: 13 June 2019**				
Author (s) Name and Title: Dr Paul Johnson, Chair Nikki Coombes, Executive Assistant		**Supporting Executive:** Dr Paul Johnson, Chair **Report Approved by:** Name and Title: Dr Paul Johnson, Chair **Date:** 19 June 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				
Executive Summary: This report contains updates on: ▪ **Visits to Partner Organisations** ▪ **NHS Clinical Commissioners – CCG Merger Learning Event** ▪ **Devon Patient Participation Group Event** ▪ **GP Membership Engagement – GB Membership** ▪ **Philippa Slinger – Devon STP Chief Executive Lead** ▪ **Celebrating You Awards**				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				
This report is for information only and the Governing Body are asked to note the contents				

Impact on Strategic Objectives		
None.		
Reference to other documents or accompanying papers:		
https://www.mhm.org.uk/the-moorings-devon		
Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality	Safety: Effectiveness: Experience:	✓
Equality		✓
Resource and Finance		✓
Legal		✓
Engagement and Consultation		✓
Risk		✓

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

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GOVERNING BODY – CHAIRS REPORT

1. Introduction

The challenges haven't changed. We still have much to do to reach our ambition of being one of the top 10 per cent performing CCGs in the country. But this month I have been greatly encouraged that we have the skills, desire and passion within our system to achieve this. I have been to several of our provider organisations and seen some of the great front line work that is going on, I've met with CCG leaders from across the country who are considering merging in the next 2 years and been encouraged by just how far ahead we are in many aspects of our commissioning function. We will be welcoming a new Interim Lead Chief Executive of the STP next month to help drive better integration and system working. And we quite proudly have celebrated some of the fantastic staff we have in the CCG.

The challenges haven't changed but I have good cause for optimism that we are in a good place to start meeting those challenges and reaching our ambition.

2. Visits to Partner Organisations

Northern Devon Healthcare NHS Trust 29 May

Simon and I visited North Devon District Hospital and met with their Chief Executive, Suzanne Tracey, and Chair, James Brent. We were greatly encouraged by the change in culture and working environment that has taken place in such a short space of time. There are still challenges but also plenty of examples of really good practice. We were particularly encouraged by visiting their maternity services, emergency department and day case oncology unit.

Devon Partnership Trust 30 May

Thank you to all the staff who gave their time to give me a tour of some of the DPT services. I met many hard working and dedicated professionals working in some very challenging and pressured services, such as liaison psychiatry and the crisis team. I heard about some of the innovation that is happening to help meet the increasing demand on services. And ended my morning seeing what can be offered away from emergency medical services for those in crisis at The Moorings in St Leonards https://www.mhm.org.uk/the-moorings-devon

3. NHS Clinical Commissioners – CCG Merger Learning Event

I was invited by NHS Clinical Commissioners to present at an event that was held in London on 5 June to share Devon's experience following the merger of NEW Devon and South Devon and Torbay CCG on 1 April. Many CCGs are looking to merge over the next two years and were keen to hear from our experience in membership engagement, pre-merger organisation alignment, and how we aim to maintain locality voice and function in a large CCG. It was really helpful to share

what we learned in the process, particularly around membership engagement, as well as showcase what we have done well.

4. Devon Patient Participation Group Conference

On 12 June the main function room at Newton Abbot Racecourse was filled with over 130 local practice PPG members meeting to support one another, build the voice of the patient in local primary care and consider how they can support the emerging Primary Care Networks. It was a privilege to be invited to speak about the CCG, our keenness to support PPGs and other public and patient voices and discuss how we can work in partnership to design future services. My thanks to the Comms Team who supported this conference and have committed to working with the PPGs as they develop their role.

5. GP Membership Engagement – GB Membership

Following our Governing Body decision last month, I have contacted our member practices to consider proposals to increase the Governing Body membership to ensure we have the right skills, experience and clinical representation for the size and complexity of the CCG.

The proposals are:

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

The member practices have been asked to consider the proposals and to raise any concerns they have by 30 June. In the absence of any significant concerns being raised in that time we will infer support for the proposals and recruit to these roles.

6. Philippa Slinger – Devon STP Lead Chief Executive

Philippa Slinger has been appointed to the role of Lead Chief Executive for the Devon system. Philippa will provide experienced leadership and strengthened capability to progress system work in Devon for the next 12-18 months.

Philippa has nearly 40 years of experience across most areas of the healthcare sector. She started work in the NHS as a registered mental health nurse, has 14 years of NHS Chief Executive experience and has spent time as Managing Director in the independent healthcare sector. Most recently Philippa has been working as an Improvement Director for NHS Improvement.

Philippa will join Devon on 1 July 2019, and her priorities will be to lead delivery of the 2019/20 System Operating Plan, prepare partners and organisations so that we can operate as a new Integrated Care System, and build relationships across the health and care sector, and with wider stakeholders, across Devon.

Having met with Philippa earlier in the month, I am confident that she will be a real asset to our

system and build on the foundation of successes we have seen working as an STP over the past two years, progressing Devon to be an Integrated Care System.

6. Celebrating You Awards

The CCG wanted to recognise those individuals and the teams who have really made a difference for the population we serve. There were ten categories in the awards to which members of staff could make nominations for colleagues who they felt deserved to be recognised. The awards ceremony took place on the 18 June 2019 and was a hugely positive event where we really did celebrate success at all levels, and in all areas of the CCG. I want to thank everyone involved in making this awards ceremony successful and would like to congratulate not only the winners but all the staff that were nominated. The winners and highly commended nominations are listed below:

Collaboration of the Year
Winner: Holsworthy Community Involvement Group – Nick Pearson and the communications team, Dr John Womersley, James Wright and local stakeholders
Highly Commended: Outsourcing activity for 52 week waits – Devon Referral Support Service (DRSS) and the commissioning team

Innovation
Winner: Dr John McCormick
Highly Commended: Prescription Ordering Direct Service (POD)

Leadership
Winner: Chris Morley
Highly Commended: Nicky Dunning

Lifetime Achievement
Winner: Oksana Riley
Highly Commended: Nikki Coombes

Making a Difference
Winner: Rebecca Heayn
Highly Commended: Miles Earl
Highly Commended: Hayley Dusgate

Recognition of Support Services

Winner: Nikki Coombes
Highly Commended: Sharon Hobbs

Team/Project of the Year
Winner: Thumbs Up For Coby (Communications and Nursing teams)
Highly Commended: Vision and Values (HR and Communications teams)
Highly Commended: Re-procurement of children's services

Unsung Hero
Winner: Keri Ross
Highly Commended: Molly Bishop
Highly Commended: Heather Edmond

Director's Awards
Winner: Karen Barry
Winner: Neringa Kemesiene
Winner: Sam Cush
Winner: Susan Harvey
Winner: Primary Care Team

Chair and Chief Executive's Award
Winner: Nicky Dunning

I would also like to take this opportunity to thank all members of staff for their continued hard work following the launch of the single CCG in April.

Dr Paul Johnson
Clinical Chair
19 June 2019

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GOVERNING BODY

Report title: Interim Accountable Officer's Report				
Date of committee: 27 June 2019 **Date report produced: 13 June 2019**				
Author (s) Name and Title: Simon Tapley, Interim Accountable Officer Sonja Manton, Interim Director of Commissioning – Northern, Eastern and Southern Jo Turl, Director of Commissioning – Western Paul O'Sullivan, Deputy Director of Strategy Alison Wilkinson, Head of Contracting Molly Bishop, Executive Assistant to Interim Accountable Officer		**Supporting Executive:** Simon Tapley, Interim Accountable Officer **Report Approved by:** Name and Title: Simon Tapley, Interim Accountable Officer **Date:** 13 June 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				
Executive Summary: This report contains updates on: ▪ Annual Report ▪ Primary Care Networks ▪ PA Consulting Report on Devon Health and Care System Leadership ▪ Operational Plan 2019/20 ▪ Planning Cycle 2020/21 ▪ Developing the NHS Long Term Plan for Devon ▪ Key meetings and visits ▪ Key messages from the Integrated Commissioning Executive meeting				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				

Key recommendations and actions requested:
This report is for information only.
Impact on Strategic Objectives
Commission Safe and Effective Services *Develop Strategic commissioning plans which improve the physical and mental health of the population* *Work in partnership with the wider health and care system to commission integrated and personalied care* *Make best use of resources*
Reference to other documents or accompanying papers:
Appendix 1 – Planning Cycle 2020/21 Appendix 2 – Developing the NHS Long Term Plan for Devon Appendix 3 – Integrated Commissioning Executive Work Plan Appendix 4 – Integrated Commissioning Executive Terms of Reference
Does this report have implications in any of the areas highlighted below?

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

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

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This report must be accompanied by a completed front sheet

Interim Accountable Officer's Report

1. Annual Report 2018/19

The annual reports of Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group (CCG) and South Devon and Torbay (SDT) CCG were submitted to NHS England at the end of May and are now published on the CCG website.

NEW Devon CCG ended the year with a planned deficit of £20 million, and SDT Devon CCG ended the year with a planned deficit of £5 million. This is in line with the plans agreed with NHS England at the start of the financial year, which subsequently qualified the CCGs to receive the Commissioner Sustainability Fund to offset the planned deficits and enable the CCGs to end the financial year in balance.

2. PA Consulting Report on Devon Health and Care System Leadership Review

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

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

The review has involved observing key meetings across Devon and interviews with a number of key stakeholders.

The emerging findings from this review have been put into a report, which is currently being considered by NHS England, CCG and STP leaders to form an action plan.

3. Primary Care Networks

The CCG has approved all 31 Primary Care Network (PCN) applications. 1 small practice (circa 850 patients) has chosen not to join a PCN. The primary care team is working with the practice and appropriate PCNs to ensure the practices patients receive network services as required within the new GP contract. The PCN population sizes range from 21,000 to 61,000.

The primary care team is currently refreshing the GP strategy and developing commissioning intentions which are planned to be discussed at the July Primary Care Commissioning Committee and other CCG meetings.

4. Operational Plan 2019/20

The final Devon System and CCG Operational Plans for 2019/20 were submitted to NHS England/NHS Improvement as agreed on 23 May. The plan is presented to Governing Body for approval later on this agenda.

The plan sets out how we will work as a system to improve performance against key standards, within the financial parameters agreed with NHS England/NHS Improvement. The scale of transformation required in order to deliver the plan is significant and will be a key focus for Governing Body reporting throughout the year.

5. Planning Cycle 2020/21

In order to allow sufficient time and resource for the production of a high-quality plan which is both ambitious and transformational, the paper in **Appendix 1** sets out an accelerated and phased process for the development of the 2020/21 Operating Plan.

The Operating Plan for 20/21 will reflect and demonstrate our maturity as an aspirant Integrated Care System (ICS), and therefore must represent the Devon system as one, with cohesive and consistent aims. However, it is also essential that the CCG's intentions are not subsumed within any System-wide plan; there must be clarity as to how the CCG is responding to the System Plan and our aspirations as the strategic commissioner of health and care services in Devon.

The Governing Body is asked to:

- Consider the proposed approach in developing the CCG 2020/21 Operating Plan
- Advise on any potential amendments or improvements to the planning process

6. Developing the NHS Long Term Plan for Devon

As previously reported, the NHS Long term plan was published in January 2019 outlining how the NHS needs to change to address the key pressures faced by staff, maximise the use of resources and accelerate the redesign of patient care to "future proof the NHS for the decade ahead'. Devon, as for all systems, will be required to produce a 5-year plan to address the three key aims of improving the experience of care, improving the health and well-being of the population and improving cost effectiveness putting the NHS onto a sustainable financial path.

The slides accompanying this report in **Appendix 2** set out:

- The timeline for the various activities which need to be completed to develop a system plan
- The proposed system governance arrangements to support the development of the plan, identifying the key matters to be addressed through system transformation plans required to achieve the key deliverables of the NHS Long Term Plan and address key local system requirements / challenges.
- The contribution of STP programmes in the above, building on existing plans and strategies.
- The role of localities in facilitating engagement with communities, complemented by additional system wide mechanisms, and enabling the delivery of integrated care.

The Governing Body is invited to note:

1. How the operating plan and long term plan coalesce as part of the single system transformation plan and therefore the importance of the agreed operating plan deliverables as part of this process.
2. The approach to engagement across the system and consider the opportunities for members to contribute.
3. The programme plan and time required at future meetings to consider:
    - The refreshed case for change and system priorities.
    - Enhancement of the STP arrangements for delivery of the system plan, including strengthening clinical leadership of the various workstreams
    - The major reforms of the financial architecture and the triple integration of primary and specialist care, physical and mental health services, and health with social care coming together as a partnership within an Integrated Care System (ICS) by 2021.
    - The key steps to ensure the Devon system is set up to deliver the required transformation through the development of its ICS arrangements including the role of the Strategic Commissioning function.

7. Key meetings and visits

- Dr Paul Johnson and I have been meeting with key stakeholders across Devon as part of an introduction to Devon CCG

8. Integrated Commissioning Executive meeting

DEVELOPING THE CCG OPERATING PLAN 2020/21

1. Introduction

1.1 The purpose of this report is to set out the planning timeline and approach for the development of the 2020/21 CCG Operating Plan, separate from but as a component part of the System Operating Plan, and to take comments and requests from Governing Body membership to further refine the plans. The Governing Body is asked to approve this approach, subject to any required amendments.

2. Background – the 2019/20 Operating Plan

2.1 The final 2019/20 Devon System Operating Plan was submitted on 23 May 2019. There was no separate CCG plan; this was included as an appendix to the System plan.

2.2 Feedback on the plan and planning process from NHS England and colleagues from within the CCG and Devon System has highlighted a number of areas where the process could be improved:

2.2.1 earlier production of the operating plan would help to ensure alignment of process with local authority plans, allow more time for governance and sign off, and would allow for plans to be worked up to implementation before 1 April;

2.2.2 greater clarity regarding the difference between the system operating plan and the CCG operating plan;

2.2.3 greater alignment between the narrative operational plan and the financial and activity/capacity planning;

2.2.4 greater workforce information and representation at an early stage - plans need to be founded on realistic workforce assumptions and address projected shortfalls in some skills, rather than assessing workforce requirements when plans are developed;

2.2.5 a need for the CCG to issue clear commissioning intentions at an early stage;

2.2.6 better join up in terms of submission of information/plans to the CCG and STP, to avoid duplication for those providing content, and consistency of plans for the year;

2.2.7 better use of intelligence to describe the impact of successfully delivering the plan.

2.3 Taking into account the suggested improvements to the process, as set out above, the purpose of this paper is to propose a revised process for production of the 20/21 CCG Operating Plan.

3. 2020/21 Planning Process

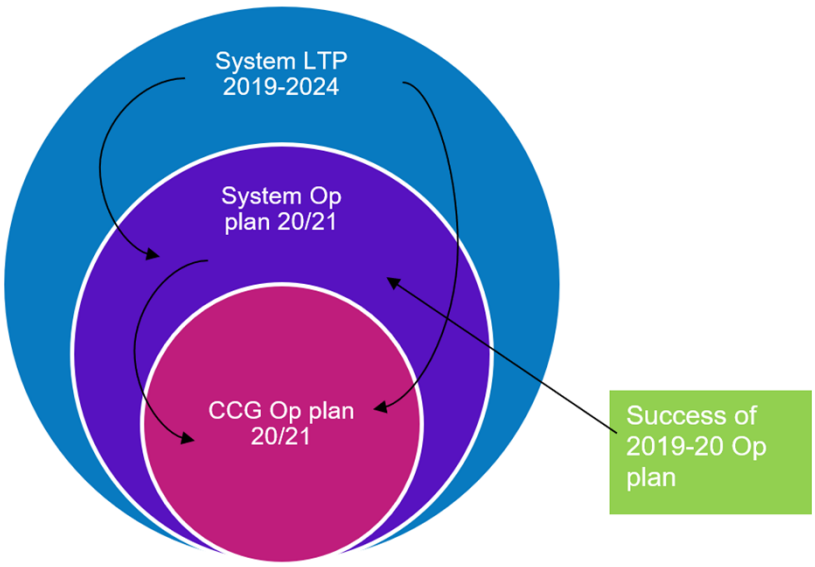
3.1 Firstly, an accelerated and phased process for the development of the 20/21 Operating Plan would allow sufficient time and resource for the production of a high-quality plan which is ambitious and transformational.

3.2 By engaging in a phased approach for the plan's development, there will be the opportunity (as described below) to simultaneously develop content to feed both the Long Term Plan (LTP) and the 20/21 CCG Operating Plan, resulting in consistent information, lack of duplication, and efficient use of resources. Given the nature of the LTP in involving the wider system, such as Local Authorities (LAs), we will also ensure that content is aligned with LA plans, while these are in development.

3.3 The proposed timeline is set out later in the paper.

4. System Plan versus CCG Plan

4.1 Clarity of the relationship between the System and CCG plans is of vital importance, as both will necessarily flow from the LTP and there is potential for significant overlap and duplication.



4.2 The Operating Plan for 20/21 will reflect and demonstrate our maturity as an aspirant Integrated Care System (ICS), and therefore must represent the Devon system as one, with cohesive and consistent aims. However, it is also essential that the CCG's intentions are not subsumed within any System-wide plan; there must be clarity as to how the CCG is responding to the System Plan and our aspirations as the strategic commissioner of health and care services in Devon.

4.3 There are several options for presentation of the plan:

- A single 20/21 System Plan, encompassing the intentions and activity of the CCG weaved into the Plan at relevant points;

- A single System Operating plan, with CCG intentions and activity included as a Appendix (as submitted in 2019);

- Separate System and CCG plans, both telling a coherent story about activity in 20/21, but with the CCG's role in the delivery of the plan completely detachable from that of the system.

4.4 National guidance on the development of the LTP, which includes early planning guidance for 20/21 operating planning was expected in May, but at time of writing, is still in development. However, based on recent correspondence from NHSE/I, it is expected that the guidance will specify a single System/CCG Operational Plan for 2020/21.

4.5 Whatever the final format, which may or may not be dictated by national guidance, the CCG needs to have an organisational Operating Plan, which sets out our aspirations and expectations in 20/21, as year 2 of the LTP.

5. Alignment

5.1 It is essential that the 20/21 CCG Operating Plan aligns with:

5.1.1 **Financial planning processes** – the intention would be to work with provider colleagues – finance directors and deputies, plus operational leads – during July and August to agree a set of financial and performance principles that will underpin the 20/21 finance and activity plans and that reflect the CCG's commissioning intentions for 20/21. The principles might include:

- Agreement on the baseline activity to be used in modelling (currently providers use the latest available 12 months of data, which is not consistent across the county);

- the use of demographic growth levels as set out in the LTP in activity planning, rather than historic referral or activity growth by provider, but taking into account the differential growth in cancer referrals;

- agreement on the improvement expected against key performance standards, such as RTT, 52 week waits and cancer standards;

- agreement around treatment of coding and counting changes.

5.1.2 These principles will be the basis on which providers will develop activity and capacity models. The bulk of activity planning will take place during September and October and the process must involve CCG finance and BI representatives at every stage, to ensure that the models are jointly owned and that any exceptions highlighted, which will potentially arise when providers discuss growth levels with clinical teams, are addressed early and collaboratively.

5.1.3 Having a detailed activity plan for each acute trust by the end of October 2019 will allow time for the CCG's commissioning intentions, provider CIP plans and System action plans to be overlaid, in terms of activity reductions and financial impact.

5.1.4 **Long Term Plan** – The 20/21 Operating Plan is expected to largely fall out of the LTP, but providing a much greater level of granularity. Lauren Benham provides the planning bridge between two working groups, to ensure alignment. Themes, questions and issues will be addressed in ongoing meetings to ensure both processes are as streamlined as possible.

5.1.5 **Local Authority plans** – strategic planning cycle work is underway to align planning activity across the system. This task is being led by Jenny McNeill, Paul O'Sullivan and Giles Colton. LA plans will be developed along similar timelines to those proposed for the CCG Plan, which will allow time for cross-checking and alignment before LAs go through their governance processes, which take place between December and February.

5.1.6 **Provider plans** – it is not clear at this stage how provider plans will be developed and both informed by and feed into the System 20/21 Plan.

6. Content of the CCG Plan

6.1 Early 20/21 planning guidance is expected to accompany the framework for developing the LTP in June. It is expected this will somewhat inform the content, but the general direction of travel will largely will be dictated by the LTP, submitted in October and published to the local system in November. As both are public-facing plans, it is of vital importance that both reflect the same intentions and ambitions for the Devon system, using consistent language and telling one story.

6.2 It is key that the plan is coherent and links to the LTP through the 7 System priorities, but it must also clearly set out the commissioning intentions, expectations and actions of the CCG within the System in 20/21, as the second year of the LTP. The Operating Plan content will give a more granular account of what will be delivered in-year to complement and build on the more strategic LTP and, due to the nature of the Operating Plan and the later timing of its submission, that it contains a more up-to-date view, taking account of what progress has been made against the 19/20 OP Plan priorities and what activity will need to roll into 20/21.

6.3 The LTP will set out workforce projections for the 5 years and these need to be a core foundation for the 20/21 plans, cross referenced with activity assumptions and aligned to commissioning intentions.

6.4 It is important that the 20/21 plan clearly articulates the impact we anticipate on services, quality and costs from delivery of the plan priorities, in order to ensure that these align with the timetable and phasing described in the LTP. Any slippage in Year 1 of the LTP (19/20) must also be addressed.

7. Proposed Timeline

7.1 The timeframe for the LTP is well defined, with plans to be agreed with Regional teams by the end of October 2019. There is not yet a process set out for a 20/21 Devon System Plan.

7.2 **Appendix A** details the LTP timeline, with key milestones in the development of the CCG 20/21 Plan overlaid. The proposed timeline is:

June

- Interpretation of early guidance and sign off for proposed Operating Planning process via Governing Body
- Further describe the process in a document which can be shared with system colleagues for transparency and assurance of the synchronicity between the LTP and CCG Operating Plan.

July/August

- Content generation for 2020/21 in line with the timetable of the LTP, meaning both plans can respond to LTP public engagement and case for change.
- Align to local authority plans.
- Agree financial and performance principles

September/October

- Provider activity and capacity planning

October

- Overlay commissioning intentions, provider CIP plans and System actions onto baseline activity and capacity plans;
- Update the Plan to include roll forward of any actions from 2019/20 that are not expected to fully deliver in year.

November

- Draft of the plan content receives sign off from Exec leads.

January/February

- Operating Plan compared against full national 2020/21 planning guidance and amendments/additions made
- Start of formal Governance process.

March

- Approval process and submission of Plan.

8. Project Group

8.1 It is recommended that a project group is established to oversee the planning process. The group must include representatives from key disciplines (commissioning, finance, quality, etc) and members who are part of the LTP project team and System planning team. Suggested membership is:

Core Op planning team
Alison Wilkinson – CCG planning lead
Lauren Benham – Planning coordinator (and link to STP/LTP)
Kelvin Grabham - BI
Derek Blackford - Finance
Simon Polak - Quality
John Finn – Commissioning
System Workforce representative, to inform commissioning intentions

Extended team
Link to system plan – Warwick Heale, Sharon Williams
Link to Local Authority plans – Damian Furniss from DCC, plus representatives of Torbay Council and Plymouth City Council
Link to LTP – Paul O'Sullivan, Jenny McNeill, Jon Taylor
Communications
Associate Directors of Commissioning

8.2 The core group will meet on a fortnightly basis, either face to face or virtually as considered necessary, from 1 July 2019 until 30 November.

9. Governance

9.1 The project group will report to the Senior Leadership Team (SLT) and formally through to Governing Body meetings.

9.2 Other meetings, such as PDEG, Clinical Cabinet, SLC, FWG and SPG, will be kept informed of progress and used to test planning assumptions (coinciding with LTP review where possible)

10. Conclusion and Recommendations

The Governing Body is asked to:

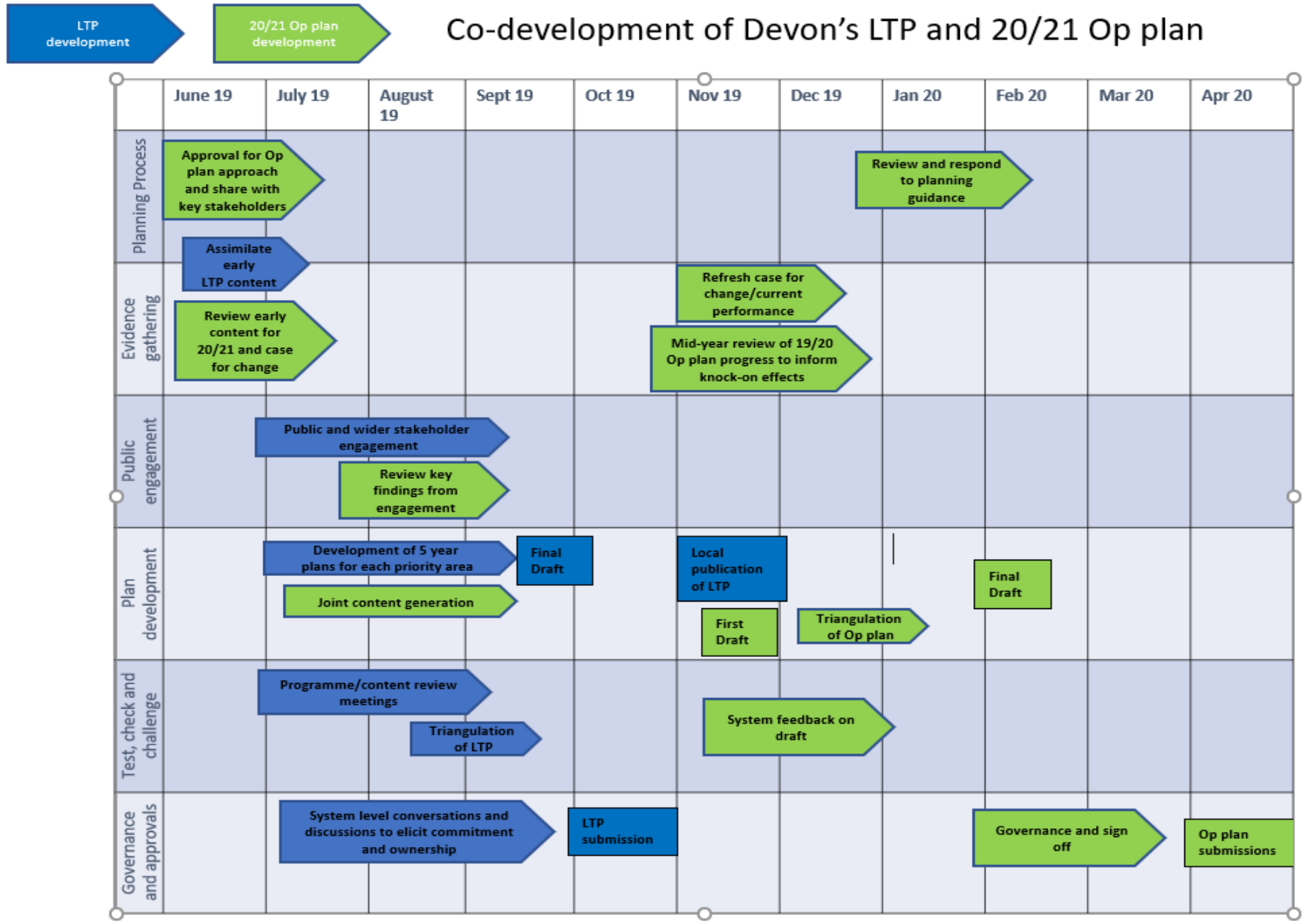
a) Consider the proposed approach to developing the CCG 2020/21 Operating Plan;

b) Advise on any potential amendments/improvements to the planning process;

Alison Wilkinson
Associate Director of Contracting

Lauren Banham
Planning Manager

Appendix A


LTP development
20/21 Op plan development
Co-development of Devon's LTP and 20/21 Op plan
June 19
July 19
August 19
Sept 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
Planning Process
Approval for Op plan approach and share with key stakeholders
Review and respond to planning guidance
Assimilate early LTP content
Evidence gathering
Refresh case for change/current performance
Review early content for 20/21 and case for change
Mid-year review of 19/20 Op plan progress to inform knock-on effects
Public engagement
Public and wider stakeholder engagement
Review key findings from engagement
Plan development
Development of 5 year plans for each priority area
Final Draft
Local publication of LTP
Final Draft
Joint content generation
First Draft
Triangulation of Op plan
Test, check and challenge
Programme/content review meetings
Triangulation of LTP
System feedback on draft
Governance and approvals
System level conversations and discussions to elicit commitment and ownership
LTP submission
Governance and sign off
Op plan submissions

LTP engagement – two-Tier approach

- NHSE national framework will be released in the next two weeks. A clear message is for things to be done at a **local level and alongside Local Authorities (LAs).**
- Some things can be achieved strategically at scale (system-wide), but strong emphasis on place based engagement.
- Our approach will take a two-Tier format, some will be strategic and undertaken by the CCG, some will be local and undertaken by the four LCPs. Health and Wellbeing Boards will work with their LAs public health teams to engage on chapter 2 of the LTP.

Tier 1 – strategic	Tier 2 Local Care Partnerships
The Devon STP will engage system-wide on the following key challenges;	Localities to agree priorities within LTP on which to engage. Designing, delivering and analysing findings. The expectation being they will;
(i) Technology and how it can better support individuals	(i) Produce a plan for engagement between 11 July and 15 September by end of June.
(ii) Creating a sustainable workforce	(iii) Agree an engagement delivery group, chaired by the LCP chair and supported by their designated comms and engagement lead
(iii) What can the NHS do to help people stay well and live longer	(iii) Identify clear themes on which they will engage to inform the Devon LTP.
(iv) Children and young people with mental health challenges	

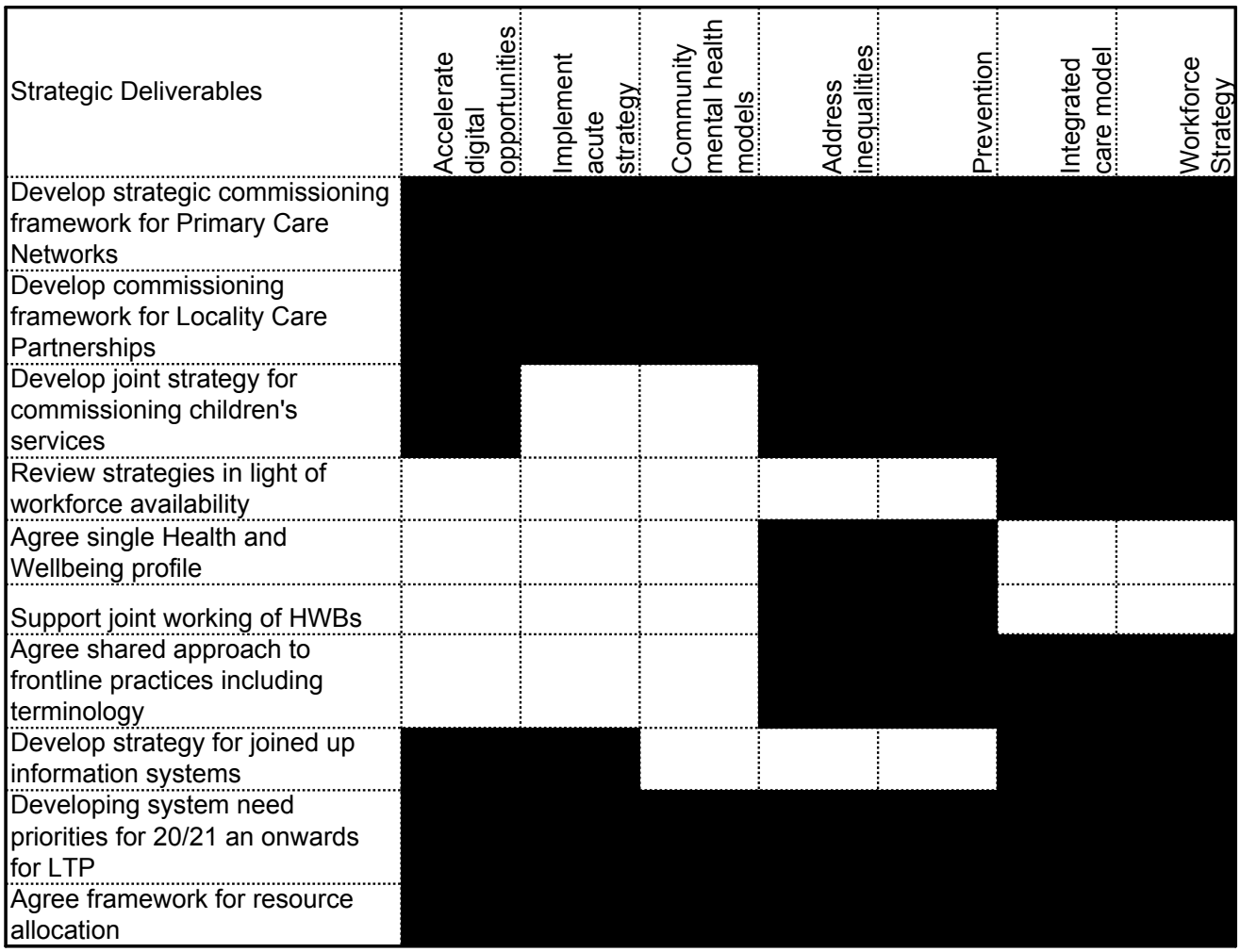
CCG (strategic system-wide)	Health and Wellbeing Boards	Local Care Partnerships
Devon Virtual Voices Panel (1500 members) X 2 surveys	HWBB Devon – as part of HWB strategy refresh (111 July)	Engagement plans to be created by end of June. To date:
Three focus groups (face-to-face), Devon-wide recruitment: 1. Technology in the NHS 2. Workforce 3. Helping people to stay well	HWBB Plymouth	Identified a comms lead per LCP, asked them to consider: (i) Themes and priorities for LCP (ii) Audiences - political (councillors/districts), staff (GPs/PCNs/Collab boards), community groups, PPGs, service users/lived experiences) (iii) Start to plan in attendance at groups, get on agendas etc **Go where there is energy*
PPG survey (online) – supported by paid for advertising online, weekly themes.	HWBB Torbay	An outline engagement 'framework' for what LCPs should consider when devising their engagement plans but design is up to them.
DRSS tele-survey – three questions (max) asked of each caller (receive 1500 calls per day) **NHSE really like this approach*		
MP engagement – session with all MPs		
Seldom heard/hard to reach – Living Options (one key theme across 9 protected characteristics) x 6 focus groups		

LCP	Exec leads	Director of Strategy	Associate Director of Commissioning	Comms and engagement lead	Comms and engagement support
Eastern	Suzanne Tracey Jennie Stephens John Dowell	STP to nominate	Tim Golby	Jeff Chinnock (RD&E)	Ross Jago (CCG) Tony Parker (DCC) Peter Leggatt (DPT)
Northern	John Womersley (chair) Suzanne Tracey Jennie Stephens Andrew Millward	Katherine Allen	John Finn	Jess Newton (NDHT)	Keri Ross (CCG) Tony Parker (DCC) Peter Leggatt (DPT)
Southern	Liz Davenport Sonja Manton Jennie Stephens Jo Williams	Dawn Butler Adel Jones	Solveig Sansom	Corinne Farrell/Jacqui Gratton (TSDFT)	Alex Cameron (CCG) Angela Cappello (TC) Peter Leggatt (DPT)
Western	Tracey Lee (chair) Ann James Adam Morris Craig McArdle Jennie Stephens Jo Turl	Ben Rom Michelle Thomas	Anna Coles	Amanda Nash (UHP)	Nicola Bonas (CCG) Sarah Hyde (Livewell) Richard Longford (PCC)
Mental Health	Melanie Walker (Chair) Jennie Stephens Jo Turl	Phil Mantay		Peter Leggatt (DPT)	Jon Sewell (CCG)

LCPs and next steps for engagement

- LCP communications leads identified and briefed
- LCP communications leads meeting week commencing 17 June to look at local themes, plans, content and timelines – *facilitated by CCG*
- LCP communications leads to make contact week commencing 17 June with LCP chairs and exec leads to agree priorities and themes to engage on
- Each LCP to work with communications and engagement counterparts from across their partnership (LA, MH trust, CCG)

**CCG will help with tools and materials and provide support to LCP comms leads in devising their engagement plans.*


Strategic Deliverables
Accelerate digital opportunities
Implement acute strategy
Community mental health models
Address inequalities
Prevention
Integrated care model
Workforce Strategy
Develop strategic commissioning framework for Primary Care Networks
Develop commissioning framework for Locality Care Partnerships
Develop joint strategy for commissioning children's services
Review strategies in light of workforce availability
Agree single Health and Wellbeing profile
Support joint working of HWBs
Agree shared approach to frontline practices including terminology
Develop strategy for joined up information systems
Developing system need priorities for 20/21 an onwards for LTP
Agree framework for resource allocation

Integrated Commissioning Executive
Terms of Reference
Draft V4

Introduction

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

The proposed arrangements for integration consist of

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

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

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

Purpose

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

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

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

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

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

Principles for working

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

Responsibilities

- **Outputs**
- Forming a joint view of the future state and communicating the vision
- Supporting the delivery of the Operating Plan 2019/20 and supporting the development of a long term plan for the wider Devon
- Ensure Commissioning Plans and Strategies take into account and addresses the needs of the population of Devon
- Agreeing a commissioning finance plan including allocation against priorities, resource distribution and incentives
- Determine future approach with relevant providers to integrated or delegated Commissioning arrangements, e.g. commissioning individual care and support packages to service level commissioning and delivery
- Oversight of delivery of commissioning plans and resultant transformation plans including reviewing the impact of these. including maintaining oversight of the outcomes framework.

– Creating the conditions to enable local partnership development inc finance, performance, delivery of Integrated Care Model, local and system transformation.
– Oversight of joint commissioning risk register

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

Attendance

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

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

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

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

Directors of Children's Services* will be invited to attend as needed to enable whole population planning and alignment of the priorities of local children and young people's plans with the wider Devon whole system plan or where

improvement in service delivery requires action at executive level across services for adults and children.

Full list of attendees:

Accountable Officer (Chair)**	NHS Devon CCG
Chief Officer for Adult Care and Health **	Devon County Council
Strategic Director for People**	Plymouth City Council
Director of Adults Services and Housing**	Torbay Council
Director of Commissioning	NHS Devon CCG
Director of Transformation	NHS Devon CCG
Director for Population Health and Wellbeing	Devon STP
Director of Children's Services*	Devon County Council
Director of Children's Services*	Plymouth City Council & Torbay Council
Director of Finance	NHS Devon CCG / STP
Director of Comms & HR	NHS Devon CCG / STP
Chief Nursing Officer	NHS Devon CCG
Locality Clinical Representative	NHS Devon CCG
Primary Care Medical Director	Devon STP
Professional / Clinical Director	Chair of Devon STP Clinical Cabinet

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

Decision making

The Integrated Commissioning Executive meeting will be a meeting of 'decision makers', with authority held by individual executives. It will therefore be a meeting rather than a joint committee of the statutory partners.
This does not preclude moving to a joint committee of the NHS and Local Authorities at a future date if deemed to be required and with agreement of all partners.

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

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

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

Register of Interests

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

Frequency of meetings

Monthly in the first instance

Reporting Arrangements

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

Administrative arrangements

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

Review

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

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee

Date of Governing Body: 27 June 2019

Dates of Committees covered in this report 11 April 2019

(Approved minutes of the April 2019 Quality Assurance Committee meeting available as an addendum)

Chair's Name and Title: Chris Hanvey, Lay Member (Acting Chair)

Contact Details: d-ccg.qac@nhs.net

Reports discussed and assurances received

- **Quality Risk & Assurance Report including Risk Register**
  Please see below with regards to Risk Register Review (changes and pertinent areas).
- **Quality Assessment Framework (QAF) – including Flash Reports**
  Northern Devon Healthcare NHS Trust (NDHT); Devon Partnership NHS Trust (DPT); South Western Ambulance Services NHS Foundation Trust (SWASFT); Children and Young People (CYP) Mobilisation; Torbay and South Devon NHS Foundation Trust (TSDFT); University Hospital Plymouth NHS Trust (UHPNT).
- **Serious Incidents (SI) beyond the 60-day deadline**
  QAC received an update that the DPT backlog has been raised at the recent regulatory annual assurance meeting and will receive both a further update at the May 2019 QAC, and an assurance position paper at the June 2019 QAC.
- **Infection, Prevention and Control**
  QAC noted the report with the proviso that the position presented for Methicillin Resistant Staphylococcus Aureus (MRSA) in March may have changed. QAC noted that there will be a change to the way in which the Clostridium difficile (C.Diff) algorithm for 2019/2020 is reported. Evidence indicates that the way in which the media has portrayed Devon's E coli position as being the second worst in the country is inaccurate as the number of cases were used rather than the percentage of number of cases against the population. QAC received assurance that Devon is not an outlier in this area.
- **Learning Disabilities Mortality Review**
  The update was noted by QAC with a request to receive a further paper (to be scheduled in line with the forward planner). QAC noted that the total number of reviews is lower than expected due to the time taken to gather the information to inform the reviews and the availability of reviewers. It was confirmed that no themes have been identified regarding the cause of early deaths of patients with learning disabilities (LD).
- **Delegated Commissioning (Primary Care) Nursing and Quality**
  QAC noted that not all of the quality functions will be handed over from NHS England (NHSE) to the CCG on 01 April 2019 in line with the concerns raised at the NHSE workshop held 28 March 2019. Specifically, further work is being undertaken with regards to the Safeguarding function, specifically with regards to the issue of workforce capacity.

- **Written Statement of Action (Special Education Needs & Disability)**
  QAC reviewed the Written Statement of Action and agreed to receive a further, final draft at the May 2019 meeting.
- **Equality, Diversity and Inclusion**
  QAC noted the work programme for the Devon Equality Co-operative and task and finish groups is in place to progress each of the objectives identified. QAC noted the recent issue identified with regards to the NHSE procurement for interpretation and language services focusing only on primary care.
- **Terms of Reference including Quality Committees in Common (QCiC) Handover Pack**
  The Quality Assurance Committee noted that the report will be presented to the Governing Body from Quality Committees in Common (QCiC) to include all relevant documentation.

Reports received and noted

In addition to the reports received and discussed above:

- N/A

Risk Register Review (changes and areas of concern)

- There were 9 risks that QAC were asked to review for closure from the corporate risk register and which QAC requested are reviewed by the risk owner. The senior leadership team were advised of all the recommendations by the QAC and therefore confirmation will also be provided to QAC as to which group or committee within the organisation will have oversight of these risks in future.
- Risks 100/101 with regards to Access to 999 ambulance will remain open until further clarification is given, as advised by QAC
- In line with the recommendations, Risks 67 (outpatient wait times) and 78 (52 week waits) were agreed as closed by QAC, with a further review at Director level of Risk 45 (children and young people speech and language therapy waiting times).
- QAC agreed that Risk 95 (third party delegation process) will remain open however acknowledged that the score may be reduced after further discussion with the risk owner.
- Risks 25/87 (111 clinical triage) will remain open and reviewed further at the May 2019 QAC.

Committee Decisions

- None.

Recommendations for Governing Body

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

Recommendations for other Committees

- None

Terms of Reference or other committee effectiveness issues

- None

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee

Date of Governing Body: 27 June 2019

Dates of Committees covered in this report 09 May 2019

(Approved minutes of the May 2019 Quality Assurance Committee meeting available as an addendum)

Chair's Name and Title: Charlotte Burrows, Lay Member Patient and Public Participation (Acting Chair)

Contact Details: charlotte.burrows@nhs.net

Reports discussed and assurances received

- **Quality Risk & Assurance Report including Risk Register**
  Please see below with regards to Risk Register Review (changes and pertinent areas).
- **Quality Assessment Framework (QAF) – including Flash Reports**
  Devon Partnership NHS Trust (DPT); South Western Ambulance Services NHS Foundation Trust (SWASFT); Care Home / Stroke Mortality; Children and Young People (CYP) Mobilisation; Torbay and South Devon NHS Foundation Trust (TSDFT); Integrated Urgent Care Services / Devon Doctors Limited (DDOC); Livewell Southwest (LSW)
- **Position Statement of Serious Incidents (SI) beyond the 60-day deadline**
  Concerns with regards to Devon Partnership NHS Trust (DPT) will meet the original trajectory for reducing Serious Incidents. Monthly meetings and weekly contacts in place. Weekly Dashboard; Letter to all providers from CCG Chief Nursing Officer; Review of internal processes with standard operating procedures (SOPs) to be brought to June Quality Assurance Committee (QAC); Training additional SI reviewers is underway to improve CCG review capacity. In addition, a review of the capacity of individual reviewers has been undertaken. A process has been developed to process potential incidents identified as investigable by the Health Safety Investigation Branch (HSIB), identifying appropriate assurance levels, based on learning. The HSIB SOP will be brought to the June QAC.
- **Written Statement of Action (Special Education Needs & Disability)**
  Quality Assurance Committee received the Written Statement of Action. QAC identified that there were no amendments or additions to the document. QAC was assured by the process to finalise the Written Statement of Action (Special Education Needs & Disability).
- **(Developing Integrated Care System) Quality Surveillance Group Briefing**
  The Associate Chief Nursing Officer (North and East) updated the Quality Assurance Committee (QAC) on the development of the Quality Surveillance Group (QSG). The QSG is moving from provider to 'system' and made the point that although risks to quality may manifest in one provider, both the causes and the solutions are usually system-wide. The current plan is for the four localities across Devon to move towards local QSGs over the next six months. The model for mental health is currently under further development with a workshop arranged for May 2019 in support of this development. *Please note that the QAC was not quorate for this item, however no decisions were taken.*

- **Quality Equality Impact Assessment (QEIA) update**
  The QAC received an update to confirm that the QEIA process is currently being applied to the System Operating Plan 2019/20 which will involve robust challenge and identifying the opportunities for adjustments. Meetings are taking place in May 2019 with provider organisations. Patient Safety Quality (PSQ) team members are each working with identified provider organisation leads to further develop specific QEIAs. An exceptional QEIA Panel will be convened (16 May 2019) to scrutinse the QEIAs produced in support of the operating plan deliverables. *Please note that the QAC was not quorate for this item, however no decisions were taken.*

- **Terms of Reference including Quality Committees in Common (QCiC) Handover Pack**
  The Quality Assurance Committee received and noted the report, including the amendment on page 2 of the document to reference 'NHS Devon' which was noted by the Governing Body. *Please note that the QAC was not quorate for this item, however no decisions were taken.*

Reports received and noted

In addition to the reports received and discussed above:

- Joint Clinical Effectiveness Group notes

Risk Register Review (changes and areas of concern)

- Risk Framework for NHS Devon will go to Governing Body on 23.08.19.
- The 8 risks that had not been reviewed for 3 months (commissioning) have been raised with the relevant risk owners and all are due to be reviewed.
- QAC noted the addition of risk 104 with regards to internal capacity to maintain, develop and fully utilise DATIX, for which a business case is being prepared.
- Risks 100/101 with regards to Access to 999 ambulance care were noted (very high risk).
- Risk 102 (DPT Serious Incidents) – see agenda item above.
- No risks were recommended for closure however several risks are due for closure at June QAC.

Committee Decisions

- None.

Recommendations for Governing Body

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

Recommendations for other Committees

- None

Terms of Reference or other committee effectiveness issues

- The Quality Assurance Committee received and noted the report, including the amendment on page 2 of the document to reference 'NHS Devon' which was noted by the Governing Body. Please note that the QAC was not quorate for this item, however no decisions were taken.

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 Public

Date of Governing Body:

Dates of Committees covered in this report 13 June 2019

(Approved minutes of the June 2019 Quality Assurance Committee meeting available as an addendum)

Chair's Name and Title: Charlotte Burrows, Lay Member Patient and Public Participation (Acting Chair)

Contact Details: charlotte.burrows@nhs.net

Reports discussed, and assurances received

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

- **Quality Assessment Framework (QAF) – including Flash Reports**
  Northern Devon Healthcare NHS Trust (NDHT); Devon Partnership NHS Trust (DPT); Torbay and South Devon NHS Foundation Trust (TSDFT); Children and Family Health Devon; University Hospitals Plymouth NHS Trust (UPHNT); South Western Ambulance Services NHS Foundation Trust (SWASFT); Urgent Care (system).

- **Patient Experience Report**
  QAC received the annual report for Patient Experience covering formal complaints and Patient Advice and Liaison Service (PALS) contacts (open and closed cases, average case duration, outcome and Ombudsman involvement), risk scores and the themes highlighted using anonymised case examples. Yellow Card (the CCG's health care professional reporting system) and the Care Opinion feedback also formed part of the report received by QAC.

- **Serious Incidents Report**
  QAC received an annual report covering the current position and type of reported serious incidents, showing an increase from last year. Reported Never Events were reported for the year, also showing an increase. An update was provided on the quality review process for serious incidents, with training in place for additional reviewers and an update to the standard operating procedure. Concerns with regards to overdue Root Cause Analysis reports remain, with Devon Partnership NHS Trust (DPT) not meeting the original trajectory for reducing Serious Incidents despite a weekly timeline and weekly contacts as well as monthly meetings in place. A process has been developed to process potential incidents identified as investigable by the Health Safety Investigation Branch (HSIB), identifying appropriate assurance levels, based on learning. The HSIB standard operating procedure was reviewed by QAC, as was the Multi Agency Serious Incident draft standard operating procedure, resulting from the multi-agency serious incidents that the CCG has led on over the past 16 months.

- **Risk arising from forthcoming NHS England LeDeR**
  QAC received a verbal update on the concerns around the number of reviews appearing in the Press. Plans have been put in place to recruit further reviewers in the various organisations within our area, which has been a national problem, and a Lead Reviewer is currently in the process of being recruited to assist with this. Following the recommendation from the Chief Nursing Officer, QAC agreed future assurance reports should be in writing.

- **Safeguarding Report**
  QAC received an update via the report on the new Safeguarding Children Board arrangements in Plymouth and Torbay; Collaborative Fees for primary care safeguarding activity; Safeguarding training compliance; Health assessments for Looked After Children; Community Deprivation of Liberty Safeguards risk register; Audit of safeguarding adult practice in NDHT; Devon Creative Solutions Forum; Prevent - an update on key areas of work; Was not brought processes
  Safeguarding Team changes.

- **Mental Health Services – proposal for deep dive**
  QAC received a verbal update and noted section 6.5 or the serious incident report. QAC agreed a deep dive into Devon Partnership NHS Trust systems and processes for managing serious incidents needs to take place. QAC to receive a progress report on this at the July meeting.

Reports received and noted

In addition to the reports received and discussed above:

- None.

Risk Register Review (changes and areas of concern)

- The Risk Management Framework Policy has been refreshed and approved by Governing Body 23 May 2019. An implementation plan is being developed. The 8 risks that had not been reviewed for 3 months (commissioning) have been raised with the relevant risk owners and all are due to be reviewed.
- Following the merger of the two risk registers mirrored risks have been reviewed and duplicates removed. The mirrored risks closed are 101, 103, 88, 91 and 96 the risks are now reported as risks 100, 102, 92, 24 and 77. Mirrored risks 87 and 25 are presented for closure by this committee and the risk is now reflected in risk 105.
- QAC approved the addition of risk 105 (out of hours GP response times) to the risk register.
- QAC were assured and approved the closure of risks 87 and 25.
- QAC were assured and approved the closure of risk 29 (shared drive) as now in place.
- QAC were not assured that the risks were being up-date regularly.

Committee Decisions

- None.

Recommendations for Governing Body

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

Recommendations for other Committees

• None.
Terms of Reference or other committee effectiveness issues
• None.

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Quality and Performance report				
Date of committee: **Date report produced:14/06/2019**				
Author (s) Name and Title: **Lorraine Webber – Associate Chief Nursing Officer (South & West) South** **Kelvin Grabham: Associate Director of Business Intelligence** **Karen Helliwell: Senior Information Specialist** **Contact Details: karen.helliwell@nhs.net**		**Supporting Executive:** **Name and Title:** **Kelvin Grabham – Associate Director of Business Intelligence** **Lorna Collingwood-Burke– Interim Deputy Chief Officer** **Contact Details:**		
		Report Approved by: **Name and Title:** **Date14/06/2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
For information and assurance				
Executive Summary: This report provides the latest information on key quality and performance indicators including those contained in the NHS Constitution. The report includes as an appendix the Improvement and Assessment Framework (IAF) indicators for the latest quarter.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				

None
Key recommendations and actions requested:
For information and assurance
Impact on Strategic Objectives
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	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.

Governing Body – Quality & Performance Report

June 2019

Summary

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

Performance against the main constitutional standards is summarised below:

- A&E 4hr wait: May showed an improvement in performance with RD&E continuing to perform relatively well at 91% and both NDHT (85%) and TSD (84%) seeing a reduction in 4-hour breaches. However, early June data shows a more challenging month with TSD falling below 80%.
- The RTT position fell in April from 80.5% to 80.1% with all providers except NDHT under trajectory and the waiting list increasing at RD&E and UHP. The recent good progress in reducing over 52-week waits was maintained, though, falling from 188 to 179 at STP level.
- All providers except for RD&E saw increased diagnostics breaches in April with the STP position moving from 10.5% to 12.0%. NDHT and RD&E continue to have the highest levels of breaches, which across Devon are primarily related to endoscopy and imaging.
- The acute delayed transfers of care (DTOC) position remained within the 3.5% target in April at 3.3%. NDHT, UHP and TSD all continued to meet the target and there was further improvement at RD&E from 4.8% to 4.5%.
- Cancer: April saw a further improvement in performance at STP level against the 62-day target from 72.4% to 75.4% with TSD, UHP and NDHT all seeing a reduced breach rate. STP level performance deteriorated against both two-week wait measures with the main 2ww standard at 78.8% and breast symptomatic at 50.3%, both remaining well under the 93% target. TSD underperformed against both measures (at slightly over 50%) whilst UHP achieved just 3.1% against the breast target.

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

summarised below.

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

Care Quality Commission

A number of CQC inspections have taken place across Devon providers in the last few weeks, including:

University Hospitals Plymouth (UHP) – an unannounced inspection of urgent and emergency care took place in April with the findings and report published 31 May 2019. This identified some improvements since the previous inspection but continuing concerns about patient flow and timeliness of initial triage assessment within the emergency department. The rating of requires improvement remains unchanged.

Royal Devon & Exeter Foundation Trust (RDEFT) – an inspection of community health services for adults, community end of life care and community inpatient services had a report published in April 2019 and an overall rating of good. Areas of community end of life care require improvement.

Development of Local Quality Surveillance Groups

Quality Surveillance Groups (QSGs) are one element of a wider framework to ensure that quality is the organising principle of our health and care system. They bring together different parts of the health and care system, to share intelligence and work in a collaborative way to improve quality locally or across the whole system. Since the national guidance was reviewed in July 2017 there is now an emphasis on evolving these groups further to include providers and Local Authorities.

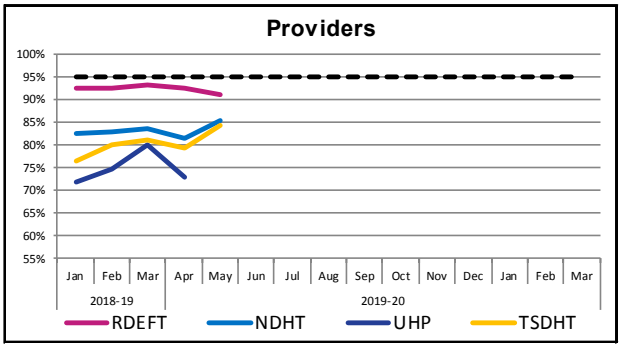
An initial workshop was held with providers, regulators and other stakeholders within the Southern locality on 28 May 2019 and a plan to progress to a QSG in this local system from July was agreed. The CCG is also liaising with NHSE/I and across organisations in other localities as part of a plan to implement local QSG's across Devon.

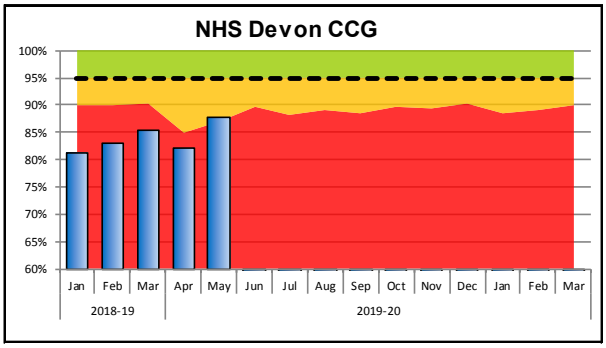
A&E Performance - Percentage of patients waiting less than 4 hours.

All types (including MIU and WiC)

Trust	Trajectory	May	2019/20
RDEFT	92%	91.1%	91.7%
NDHT	84%	85.2%	83.3%
UHP	81%	N/A	N/A
TSDFT	78%	84.2%	81.7%

CCG	Trajectory	May	2019/20
NHS Devon	88%	87.9%	84.5%
ENGLAND		88.0%	86.6%

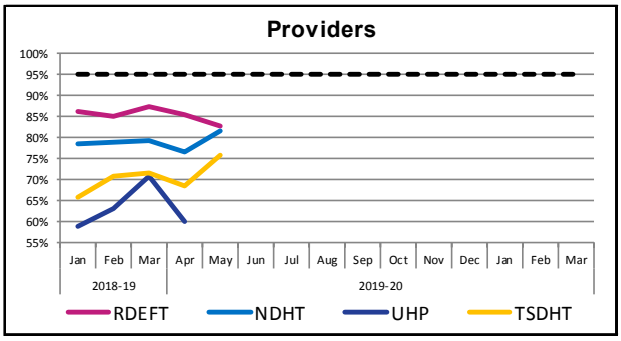


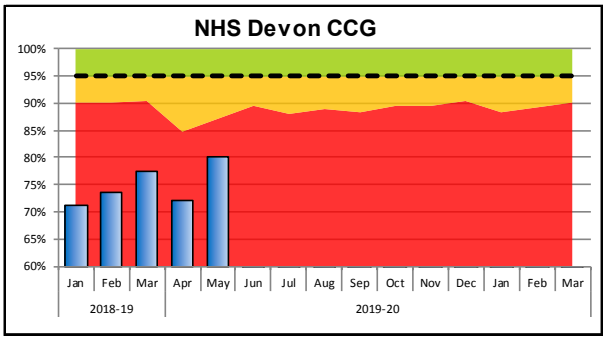


Type 1 A&E only

Trust	Trajectory	May	2019/20
RDEFT	92%	82.9%	84.1%
NDHT	84%	81.7%	79.3%
UHP	81%	N/A	N/A
TSDFT	78%	75.9%	72.2%

CCG	Trajectory	May	2019/20
NHS Devon	88%	80.3%	75.4%
ENGLAND		81.5%	79.3%





Performance Commentary

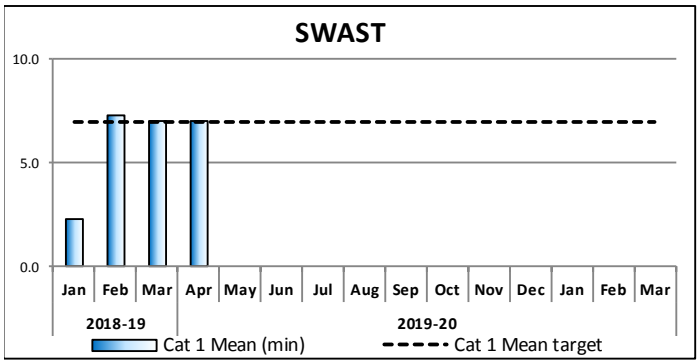
In May the STP position was 87.9%, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. RD&E performance fell slightly from 92.4% to 91.1%, NDHT improved from 81.3% to 85.2% and TSD rose from 79.1% to 84.2%.
Provisional June performance shows NDHT and RD&E maintaining a similar position but TSD falling to 80%.

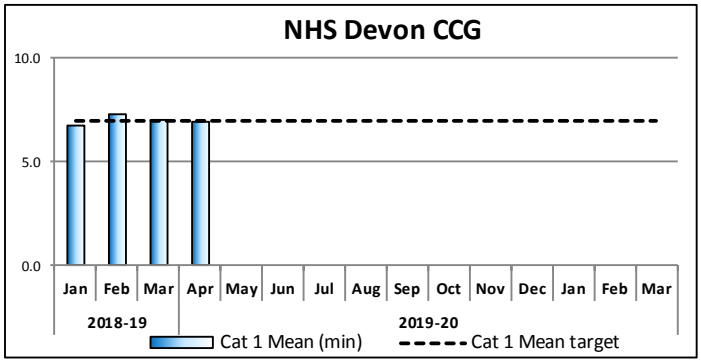
Quality Commentary and Improvement Actions

The South and West localities continue to experience increased demand impacts within their urgent and emergency care pathways and the CCG is therefore continuing with additional quality reviews. Information around patient experience, safety and effectiveness of care from this additional surveillance is shared with the providers and informs the local system escalation calls that are in place in these localities. This also enables providers to develop their internal assurance mechanisms for checking care quality during periods of escalation which will provide further assurance. It is clear from the reviews that patient experience and privacy and dignity are often adversely impacted during periods of escalation. A CQC inspection report published 31 May 2019 following an unannounced inspection in UHP has also identified continued challenges around patient flow and early triage assessment.
Observational and patient experience reviews conducted by the CCG are planned as ongoing work programmes across all providers. End to end reviews of patients experiencing lengthy periods within emergency departments during days of escalation are also completed.

SWAST Cat 1 Mean response time

Trust	Target	April	2019/20
NHS Devon	7.00	7.00	7.0
SWAST	8.00	7.00	7.0





Performance Commentary

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

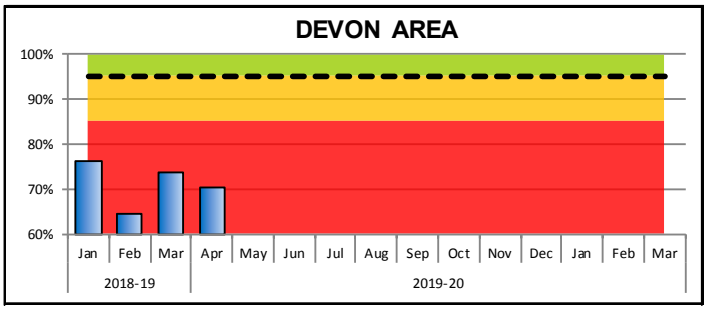
Quality Commentary and Improvement Actions

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

To support SWASFT in mitigating this risk the CCG is working with emergency department providers in focusing on handover delays (to enable earlier release of ambulances). Three of the four emergency departments have undertaken an end to end review of one 60+ handover delay (NDHT undertook six reviews) and findings were reported to the Devon A&E Delivery Board in May. In broad terms findings were unremarkable and related to capacity within the organisation and system. It was also noted that conveyance to emergency departments might not have been the most appropriate outcome for several of the patients involved. In one case a GP, who had not seen the patient, called for an ambulance to a patient with influenza. Notably, communication was highlighted as a learning point generally, with a stated need to improve communications both internally and within the system. For example, ensuring that GPs are aware of current OPEL status. Organisations will take the learning forward

NHS 111 answering calls within 60 Seconds

Trust	Target	April	2019/20
DEVON	95%	70.4%	70.4%
ENGLAND	95%	87.4%	87.4%



Performance Commentary

The proportion of calls answered within 60 seconds fell in April to 70.4% from 73.8% in March. Performance remains well below the target of 95%.

Quality Commentary and Improvement Actions

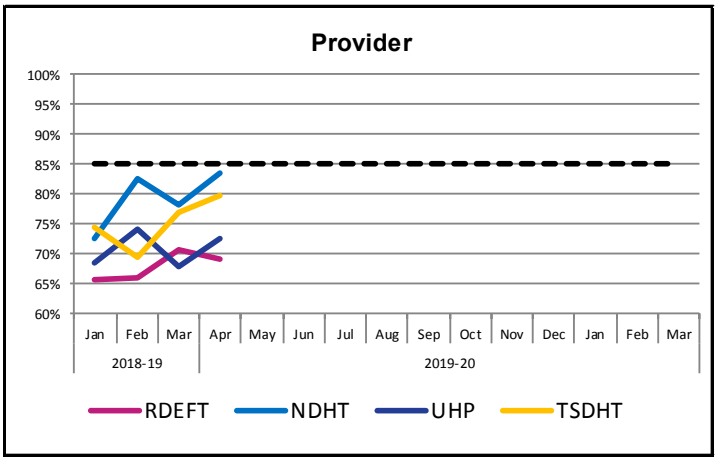
A number of calls are abandoned by patients before answering: it is not clear if this is due to length of wait to be answered or some other reason. Collating information and experiences from these patients is challenging as it is not clear if these patients then access alternative services such as ED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

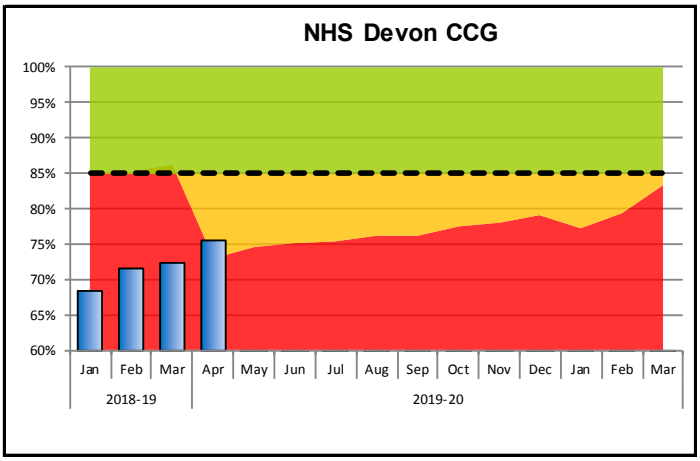
Devon Doctors Ltd continue to report challenges with staffing and the impact on waiting times and experience for patients as well as on the health and wellbeing of staff. They have participated in local escalation calls and system planning. The CCG met with Devon Doctors Ltd this month to fully explore the workforce and staffing issue and resulting impact on the urgent and emergency care system. An improvement plan is in place and this includes additional nurse staffing (due to commence employment between now and September) in the Treatment Centres, thus releasing GP time back to call triage. A new rota is also proposed and trials of this have shown benefits in the form of reducing the call stack.

Cancer 62 day Urgent Referral

Trust	Trajectory	April	2019/20
RDEFT	73%	69.3%	69.3%
NDHT	85%	83.6%	83.6%
UHP	69%	72.6%	72.6%
TSDFT	78%	79.9%	79.9%

CCG	Trajectory	April	2019/20
NHS Devon	73%	75.4%	75.4%
ENGLAND	85%	79.4%	79.4%





Performance Commentary

April saw an improvement in performance at STP level from 72.4% to 75.4%. NDHT increased from 78.4% to 83.6%, UHP improved from 68.0% to 72.6% and TSD performance also improved from 77.0% to 79.9%. UHP and TSD are both ahead of their planned improvement trajectory.

Quality Commentary and Improvement Actions

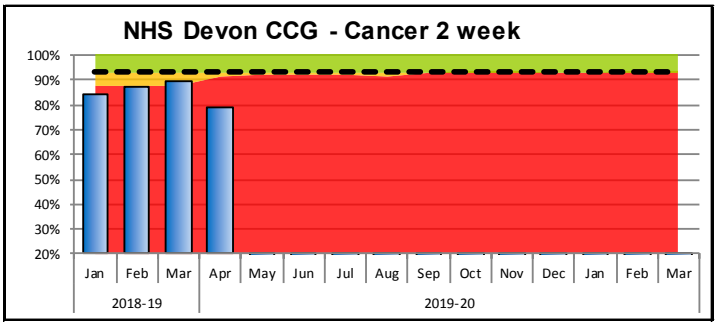
The CCG is engaged in focused work with Devon providers to improve diagnostic pathways and has already implemented best practice pathways across Devon for prostate and lung cancers. Devon CCG has a strategic plan in place that clearly sets out key areas of work that will enable sustainable achievement of the 62 day standard. Each provider's improvement plan is overseen by the CCG and it is envisaged that these plans will not only ensure patients are seen safely within the given time frames, but also have a positive experience of services at this potentially difficult time.

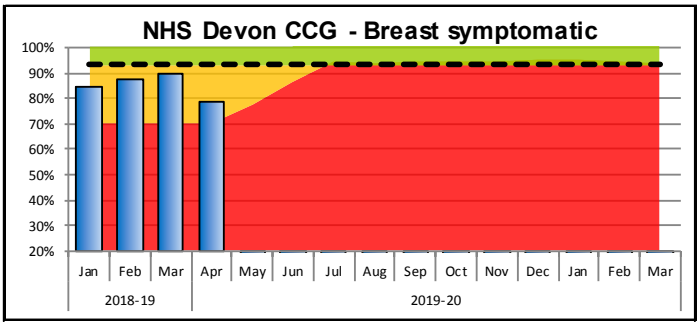
Provider organisations have given assurance on the mechanisms by which they maintain patient safety through clinical triage processes, ensuring long waiting patients on cancer pathways remain safe.

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

Cancer Targets (April-2019)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	78.8%	80.4%	95.2%	92.0%	53.4%
93%	2 week breast	50.2%	72.5%	91.4%	3.1%	50.7%
90%	62 day screening	95.6%	93.8%	N/A	94.7%	93.3%
85%	62 day consultant	76.5%	81.5%	73.5%	66.7%	80.0%
96%	31 day first	92.8%	89.4%	97.9%	89.6%	96.7%
94%	31 day surgery	93.0%	85.1%	92.3%	89.9%	94.7%
98%	31 day drugs	99.3%	99.2%	100.0%	98.2%	100.0%
94%	31 day radiotherapy	92.8%	98.0%	100.0%	75.9%	98.6%





Performance Commentary

Across the wider range of cancer targets NDHT performed relatively well but there was more mixed performance at other providers with RD&E achieving three of the eight measures and UHP only meeting two. Whilst TSD achieved five targets the Trust's two week wait performance was significantly below target for both measures

Breast symptomatic performance remained below target overall at 50.2% with TSD (50.7%) and UHP (3.1%) underperforming.

2ww performance remained above target at NDHT and slightly under at UHP but was significantly below target at TSD (53.4%).

Quality Commentary and Improvement Actions

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

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

The annual acute provider self-assessments against the cancer standards is now commencing, led by NHS England Quality Surveillance teams and requiring CCG review of recommended surveillance levels. The CCG is planning to complete their review of these self-assessments in partnership with each provider this year and this will enable a clear understanding of system wide themes and provider specific actions required.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

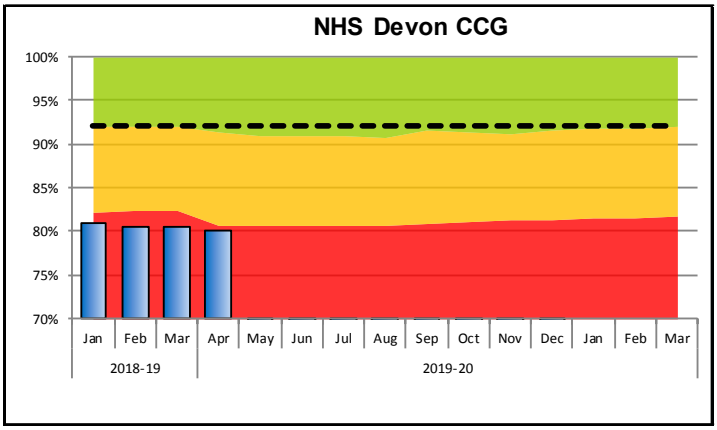
Trust	Trajectory	April	2019/20
RDEFT	82.6%	81.6%	81.6%
NDHT	79.1%	79.3%	79.3%
UHP	77.7%	76.4%	76.4%
TSDFT	81.0%	80.8%	80.8%

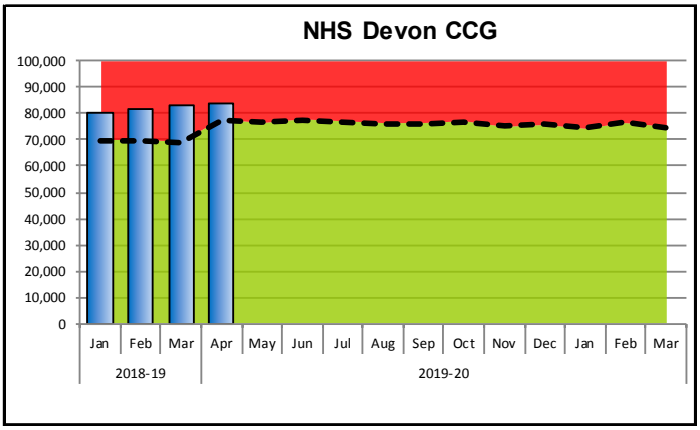
CCG	Trajectory	April	2019/20
NHS Devon	80.6%	80.1%	80.1%
ENGLAND	92.0%	86.5%	86.5%

RTT incomplete waits volume

Trust	Trajectory	April
RDEFT	34,555	35,417
NDHT	11,797	11,390
UHP	28,351	28,195
TSDFT	18,567	19,018

CCG	Trajectory	April
NHS Devon	77,423	83,546





Performance Commentary

The STP level RTT position fell in April to 80.1%. RD&E performance decreased from 81.9% to 81.6%, UHP deteriorated from 77.3% to 76.4% whilst TSD fell from 81.3% to 80.8%, all below the planned 19/20 trajectory. NDHT saw performance slightly improve to 79.3%, above their trajectory. The incomplete waiting list increased at RD&E & UHP but fell at other providers.

Quality Commentary and Improvement Actions

The CCG continues to seek assurance that patient harm has not occurred where performance is reduced.

There have been noted improvements across providers for some planned care pathways for example the dermatology and nephrology waiting times at NDHT has improved and this has had a positive impact on patient experience and reduced the risk of patient safety being compromised. Working collaboratively with RDEFT has also contributed to this improvement, with patients experiencing the positive impact of mutual support and other joint working arrangements.

Cardiology waits within RDEFT remain affected and the provider has assured the CCG that no lower level incidents have resulted due to prolonged waits. They have however confirmed that complaints, linked to this issue, have been received. Yellow cards received by the CCG also indicate primary care continues to have concerns around this issue. The CCG is working closely with the provider lead for Planned Care, as there are potential alternative models that may support current provision, such as in the community. This may improve experience for patients. NHSE/I have been informed of the CCG assurance actions.

Ophthalmology pathways remain a key risk for NDHT and was discussed at the System Oversight Meeting in May, chaired by the regulators. NDHT assured the group that the action plan, now shifting from planning to implementation, has close executive oversight; this should lead to an improved position of reduced risk and improved patient experience. Incidents reported relating to long wait times are currently being investigated.

UHP has identified a number of patients that have chosen to delay their treatments significantly and those patients are now being contacted each week to further discuss whether they wish to remain on the waiting list – this is being undertaken with NHSI and CCG oversight.
TSDFT continue to be challenged as a result of their ongoing reduced theatre capacity and a monthly patient impact report is overseen through their Quality Improvement Group. Patients for many specialities continue to be offered alternative locations for treatment during this period. Planned reopening of full theatres is expected in August 2019

RTT Incomplete Pathways long waiters

40-52 week waits

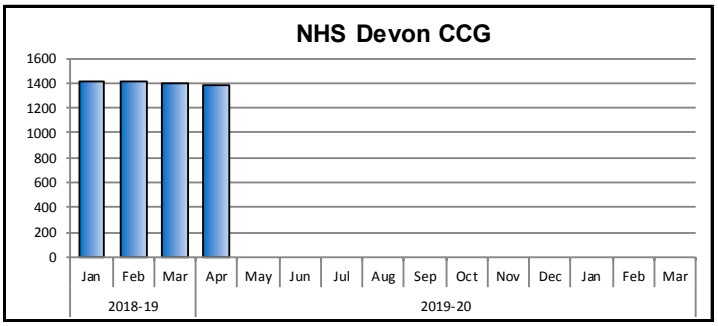
Trust	April	2019/20
RDEFT	619	619
NDHT	121	121
UHP	639	639
TSDFT	308	308

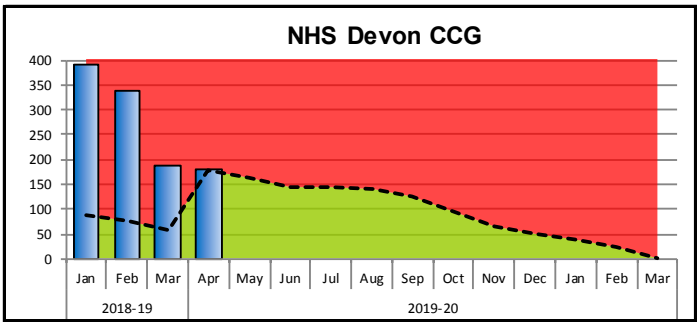
CCG	April	2019/20
NHS Devon	1381	1381

Over 52 week waits

Trust	Trajectory	April	2019/20
RDEFT	40	67	67
NDHT	16	17	17
UHP	52	49	49
TSDFT	94	71	71

CCG	Trajectory	April	2019/20
NHS Devon	177	179	179





Performance Commentary

Over 52 week waits fell slightly in April moving from 188 to 179 at STP level, although just above the improvement trajectory. RD&E, UHP and NDHT remained relatively static with TSD seeing breaches fall from 79 to 71.

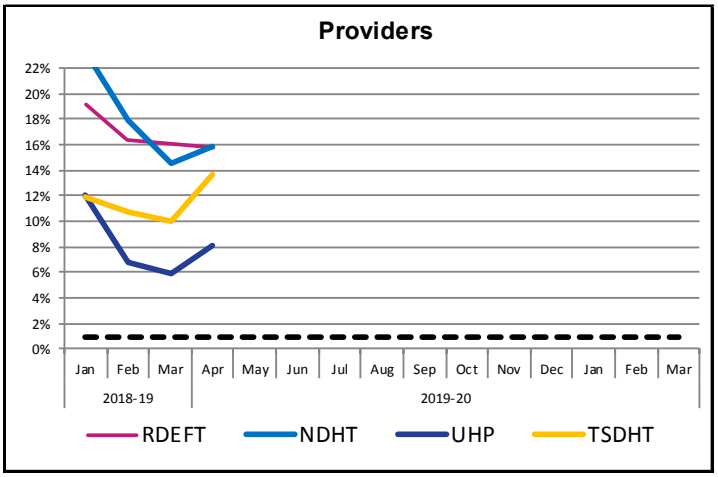
Quality Commentary and Improvement Actions

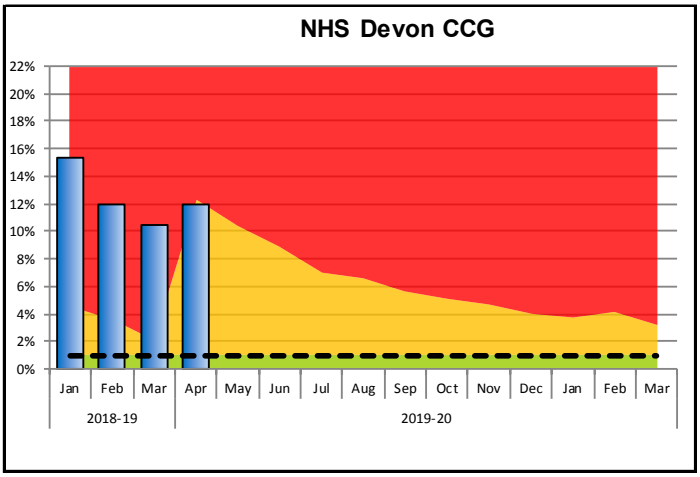
Across the STP providers have given assurance on how they check for harm, as well as ensuring as positive an experience as possible for patients, through clinical reviews and communicating with patients.
Elements of planned care work continue to be outsourced to the independent sector, with the aim of improving choice and experience and reducing potential risk from a long wait. The CCG's continue to seek assurance that provider Trusts are undertaking surveillance to ensure quality is maintained when outsourcing service provision.
Quality and equality impact assessments are undertaken by providers when planning their activity improvement trajectories and/or as part of the overall transformation work by service line. These are reviewed by the CCG Quality, Equality Impact Assessment (QEIA) Panel. These assessments enable consideration of the potential positive or negative impacts to patient safety, effectiveness, experience and the wider system

Diagnostic 6 week wait

Trust	Trajectory	April	2019/20
RDEFT	16.1%	15.7%	15.7%
NDHT	16.6%	15.9%	15.9%
UHP	7.2%	8.1%	8.1%
TSDFT	13.7%	13.7%	13.7%

CCG	Trajectory	April	2019/20
NHS Devon	12.4%	12.0%	12.0%
ENGLAND	1.0%	3.6%	3.6%





Performance Commentary

All providers except for RD&E saw increased breaches in April. UHP increased from 5.9% to 8.1%, NDHT rose from 14.6% to 15.9% and TSD performance decreased from 10.0% to 13.7%, although achieving their improvement trajectory. RD&E moved from 16.1% to 15.7%, also achieving April's trajectory. The majority of breaches continue to be for imaging and endoscopy.

Quality Commentary and Improvement Actions

There are some improvements in certain pathways across the STP, but patients continue to experience long delays in others, so continued assurance is sought to ensure no harm occurs, recognising patient experience may be affected. Providers continue to demonstrate a Devon wide approach to quality, by liaising and planning improvements together, supported closely by DRSS.

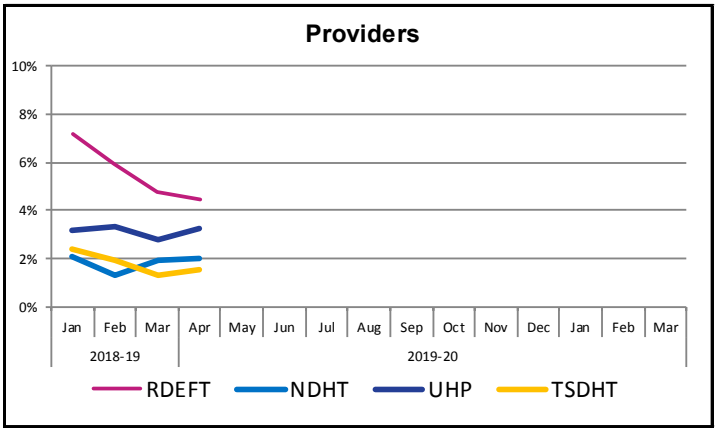
A number of incidents reported by UHP as a result of diagnostic reporting delays are currently under review. The provider and CCG are analysing any themes or trends evident through the review process. The CCG is also involved and taking assurance from the NHS Improvement 'Four Eyes Insight' work that is taking place within UHP. This provides clinically focused support with the aim of maximising productivity and efficiency in order that delays for patients can be minimised.

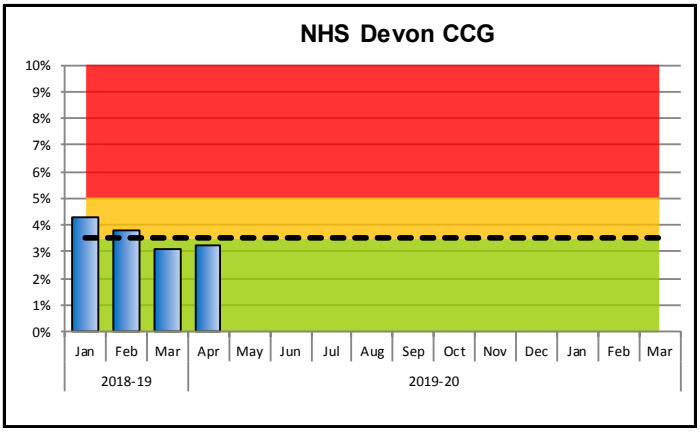
The CCG continues to review clinical and non-clinical information, monitor incidents, complaints and feedback about diagnostic delays and diagnostic reporting delays across all providers. Where delays in tests or reporting occur, all providers conduct a review.

Acute Delayed Transfers of care

Trust	Target	April	2019/20
RDEFT	3.50%	4.5%	4.5%
NDHT	3.50%	2.0%	2.0%
UHP	3.50%	3.3%	3.3%
TSDFT	3.50%	1.5%	1.5%

CCG	Target	April	2019/20
NHS Devon	3.50%	3.3%	3.3%





Performance Commentary

The acute delayed transfers of care (DTOC) position remained better than the 3.5% target in April, moving slightly upwards from 3.1% to 3.3%. NDHT, UHP and TSD all remain under 3.5% and there was continued improvement at RD&E from 4.8% to 4.5%.

Quality Commentary and Improvement Actions

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

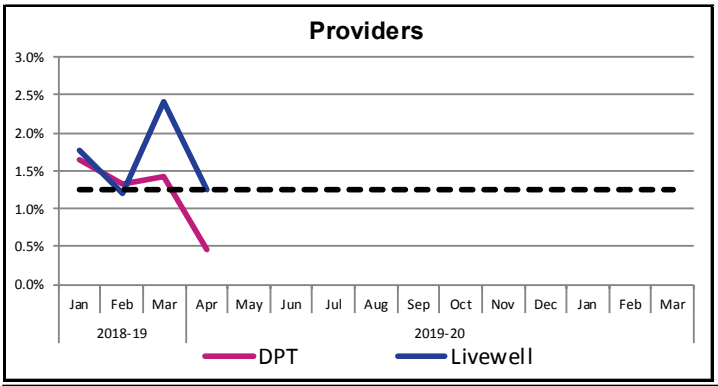
Each locality monitors and manages delayed transfers of care for individual patients and they consider their local system capacity to ensure patients are transferred in a timely way. In the last month some key areas impacting on patient transfer delays have been identified and include issues with discharge medicines not being ready, challenge in accessing appropriate patient transport and the timely repatriation of patients back to county of origin. End-to-end reviews from two providers (with the potential implementation of this review process in the remaining two providers) have provided recommendations that will lead to actions to improve flow. This includes improvements in the discharge process.

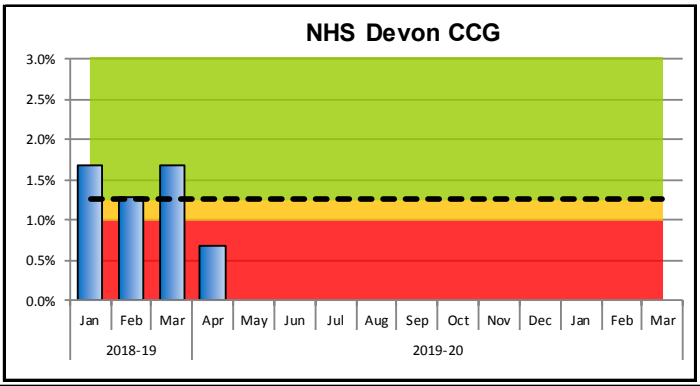
A consistent reduction in the number of patients experiencing delayed transfers of care has now been seen over several months within RDEFT. There is continued evidence that quality is improving following the increased focus on improving the timeliness of transfers, allowing patients to be discharged safely and for that discharge experience to be effective and positive.

IAPT Monthly Access rate

Trust	Target	April	2019/20
DPT	1.25%	0.5%	0.5%
LIVEWELL	1.25%	1.25%	1.25%

CCG	Target	April	2019/20
NHS Devon	1.25%	0.7%	0.7%





Performance Commentary

Performance for the IAPT access rate indicator was under target at STP level for April with Livewell meeting the standard but DPT underperforming.

Quality Commentary and Improvement Actions

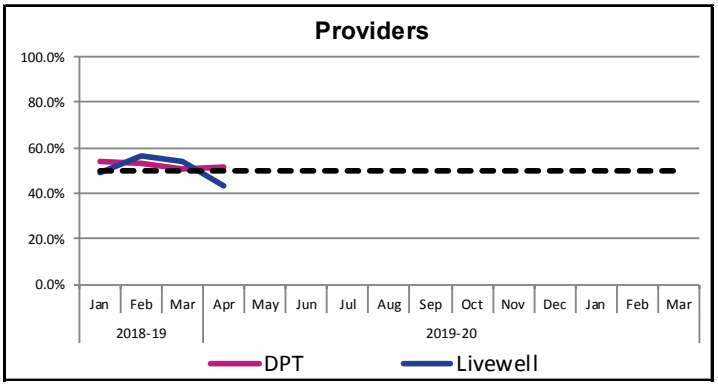
Quality assurance continues through a range of sources and the CCG also receives feedback via the yellow card system from professionals working within the system and these are shared with the providers for review and response. This enables any concerns around crisis response timeliness to be identified.

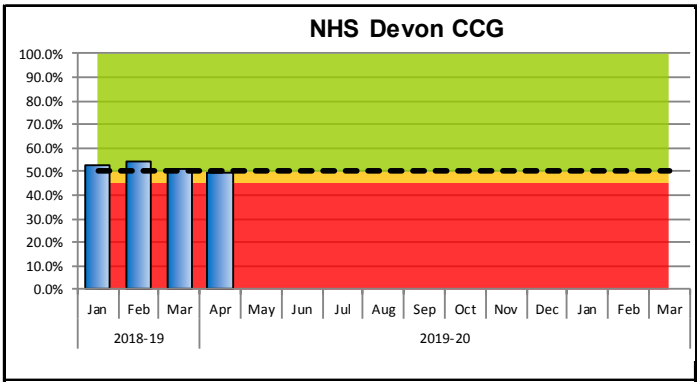
There is a continued high demand within Plymouth for trauma focussed therapy. Available trauma therapies within the service consists currently of Eye Movement Desensitisation Reprogramming (EMDR) and Trauma focussed Cognitive Behavioural Therapy (CBT). To provide assurance that those patients were being kept safe whilst waiting for treatment LWSW undertook a review of every client. In total 96 clients were reviewed who had waited 18 weeks or more. Staff contacted these clients to review their current needs, establish ongoing requirement for therapy, and if appropriate reviewed for trauma-based CBT. There is good evidence that this further supports people to be therapy ready and reduces the amount of time required in therapy with positive results for the individual.

IAPT Recovery rate

Trust	Target	April	2019/20
DPT	50%	51.5%	51.5%
LIVEWELL	50%	43.0%	43.0%

CCG	Target	April	2019/20
NHS Devon	50%	49.8%	49.8%





Performance Commentary

The STP was very slightly under target for IAPT recovery. DPT achieved the recovery measure but Livewell performance dropped below target at 43.0%.

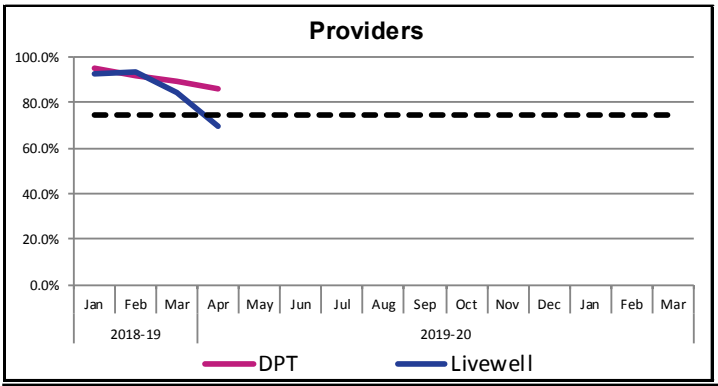
Quality Commentary and Improvement Actions

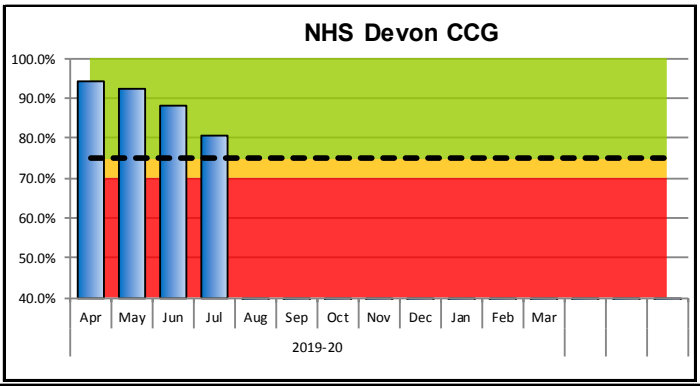
The CCG continues to review all information from provider meetings and other sources to inform the range of indicators within the quality assurance process.

IAPT waiting 6 weeks

Trust	Target	April	2019/20
DPT	75%	85.9%	85.9%
LIVEWELL	75%	69.5%	69.5%

CCG	Target	April	2019/20
NHS Devon	75%	80.7%	80.7%





Performance Commentary

DPT achieved the target in April however Livewell SW fell below at 69.5%

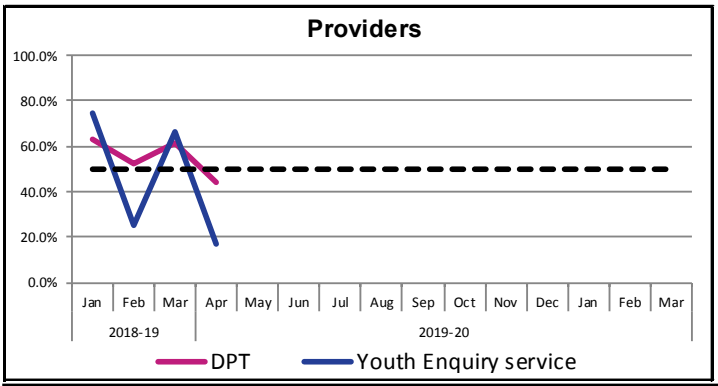
Quality Commentary and Improvement Actions

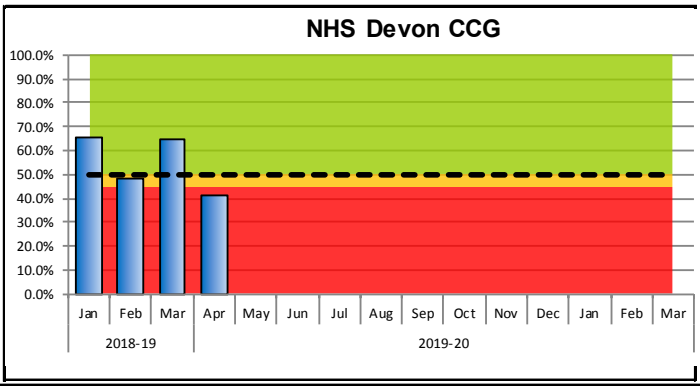
Provider quality assurance continues through the quality assurance framework process.

Mental Health Early Intervention

Trust	Target	April	2019/20
DPT	50%	43.8%	43.8%
THE ZONE	50%	16.7%	16.7%

CCG	Target	April	2019/20
NHS Devon	50%	40.9%	40.9%
ENGLAND	50%	73.4%	73.4%





Performance Commentary

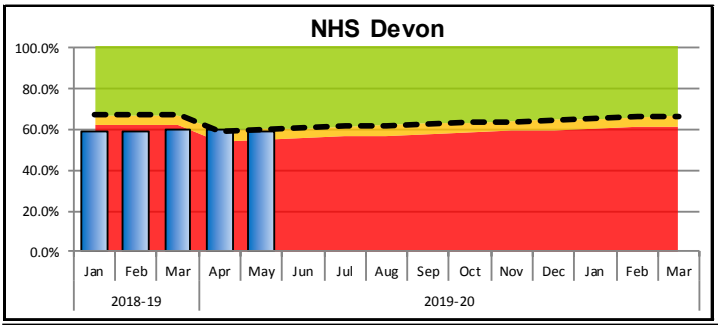
This is a two part indicator for patients with suspected first episode psychosis or at risk mental state on a completed pathway receiving NICE-recommended care package and allocated to and engaged with an EIP care co-ordinator. Very small numbers at The Zone (Plymouth) result in large variances in monthly performance. Performance fell in April to 40.9%, below the 50% national target, with DPT and the Youth Enquiry both underachieving against the standard.

Quality Commentary and Improvement Actions

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

Dementia Diagnosis Rate

CCG	Trajectory	May	2019/20
NHS Devon	60.0%	59.3%	59.4%
ENGLAND	67.0%	68.4%	68.4%



Performance Commentary

STP level performance remained static and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (41.3), Mid Devon (53.7) and Plymouth (56.0). Conversely Exeter is at 71.2%, Torbay 62.7% and East Devon at 64.7%.

Quality Commentary and Improvement Actions

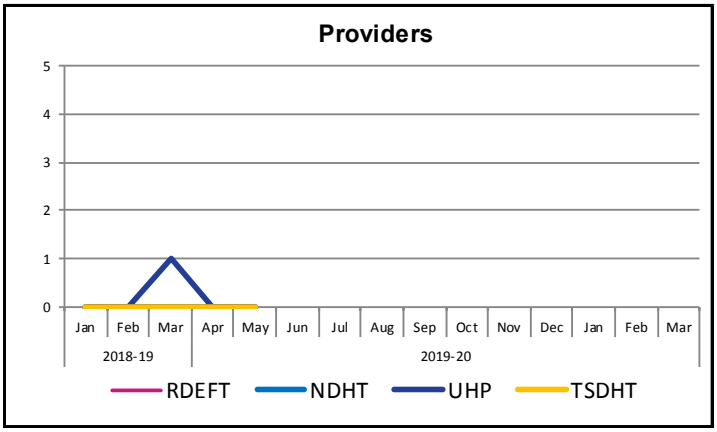
The dementia diagnosis dashboard is in place and gives information on diagnosis rates by locality and individual GP practice. Correct coding of patients diagnosed with dementia within primary care remains a key piece of improvement work. Following analysis with DPT and LWSW, letters to GP practices to support in correctly coding those patients who have a confirmed diagnosis are planned. The CCG are also seeking input from clinical colleagues to develop a proposal for improving the early identification and diagnosis of dementia in care home residents.

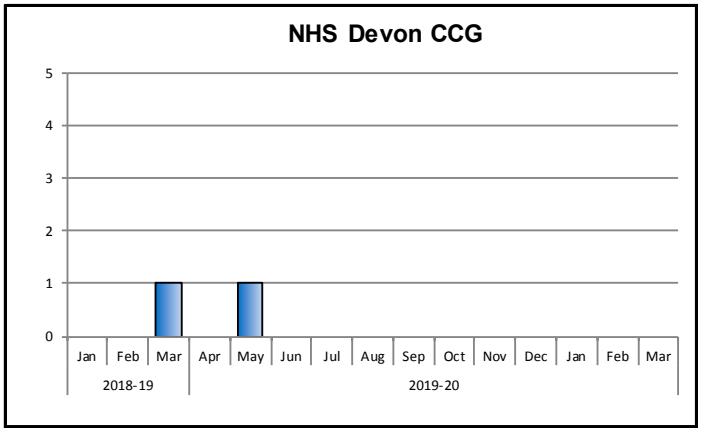
Early identification and diagnosis of dementia can positively impact on both patients and their family and carer's as treatments, education and support options can be offered.

MRSA breaches

Trust	Target	May	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	0	0
TSDFT	0	0	0

CCG	Target	May	2019/20
NHS Devon	0	1	1





Performance Commentary

There was one reported MRSA case in May which was out of area.

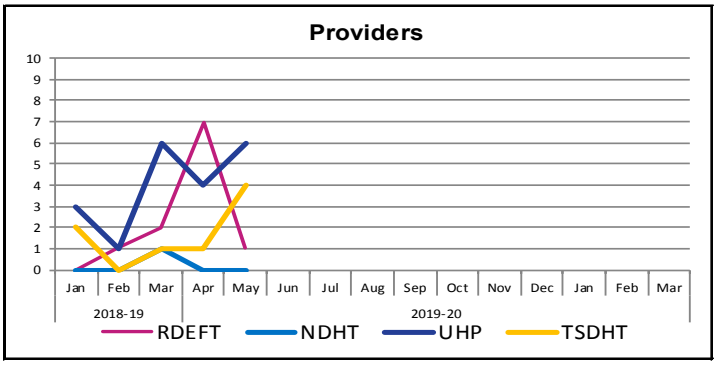
Quality Commentary and Improvement Actions

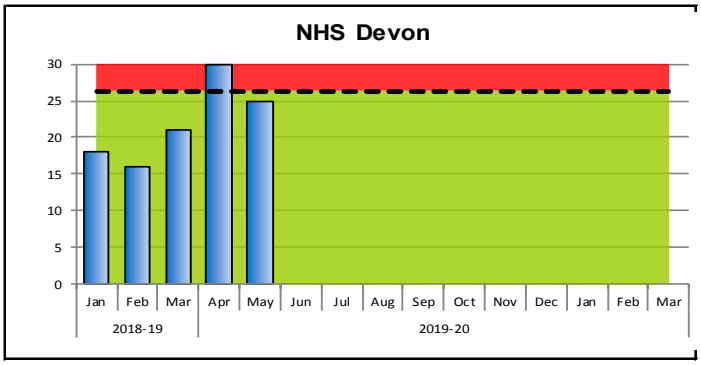
Local reviews of any MRSA case that occurs continues.

C-Diff breaches

Trust	Target	May	2019/20
RDEFT	<31	1	8
NDHT	<7	0	0
UHP	<35	6	10
TSDFT	<18	4	5

CCG	Target	May	2019/20
DEVON STP	<316	25	55





Performance Commentary

There were 11 C-Diff cases acquired within the acute providers and 25 across the STP in May.

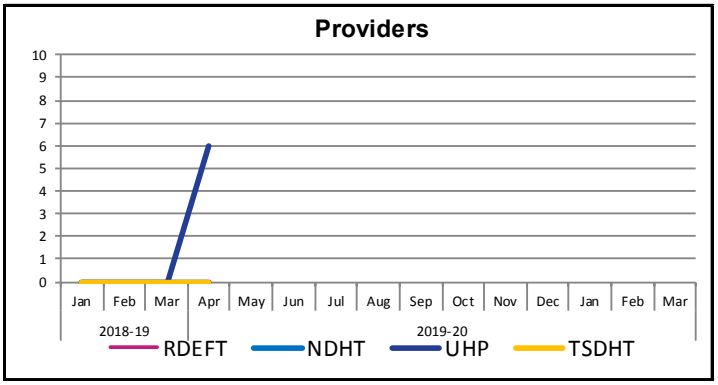
Quality Commentary and Improvement Actions

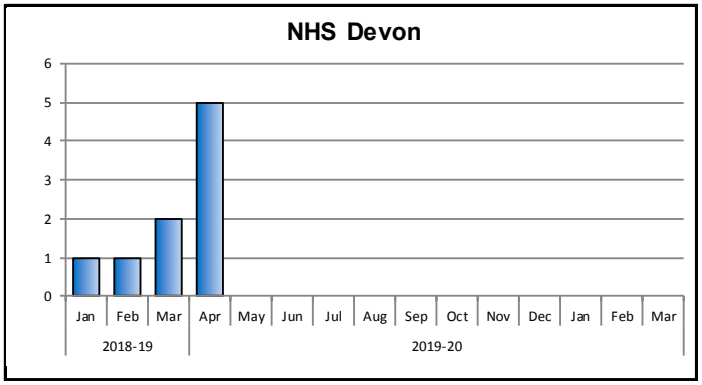
Case numbers for acute Trusts and the CCGs were all under the nationally set trajectory at the end of 2018/19, which demonstrated a positive commitment to reduction across the system.
There has been a period of Increased Incidence of C difficile at RDEFT in April, involving ten cases. These have been fully reviewed and ribotyped, and there is no evidence of an outbreak. Provider annual infection prevention & control reports (IPC) are now being shared with the CCG and we use this information within our assurance framework. These reports provide information on all health care associated infections (HCAI) and the management and improvement work undertaken throughout the previous year.

Mixed Sex accommodation breaches

Trust	Target	April	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	6	6
TSDFT	0	0	0

CCG	Target	April	2019/20
NHS Devon	0	5	5





Performance Commentary

UHP have seen six breaches in April, 5 of which are attributed to NHS Devon.

Quality Commentary and Improvement Actions

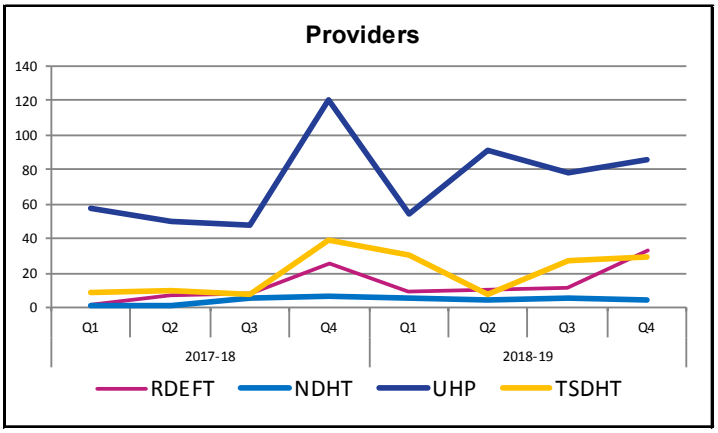
EMSA data continues to be provided on a monthly basis and only where there is a clear clinically justifiable need to do so, will the guidelines be breached. If a breach has occurred the providers EMSA local decision matrix is submitted for the CCG to review.

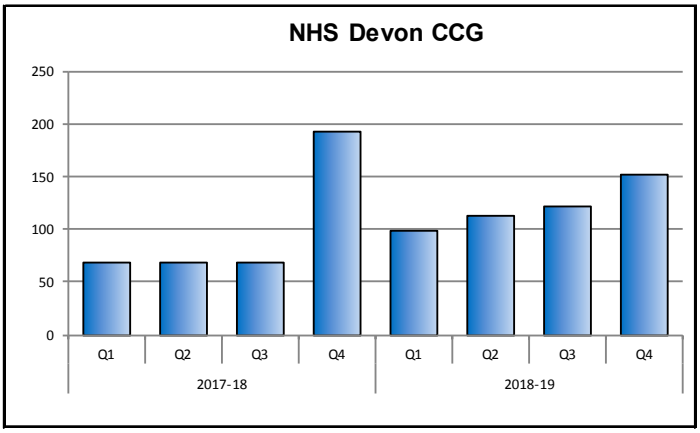
There have been no breaches reported in the previous month

Cancelled operations not treated with 28 days of cancellation

Trust	Target	Q4	2018/19
RDEFT	0	33	63
NDHT	0	4	18
UHP	0	86	309
TSDFT	0	29	94

CCG	Target	Q4	2018/19
NHS Devon	0	152	484





Performance Commentary

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

Quality Commentary and Improvement Actions

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

NHS Northern Eastern Western Devon

Summary

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

Direction of change arrows
- ↑ Increase
- ↓ Decrease
- \+ Equal
- X No data

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

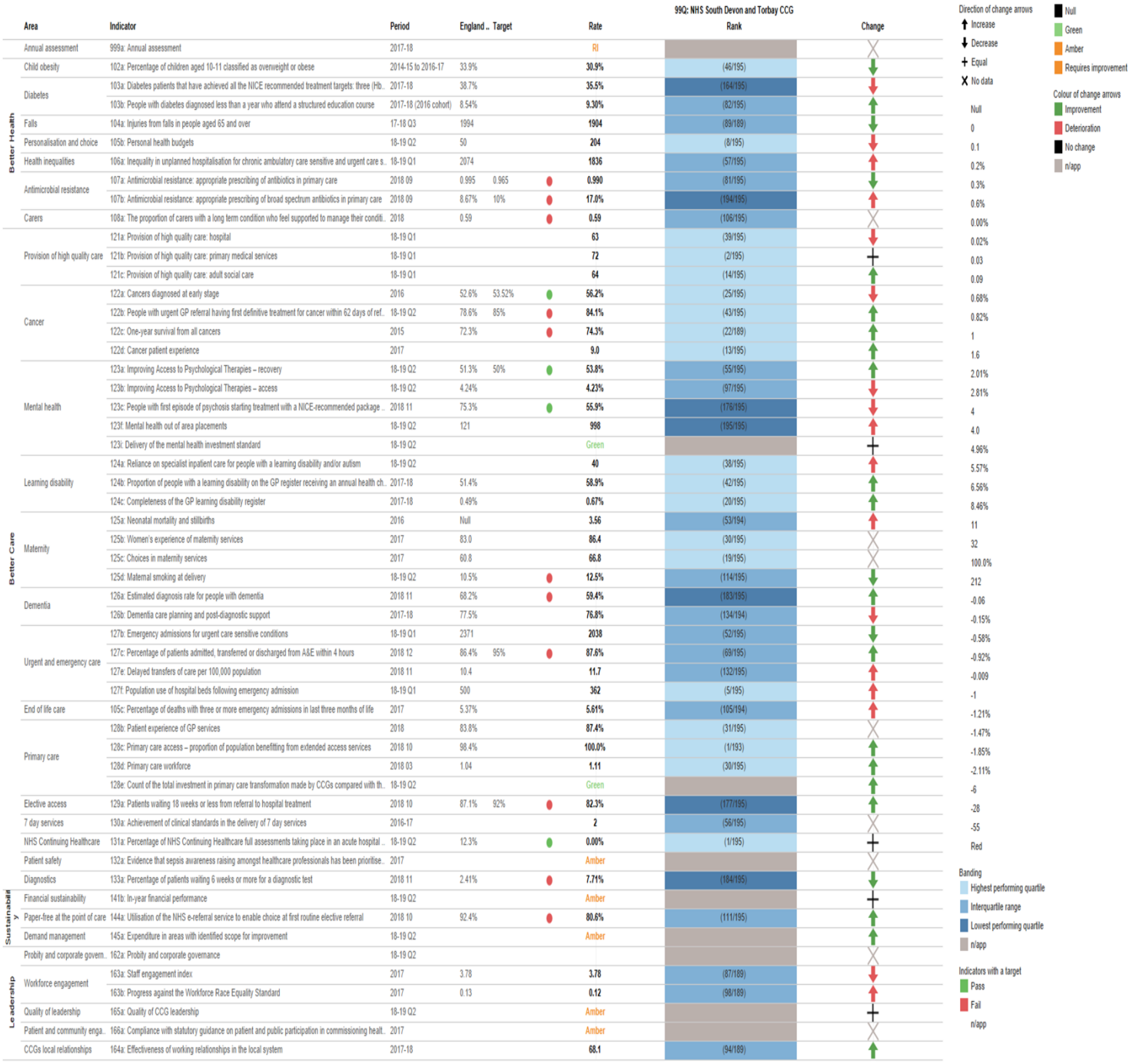
Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile
- n/app

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

- Null
- Green
- Amber
- Red
- Good

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

Summary



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

Appendix B. Key performance indicators – NHS Devon CCG

FIGURES FOR NORTHERN EASTERN WESTERN DEVON & NHS SOUTH DEVON AND TORBAY CLINICAL COMMISSIONING GROUP

PERFORMANCE MEASURES

INDICATOR	TARGET	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	2018/19 YTD
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	>=92%	80.9%	80.6%	80.5%	80.1%												80.1%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	391	339	188	179												179
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	<=1%	15.3%	11.9%	10.5%	12.0%												12.0%
Cancer - percentage seen within 2 weeks - urgent referral to first seen	>=93%	84.3%	87.7%	89.5%	78.8%												78.8%
Breast symptomatic- percentage seen within 2 weeks	>=93%	89.1%	80.0%	69.6%	50.2%												50.2%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	>=85%	68.4%	71.5%	72.4%	75.4%												75.4%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.4%	91.9%	91.4%	95.6%												95.6%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	86.1%	82.2%	85.4%	76.5%												76.5%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	94.5%	92.9%	92.3%	92.8%												92.8%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	88.6%	88.3%	87.7%	93.0%												93.0%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.7%	99.7%	100.0%	99.3%												99.3%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	93.2%	93.5%	87.1%	92.8%												92.8%
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	71.3%	73.7%	77.4%	72.0%	80.3%											75.4%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	>=95%	81.3%	82.9%	85.4%	82.1%	87.9%											84.5%
Ambulance Category 1 Mean response Duration (min)	7	6.8	7.3	7.0	6.9												6.9
Ambulance Category 1 90th response Duration (min)	15	12.0	13.1	12.3	13.1												13.1
Ambulance Category 2 Mean response Duration (min)	18	28.5	28.3	27.3	26.0												26.0
Ambulance Category 2 90th response Duration (min)	40	58.7	59.5	56.0	53.7												53.7
Ambulance Category 3 90th response Duration (min)	120	169.7	161.3	156.5	162.4												162.4
Ambulance Category 4 90th response Duration (min)	180	220.2	214.4	200.1	196.4												196.4
Cancelled Operations - Number of patients not treated within 28 days of cancellation	0			152													250
IAPT Percentage of people entering treatment against the level of need in the general population (Monthly Access rate)	1.25%	2%	1%	2%	0.7%												0.7%
IAPT recovery rate - percentage of people who are moving to recovery	50%	52.9%	54.1%	51.0%	49.8%												49.8%
IAPT - started treatment with 6 weeks of referral	75%	94.1%	92.3%	88.1%	80.7%												80.7%
Mental Health - Percentage of people on CPA who were followed up with in 7 days of discharge	95%	97.9%	86.4%	98.0%	94.3%												94.3%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	93.4%	93.5%	93.6%	91.5%												91.5%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	65.2%	48.1%	64.7%	40.9%												40.9%
Dementia diagnosis rate	62%	59.1%	58.9%	59.6%	59.5%	59.3%											59.4%

QUALITY MEASURES

INDICATOR	TARGET	Jan-18	Feb-18	Mar-18	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	2017/18 YTD
MRSA bacteraemia - number of hospital infections	0	0	0	1	0	1											1
Clostridium difficile - number of hospital infections	316	18	16	21	30	25											55
Mixed sex accommodation (MSA) - number of hospital breaches	0	1	1	2	5												5
Delayed transfers of care - patient delays as a percentage of occupied beds (Acute only)	3.5%	4.3%	3.8%	3.1%	3.3%												3.3%
Delayed transfers of care (all) - Percentage of delays per Occupied bed	3.5%	5.3%	4.9%	3.9%	4.2%												4.2%

Appendix C: Sustainability Transformation Plan (STP) Summary

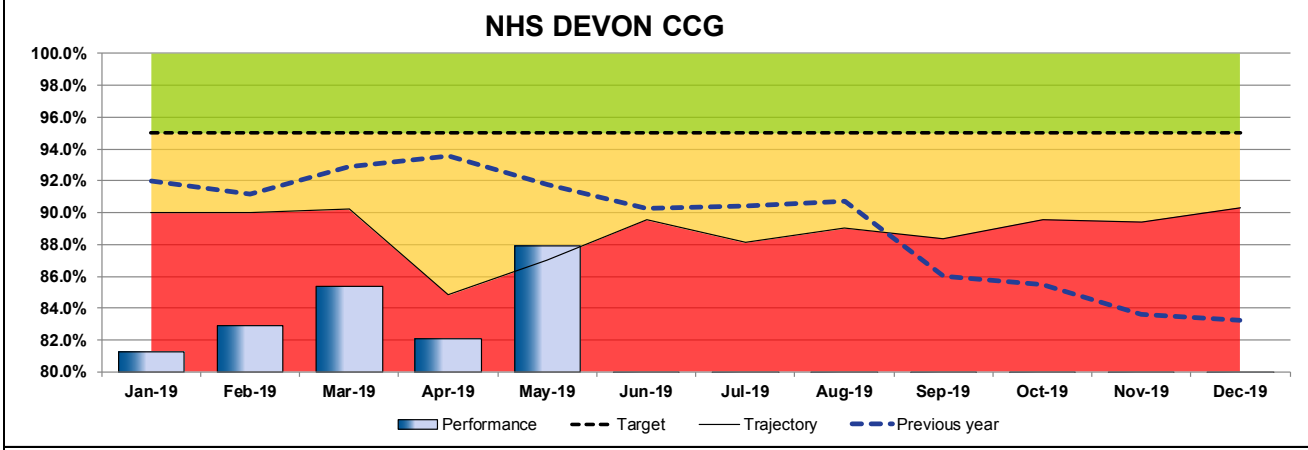
STP KPI Summary

INDICATOR	TARGET	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	ENGLAND March position	STP March Position
Referrl to treatment - Incomplete waits	78364	80,089	81,661	82,913	83,546												N/A	N/A
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	STP Trajectory	80.9%	80.6%	80.5%	80.1%												86.7%	43 / 44
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	391	339	188	179												N/A	N/A
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	STP Trajectory	15.3%	11.9%	10.5%	12.0%												2.5%	43 / 44
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	71.3%	73.7%	77.4%	72.0%	72.0%											81.5%	33 / 44
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	STP Trajectory	81.3%	82.9%	85.4%	82.1%	82.1%											88.0%	30 / 44
Accident and Emergency over 12 hour trolley waits	0	26	7	8	14	14											1 Average	5 / 44
Cancer - percentage seen within 2 weeks - urgent referral to first seen	STP Trajectory	84.3%	87.7%	89.5%	78.8%												91.8%	42 / 44
Breast Symptomatic - percentage seen within 2 weeks	>=93%	89.1%	80.0%	69.6%	50.2%												78.6%	21 / 44
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	STP Trajectory	68.4%	71.5%	72.4%	75.4%												79.7%	39 / 44
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.4%	91.9%	91.4%	95.6%												89.6%	14 / 44
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	86.1%	82.2%	85.4%	76.5%												84.9%	20 / 44
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	94.5%	92.9%	92.3%	92.8%												96.5%	29 / 44
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	88.6%	88.3%	87.7%	93.0%												92.3%	29 / 44
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.7%	99.7%	100.0%	99.3%												99.3%	11 / 44
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	93.2%	93.5%	87.1%	92.8%												97.0%	35 / 44
Cancelled Operations - Number of patients not treated within 28 days of cancellation (Acute only)	0																N/A	N/A
Cancelled Operations - Urgent Operations cancelled for a 2nd or more time	0	1															N/A	N/A
Delayed transfers of care - days delays as a percentage of occupied beds (Acute only)	3.5%	4.3%	3.8%	3.1%	3.3%												N/A	N/A
Delayed transfers of care - days delays as a percentage of occupied beds (Acute &community)	3.5%	5.3%	4.9%	3.9%	4.2%												N/A	N/A
Delayed transfers of care - days delays as a percentage of occupied beds (MH only)	7.5%	4.5%	4.6%	5.2%	5.1%												N/A	N/A
Category 1 Mean response Duration (min)	7	6.8	7.3	7.0	6.9												18	N/A
Category 1 90th response Duration (min)	15	12.0	13.1	12.3	13.1												31	N/A
Category 2 Mean response Duration (min)	18	28.5	28.3	27.3	26.0												22	N/A
Category 2 90th response Duration (min)	40	58.7	59.5	56.0	53.7												45	N/A
Category 3 90th response Duration (min)	120	169.7	161.3	156.5	162.4												148.50	N/A
Category 4 90th response Duration (min)	180	220.2	214.4	200.1	196.4												197.13	N/A
Hear & Treat	11%	12.5%	12.4%	11.4%	11.1%												N/A	N/A
Ambulance Incidents Resolved Without Conveyance to an Emergency Department	54.6%	52.1%	52.9%	52.0%	52.2%												N/A	N/A
Ambulance Handovers Taking Between 30 and 60 minutes	0	444	324	648	260												N/A	N/A
Ambulance Handovers Taking over 60 Min	0	32	19	17	21												N/A	N/A
Care Programme Approach (CPA) proportion of people under adult MH specialties on CPA followed up within 7 days of discharge from psychiatric in-patient care	95%	97.9%	86.4%	98.0%	94.3%												N/A	N/A
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	93.4%	93.5%	93.6%	91.5%												N/A	N/A
IAPT Percentage of people entering treatment against the level of need in the general population (Monthly Access rate)	1.25%	1.7%	1.3%	1.7%	0.7%												N/A	N/A
IAPT recovery rate - percentage of people who are moving to recovery	50%	52.9%	54.1%	51.0%	49.8%												N/A	N/A
IAPT - started treatment with 6 weeks of referral	75%	94.1%	92.3%	88.1%	80.7%												N/A	N/A
IAPT - started treatment with 18 weeks of referral	95%	100.0%	100.0%	99.8%													N/A	N/A
Dementia diagnosis rate	67%	59.1%	58.9%	59.6%	59.5%	59.3%											68.4%	40 / 44
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	65.2%	48.1%	64.7%	40.9%												76.8%	39 / 44
MRSA bacteraemia - number of hospital & community infections	0	0	0	1	0	1											N/A	N/A
Clostridium difficile - number of hospital & community infections	<=316	18	16	21	30	25											N/A	N/A
Mixed sex accommodation (MSA) - number of hospital breaches	0	1	1	2	5												N/A	N/A

4 hour waits A&E &MIU

NHS Devon CCG

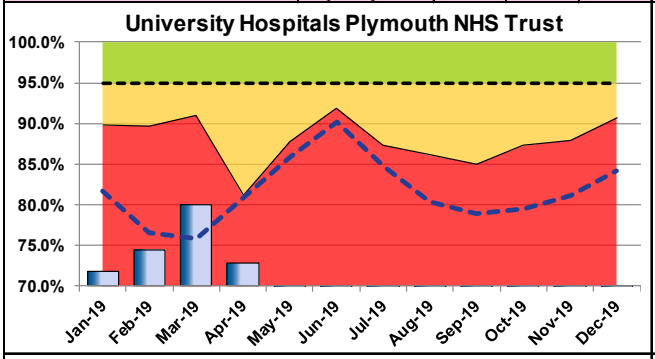
STP footprint	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>95%	81.3%	82.9%	85.4%	82.1%	87.9%							
Trajectory		90.0%	90.0%	90.2%	84.8%	87.0%	89.5%	88.1%	89.0%	88.4%	89.6%	89.4%	90.3%
NHS England		84.4%	84.2%	86.6%	85.1%	88.0%							

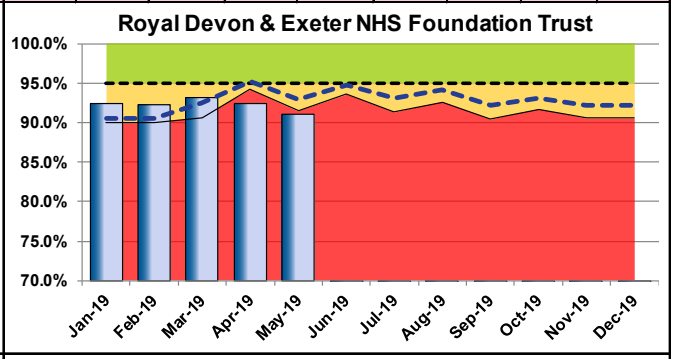


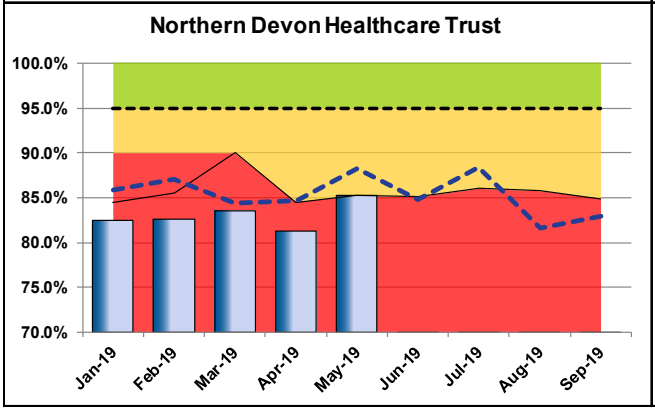
Comment:
In May the STP position was 87.9%, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. RD&E performance fell slightly from 92.4% to 91.1%, NDHT improved from 81.3% to 85.2% and TSD rose from 79.1% to 84.2%.
Provisional June performance shows NDHT and RD&E maintaining a similar position but TSD falling to 80%.

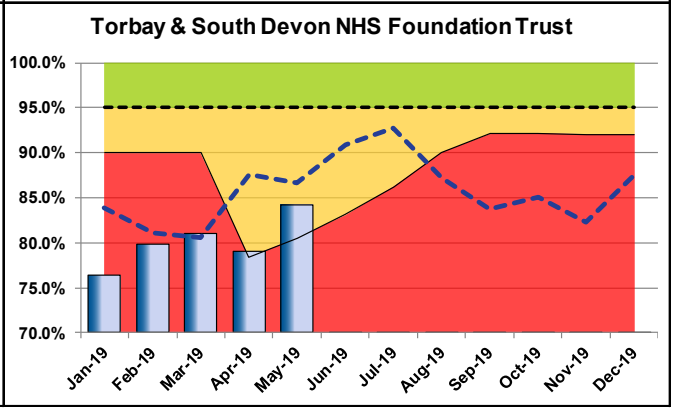
Provider level

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





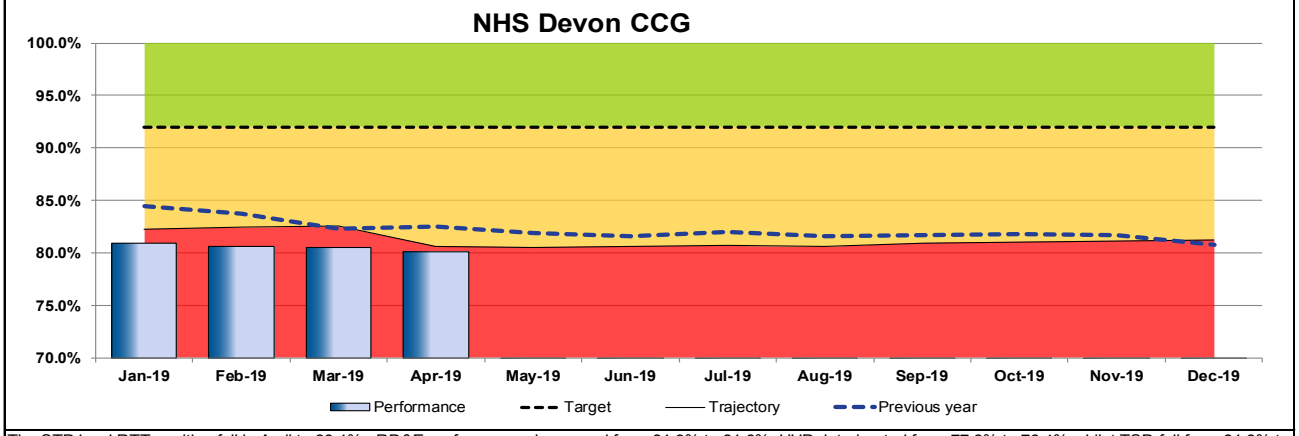




18-week RTT (incomplete pathway)

NHS Devon CCG

NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>92%	80.9%	80.6%	80.5%	80.1%								
Trajectory		82.3%	82.4%	82.5%	80.6%	80.6%	80.7%	80.7%	80.6%	80.9%	81.0%	81.2%	81.3%
NHS England		86.7%	87.0%	86.7%									
RTT total waiting list	78,364	80,089	81,661	82,913	83,546								
Trajectory		75,616	75,353	74,733	77,423	76,682	77,446	76,875	76,319	76,099	76,818	75,252	75,669

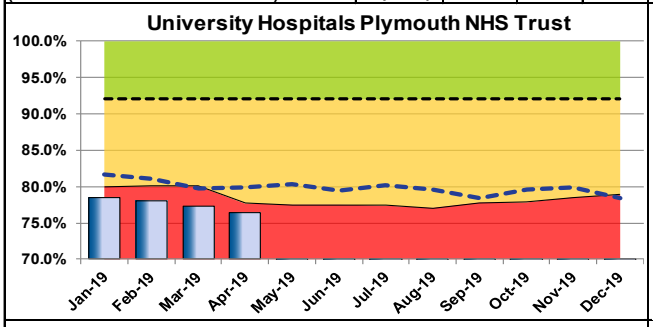


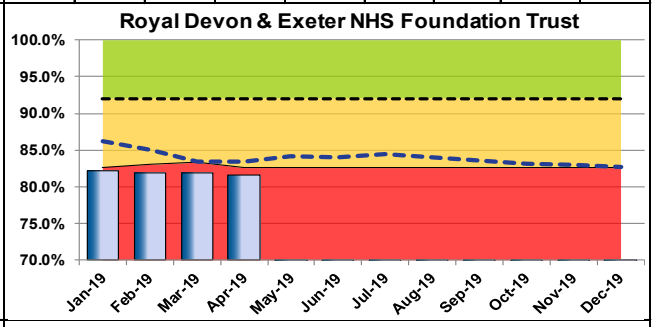
The STP level RTT position fell in April to 80.1%. RD&E performance decreased from 81.9% to 81.6%, UHP deteriorated from 77.3% to 76.4% whilst TSD fell from 81.3% to 80.8%, all below trajectory. NDHT saw performance slightly improve to 79.3%. The incomplete waiting list increased at RD&E but fell at other providers.

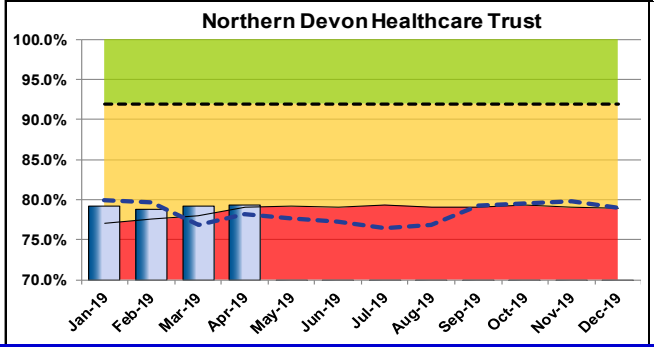
Over 52 week waits fell slightly in April moving from 188 to 179 at STP level. RD&E, UHP and NDHT remained relatively static with TSD seeing breaches fall from 79 to 71.

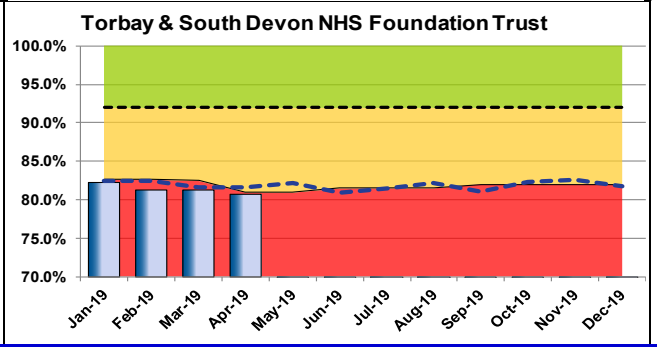
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	78.4%	78.0%	77.3%	76.4%								
	Trajectory	80.0%	80.0%	80.1%	77.7%	77.5%	77.5%	77.4%	77.0%	77.8%	77.9%	78.5%	78.9%
	Waiting list	27,356	27,872	27,922	28,195								
	Trajectory	25,772	25,725	26,347	28,351	28,476	28,496	28,533	28,730	28,354	28,277	27,927	27,703
RDEFT	Actual	82.2%	82.0%	81.9%	81.6%								
	Trajectory	82.7%	83.0%	83.3%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%
	Waiting list	33,386	33,770	34,262	35,417								
	Trajectory	30,783	30,496	30,178	34,555	33,783	34,857	34,374	33,707	33,992	35,016	33,628	34,374
NDHT	Actual	79.2%	78.9%	79.2%	79.3%								
	Trajectory	77.1%	77.6%	78.0%	79.1%	79.2%	79.1%	79.4%	79.1%	79.1%	79.3%	79.1%	78.9%
	Waiting list	11,790	11,633	11,520	11,390								
	Trajectory	13,439	13,299	13,101	11,797	11,665	11,564	11,396	11,313	11,194	11,044	10,960	10,863
TSDFT	Actual	82.2%	81.3%	81.3%	80.8%								
	Trajectory	82.7%	82.6%	82.5%	81.0%	81.0%	81.5%	81.5%	81.5%	82.0%	82.0%	82.0%	82.0%
	Waiting list	18,430	18,564	19,425	19,018								
	Trajectory	18,282	18,332	18,332	18,567	18,548	18,416	18,398	18,379	18,249	18,231	18,213	18,194
Other providers (NHS Devon CCG commissioned)	Actual	82.7%	82.2%	82.1%	81.7%								
	Trajectory	87.8%	87.9%	87.2%									





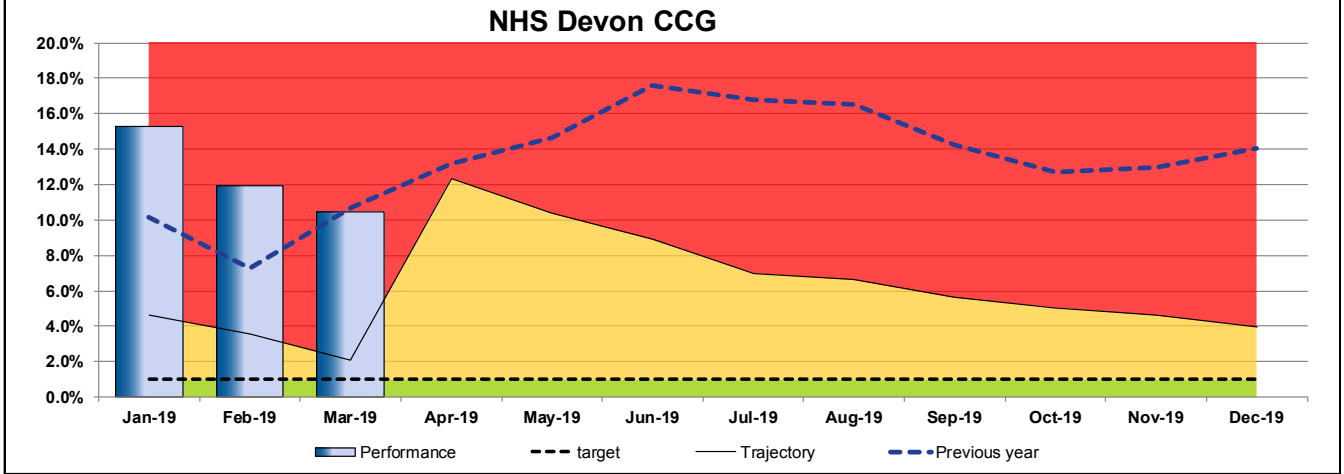




6 Week Diagnostics

NHS Devon CCG

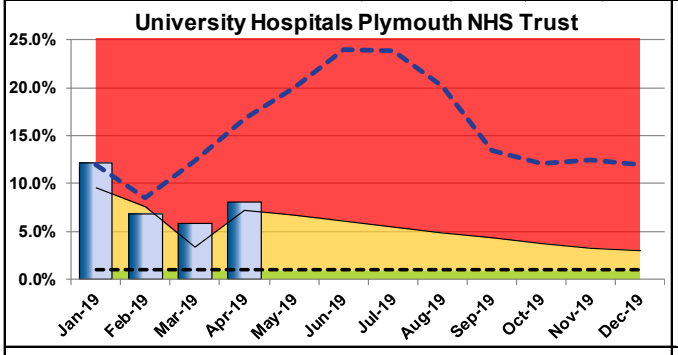
NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>1%	15.3%	11.9%	10.5%									
Trajectory		4.6%	3.6%	2.1%	12.4%	10.4%	8.9%	7.0%	6.6%	5.6%	5.0%	4.6%	4.0%
NHS England		3.6%	2.3%	2.5%									

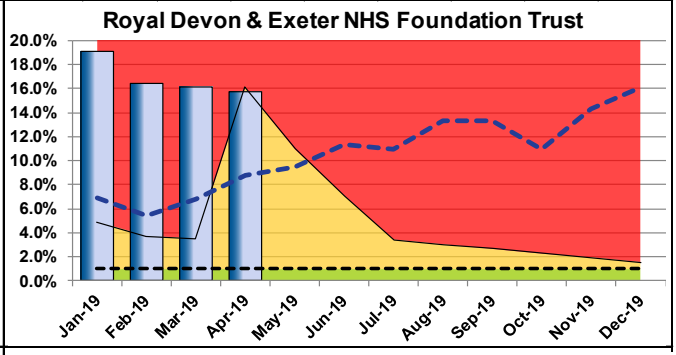


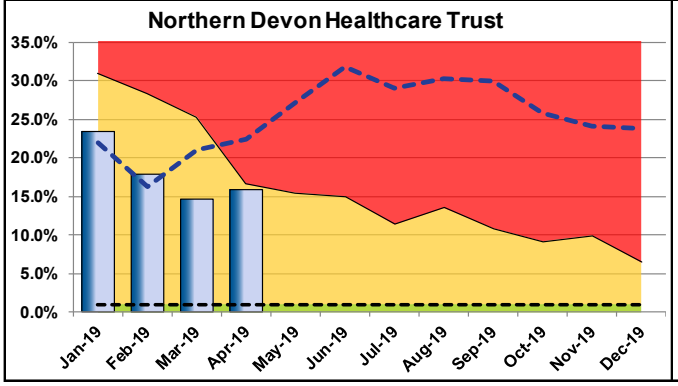
All providers except for RD&E saw increased breaches in April. UHP increased from 5.9% to 8.1%, NDHT rose from 14.6% to 15.9% and TSD performance decreased from 10.0% to 13.7%, although achieving trajectory. RD&E moved from 16.1% to 15.7%, also achieving April's trajectory. The majority of breaches continue to be for imaging and endoscopy.

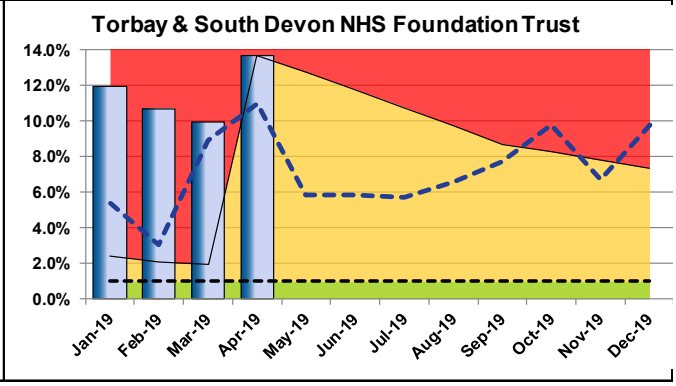
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	12.1%	6.8%	5.9%	8.1%								
	Trajectory	9.6%	7.5%	3.4%	7.2%	6.7%	6.1%	5.4%	4.9%	4.4%	3.8%	3.3%	3.0%
RDEFT	Actual	19.1%	16.4%	16.1%	15.7%								
	Trajectory	4.9%	3.7%	3.5%	16.1%	11.0%	7.1%	3.4%	3.0%	2.7%	2.3%	1.9%	1.6%
NDHT	Actual	23.3%	17.9%	14.6%	15.9%								
	Trajectory	30.9%	28.3%	25.3%	16.6%	15.5%	15.0%	11.4%	13.5%	10.8%	9.1%	9.9%	6.4%
TSDFT	Actual	12.0%	10.7%	10.0%	13.7%								
	Trajectory	2.4%	2.1%	1.9%	13.7%	12.7%	11.8%	10.8%	9.7%	8.7%	8.3%	7.8%	7.3%
Other providers (NHS Devon CCG commissioned)	Actual	6.7%	5.3%	5.9%									
	Trajectory	4.2%	3.5%	2.6%	5.1%	7.6%	9.6%	10.8%	7.5%	6.9%	6.4%	5.2%	6.9%





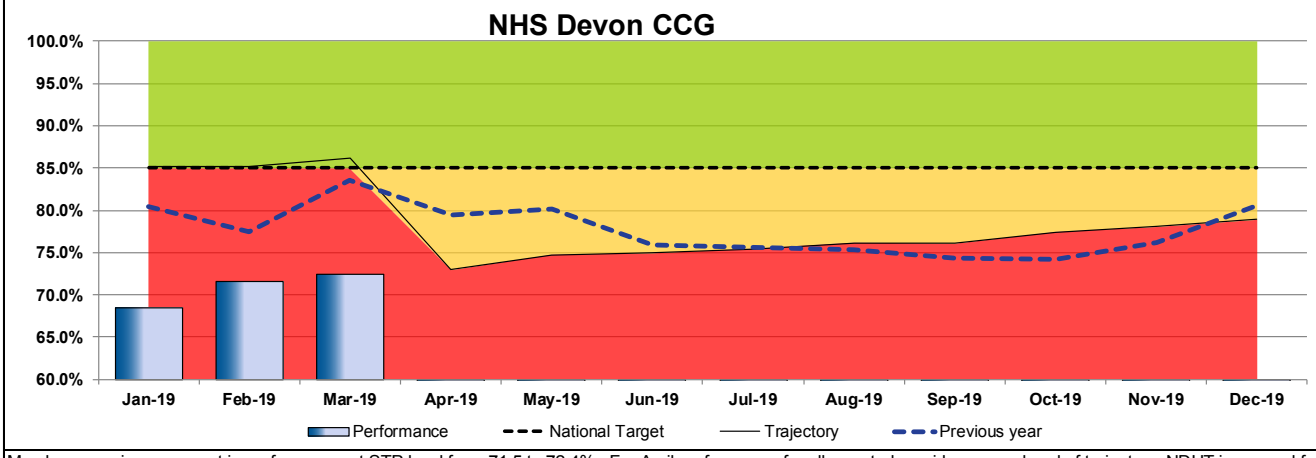




62 day standard Cancer waits

NHS Devon CCG

NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>85%	68.4%	71.5%	72.4%									
Trajectory		85.2%	85.2%	86.1%	73.0%	74.7%	74.9%	75.4%	76.1%	76.1%	77.4%	78.1%	78.9%
NHS England		76.2%	76.1%	79.7%									

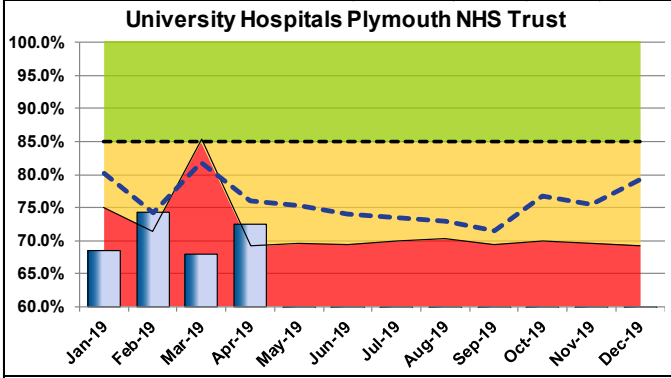


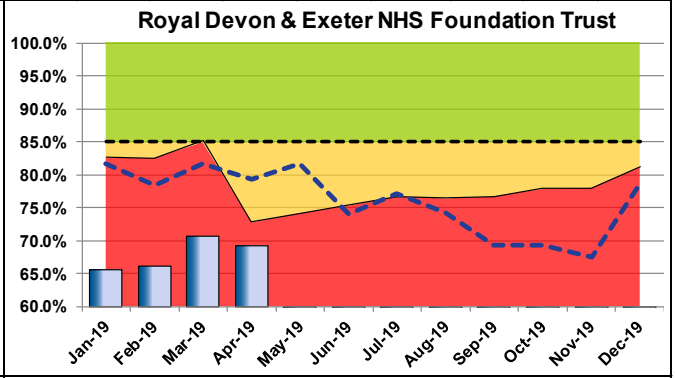
March saw an improvement in performance at STP level from 71.5 to 72.4%. For April performance for all reported providers was ahead of trajectory. NDHT increased from 78.4% to 80.5%, UHP improved from 68.0% to 73.0% and TSD performance also improved from 77.0% to 79.7%.

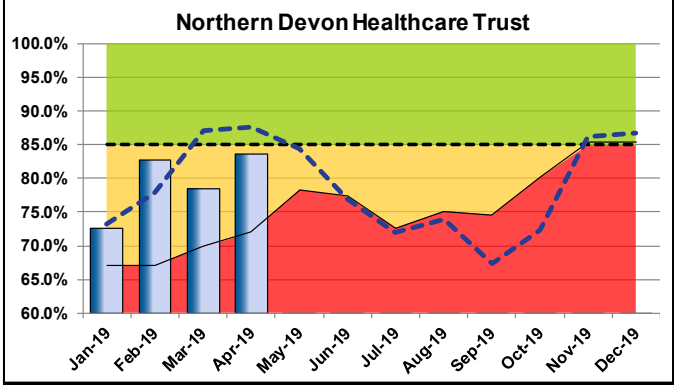
The April backlog position increased slightly at all providers except for TSD.

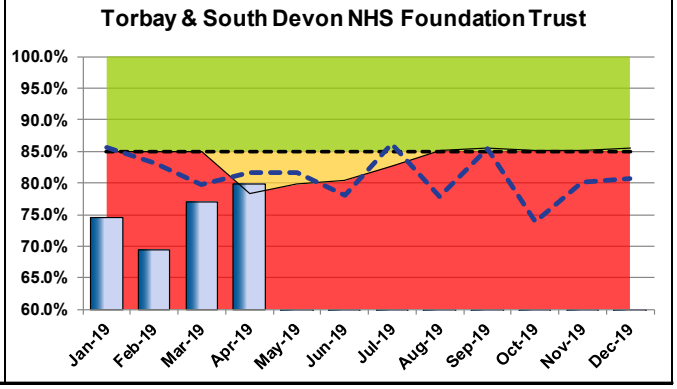
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	68.5%	74.3%	68.0%	72.6%								
	Trajectory	75.0%	71.4%	85.4%	69.2%	69.6%	69.4%	69.9%	70.2%	69.5%	70.0%	69.7%	69.2%
RDEFT	Actual	65.7%	66.1%	70.8%	69.3%								
	Trajectory	82.7%	82.6%	85.2%	72.8%	74.2%	75.4%	76.8%	76.5%	76.7%	77.9%	78.0%	81.2%
NDHT	Actual	72.6%	82.7%	78.4%	83.6%								
	Trajectory	67.0%	67.1%	69.9%	72.0%	78.3%	77.3%	72.6%	75.1%	74.6%	80.2%	85.4%	85.3%
TSDFT	Actual	74.5%	69.4%	77.0%	79.9%								
	Trajectory	85.0%	85.0%	85.0%	78.3%	79.8%	80.4%	82.8%	85.1%	85.5%	85.1%	85.1%	85.5%









NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Effectiveness report					
Date of committee: 27th June 2019 **Date report produced: 16th May 2019**					
Author (s) Name and Title: **Lauren Wellington, Compliance and Governance Officer** **Contact Details:** **laurenwellington1@nhs.net**			**Supporting Executive:** **Name and Title:** **Ginny Snaith, Board Secretary** **Contact Details: g.snaith@nhs.net** **Report Reviewed/ Approved by:** **Name and Title: Clare Doble, Head of Governance** **Date: 11 June 2019**		
Public or Private (Governing Body only):			**Public**		**Private** ✓
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): **This is an internal report to the Governing Body to detail the responses to the committee effectiveness survey recently completed by CCG Committee members.**					
Purpose and scope of report:	**Consultation**		**Approval** ✓		**Information**
Does this report place individuals at the centre?			**Yes** ✓		**No**

Executive Summary:

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 a time of significant change.

The purpose of this paper is to present the findings of the reviews of effectiveness of the CCG Committees which were undertaken during 2018/19 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:

Individual Committee Effectiveness reports have been presented to each Committee.

Key recommendations and actions requested:
Recommendation 1 – Development of a full CCG Committee and group structure diagram, to include all lower-level groups and their responsibilities. Additionally, a review of these responsibilities to be undertaken to ensure that all items presented to Committees are appropriate and could not be more suitably dealt with elsewhere. **Recommendation 2** – Approval of the Committee Effectiveness process outlined above, including the process for following up on recommendations made to Committees. **Recommendation 3** – A review of Committee objectives to ensure that they are adequate and suitable, as well as ascertaining that they are published and widely known by all Committee members and attendees. **Recommendation 4** – A suite of Standard Operating Procedures to be developed for Committees to include administration tasks such as minutes, action logs, forward planners etc. to aid with consistency across the CCG Committees. **Recommendation 5** – A review of the training offered to Committee members regarding the Committee's role and responsibilities to be undertaken. This will ensure that all members have the optimal level of knowledge and skills to wholly fulfil their role.
Reference to other documents or accompanying papers:
N/A
Have the legal implications been considered?
Yes
Equality Impact Assessment:

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

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

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

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

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

NHS
Devon
Clinical Commissioning Group

CCG Committee Effectiveness Report
April 2018 – March 2019

1. Introduction

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 This report outlines the committee effectiveness of the committees of the Governing Body meetings in common 2018/19 in accordance with the constitutions for two CCGs at that time. The below table shows the Committees of the CCG prior to and following the merger of Northern, Eastern & Western Devon CCG and South Devon & Torbay CCG into the current Devon CCG.

2018/19 Prior to Merger	2019/20 Post Merger
Governing Bodies in Common	Governing Body
Audit Committees in Common	Audit Committee
Primary Care Committees in Common	Primary Care Commissioning Committee
Remuneration Committees in Common	Remuneration Committee
Strategic Leadership Committee (SLC)	Integrated Commissioning Executive - this committee includes Executives from the CCG, providers and local authorities
Quality Committees in Common	Quality Assurance Committee
Finance Committees in Common	Finance & Performance Committee
Engagement Committees in Common	No equivalent
Northern Locality Board Eastern Locality Board Western Locality Board	These have been replaced by integrated groups consisting of the CCG, providers and local authorities for each locality

1.3 Effectiveness reviews were undertaken for all committees except the Engagement Committees in Common. The rationale for not including the Engagement committees in common were that they were not continuing after the merging of the two Devon CCGs on 1st April 2019, it was agreed with the Committee Chairs that a review was not necessary.

1.4 Due to the changes in Committees following the merger, these terms of references for these Committees have been updated and were approved as part of the NHS Devon Constitution and the Governance Handbook at 25th April 2019 Governing Body meeting.

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:

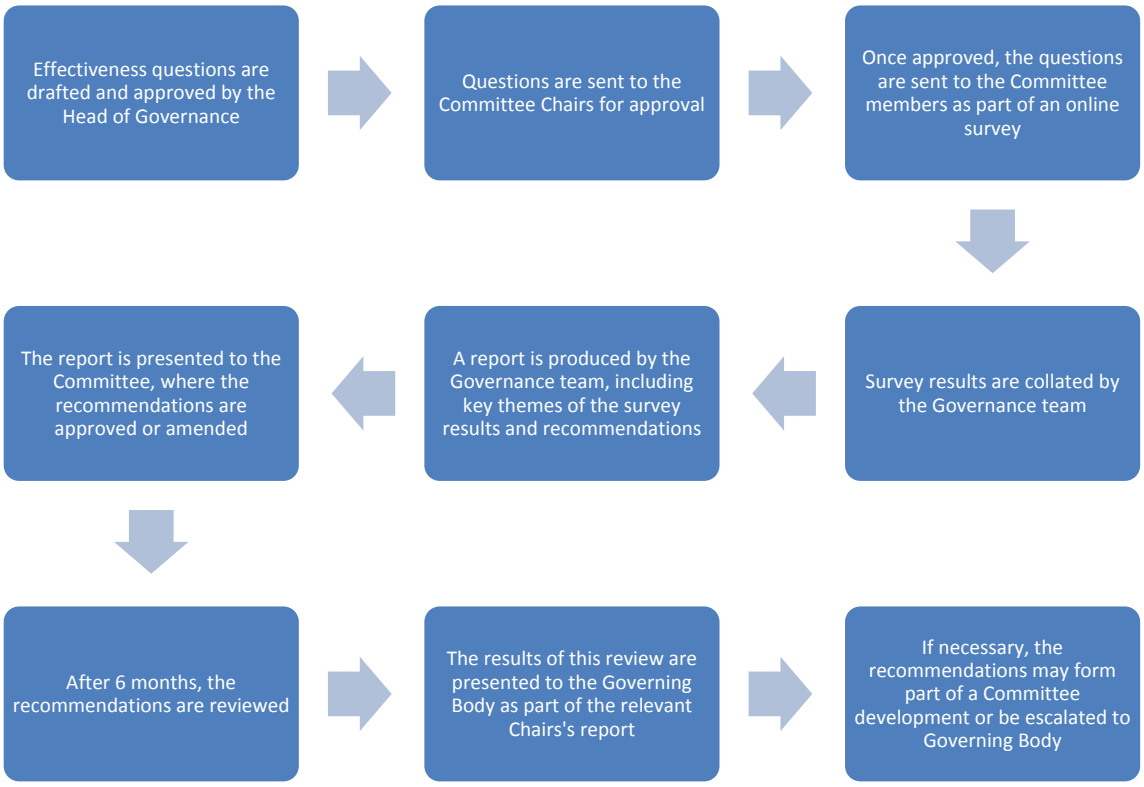
- The need for committees to be clear about their roles in strengthening the governance arrangements of the CCG and support the Governing Bodies in the achievement of their CCG's strategic objectives, as well as acknowledging their own committee objectives outlined in the terms of reference;
- The requirement for a committee structure that strengthens the role of the Governing Bodies in strategic decision making and supports the role of 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 Bodies in fulfilling their roles, given the nature and content of the committee's agenda.

2.2 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. The reviews have been broken down into the following subsections, known as themes:

- Committee focus and responsibilities
- Committee effectiveness
- Committee engagement
- Membership and Behaviours
- Reporting arrangement and papers

2.3 The purpose of this paper is to present the findings of the reviews of effectiveness of the CCG Committees during 2018/19 which were undertaken using an electronic questionnaire, and to summarise the effectiveness review process.

2.4 The Committee Effectiveness review process is outlined below:



3. Key Findings

3.1 The effectiveness reviews were issued to all CCG Committee members and 393 total responses for all committees were received.

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 – Committee focus and responsibilities

- There was some disagreement that all committees have set themselves a series of objectives they want to achieve. In particular, a lack of clarity regarding objectives was noted by members of the Finance Committees, Remuneration Committees and Locality Boards. One Committee member noted that Committee objectives were not recorded in the terms of reference and that this may be beneficial. It was noted by several members that the margining of the organisation led to a lack of clarity and less time to develop Committee direction.
- The majority of respondents agreed that their Committee was discussing the right topics.
- There was some disagreement from Committee members regarding whether their Committee was strategic enough. It was noted by members of several committees that their Committee was discussing matters which would have been better devolved to lower-level groups or senior managers and that this would free up time to discuss more strategic matters.

Theme 2 – Committee Effectiveness

- There was some disagreement regarding whether sufficient time is given to each agenda item, and the outcome made clear. It was noted, in Strategic Leadership Committee, Quality Committees, Remuneration Committees and Primary Care Committees in particular, that this is not always sufficiently clear, particularly the ownership of an action and sometimes the agenda is too long or rushed, causing problems with time running over.
- There was some disagreement regarding the level of information the committees would like to receive for each of the items on their cycle of business. However, it was noted that some areas of activity are still in development due to the transition to a single Devon CCG and regular reviews to ensure information is fit for purpose should be undertaken.

Theme 3 – Committee Engagement

- It was agreed that during committee meetings, members are listened to and able to contribute to the range of issues discussed. The majority of the comments regarding this were positive and highlighted positive Committee leadership from the Chairs**.** However, it was also commented that timing issues such as overlong presentations can result in members not feeling able to seek clarification or ask necessary questions.
- It was also agreed that members are able to provide real and genuine challenge - rather than just seeking clarification and/or reassurance. One Committee member stated that this is now a much stronger feature of current meetings. Similarly, it was stated that this had improved recently and there seems to be a developing trust between the members to facilitate a more robustly analytical culture. However, another noted that this is sometimes not explored enough.
- The majority of respondents felt that they could meaningfully contribute to committee discussions.

Theme 4 – Membership and Behaviours

- The majority of respondents stated that they had attended the required number of meetings.
- It was agreed that Committee members declare any interests at the beginning of the meeting or where an agenda item may require declaration. The scores in this area were particularly positive.

Theme 5 – Reporting arrangements and papers

- There was some disagreement regarding the committee papers with members or several committees, including Quality Committees, Remuneration Committees and SLC, noting that the papers are too lengthy and that there is too much duplication.
- Similarly, further respondents noted that the papers have been variable in terms of style and content and some authors appear to be less clear about the reason for presenting the item to the Committees and the actions or recommendations that are requested of them.

3.4 Additional comments from Committee members to note are summarised below:

Committee	Comments
Governing Body	Only bring items that need clarification, direction or signing off. If the Executive committees have no concerns - trust them.

	Ensure there is enough GB development in the new organisation to allow the GB to make good decisions
Audit	There is some duplication, where possible, this should be reduced.
	Reduction of the length of papers would be beneficial
	The role of the Audit Committee may need to be reviewed in light of the new governance arrangements.
	An operational development piece may be necessary to aid understanding of how the Audit Committee functions.
Finance	The Committee should link the agenda to the Strategic Objectives and Assurance Framework.
Primary Care	Provider representation would be useful in a different model of meeting
	The Committee needs to ensure there is effective patient representation
	System information should be presented to the committee routinely for context
	Greater emphasis on whole system working would be beneficial in future to help inform decisions that impact on the development of ICM at local levels
Remuneration	Greater clarity on the time allocated for individual items would be beneficial
	Greater notice and for papers to be circulated earlier would be helpful
	A work programme/plan of issues for the meetings in the coming year would be advantageous
	More emphasis on reviewing outcomes
Strategic Leadership Committee	To reduce paper size and to be clear of areas of accountability
	To gain clarity on the Committee's role - CCG business or strategic commissioning in partnership.
	Empowering greater levels of decision making at the appropriate place through accountability and decision-making frameworks.
Quality	The principle of exception reporting should ensure members of the Committee have time to challenge & consider in order to ascertain their level of assurance.
	Greater focus on the breadth of the CCG for assurance not solely the quality team.
	Shorter papers with clear recommendations and points for action. Each paper to be clearly highlighted as being for information/decision etc.
	Actions could be more Specific, Measurable, Assignable, Realistic and Timely.
	Items from other Committees need to provide information ahead of the meeting so the committee can consider the quality impacts.
	Be clear about expectations from authors of reports in order to obtain assurance
	There should be a clear assumption that all papers have been pre-read and do not need to be presented in detail.

4. Recommendations

4.1 The Governing Body is requested to note the following:

- The feedback from Committee members was in the main very positive
- The response to the surveys included 393 replies across all committees. However, it is difficult to ascertain how representative this is of Committee membership as there will be several members who have completed surveys for multiple Committees. Furthermore, the level of participation differed significantly between Committees as well as between individuals.

<u>Recommendation 1</u> – Development of a full CCG Committee and group structure diagram, to include all lower-level groups and their responsibilities. Additionally, a

review of these responsibilities to be undertaken to ensure that all items presented to Committees are appropriate and could not be more suitably dealt with elsewhere.

<u>Recommendation 2</u> – Approval of the Committee Effectiveness process outlined above, including the process for following up on recommendations made to Committees.

<u>Recommendation 3</u> – A review of Committee objectives to ensure that they are adequate and suitable, as well as ascertaining that they are published and widely known by all Committee members and attendees.

<u>Recommendation 4</u> – A Standard Operating Procedure to be developed for Committees to include administration tasks such as minutes, action logs, forward planners etc. to aid with consistency across the CCG Committees.

<u>Recommendation 5</u> – A review of the training offered to Committee members regarding the Committee's role and responsibilities to be undertaken. This will ensure that all members have the optimal level of knowledge and skills to wholly fulfil their role.

<u>Recommendation 6</u> – A review of Committee Effectiveness recommendations to be undertaken by each Committee, with progress and feedback to be presented to Governing Body by October as part of the relevant Committee Chair's report.

The Governing Body is asked to note the results of the reviews and that relevant actions included will be taken forward. The next effectiveness review of the governing body will be undertaken in January 2020 ahead of the annual report co-ordination in March 2020.

Report author and job title: Lauren Wellington, Compliance and Governance Officer

Executive Lead: Ginny Snaith

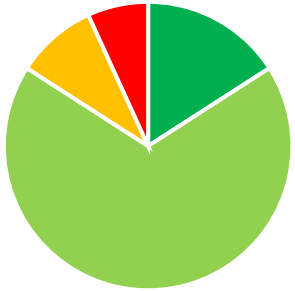
Job Title: Board Secretary

Q1	The committee has set itself a series of objectives it wants to achieve this year
Q2	The committee has made a conscious decision about the level of information it would like to receive for each of the items on its cycle of business.
Q3	The Committee papers are of a good standard and received in good time for meetings
Q4	Committee members declare any interests at the beginning of the meeting or where an agenda item may require declaration
Q5	During Committee meetings, members are listened to and able to contribute to the range of issues discussed.
Q6	Members are able to provide real and genuine challenge - rather than just seeking clarification and/or reassurance.
Q7	Sufficient time is given to each agenda item, and the outcome made clear: who is doing what, when and how etc., and how it is being monitored?

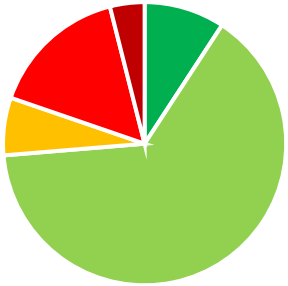
	Q1	Q2	Q3	Q4	Q5	Q6	Q7
Strongly Agree	6	7	7	31	27	19	10
Agree	19	30	49	3	33	40	39
Neither Agree nor Disagree	12	4	5	1	4	6	10
Disagree	7	3	12	0	0	0	6
Strongly Disagree	0	0	3	0	0	0	0

Q1

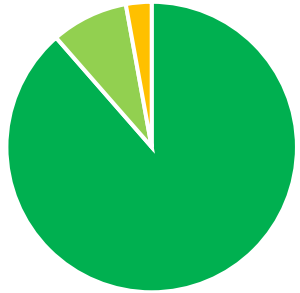
Q2



Q3



Q4



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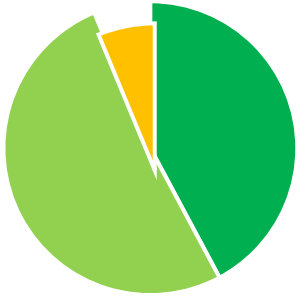
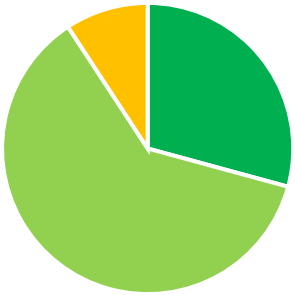
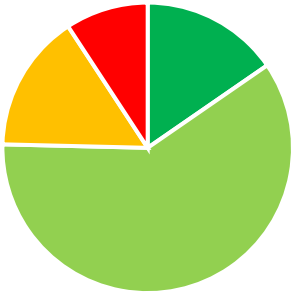


Q6



Q7



GOVERNING BODY

Report title: Approval Emergency Preparedness, Resilience and Response Policy					
Date of committee: 27 June 2019 **Date report produced:** 17 June 2019					
Author (s) Name and Title: Phil Coutie, EPRR Lead Clare Doble, Head of Governance **Contact Details:** 07814 229056 / Philip.coutie@nhs.net Clare.doble@nhs.net			**Supporting Executive:** **Name and Title:** Sonja Manton, Accountable Emergency Officer EPRR **Contact Details:** Sonja.manton@nhs.net **Report Approved by:** **Name and Title:** Ginny Snaith, Board Secretary **Date**		
Public or Private (Governing Body only):			**Public**	**X**	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A					
Purpose and scope of report:	**Consultation**		**Approval**	**X**	**Information**
Does this report place individuals at the centre?			**Yes**	X	**No**

Executive Summary:

The attached report describes the CCGs' Emergency Planning, Response and Resilience Management and is being presented as assurance that the CCG has in place a robust provision in the event of an EPRR emergency.

1.1 All NHS organisations have a responsibility to prepare for, and respond to, emergency incidents and other disruptive events that impact upon their community or their service delivery.

1.2 NHS Devon Clinical Commissioning Group (CCG) has a leadership role both in ensuring that the delivery of essential healthcare to the community is maintained and in support of NHS England, leading the local health response to emergencies that affect our communities.

1.3 By implementing this policy, the CCG will integrate its response into the wider NHS response to emergencies in the community; it will also enable the CCG to maintain its critical functions, despite disruption affecting its services.

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

Management of Conflict of interests:
Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations

must be fully recorded and included in the minutes of the meeting and notified to your own organisation via either
d-ccg.Governance@nhs.net to update the central register.

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

N/A

Key recommendations and actions requested:

The Governing Body is asked to approve this policy which sets out how NHS Devon Clinical Commissioning Group (CCG) will ensure that it meets its Emergency Preparedness, Resilience and Response (EPRR) responsibilities, as required by statute and national policy.

Reference to other documents or accompanying papers:

None

Have the legal implications been considered?

The CCGs' EPRR plans are required by statute (the Civil Contingencies Act 2004), national policy (the NHS England EPRR Framework) which requires compliance with the 2018 NHS England Core Standards for EPRR - a contractual requirement for all NHS organisations, and by the NHS Standard Contract.

Equality Impact Assessment:

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

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

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

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

NHS
Devon
Clinical Commissioning Group

Emergency Preparedness, Resilience & Response Policy

NHS Devon

Clinical Commissioning Group

Owner(s): *Phil Coutie, EPRR Lead* *Clare Doble, Head of Governance*	Contact Details: philip.coutie@nhs.net clare.doble@nhs.net	
Review by: Clare Doble, Head of Governance Approved by: Sonja Manton, AEO and Ginny Snaith, Board Secretary	Date of formal approval **dd/mm/yyyy*	Review Date: *July 2021*
Date Issued: **17 June 2019 for consideration of approval by the Governing Body*		Version *0.1*

Document Change History:		
Version	**Date**	**Comments (i.e. reviewed/amended/approved)**
0.1 DRAFT	June 2019	New EPRR Policy for NHS Devon CCG, replacing predecessor policies and frameworks

Equality, diversity and inclusion statement

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

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

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

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

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

1. Introduction

1.1 All NHS organisations have a responsibility to prepare for, and respond to, emergency incidents and other disruptive events that impact upon their community or their service delivery.

1.2 NHS Devon Clinical Commissioning Group (CCG) has a leadership role both in ensuring that the delivery of essential healthcare to the community is maintained and in support of NHS England, leading the local health response to emergencies that affect our communities.

1.3 By implementing this policy, the CCG will integrate its response into the wider NHS response to emergencies in the community; it will also enable the CCG to maintain its critical functions, despite disruption affecting its services.

2. Purpose

2.1. This Policy sets out how NHS Devon Clinical Commissioning Group (CCG) will ensure that it meets its Emergency Preparedness, Resilience and Response (EPRR) responsibilities, as required by statute and national policy.

3. Definitions

3.1. As a discipline, EPRR has its own terminology which is used by all NHS emergency response organisations. The table below sets out the definitions of those terms which are used in this document.

Term	Definition
AEO	Accountable Emergency Officer – an Executive Director with responsibility for discharging the organisation's EPRR duties under the NHS Act 2006, Section 252A
BCMS	Business Continuity Management System – the system through which business continuity preparedness will be managed
BCP	Business Continuity Plan – a plan for how the response to a disruptive incident will be managed, ensuring that the organisation's critical functions are maintained or swiftly re-established
CRR	Community Risk Register – a risk assessment of the hazards and threats faced by the local area, undertaken by LRF participants based upon historical evidence and the advice of national experts.
EPRR	Emergency Preparedness, Resilience and Response – this is the nationally used NHS term for what was previously known as Emergency Planning

Term	Definition
LHRG	Local Health Resilience Group – an EPRR practitioner group responsible for implementing the strategic direction set out by the LHRP.
LHRP	Local Health Resilience Partnership – a national policy mandated group of NHS Accountable Emergency Officers from all NHS organisations in Devon, Cornwall and the Isles of Scilly (DCIoS), who provide an integrated strategic direction to the EPRR work undertaken by their constituent organisations.
Loggist	An individual trained to record decisions in a manner that promotes the credibility and defensibility of the Incident Log in which the organisation's incident response decisions are written
LRF	Local Resilience Forum – a statutory process under the Civil Contingencies Act 2004, whereby emergency responding organisations co-operate and co-ordinate their emergency planning to promote an integrated emergency response – chaired by the Police and based upon Police Force boundaries. Divided into an Exec group – Chief Officers Group (COG) and an EPRR practitioners' group – Monthly on Thursday (MoT)

4. Legislation & Policy

4.1. As an NHS organisation, the CCG is subject to certain pieces of legislation and national policy that govern the EPRR landscape; these are set out below.

Legislation

- NHS Act 2006, Sections 252A & 253 (as amended by the Health & Social Care Act 2012)
- Civil Contingencies Act 2004
- Health and Social Care Act 2012

Policy

- NHS England EPRR Framework 2015
- NHS England Business Continuity Management Framework (Service Resilience) 2013
- NHS England Core Standards for EPRR

5. Roles and Responsibilities

Accountable Officer

5.1. The Accountable Officer (AO) is accountable for the preparedness of the CCG and for its response to emergency incidents and other disruptive events; this may be delegated to another Executive Director in the role of Accountable Emergency Officer.

Accountable Emergency Officer

5.2. The Accountable Emergency Officer (AEO) is an Executive Director to whom the AO has delegated the executive responsibility for the CCG's EPRR obligations. The managerial oversight of the EPRR function is delegated to the Head of Governance.

Non-Executive Director

5.3. NHS England Core Standards for EPRR states that a Non-Executive Director should be appointed to support the AEO in their role; this role is that of a 'critical friend' on the Governing Body.

Head of Governance

5.4. The Head of Governance has had the managerial oversight of the EPRR function delegated to them and is responsible for ensuring that the CCG's operational requirements in respect of EPRR are delivered to an acceptable standard. The line management of the EPRR Lead sits with the Head of Governance.

EPRR Lead

5.5. The EPRR Lead is responsible for the day-to-day delivery of the EPRR function, ensuring that the CCG meets its statutory and other obligations in line with the NHS England Core Standards for EPRR.

5.6. The delivery of this function will require the post-holder to undertake the annual EPRR Assurance process on behalf of the CCG, liaising with provider EPRR Leads and NHS England EPRR Team as necessary to delivering this.

5.7. The primary functions of the role are to:

- develop and maintain emergency plans;
- develop and support business continuity preparedness within the CCG;
- maintain and support the 24/7 Director On-call system;
- develop and arrange/ deliver the training necessary for key staff to enable preparedness;
- develop and arrange/ deliver exercises to validate emergency and business continuity plans;
- liaise with Health and multi-agency partners, as necessary, in the pursuit of the above;
- prepare and provide evidence in support of the CCG submission for the annual EPRR Assurance;
- undertake the annual EPRR Assurance of Devon Providers as part of the national process.

On-call Staff

5.8. On-call staff are responsible for leading the CCG in response to any emergency incident or disruptive event that occurs during their period of on-call duty. They have the delegated

authority to commit and direct CCG resources in support of the Health response to an incident, as they deem it necessary and appropriate.

5.9. If requested, during an emergency in the community, On-call staff will support NHS England by attending a multi-agency Tactical Co-ordinating Group in order to represent the local Healthcare system and provide leadership to Providers responding at that level.

5.10. On-call staff are to be available and contactable 24/7 for the duration of their period of duty.

5.11. On-call staff are required to ensure their preparedness and familiarity with the role by committing themselves to:

- On-call Induction training prior to commencement of on-call duties;
- Annual On-call Refresher training;
- Strategic Leadership Training, with a refresher undertaken at least every three years;
- Other training identified as necessary for undertaking the On-call role;
- Participation in internal CCG, external Health and Multi-Agency emergency preparedness exercises, to validate their training and the CCG's plans.

Business Continuity Leads

5.12. Each Directorate is required to nominate a Business Continuity (BC) Lead who will lead on their business continuity preparedness and, with training and direction from the EPRR Lead, develop their Directorate Business Continuity Plan.

5.13. Directorate BC Leads will have the necessary seniority and knowledge of their Directorate to be able to complete the Business Continuity Plan (BCP) template sufficiently well for it to provide a robust basis for a response to a disruptive event.

Loggists

5.14. The Loggist role is recognised in national policy as being necessary to ensure that decisions made during emergency incident responses are recorded in a sufficiently robust manner, that the Incident Log itself will be defensible in a court or Public Inquiry.

5.15. Sufficient Loggists will be trained to enable On-call staff to be supported by them in the fulfilment of their duties, and a list of loggists maintained by the EPRR Lead.

5.16. On-call staff will be briefed on the role of the Loggist in order to understand their importance to them and the CCG, and how best to work with them.

6. Governance

6.1. In order that EPRR plans and policies are properly scrutinised and authorised, they will undergo the following sign off steps:

- Initial approval by the Accountable Emergency Officer
- Approval by the Policy Review Group
- Assurance received by the Audit and Assurance Committee
- Sign off by the Governing Body to fulfil statutory responsibility.

7. Resources

7.1. The Governing Body will ensure that sufficient resource is provided to fulfil the EPRR function, in order that the CCG may effectively fulfil its obligations under statute and national policy.

8. On-call System

8.1. The On-call system will comprise a single tier Director on-call rota, staffed by Executive Directors and senior managers.

8.2. On-call staff will participate in an On-call rota that allocates them to duty periods that are primarily a period of seven days, starting at 09:00 hours on a Tuesday and finishing at 09:00 hours the following Tuesday. The on-call period is 24/7 duty.

8.3. On-call staff will be activated via a single point of contact telephone number which will enable partners and staff to contact whoever is on-call at the time they dial the number.

8.4. On-call staff will be supported by an On-call pack prepared and maintained by the EPRR Lead.

8.5. On-call staff may swap duty periods by the method of finding another rota participant to cover their duty period and the notifying the EPRR Lead of the change; the EPRR Lead or nominated administrative support will then amend the on-call rota.

9. Emergency Plans

9.1. As required by the NHS England Core Standards for EPRR, the CCG will develop and exercise a suite of emergency plans. The plans that are required will provide for a response to (this list is not exhaustive):

- Emergency incidents
- Severe Weather
- Fuel disruption

- Pandemic Influenza
- Communicable Disease
- Mass Casualty

Risk Assessment

9.2. The CCG's suite of emergency plans will be based upon assessed risk. This risk assessment will take into consideration the assessment of risks undertaken by the Local Resilience Forum (LRF) and published in the Community Risk Register (CRR); it will also take into consideration any risk assessment undertaken by the Local Health Resilience Partnership (LHRP).

9.3. The risk assessment will be undertaken by the EPRR Lead and, where a risk is identified as High or Very High, consideration must be given to escalating it onto the CCG Corporate Risk Register.

9.4. Where a High or Very High risk is mitigated or prepared for by an emergency plan and training, consideration should be given to whether the residual risk is accepted (thereby not requiring addition to the CCG Corporate Risk Register) or not (requiring addition to the CCG Corporate Risk Register and further action being required). The decision to accept the residual risk and not add it to the CCG Corporate Risk Register must be justified in writing by the EPRR Lead and signed off by the AEO.

10. Business Continuity Management System

10.1. In order to be able to maintain its critical business functions, the CCG will put in place a Business Continuity Management System (BCMS). This BCMS will be developed and maintained by the EPRR Lead, supported by Directorate BC Leads.

10.2. The BCMS will comprise the following elements:
- CCG Business Continuity Policy and Plan – maintained by the EPRR Lead
- Directorate Business Continuity Plans – maintained by Directorate Business Continuity Leads

10.3. The CCG BCMS will be aligned with ISO 22301 'Societal Security – Business Continuity Management Systems – Requirements'.

11. Participation in Health and Multi-Agency EPRR Structures

Local Health Resilience Partnership

11.1. The Local Health Resilience Partnership (LHRP) for Devon, Cornwall and the Isles of Scilly (DCIoS) provides the strategic direction for Health EPRR work within its area.

11.2. It is an Executive level group attended by AEOs from all CCGs and Providers, co-chaired by an NHS England Director and a lead local Director of Public Health.

11.3. The CCG will be represented at the LHRP by the AEO, in their absence this will be deputised through approved delegations to either the CCGs Board Secretary or the CCGs Head of Governance to ensure attendance.

Local Health Resilience Group

11.4. The Local Health Resilience Group (LHRG) is the EPRR operational level group with the responsibility for implementing the strategic direction of the LHRP.

11.5. It is an EPRR practitioner group, chaired by an NHS England EPRR Manager, whose purpose is to implement the strategic directions provided by the LHRP.

11.6. The CCG will be represented at the LHRP by the EPRR Lead.

Local Resilience Forum

11.7. The Local Resilience Forum (LRF) is a statutory process for the integration of emergency preparedness in the local area, to the benefit of the community. The LRF has an Executive meeting element (the Chief Officers Group (COG)) and an emergency planning practitioner element (the Monthly on Thursday (MoT) meeting).

11.8. The NHS is formally represented at the LRF COG and the LRF MoT by NHS England; however, all emergency responding organisations listed as Category 1 or 2 in the Civil Contingencies Act 2004 are invited to participate in the LRF MoT meetings. CCGs are listed as Category 2 emergency responding organisations in the Act.

11.9. The CCG may be represented by the EPRR Lead when attendance at the LRF MoT is required.

12. Training and Exercising

12.1. To ensure that they are prepared for their on-call role, the CCG's key staff must undergo regular training. This training required for different roles is set out below:

Training	Who	Frequency
On-call Induction training	Director on-call	Once, prior to first on-call duty

On-call Refresher training	Director on-call	Annually
Strategic Leadership Training	Director on-call	Every three years
Media training	AO or selected Execs	Once (recommended)
Surviving Public Inquiries	Director on-call	Once (recommended)
Decision Loggist training	Loggist volunteers	Every three years
BC Lead training	Directorate BC Leads	Every three years

12.2. All NHS organisations are required to exercise their emergency and business continuity plans and the NHS England Core Standards for EPRR sets out the following frequencies:

- A communications exercise every six months
- A table-top exercise every year
- A live exercise every three years*

*This requirement may also be met by a live incident response which has required a plan to be activated, followed by a post-incident debrief, with lessons identified and a post-incident report having been written.

12.3. The responsibility for ensuring that the training and exercising requirements are met lies with the EPRR Lead.

13. Annual EPRR Assurance

13.1. Each year, NHS England requires that all NHS organisations are assured against the NHS England Core Standards for EPRR.

13.2. The responsibility for undertaking the assurance of Devon's NHS providers lies with the CCG and will be carried out by the EPRR Lead in liaison with NHS England.

13.3. Following the assurance of all Devon NHS providers, the EPRR Lead will provide the Governing Body with a written report on the state of the CCG and Devon's NHS providers' emergency preparedness.

13.4. The CCG will then provide a written submission to the LHRP, presented and explained by the AEO, on the EPRR Assurance outcomes for the CCG and all Devon providers.

GOVERNING BODY

Report title: **Commissioning of An Integrated Care Partnership for Western Devon and Mayflower Medical Group**					
Date of committee: **27th June 2019** **Date report produced:** **17th June 2019**					
Author (s) Name and Title: Anna Coles, Director of Integrated Commissioning (Interim) Caroline Stead, Head of Performance (Western) **Contact Details:** caroline.stead@nhs.net			**Supporting Executive:** **Name and Title: Jo Turl- Director of Transformation** **Contact Details:** **Report Approved by:** **Name and Title: Anna Coles- Director of Integrated Commissioning (Interim)** Date 17th June 2019		
Public or Private (Governing Body only):			**Public**	**X**	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**	**X**	**Information**
Does this report place individuals at the centre?			**Yes**	**X**	**No**

Executive Summary:

The preparatory phase for the procurement of an Integrated Care Partnership (ICP) to deliver Integrated Community Health and Social Care, Mental Health and Learning Disability Services for Adults in Western Devon and Mayflower Medical Group contract will be complete on 28th June 2019.

A Standard NHS Contract will be used for the ICP (lot 1). The scope of this covers Community Health, Care and Mental Health Services in Western Devon. The contract is for 10 years with a possible five- year extension. The contract value over the period (including extension period) is £1,201,957,000. The start date for this contract is 1st July 2020.

An APMS contract will be used for Mayflower Medical Group (lot 2). The scope covers the provision of Primary Care provided at the following sites with in Plymouth: Ernesettle, Mount Gould, Trelawney, Stirling Road and Collings Park surgeries with the recent addition of Mannamead Surgery. The current registered population is 42,292. The value of the contract over period (including extension period) is. £54,350,620 with a further £500,000 innovation funding being available in the first two years. The start date for this contract is 1st April 2020.

The paper describes the processes undertaken to date. It sets out the assurances gained as a part of the preparatory work. It confirms that the preparatory work for both lots has been supported by NHS South, Central and West Commissioning Support Unit and that the ICP Procurement is subject to a regional NHS England and NHS Improvement assurance process. This process will conclude with a checkpoint meeting on 20th June 2019.

The Governing Body is being asked to confirm that procurement should start on 1st July 2019.				
Strategic risk: (include risk number if on register)	**Mitigating Actions:**			
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to your own organisation via either **d-ccg.corporateservices@nhs.net** or **corporate.sdtccg@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				
It is recommended that the Governing Body approves the decision to proceed to a full procurement exercise commencing July 2019				
Reference to other documents or accompanying papers:				
N/A				
Have the legal implications been considered?				
Yes				
Equality Impact Assessment:				
Who does the proposed piece of work affect?	**Patients**	**X**	**Carers**	**X**
	Staff	**X**	**Public**	**X**
			Yes	**No**
1. Will the proposal increase discrimination for people in protected groups?				X
2. Will the proposal reduce discrimination for people in protected groups?				X

3. Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		X
4. Will the patients or workforce be disadvantaged as a result of the proposed work?		X
5. Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?		
If the answer to any of the above questions is yes (other than questions 2 and 3) or you are unsure of your answers to any of the above, you should provide further information using **Quality and Equality Impact Assessment**. If an equality assessment is not required briefly explain why and provide evidence for the decision.		

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

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

Procurement of an Integrated Care Partnership for Western Devon and Mayflower Medical Group

1. Executive Summary

The procurement of an Integrated Care Partnership (ICP) to deliver Integrated Community Health and Care and Mental Health Services in Western Devon and Mayflower Medical Group presents a unique opportunity to commission long term contracts to deliver integrated care to the population of Western Devon.

Devon CCG is leading the commissioning the ICP on behalf of both Kernow CCG and Plymouth City Council and is commissioning Mayflower Medical Group under delegated commissioning authority from NHS England.

A Standard NHS Contract will be used for the ICP. The scope of this covers Community Health, Care and Mental Health Services in Western Devon. The contract is for 10 years with a possible five-year extension. The contract value over the period (including extension period) is £1,201,957,000. The start date for this contract is 1st July 2020. The contract will include an Outcome Framework which will enable commissioners to track the impact of integration.

The majority of services included in the scope of the ICP are currently delivered by Livewell Southwest (LSW). It should be noted that there are a number of services currently delivered by LSW which are out of scope for this procurement. The CCG has reviewed these with other commissioners to reduce the risk of unintended consequences resulting from the outcome of this procurement. An assessment of the value of these services suggests that this is sufficient to enable the ongoing delivery of out of scope services by Livewell Southwest, however work has also taken place to identify mitigating actions should this not be the case.

An APMS contract will be used for Mayflower Medical Group. The scope covers the provision of Primary Care provided at the following sites within Plymouth: Ernesettle, Mount Gould, Trelawney, Stirling Road and Collings Park Surgeries with the recent addition of Mannamead Surgery. The current registered population is 42,292. The value of the contract over period (including extension period) is £54,350,620 with a further £500,000 innovation funding being available in the first two years. The start date for this contract is 1st April 2020.

The paper describes the processes undertaken to date. It sets out the assurances gained as a part of the preparatory work. It confirms that the preparatory work for both lots has been supported by NHS South, Central and West Commissioning Support Unit and has been supported through legal advice as appropriate The ICP Procurement is also subject to a regional NHS England and NHS Improvement assurance process. This will conclude with a checkpoint meeting on 20th June 2019." This requirement was introduced by NHS England and NHS Improvement in April 2019, not because the procurement triggered the criteria for this assurance process but rather because the regulators felt that they required this level of assurance due to the financial and performance position of the system.

The Governing Body is being asked to confirm that procurement should start on 1st July 2019.

2. Purpose of report

The purpose of this report is to provide the Governing Body with the assurances required to enable approval of the commencement of the procurement in July 2019 via the publication of OJEU and Contract Finder Notes.

3. Commissioning Intentions

Following an options appraisal, it was determined by the Integrated Care Partnership Executive Group that the procurement for ICP and Mayflower Medical Group be combined into a two-lot procurement process. The Commissioning intentions for the two lots are described below.

Lot 1: Integrated Care Partnership

Early in 2018 NEW Devon CCG (now Devon CCG) and Plymouth City Council published their strategic ambitions for delivering Integrated Care in the Plymouth System. These intentions set out a number of priorities, including commissioning an Integrated Care Partnership for Adults and Older People. A paper was drafted setting out the contracting approach for the procurement of an Integrated Care Partnership, to include Community Health, Adult Social Care, Acute, Local Mental Health Services and some Primary Care Services.

Since the original paper was produced the ambitions around an ICP have evolved, in line with developing an Integrated Care Model, Primary Care Networks and the Long-Term Plan, to focus on integration of care.

As the Livewell South West (LWS) contracts for Complex Adults and Mental Health, Learning Disability & Older People's Mental Health are coming to an end on 30th June 2020, there is a need agree how these services will be commissioned in the future.

Consideration has been given to the most appropriate contracting approach for an integrated care model within Western Devon. Advice has been taken that a 'competitive dialogue' approach has the best chance of giving us the desired outcomes as this enables the commissioner to discuss the specification with providers, therefore, giving providers a better understanding of the strategic intent of the commissioner and enable both parties to discuss the specification and give clarity and make suggestions on further development.

The intention of commissioners is to commission an integrated care partnership through one overarching contract with a single provider. Due to the scale of the challenge and the system complexity, this has been identified as the preferred delivery model as there is a need to achieve greater structural, functional and financial integration than collaboration and partnership working alone can achieve.

Integrating care under a single model will bring together constrained resources under a single governance and management arrangement. Pooling resources, workforce and assets will provide sufficient scale, greater sustainability and be more cost effective. In addition, it will facilitate a more consistent seamless approach to care delivery by working as a whole, facilitating better communication through single systems and operating to consistent standards. Through dialogue the CCG will explore with bidders their proposed service model and how they will transform service delivery and remodel the workforce to support Primary Care Networks, improve sustainability and reduce the level of demand on the hospital emergency department.

The critical success factors of this procurement are:

- A comprehensive offer for prevention and self-care for the whole population;
- Services which are wrapped around primary care networks to support our most vulnerable people through population health management (PHM);
- Integrated physical and mental health and care services in the community;
- Seamless pathways for people with long term conditions between community and acute services;

- Integrated pathways for people with serious mental illness;
- Partnership working with the wider health and care system to ensure that sustainable services are delivered within a financially sustainable system.

The achievement of these success criteria will be tracked through a detailed outcome framework which will be agreed as a part of the contract.

The ICP Contract will be for 10 years with a potential 5-year extension.

The full service specification for the ICP is included in Appendix 1

To maximise the benefits of the ICP during the life of the contract, additional services may be included in scope following commissioners' review of services and negotiation with potential providers.

Lot 2: Mayflower Medical Group

The Mayflower Medical Group Procurement is an exciting opportunity to provide quality primary care services working at scale within the city of Plymouth and help shape primary care services for the future, which has arisen as a result of a number of primary care contract handbacks with four previous contracts forming the Mayflower Medical Group Procurement.

Following patient engagement and a comprehensive needs assessment, Ernesettle Primary Care Centre (10,700 patients), comprising three sites; Ernesettle, Mount Gould and Trelawny went out for re-procurement in 2017, but was unfortunately unsuccessful. Following the procurement process two Personal Medical Services (PMS) contracts were resigned in Plymouth; Freedom Health Centre and the Ocean Health Group, providing services at three sites; Stirling Road, Chard Road and Collings Park, resigned their PMS contracts. These contracts were therefore amalgamated into the Ernesettle contract to form the Mayflower Medical Group and went out for re-procurement in 2018, again this was unsuccessful.

Mannamead was added into the Mayflower Medical Group procurement in May 2019, following receipt of the contractual resignation of the Mannamead partners. The geographical location of the practice means it is an appropriate fit for this Group; (the practice is close to the Collings Park site providing further opportunities to work at scale whilst ensuring good access to primary care in this part of the city).

The critical success factor for this procurement is: A longer terms Alternative Primary Medical Services (APMS) contract commencing on 1st April 2020 which will work towards full integration with the Integrated Care Partnership.

The Mayflower Group contract is for 7 years with a potential 3-year extension

The full service specification for Mayflower is included in Appendix 2

As this is an APMS contract it should be noted that this can be adapted, by mutual agreement, over the duration of the contract, including the addition of other sites and the contract- holder may also work as a caretaker provider for other resigned contracts in Plymouth.

4. Scope

The scope of each of the two lots is described below.

Lot 1: Integrated Care Partnership

The majority of services in scope for the ICP are currently delivered by Livewell Southwest whose current contract arrangements expire on 30th June 2020.

The scope also includes spirometry services which are currently delivered by Express Diagnostics whose current contract expires on 30th June 2020.

In terms of geographical scope, it should be noted the services included in this procurement will be delivered as follows:

Western Devon:	Physical Health Services (previously provided under the Adults with complex needs contract held by Livewell Southwest)
Plymouth Only:	Adult Social Care, Mental Health and Learning Disability services.

The ICPs responsibilities also encompass the provision of some services to residents of East Cornwall who access inpatient services in Plymouth.

Given the intention for a fully integrated offer, it expected that the ICP will work closely with providers of Adult Social Care, Mental Health and Learning Disability services in South Hams and West Devon to ensure a consistency of offer. Devon County Council are also a key partner as a strategic commissioner of services in South Hams and West Devon.

Full details on the scope are available in the service specification included in appendix 1

As the scope for ICP does not cover all the services provided by Livewell Southwest, there has been discussion both within the CCG and with other commissioners to reduce the risk of unintended consequences resulting from the outcome of this procurement. An assessment of the value of these services suggest that this is sufficient to enable the ongoing delivery of out of scope services by Livewell Southwest, however work has also taken place to identify mitigating actions should this not be the case.

Lot 2: Mayflower Medical Group

The Mayflower Medical Group covers the provision of Primary Care provided at the following sites with in Plymouth: Ernesettle, Mount Gould, Trelawney, Stirling Road, Collings Park and Mannamead Surgeries. The current registered population is 42,292, As this is an APMS contract it should be noted that this can be adapted, by mutual agreement, over the duration of the contract, including the addition of other sites and the contract- holder may also work as a caretaker provider for other resigned contracts in Plymouth.

The CCG will be expected to implement the national specification offer for improved access. This creates the potential for the provider to increase income, but this would also be likely to require additional manpower. The model for delivering improved access in Plymouth is not yet agreed but is likely to require hub-based working to serve a number of GP practices. This will be superseded in 2021/22 by the combined Extended Hours Access DES and CCG Commissioning enhanced access as announced in the GP contract framework.

In the NHS Long Term Plan, Primary Care Networks (PCN) become an essential building block of every Integrated Care System, and under the Network Contract DES, general practice takes the leading role in every PCN. This will mean much closer working between PCNs and their Integrated Care System. Due to the size of the patient list the Mayflower practice will be a PCN in its own right.

5. Procurement approach

There will be a combined procurement process for ICP and Mayflower Medical Group consisting of two lots. The procurement will be launched on 1st July 2019. We will look to award lot 1, ICP, by 30th January 2020 with a contract commencement date of 1st July 2020. For Lot 2, Mayflower Medical Group, contract award date is 20th December 2019 with a contract commencement date of 1st April 2020.

Lot 1: Integrated Care Partnership

A range of options were considered when determining the most appropriate and efficient procurement route for the Integrated Care Partnership for the Western Locality of Devon and the procurement will follow a Competitive Dialogue Procurement Process which is is effective for complex projects where the contracting authority may be unable to define how to meet their needs or assess what the market can offer in terms of technical, financial or legal solutions.

The first stage of this is for bidders to submit a response to an Invitation to Submit Outline Solutions (ISOS).

Following a first stage submission of outline solutions the Competitive Dialogue procedure aims to provide a certain amount of flexibility for particularly complex purchases. Its benefits include:

- Limited number of candidates allowed to submit a tender
- A high level of dialogue between the CCG and the bidders

The dialogue stage allows for the opportunity to develop ideas, explore options and issues. It enables:

- A two-way discussion where both parties work through the proposed solutions to prepare for the next stage – the Invitation to Submit Detailed Solutions
- Commissioners to be informed of any changes needed to the service model or evaluation process
- bidders to form a clearer picture of the commissioner's requirements
- bidders to have a full understanding of the process and support the submission of a high-quality final solution at the next stage.

And aims to ensure:

- The CCG's vision for integrated services is understood by the providers
- The Critical Success Factors are achievable, and the proposed solutions are in line with them
- The Outcomes Framework is understood, and the specified outcomes targets are achievable
- Innovative solutions have been proposed that can be explored and developed
- The solution proposed is within the financial cost envelope and the provider can evidence a fully costed model where services have received adequate resources
- The desired level of integration is understood with defined timescales to achievement
- The service change is understood with defined timescales to achievement

Lot 2: Mayflower Medical Group

As with Lot 1 a range of options were considered when determining the most appropriate and efficient procurement route and the procurement will follow a Competitive Dialogue Procurement Process which is effective for complex projects where the contracting authority may be unable to define how to meet their needs or assess what the market can offer in terms of technical, financial or legal solutions.

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- Innovative solutions have been proposed that can be explored and developed
- The solution proposed is within the financial cost envelope and the provider can evidence a fully costed model where services have received adequate resources
- The desired level of integration is understood with defined timescales to achievement
- The service change is understood with defined timescales to achievement

6. Governance Arrangements

Prior to procurement launch there were separate Governance arrangements for the two lots.

- The ICP pre-procurement phase was overseen by an ICP Executive Group chaired by The Director of Transformation who also acts as Senior Responsible Officer. The ICP Executive group is supported by a dedicated Programme Manager and an Implementation group consisting of workstream leads from across the CCG.

- Mayflower pre-procurement was overseen by an Oversight Group co-chaired by an Executive Director and NHS England's Local area Team Director of Assurance and Delivery. It has had a dedicated Programme Manager and an operational group consisting of workstream leads, patient representative and Healthwatch.

From procurement go live these governance arrangements will be combined, with the ICP Executive Group having oversight of both lots. It should be noted that this group will have delegated authority from the Primary Care Committee in relation to Mayflower. The award of contracts for both lots will be subject to Governing Body Approval.

The NHS South Central and West Commissioning Support Unit (CSU) have supported all aspects of the Programme and have worked with commissioners (including Plymouth City Council Commissioners) ensure readiness to proceed to procurement.

For both lots there has been a robust process around conflicts of interest. Registers of interests are in place for both lots and for the ICP a panel, chaired by the board secretary to review all declared conflicts and to agree how these will be managed.

Lot 1: Integrated Care Partnership

Progress towards the procurement has been discussed by the following Committees within the CCG/s and they have been assured of the processes that have been followed during the preparatory phase of the procurement:

- Integrated Care Partnership Executive Group
- Integrated Care Partnership Implementation Group
- Commissioning Directorate Business Meeting
- CCG Executive Meeting
- Integrated Commissioning Executive
- Governing Body

Lot 2: Mayflower Medical Group

Progress towards the procurement has been discussed by the following groups and Committees within the CCG/s and they have been assured of the processes that have been followed during the preparatory phase of the procurement:

- Mayflower Oversight Group
- Mayflower Operational Group
- CCG Executive Meeting
- Primary Care Commissioning Committee
- Governing Body

7. Finance

The financial arrangements for each of the two lots are set out below.

Lot 1: Integrated Care Partnership

- The total contract value for the contract is £1,201,957,000 (figure includes extension period).
- The valuation of the financial envelope is based initially on the cost of services currently provided.
- There has not been a reduction in the commissioner cost of current service provision for the valuation of the initial procurement envelope

- The services and the valuation of the services that remain out of scope has been agreed with the current provider, the financial envelope assumes all other services currently provided are included within the envelope and contract.
- This is a flat cash envelope to the extent that this value will not be changed for any demographic changes during the contract period.
- NHS inflation (as applied to tariff, and where appropriate to this contract) will be applied in future years. There is an implicit assumption here that tariff also requires at least a minimum level of efficiencies, and this also will be expected of this contract. Other specific funding uplifts that are nationally agreed, or pass through allocations, where appropriate to this contract, and where agreed through system financial planning, will be passed on to the provider. For example, where there is a nationally mandated Mental Health Investment Standard (MHIS), this may be applied into this contract where it specifically and explicitly funds additional service or capacity.
- Further efficiencies will be required in order to manage demographic growth, and also to manage the cost of transformation. The financial template requires these plans to be exemplified at an assumed 2% per annum in the first instance.
- As this is an outcome-based contract the envelope is not identified by specific services, however, service line costings have been specified in the financial template. In order to manage and monitor the ongoing Mental Health Investment Standards, the envelope has been indicated at this programme level.
- Table 1 sets out the financial envelope for the initial period of the contract

Table 1: Initial Contract period Financial envelope

Summary	Devon CCG			Kernow CCG	Total	Minimum Level of Programme Spend		
	Rec Baseline	Non Rec Asset LTU	Contract			Community	Mental Health	Total
	£k	£k	£k	£k	£k	£k	£k	£k
Yr 1	79,173	-522	78,651	1,019	79,670	47,533	32,137	79,670
Yr 2	79,173	-401	78,772	1,019	79,791	47,609	32,182	79,791
Yr 3	79,173	0	79,173	1,019	80,192	47,860	32,332	80,192
Stead State	79,173	0	79,173	1,019	80,192	47,860	32,332	80,192
10 Year Value	791,730	-923	790,807	10,190	800,997	478,022	322,975	800,997
10 + 5 Year Value	1,187,595	-923	1,186,672	15,285	1,201,957	717,322	484,635	1,201,957

The financial envelope for the Integrated Care Partnership (ICP) has been identified using the following set of principles:

- The contract value is based on a flat cash contract for demographic growth.
- The baseline contract is based on 2019/20 opening contract value
- Inflationary uplifts and MHIS uplifts will be funded in accordance with national tariff expectations in future years.
- MHIS top up investments will be agreed on an annual basis including the services on which these will be invested.
- The value includes the contract increase to recognise the continued management of Individual Patient Placement (IPP) expenditure below threshold levels (the IPP risk share). This is set out below.

- The value includes the winding down of the cost of use of CCG assets under the License to Use, which reduces over years 1 to 2. As the contract reduction reduces in line with the license value, the balance is freed up to cover increasing costs of depreciation in the provider.
- No further investment has been included for ongoing infrastructure investment (capital). It is assumed a level of surplus will be managed to fund the business as usual capital programme.
- The contract value is gross to include both health and social care funding sources as a single contract value.
- The contract value has been split by Mental Health and non-Mental Health programmes, this will aid future analysis and valuation of MHIS.
- The contract value is identified by commissioner and includes the Kernow contract value.
- The contract value represents only the CCG income and does not make assumptions regarding other sources of income required to provide the service base.
- The contract value assumes total current (2019/20) contract value, less any services that are outside of scope, plus the 19/20 contract values for other contracts to be included in the envelope.
- The contract value of out of scope services is based on 2019/20 contract value and has been agreed with the current provider.
- The contract value of additional services and contracts is based on 2019/20 contract values and includes inflationary and investment standard uplifts.
- The contract value recognises the following:

  IPP Risk Share –
  The investment of £300k in the contract for the management of Individual Patient Placements (IPPs) is a recurrent investment whilst the value of IPP's (including s117) remains below £10.2m (including the cost of the risk share). Should the cost of IPP's grow to exceed this minimum level, the first call will be the reduction of this risk share, through negotiation. This may be mitigated by negotiation with an agreed variation or recovery plan. It should be noted that currently the cost of placements remains outside of the contract envelope. It is possible in the future, and within the life of this contract, that the commissioner might plan to agree, through full negotiation, with the provider for the full delegation of these budgets

  Commissioning for Quality and Innovation (CQUIN)-
  Of the above contract value 1.25% of the annual value is assumed to be CQUIN. CQUIN schemes will be developed annually based on national as well as local quality improvements or innovations. Whilst the value of these CQUIN will be included in the block contract value, the delivery of CQUIN's is a key indicator of success.

Lot 2: Mayflower Medical Group

The overall procurement envelope is identified at £54,350,620. This is inclusive of VAT and is indicative over the life of the contract, inclusive of the potential extension period (a total of 10 years).

The contract type is Alternative Primary Medical Services (APMS) and will run variably maintaining equity with General Medical Services (GMS) contracts.

The overall procurement envelope is indicative as the contract is based on core General Medical Service values. The value of income to the practice is variable based on either list size or activity, and the envelope has been identified as such.

The contract value is based on a likely income from the Clinical Commissioning Group of £5,335,062 per annum. This is based on an estimated weighted list size of 42,292.

The Clinical Commissioning Group recognise that it may not be possible to immediately transform the practice costs to be managed within the core GMS funding envelope and is incorporating a two-year mobilisation and transformation timescale. During this period the Clinical Commissioning Group has identified the following measures to maximise the security of income streams to the practice:

- The annual contract value of £5,335,062 is set as a minimum but may increase if the list size increases above 42,292. In the mobilisation and transformation period if the list size falls below this level, income will not reduce. A trigger for a review of this arrangement is set at a weighted list of 40,000.

- An additional mobilisation fund of £500,000 will be made available in each of the first two years.

- In addition to the mobilisation fund, the Clinical Commissioning Group has access to a further small transformation fund, the use of which is at the full discretion of the Clinical Commissioning Group, and for which agreement must be reached with the provider through dialogue.

- The indicative envelope is set at 2019/20 pay and price levels, future inflation will be added at DDRB including for 2020/21 from contract go live.

After the initial two- year mobilisation and transformation period the contract will move to a fully variable APMS contract based on core GMS values, with list size- based payments based on actual list size and activity- based payments on actual activity.

For the mobilisation fund, the provider will need to set out the plans for the utilisation of this fund, the benefits it delivers and the proposals for the transformation that will enable its withdrawal safely after two years.

8. Engagement

In order to meet legal requirements in relation to the Health and Social Care Act (2012), a range of engagement activities have been undertaken by commissioners.

Lot 1: Integrated Care Partnership

The design of the Integrated Care Partnership has been influenced by a range of community engagement that have taken place over the past five years. Most specifically its design has been influenced by the engagement that took place in relation to Transforming Community Services and the Health and Wellbeing hubs through which commissioners spoke with over 2000 members of the pubic and held 13 community sessions. From the feedback from these sessions a of statements were created which summarised what was important to people and what they wanted to improve about community-based care these statements have informed the development of the Integrated Care Partnership Service Specification.

During April and May 2019, the CCG commissioned Living Options to undertake some further engagement via both an online survey and a series of focus group sessions to check with the public whether these statements are still accurate and important and to also gain an understanding of how people believe services can be further improved. Interim findings from the survey and focus groups have already been used to inform the development of the final service specification and will be further used to inform the approach to dialogue which will be carried out during the formal procurement process

The intention to procure an Integrated Care Partnership has been signalled via two market engagement events held in February and May 2019 aimed at stimulating the market. Both were advertised via OJEU using a Prior Information Notice. Commissioners used these events to invite discussion and comment on both the service model and the service specification Both events were attended by a range of organisations, mostly from the local provider market. Feedback from both events has been used to further develop the commissioning plans. Documents providing background on the commissioning intentions have also been made publicly available via the CCGs website,.

Engagement with clinicians about the approach has taken place via presentation and discussion at Western Primary Care Partnership, Western Locality GP forum. Clinical representatives have been part of more formal discussions on the proposals via the Integrated Care Partnership Executive Group and the Integrated Commissioning Executives.

Engagement with Plymouth City Council members has also taken place through presentation to Health Overview and Scrutiny Committee.

Lot 2: Mayflower Medical Group

There has been significant stakeholder engagement with this process. One of the key actions to arise following the previous procurement was the establishment of a Patient Reference Group, whose memberships consist of patient representatives from each of the practice sites and HealthWatch. This purpose of this group was to actively participate in developing the patient engagement which included the issuing of a patient survey (see section 5.1 – Patient Impact) during the period November – December 2018.

Healthwatch have also been a keen contributor and have membership on both the Patient Reference Group and the Mayflower Project Delivery Group.

The Mayflower Project Delivery Group was established last year and has joint Chairs, representing NHS England and NEW Devon CCG. This has therefore meant there has been a collaborative approach to the development of this procurement right from the outset.

The Patient Reference Group considered in detail the Options Appraisal and were supportive of the recommendation particularly as this was in line with the results of the patient survey (see Section 5.1 – Patient Impact) in regard to the development of a more integrated approach to service delivery.

The outcome from the patient research was considered with equal status in the development and assessment of the options appraisal alongside the commissioning strategy and provider engagement feedback.

Conflicts of interest have been declared and registered for each of the groups working on the Mayflower Procurement.

This will be the third occasion elements of these services have gone to market. On the two previous occasions market soundings suggested that there would be sufficient interest in the services. However, once these providers conducted a more thorough due diligence review it became clear the services were not attractive or viable with the commercial offering within the Invitation to Tender (ITT). Following the second procurement 1:1 exit meetings were held with all providers who expressed an interest to discover the exact reasons for not submitting a bid. The key themes from these meetings were:

- Contract length too short (up to 5 years)
- Not enough money to cover service needs (if it was offered at the global sum/equivalent to GMS)
- Existing services were poor, and turnaround would be expensive and risky
- Recruitment was challenging
- The level of deprivation of the area required continuity and sustained services
- The maturity in the marketplace was insufficient to take on such a commitment

On this basis the Mayflower Procurement Oversight Group approved a pre-procurement market engagement plan to explore these themes further and to develop the marketplace to such an extent that a future procurement could attract sufficient interest. The market engagement plan consisted of three elements:

- a desktop questionnaire for providers to complete,
- a number of briefings and open discussion sessions held on 13 and 21 November 2018
- a day dedicated to 1:1 meetings to encourage more candid feedback. Prior to starting the engagement, a prospectus was produced as part of the marketing plan and shared widely with commissioners, providers and patient groups. These were held on 10 and 18 December 2018 and 15 February 2019.

This pre-procurement market engagement plan was conducted during the period of November and December 2018 and in particular explored the following areas:

- What the potential barriers to the procurement are
- The opportunities available for integration
- The preferred contractual model

We received completed questionnaires from 3 providers and met with 5 separate organisations on a 1:1 basis.

The key themes to emerge from this engagement were as follows:

- The need to look at a longer length contract. All of the responses received, both from the questionnaires and the face to face meetings, highlighted that a contract of 10 years+ would be required. This would enable greater stability for this cohort of patients, who were perceived to have had a turbulent few years. It would also enable greater financial stability for the practice.
- There was a consensus that delivering this contract for core GMS would be difficult initially and therefore it was felt there was a need to pump-prime funding with the expectation that over time the contract would align with core GMS.
- There was recognition that there was a need to be innovative with this service and that the historic model of general practice was not fit for purpose for this contract.

- The consensus from the provider feedback from the 1:1 meetings was that it may not be beneficial, in fact it may be too early, to include the Mayflower Group as an integral element of the up and coming Integrated Care Programme.

The feedback from the market engagement served these purposes: firstly, to confirm that if the correct commercial package could be constructed then there would be interest by key providers when bidding for the services; Secondly, it informed an options appraisal which was considered by the Mayflower Delivery and Oversight groups supporting the strategic direction of travel and finally to use as evidence for this business case of a robust and thorough analytical approach to support the request for a contract period greater than five years**.**

9. Regulator Assurance

Preparatory work for both lots has been supported by NHS South, Central and West Commissioning Support Unit. The ICP Procurement is also subject to a regional NHS England and NHS Improvement assurance process. This will conclude with a checkpoint meeting on 20th June 2019.". This requirement was introduced by NHS England and NHS Improvement in April 2019, not because the procurement triggered the criteria for this assurance process but rather because the regulators felt that they required this level of assurance due to the financial and performance position of the system.

Lot 1: Integrated Care Partnership

The regional NHS England and NHS Improvement assurance process for the Integrated Care Partnership mirrors the nationally agreed Integrated Support and Assurance Process (ISAP). The purpose of this process is to support the work of local commissioners and providers in creating successful and safe schemes, its aims are to:

- Ensure the proposals represent a good solution in the interests of patients and the public;
- Take a system view of the potential consequences of the contract award;
- Enable the risks of the complex contract to be identified, understood and mitigated as far as possible; and
- Improve efficiency and reduce duplication in the work of NHS England and NHS Improvement, increasing the speed of the national assurance for complex contracts.

The process involves three checkpoint meetings the first of which takes place before the procurement commences. For the ICP procurement this is scheduled to take place on 20th June 2019. To prepare for this the CCG has completed a Repeatable Assurance Model (RAM) template which includes key lines of enquiry which address the questions above. This has been submitted to NHS England and NHS Improvement along with comprehensive supporting evidence. This will be reviewed by NHS England and Improvement and will inform the agenda setting for the 20th June.

Lot 2: Mayflower Medical Group

Mayflower Medical Group was not subject to any regulator assurance process although NHS England has been integral to the procurement process.

10. Legal Assurance

Legal advice has been sought in relation to each lot as appropriate and is described below.

Lot 1: Integrated Care Partnership

The CCG have appointed DAC Beachcroft to act as legal advisors and have instructed them to provide advice on three separate work packages:

- Financial Risk
- VAT
- Contingency Planning

A meeting was held to work through these on 13th June 2019 the conclusion of which was that whilst no significant changes were required there would be amendments were required to clarify:

- The total estimated contract value over the life of the agreement to future-proof potential delegation of CCG and local authority budgets in relation to packages. Given the length of the contract this a provision to allow this to occur without the need for future procurement.
- the linkage between the outcomes framework and contractual levers and ensure this forms part of the dialogue.
- how the procurement process will continue in the event of only receiving one bid

Lot 2: Mayflower Medical Group

All primary medical services contracts are regulated through directions and contractual requirements. This along with the level of procurement support along with the application of the NHS England Commissioning Executive Group process has negated the need for separate legal advice.

11. Quality & Equality Impact Assessment (QEIA) Assurance

In order to comply with the obligations described under the Equality Act 2010, the impact assessments undertaken by commissioners are described below.

Lot 1: Integrated Care Partnership

Two QEIA workshops were held in relation to the service specification which resulted in a QEIA being completed and submitted for assessment by the QEIA panel

The QEIA panel met on 15th May. The Panel agreed to approve the QEIA subject to additional evidence being provided in relation to Experience and System and Other Impacts. This action has been completed. The completed QEIA is included in Appendix 3.

Lot 2: Mayflower Medical Group

The Mayflower procurement has also been subject to an EHIA (Equality and Health Inequalities Assessment) process which gave approval with no further action required. The completed EHIA is included in appendix 4.

12. Contract Assurance Post Contract award

Contract assurance arrangements post contract award for each of the lots are described below.

Lot 1: Integrated Care Partnership

The standard NHS Contract will be used as the basis of the contractual arrangement for the ICP, it will be augmented by an additional clause which clearly defines system responsibilities. The CCG will wish to review and approve any sub-contracting arrangements prior to service commencement to ensure adequate assurance on the arrangements in place for managing poor sub- contractor performance.

Delivery of the success criteria for the ICP will be measured through the achievement of measures set out in an outcome framework. A draft of this will be included in the procurement pack for prospective bidders.

The Outcome Framework has been has been developed using the Integrated Care System Outcomes Framework, ICP Critical Success Factors and ICP Standards to inform a reasonable range of measures.
The indicative outcomes framework (Appendix 5) included in the specification has the following key elements:

Level 1: Population Outcomes indicators including all measures in the Devon Integrated Care System Outcomes Framework with supplementary measures deemed important and relevant to the ICP. These are system-wide measures with a number of contributing factors due to the nature of the wide and integrated role of the ICP and in part they reflect the key role the ICP will play in addressing health inequalities.

Level 2: ICP Standards (as set out in the service specification).

Level 3: Service Specific Measures.

For each measure, the desired direction of travel is indicated and, where applicable, a threshold target is also provided. These will be developed further through the dialogue stage of the procurement process with targets and thresholds agreed as appropriate. Once agreed these will be contractualised through the relevant contract schedules and the ICP will be held to account for delivery

As a part of the dialogue sessions there will also be discussion and agreement on how breaches will be dealt this will include consideration of financial penalties/incentives and the governance processes to ensure system wide impacts are considered.
Following mobilisation, the contract and performance management arrangements will be put in place to ensure the provider is held account for delivery, the full range of services including provided under any sub-contracting arrangement.

Lot 2: Mayflower Medical Group

Post procurement the new provider will be monitored by the usual CCG primary care contract management process which reports into the Primary Care Operational Group l group and the Primary Care Commissioning Committee.

13. Recommendation

It is recommended that the Governing Body approves the decision to proceed to a full procurement exercise commencing July 2019 via the publication of OJEU and Contract finder note.

Appendices

Due to the size of these supporting documents, they included in a separate pack and are available on request.

Appendix 1: Service Specification: ICP
Appendix 2: Service Specification: Mayflower
Appendix 3: ICP QEIA
Appendix 4: Mayflower Medical Group HIA
Appendix 5: ICP Outcome Framework

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Peninsula Clinical Services Strategy (PCSS) Initiation Document				
Date of committee: 27/06/2019 **Date report produced:18/04/2019**				
Author (s) Name and Title: Mairead McAlinden **Senior Responsible Officer, Peninsula Clinical Services Strategy, Devon and Cornwall IOS STPs** **Contact Details:m.mcalinden@nhs.net**		**Supporting Executive: Dr Sonja Manton** **Name and Title:** **Director of Commissioning- Northern, Eastern and Southern Devon** **(Interim)** **Contact Details: Sonja.manton@nhs.net** **Report Approved by: Dr Sonja Manton** **Name and Title:** **Director of Commissioning- Northern, Eastern and Southern Devon** **(Interim)** **Date:18/04/2019**		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

Building on previous work in both Devon and Cornwall & IOS to shape the future provision of hospital-based clinical services, the senior leadership of both STPs have agreed to participate in a collaborative piece of work which will provide a strategic view of the configuration of clinical services across the two counties where planning those services at Peninsula level for the next 5 – 10 years brings benefits in terms of safety, quality, resilience, performance and affordability.

The scope of the Strategy is described as hospital-based clinical services, but recognising and respecting the contribution of other sectors of care in transforming these services.

The Strategy will build on the strategic decisions already made in both STPs, and does not intend to revisit this work unless there are material changes since these decisions were made. The strategy will also consider all recommendations from specialty based work both locally and by Specialised Commissioning, taking account of latest evidence on clinical interdependencies and new ways of working.

The Governance of the Strategy is described in the paper, ensuring that recommendations from the Strategy are properly considered and tested, and have the support of the partner organisations within both STPs

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:

Devon STP Programme Delivery Executive Group

Devon CCG Governing Body (Private session)

Devon Provider Trust Boards (Private session)

Equivalent governance in Cornwall IOS system

Key recommendations and actions requested:

The CCG Governing Body is asked to:

1) Endorse the scope, vision and strategic principles set out in the Peninsula Clinical Services Strategy.
2) Commit the organisation to support the delivery of the challenging timescale to deliver the outcomes defined in this paper, so that they can inform the Long Term Plan for each county.
3) Support their organisation's nominations to the PCSS Leadership Group and the input of clinical leads and operational teams to shape and inform Strategy priority areas for service transformation.

Ensure regular feedback on progress is communicated to the organisation.

Impact on Strategic Objectives

Commission Safe and Effective Services

Develop Strategic commissioning plans which improve the physical and mental health of the population

Work in partnership with the wider health and care system to commission integrated and personalized care

Make best use of resources

The strategic drivers as described in the report align to the CCG's strategic objectives. This work is system wide incorporating the system in Cornwall and IOS and key partners such as NHS England specialised commissioners. Whilst this strategy has an acute hospital service scope careful consideration will be given to the interface between mental health services and physical health services at every stage.

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	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.

SHAPING OUR FUTURE
Cornwall and The Isles of Scilly Health and Social Care Partnership

Devon County Council · Plymouth · NHS · Livewell Southwest · Torbay Council
Devon Sustainability and Transformation Partnership

Peninsula Clinical Services Strategy

This paper sets out agreements in principle, actions and next steps to further the proposal to develop a clinical service strategy for Cornwall & the Isles of Scilly (CIOS) and Devon, as set out in the Devon STP Programme Delivery Executive Group paper of 18 January and discussed through Cornwall governance system at both the Cornwall and IOS Clinical Practitioner Committee and Planned Care Board. Senior leaders from across Cornwall and Devon met in Lifton on 22 March to discuss and progress the work needed to initiate the development of this strategy. The invitees and attendees at this meeting are included in Appendix 1.

To ensure ownership across CIOS and Devon systems, it was AGREED that the review should be named the PENINSULA CLINICAL SERVICES STRATEGY (PCSS), with 'Peninsula' defined as the geography covered by CIOS STP and Devon STP.

CIOS have developed a wider clinical services strategy encompassing primary and community care, and see the value in collaboration on hospital based clinical care where there are issues of mutual concern or opportunity with Devon.

The CIOS and Devon system leaders have reviewed and revised the project initiation paper for the PCSS and have agreed the following:

1. **The SCOPE of the Strategy was agreed as:**

   The Peninsula Clinical Services Strategy will focus on hospital based physical health services, and will take account of the contribution of and impact on mental health, primary care and community services where there are critical clinical interdependencies, fully engaging these services when redesigning models of clinical care for optimum service delivery and outcomes.

2. **The VISION for the Strategy was agreed as:**

   Providing safe, high quality, affordable clinical care which provides equitable outcomes and timely access for the people of Cornwall and Devon through a sustainable network of local and specialist services that will attract and retain the high calibre workforce we need.

3. The **STRATEGIC PRINCIPLES** for the Strategy draw on principles and priorities already developed across the Peninsula in various plans, and have been agreed as:
   - Safe and Sustainable Care that provides 'Best Care for the Peninsula's population now and in the future
   - Equal standards of high quality care, accessible regardless of where people live, provided locally where possible, but recognising that we have to provide more specialised care in fewer locations that are Centres of Excellence to achieve these standards
   - Providing as much care as possible for the local population within the South West Peninsula and supporting local service sustainability by repatriating any tertiary services where to do so is clinically and financially viable as part of a new commissioning agreement
   - Affordable care, eliminating the current and predicted gap between funding and the cost of providing care
   - Transformed care, drawing on latest evidence and best practice to maximise the contribution to improved population health outcomes, including use of new technology and digital solutions, with a research focus to drive ongoing improvement
   - More integrated care, developing care pathways that manage demand/need in the most appropriate place and improve the user experience, delivered by skilled clinicians with the capacity to effectively manage these needs with the support that ensures they feel safe to do so
   - Resilient care, with service models that provides training and research opportunities and which attract the high calibre workforce we need to provide excellent care for the people of the Peninsula
   - Partnerships of care, developing new ways for clinical teams to collaborate and work together to improve service delivery, improving staff experience and wellbeing
   - Improved performance against key NHS standards, organising care to improve timeliness of access and responsiveness to urgent need
   - Changing with pace and scale – learning from success of initiatives and work underway across the Peninsula and beyond, adopting what is driving improvement, standardising to optimum care models but allowing flexibility for local circumstances
   - Ensure that proposals fully consider and are consistent with the direction and decisions of both STPs and with the strategic direction of other service strategy groups both within and beyond our STP systems
   - Contribute to the improvement of population outcomes as required under the NHS Long Term Plan

   These strategic principles need to be translated into more easily accessible language which will be undertaken by Communications leads from Cornwall and Devon.

4. **The <u>STRATEGY OUTCOMES</u> and <u>DRIVERS FOR CHANGE</u>** to guide decisions on identifying and prioritising service reviews were AGREED as:

   The development of a Service Framework design, categorising hospital based clinical services into the following categories, is a key deliverable of the PCSS. The following Categories have been agreed in principle:

   - Category 1: Specialist DGH level services which should be provided in all acute hospitals across the peninsula
   - Category 2: Specialist DGH 'plus' services which may be provided differently given the cost and workforce requirements to deliver these services
   - Category 3: Highly specialised/tertiary services, provided within or outside the Peninsula for the population of CIOS and Devon

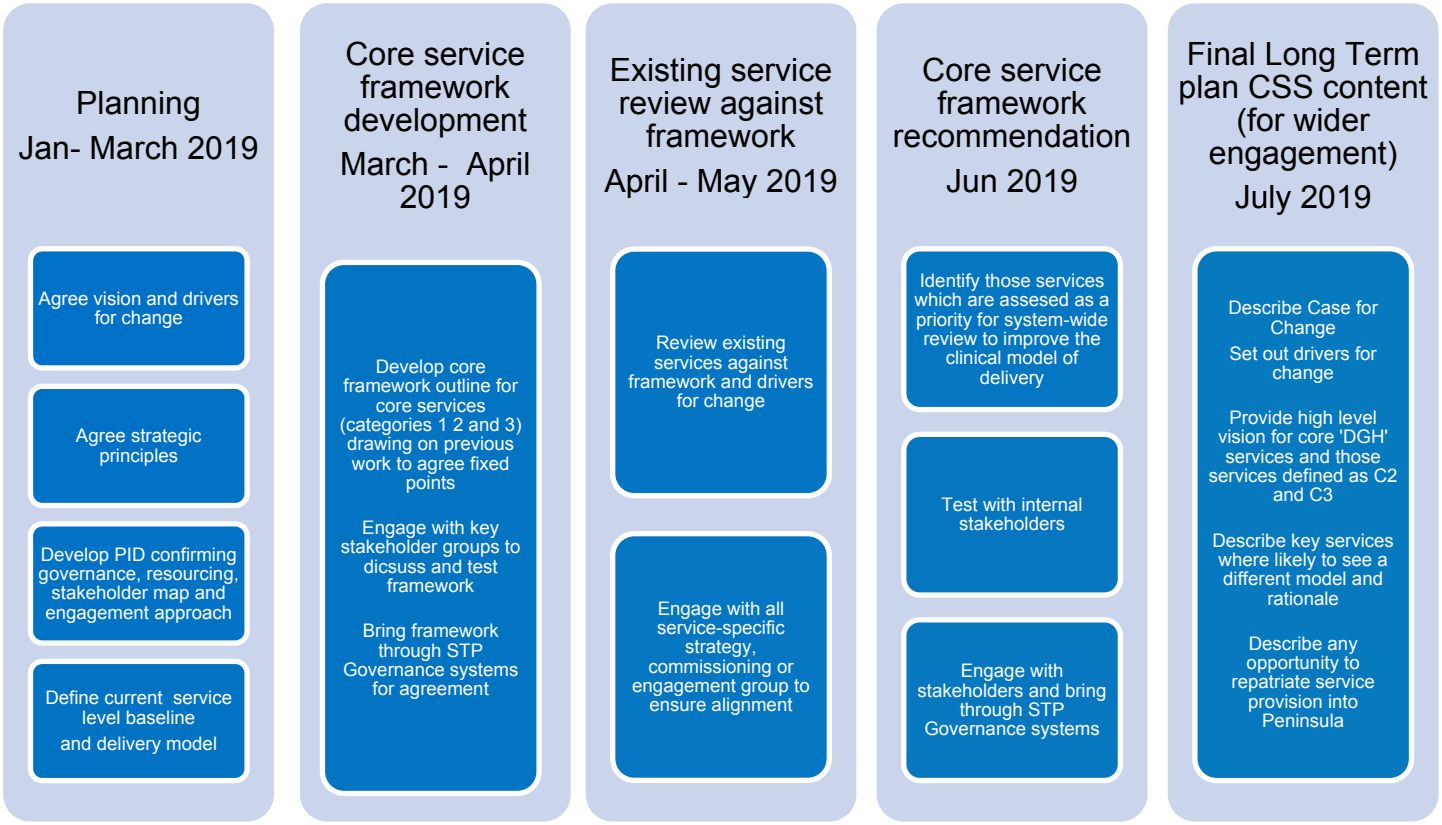
   To inform the outcome of the Categorisation process, and to inform decisions on opportunities for improvement, the following Drivers for Change have been agreed:

   1. Service safety – where safety concerns have been identified with no immediate and affordable plan to address.
   2. Service resilience – where there is significant and long-term dependence on locum/agency staff (current or predicted) to maintain the service, with no resolution available. Where facilities or equipment do not enable reliable provision, with no resolution available.
   3. Service performance – where the service is not meeting key performance standards or is significantly below performance levels elsewhere, and there is no confidence that this can be improved to acceptable levels.
   4. Service cost – where the premium cost to deliver the service in its current configuration is significantly above average cost/tariff due to the service model, over provision or other factors.

5. Phases of Strategy Development, Outputs and Timeline

The PCSS is a key element of both STPs/CCGs' response to the NHS Long Term Plan (LTP). It is critical that the stages, outputs and timeline for PCSS aligns to the process for the development of the LTP and any similar plans and engagement under development by Local Authority partners.

The diagram below is an ambitious but deliverable timescale for the PCSS, and assumes that stakeholder engagement will be aligned with, not separate to, that already in planning for the development of the LTP.



Further work is underway to set out the specific deliverables, milestone and interdependences for the above project phases.

6. Information Sharing

At the Leadership meeting on 25th February, attendees agreed in principle to an open and transparent process for information sharing, and that requests for information associated with this project would be responded to in a timely manner.

Information requirements are being defined following the leadership meeting on 22 March, with the agreed approach of keeping the data analysis high level but clearly aligned to the agreed Drivers for Change in Section 4. This is intended to enable decision making on the services in Category 2 and 3 where there are strategic opportunities for improvement through closer collaboration as a Peninsula/STP system.

7. PCSS Governance

Although there is agreement in principle to work collaboratively on this Strategy, it is critical that the development of the Strategy is supported and has formal engagement and approval mechanisms through each participating STP/CCG/LA/Provider system.

The CIOS and Devon STP Governance decision making and engagement mechanisms for PCSS are described below, with (J) indicating joint membership, (D) indicating those fora where approval must be sought for any proposals and (A) indicating key internal advisory fora that must be effectively consulted and engaged:

DEVON STP	CORNWALL & ISLES OF SCILLY STP
Collaborative Board (D)	Shaping our Future Transformation Board (D)
Programme Delivery Executive Group (D)	Integrated Care System CEO Group (D)
CEO Forum (A) Devon	Planned Care Board (D) (A)

PCSS Leadership Group (J) (D)

Peninsula Operational Delivery Group (J) (A)

Clinical Cabinet (A)	Clinical Practitioners' Committee (A)

Clinical Service Delivery Networks (A) (J – where confirmed mutual priority)

Planned Care Control Centre (A)

Specialised Commissioning Groups (J) (A) (D)

Alongside the STP Governance Systems, each partner organisation will be responsible for bringing PCSS information and proposals through their governance systems and providing feedback through their membership of the PCSS Leadership Group.

This request to all PCSS partner organisations to consider and endorse this Initiation Paper is a key element of that Governance process.

Within the process for development of both systems' LTPs, engagement and consultation with key political and representative groups is planned and the PCSS will be a key element of that process.

8. PCSS Leadership Group

The Strategy will be shaped and driven by a Peninsula Clinical Services Strategy Leadership Group with the following agreed membership:

- Clinical Chair*
- Senior Responsible Officer for the Strategy

- STP Leads
- LA/CCG Lead Commissioners
- Providers' Medical/Nursing Directors and COOs
- Strategic Mental Health representation
- Primary Care representation
- NHSE Specialist Commissioners

* Joint clinical chairmanship has been proposed (Tamsyn Anderson, Cornwall & IOS STP Clinical lead, Rob Dyer, Devon STP lead Medical Director)

Population of the membership of the above Leadership Group has been formally agreed by system leaders at the PCSS meeting on 22 March, and a formal request for nominations issued.

The appropriate engagement and inclusion of user representatives was discussed and it was agreed that the Joint Communications Leads would review the service user representation in the current STP governance structures to assess whether there would be sufficient influence through those channels to inform the work of the Strategy or whether membership of the PCSS Leadership Group is required.

As the PCSS process identifies the priority areas for service specific but system wide improvement opportunities, a more targeted user involvement approach will be put in place to shape and inform this more detailed work.

9. Project Team Resources

To support the PCSS Leadership Group to move at pace to deliver a significant service strategy as envisaged in the project brief, significant project resources are required as well as co-ordination across other areas of work such as specialised commissioning, clinical networks, planned care, etc.

Discussions are underway with NHSI/E, STP and CCG senior staff as to how we could populate the skills and capacity required and how any gaps could be addressed. Many of the existing clinical engagement groups will be involved in the 'check and challenge' development process for the Strategy, so there is an assumption that provider input to these groups will be maintained and strengthened as required**,** with additional clinical engagement supported as required.

Our STPs do not have resources for significant engagement of external consultancy, so it is proposed that the majority of the skills and capacity required to deliver PCSS comes from within the current capacity of the partner organisations within both STPs, and links with current workstreams will provide intelligence and alignment.

The skills and capacity requirements are broadly described below:

Project Director, supported by PMO lead(s)

Clinical Network Development and Engagement lead(s)

New models of care horizon scanning

Planned Care lead(s)

Information and analytics

Finance

Communications

The PCSS must be underpinned by the wider financial strategy of both STPs as part of the LTP, ensuring that it enables and supports the changes proposed.

10. Next Steps

At the meeting on 25 March, Dr Rob Dyer and Dr Tamsyn Anderson and the Peninsula Medical Directors were mandated to finalise the Categorisation of Services to bring back to the next Leadership meeting in early May.

As part of Stage 1, an analysis of the current state will be progressed to provide a baseline for the Strategy, informed through planned engagement with the Leadership nominees for each Provider and their lead Commissioner to discuss service risks. It is hoped that this can be completed at pace so that an assessment of the 'current state' analysis can be brought to the meeting in May.

Discussions have been held with Specialised Commissioning colleagues and there is an agreement that there should be an alignment of their key priority areas with the work of the PCSS, with joint working on those priorities to ensure consistency.

Appendix 1 – Invitees and attendees of the Clinical Services Strategy engagement and scoping meeting on 22nd March 2019, 2 – 4pm, the Arundell Arms, Lifton.

Attendees	Job Title	Organisation
Pete Adey (PA)	Chief Operating Officer	RD&E Foundation Trust and Northern Devon Healthcare Trust

Jayne Carroll (JC)	Programme Director for Clinical Services Strategy	New Devon and SD&T CCGs
Shane Coe (SC)	Head of Locality Support	NEW Devon and SD&T CCGs
Luke Culverwell (LC)	Chief Operating Officer	NHSE South - Specialised Commissioning
Liz Davenport (LD)	Chief Executive Officer	Torbay and South Devon NHS Foundation Trust
Rob Dyer (RD)	Lead Medical Director, Devon STP	Torbay and South Devon NHS Foundation Trust
John Harrison (JH)	Chief Operating Officer	Torbay and South Devon NHS Foundation Trust
Warwick Heale (WH)	Programme Director	Devon STP
Phil Hughes (PH)	Medical Director	University Hospitals Plymouth NHS Trust
Ann James (AJ)	Chief Executive Officer	University Hospitals Plymouth NHS Trust
Susan Joy	STP Programme Support	Devon STP
Sonja Manton (SM)	Director of Strategy	South Devon and Torbay and NEW Devon CCGs
Ethna McCarthy (EMc)	Director of Planned Care	Cornwall and IOS Health & Care System
Mairead McAlinden (MMc)	Peninsula Clinical Services Strategy SRO	Devon STP
Adam Morris (AMo)	Chief Executive Officer	Livewell Southwest
Rob Parry (RP)	Medical Director	Royal Cornwall Hospitals NHS Trust
Jackie Pendleton (JP)	Chief Officer	NHS Kernow CCG

Kate Shields (KS)	Chief Executive Officer	Royal Cornwall Hospitals NHS Trust
Suzanne Tracey (ST)	Chief Executive Officer	RD&E Foundation Trust and Northern Devon Healthcare Trust
Apologies		
Darryn Allcorn (DA),	Chief Nurse	Northern Devon Healthcare Trust
Tamsyn Anderson (TA)	Director of Primary Care, System Clinical Lead	Cornwall Partnership NHS Foundation Trust
Penny Atkinson (PA)	East Cornwall Locality Lead	NHS Kernow CCG
Kevin Baber (KB)	Chief Operating Officer	University Hospitals Plymouth NHS Trust
Jo Beer (JB)	Director of Winter and Partnerships	University Hospitals Plymouth NHS Trust
David Brown (DB)	General Manager, Primary Care Development	University Hospitals Plymouth NHS Trust
Peter Burbridge (PB)	Consultant Physician	Livewell Southwest
Chris Burford (CB)	Deputy Director of Nursing	Devon Partnership NHS Trust
Phil Confue (PC)	Chief Executive Officer	Cornwall Partnership NHS Foundation Trust
Caroline Gamlin (CG)	Medical Director	NHSE (SW)
Lorna Collingwood-Burke	Deputy Chief Officer/Chief Nursing Officer	NEW Devon and SD&T CCGs
Helen Childs (HC)	Chief Operating Officer and Specialised Services Lead for Cornwall	NHS Kernow CCG
Iain Chorlton (IC)	Chair	NHS Kernow CCG

Mike Cooper (MC)	Medical Director	Livewell Southwest
Greg Dix (GD)	Director of Nursing	University Hospitals Plymouth NHS Trust
John Dowell (JD)	STP Director of Finance	SD&T CCG
Adrian Harris (AH)	Medical Director	RD&E Foundation Trust and Northern Devon Healthcare Trust
Emma Herd (EH)	Head of Strategic Developments	South Devon and Torbay and NEW Devon CCGs
Paul Keedwell (PK)	Executive Director of Nursing	Devon Partnership NHS Trust
Tracey Lee (TL)	Programme Director	Shaping our Future, Cornwall and Isles of Scilly
Vaughan Lewis (VL)	Medical Director	NHSE South – Specialised Commissioning
Sharon Linter (SL)	Director of Nursing	Cornwall Partnership NHS Foundation Trust
Liz Mearns (LM)	Interim Regional Medical Director and Higher Level Responsible Officer (South West)	NHS England
Andrew Millward (AM)	Systems Director of Communications and Engagement	Devon STP
David Somerfield (DS)	Medical Director	Devon Partnership NHS Trust
Simon Tapley (ST)	Chief Executive (Represented by Sonja Manton)	NEW Devon and SD&T CCGs
Piers Tetley (PT)	STP Director of HR & OD	NEW Devon CCG
Liz Thomas (LT)	Deputy Medical Director	NHS England (SW)
Michelle Thomas (MT)	Chief Operating Officer	Livewell Southwest

Jane Viner (JV)	Chief Nurse	Torbay and South Devon NHS Foundation Trust
Melanie Walker (MW)	Chief Executive Officer	Devon Partnership Trust
Robert White (RW)	CCG GP Lead in Hospital Services	Cornwall and IOS System
Em Wilkinson-Brice (EW-B)	Deputy Chief Exec/Chief Nurse	RD&E Foundation Trust

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(GOVERNING BODY)

Report title: 2019/20 System and CCG Operating Plan				
Date of committee: 27th June 2019 **Date report produced: 13th June 2019**				
Author (s) Name and Title: **Nick Pearson, Head of Communications & Engagement** **John Dowell, Director of Finance** **Contact Details:**		**Supporting Executive:** **Name and Title: John Dowell, Director of Finance** **Contact Details:** **Report Approved by:** **Name and Title:** **John Dowell, Director of Finance** **Date 16th June 2019**		
Public or Private (Governing Body only):	**Public**	**Public**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report sets out the summarised financial and performance plans for the CCG for the 2019/20 year. It also sets this plan in the context of the wider Devon Health System.

The financial and performance plans will form the basis against which monthly reporting to Governing Body will be undertaken throughout the year.

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 Committee

Governing Body in Development Session

Key recommendations and actions requested:
The Governing Body is asked to • **Note the STP context and key deliverables contained in the 2019/20 Operating Plan** • **Approve the CCG Financial Plan for the year**
Impact on Strategic Objectives
The Operational plan is developed in order to deliver the CCG's strategic objectives: **Commission Safe and Effective Services** **Develop Strategic commissioning plans which improve the physical and mental health of the population** **Work in partnership with the wider health and care system to commission integrated and personalized care** **Make best use of 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	Any service implications from this operational plan are subject to the CCG Equality and quality impact assessment (EQIA) processes	Yes
Equality	Any service implications from this operational plan are subject to the CCG Equality and quality impact assessment (EQIA) processes	Yes
Resource and Finance	This plan sets out the budgets set to deliver the CCGs financial objectives	Yes
Legal		No
Engagement and Consultation		No

Risk	Operational and financial risk against delivery of corporate objectives that guide the development of this operational plan are regularly assessed and reported as part of the CCG risk management process	Yes

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

STP & CCG 2019/20 Operational Plan

Introduction

Devon Clinical Commissioning Group was established on April 1, 2019 (CCG). It is the fifth largest CCG in the country with an annual commissioning budget of £1.8 billion.

The new organisation creates a significant opportunity to improve efficiencies by working at scale, and to be a key partner with local authority colleagues to achieve truly integrated services for the population.

All CCGs are required to submit an annual operating plan to NHS England.

This year for the first time NHS partners within Devon were also required to submit a system operating plan. This is known as the Devon Sustainability and Transformation (STP) plan.

The following paper sets out the key elements of this.

Background

The Devon Sustainability and Transformation Partnership (STP) operating plan for 2019/20 demonstrates Devon's integrated approach to planning and reflects and connects the CCGs ambitions with those of the wider system.

As an aspirant Integrated Care System (ICS), this partnership approach underpins the CCG leadership role that will support and enable a high functioning ICS in the county.

In this context, the CCG has a key responsibility to shape the future strategic commissioning function with partners, be a catalyst for change and to pro-actively engage with providers and local communities to achieve better health, wellbeing and care for the population.

System vision and objectives

The STP 2019/20 operating plan sits within a common Devon-wide vision and a set of shared strategic objectives.

The STP vision is "to *transform our services so that we can achieve improved wellbeing, better health and better care for the populations we serve, as well as improved efficiency so that we can continue to offer the services that people need within the budget available*."

The STP objectives are to achieve:

- Excellence in service delivery and performance.
- Improved health and wellbeing for communities.
- Integrated care for people.
- Improved care for people.
- Empowered patients/users who are experts in managing their care needs.

Achievements to date

Devon has benefited from working as a system since 2016. The STP has enabled health and social care partners to collaborate to tackle historic challenges.

This has seen progress on financial and service challenges, and has helped build a stronger foundation for Devon's health and care services for the future.

Together, our partners have worked to reduce overspending within the health system.

Services in Devon have improved: Care Quality Commission ratings for our adult social care providers are better than national averages and all GP practices are rated as 'outstanding' or 'good'.

Devon has been recognised in the NHS Long Term Plan published earlier this year as second in the country for introducing alternatives to face-to-face appointments with GPs: e-Consult is available to over 600,000 patients, with a 500% rise in activity in just nine months.

Key challenges

Despite notable achievements during 2018/19, Devon remained one of the most challenged systems in the country when meeting core standards, including 6 week diagnostic waits, 62-day and 2-week cancer waits, 18 and 52 week waits, referral to treatment targets and 4-hour waits.

The causes of this are multi-factorial. For example, there have been significant increases in cancer referrals, a higher level of A&E attendances and greater acuity of patients admitted emergencies.

Like other parts of the country. Devon is also suffering from a shortage of clinical staff, making it more difficult to run some services effectively.

Overall strategy

The Devon STP operating plan for 2019/20 is focused on balancing both financial and service priorities.

The STP also continues to develop and mature our system working arrangements in line with our ambition to move from a Sustainability and Transformation Partnership towards an Integrated Care System.

To achieve this in 2019/20 we will be focusing on the following:

- Further development of our system financial operating model, strengthening the relationship between care redesign and finance;
- Further development of our population health management capability;
- Maturing our approaches to system working, including a refresh of our system governance to support a 'system first' approach.

Meeting core standards

The STP operating plan commits system partners to improving performance in core standards.

During 2019/20 the system plans to:

- Eliminate 52 week waits.
- Reduce diagnostic 6-week waits, where the CCG is a national outlier, from 14% in 2018/19 to 3% with progress made in reducing long waits at all providers.

By March 2020, recovering cancer performance against the 2 week wait targets and making progress against the 62-day target sustainably, reducing longest wait patients.

The STP will also:

- accelerate the Integrated Care Model, ensuring this is implemented in the CCG's four localities to improve care and reduce emergency demand. This new model will see closer working between acute, community, primary care, social care and mental health.
- deliver a new Clinical Services Strategy, which will have key short, medium and long term benefits and develop our new Clinical Service Delivery Networks to improve the resilience of acute services and mitigate risks to performance standards
- meet the required investment level in mental health and make further improvements across these services.
- rebalance system resources in order to reduce health inequalities, including a £2m system investment in prevention
- improve the cost-effectiveness of provision across the system, increasing day case and outpatient procedure rates.
- tackle workforce shortages across the health and care system and reduce dependency on agency staff.
- contain growth in GP referrals and outpatient appointments through universal access to consultant advice and guidance; implementation of agreed system standards for outpatient follow ups; and using opportunities presented by the development of PCNs.
- implement a Devon-wide approach for patients at risk of waiting more than 52-weeks

The STP is also focused on building leadership capacity and strengthening our governance and accountability arrangements to drive our key system programmes, including strengthening local leadership to support the implementation of our Integrated Care Model and other developments at locality level.

Priorities for 2019/20

To achieve the objectives outlined in Devon this year we will focus on the following priorities.

This year we will:

1. Accelerate the digital opportunities for the system:
    - Making Devon 'feel' like one system with shared, consolidated and integrated patient records
    - Sharing technological infrastructure and technical design
    - Digital citizen: addressing public demand for digital services and self-care options
    - Harnessing information for data analytics, intelligence and governance.
2. Develop a Clinical Services Strategy for Devon, Cornwall and the Isles of Scilly and develop clinical service delivery networks to promote greater collaboration between clinical teams, improve service resilience, reducing unwarranted variation and improve efficiency.
3. Pilot implementation of national community models for mental health: improving the interface between primary and secondary care, work on geographical scope of specialist services and shifts in investment to achieve this. The system has committed to the Mental Health Investment Standard in the system finance plan.
4. Invest in prevention, with a ring-fenced additional £2 million.
5. Address financial inequalities and health inequalities with a focus on people or groups suffering the poorest health outcomes.
6. Implement our Integrated Care Model. Completing the integration of the system-wide Integrated Care Model blueprint, embedding Population Health Management with targeted interventions within the community.
7. Implement our workforce strategy to:
    - Reduce reliance on agency staff and reduce cost.
    - Create a Devon-wide recruitment bureau.
    - Manage talent across all organisations to aid retention and boost recruitment.
    - Introduce workable, flexible shift patterns that meet the needs of modern workers.
    - Train staff so that they can use new technology.

STP Financial framework & CCG Financial Plan

Health commissioners and providers within Devon operate within an agreed financial framework, with a system control total and a focus on reducing real cost in the short and long term.

In the year just ended (2018/19), the Devon System delivered an aggregate deficit of £82.1m before the benefit of external sustainability funding (PSF and CSF), reducing to £18.2m with the benefit of that support.

Table 1: 2018/19 Devon STP Financial Outturn

Organisation	Surplus/ (deficit) including PSF & CSF £'m	Surplus/ (deficit) excluding PSF & CSF £'m	Savings achieved £'m	CIP %
NHS Devon CCG	0.0	-25.0	72.0	4.4%
Royal Devon & Exeter NHS FT	19.7	-2.9	20.5	4.2%
University Hospitals Plymouth Trust	-27.2	-33.3	23.0	4.5%
Northern Devon Healthcare NHS Trust	-16.6	-16.6	6.5	3.1%
Torbay and South Devon NHS FT	-2.7	-8.2	18.5	4.2%
Devon Partnership Trust	7.4	2.7	7.6	4.5%
Livewell Southwest	1.1	1.1	4.0	3.5%
Total	**-18.2**	**-82.1**	**152.2**	

For 2019/20 we have been set a challenging control total of a £43m deficit, but with further recognition from NHS England that £25m of spending supported by central Commissioner Sustainability Funds (CSF) would again be allowable in 2019/20, plus a further £2m on a one-off basis.

Table 2: Devon STP Summary 2019/20 Financial Plan

Organisation	Surplus/ (deficit) including PSF, FRF, MRET £'m	Surplus/ (deficit) excluding PSF, FRF, MRET £'m	Savings planned £'m	CIP %
NHS Devon CCG	-27.0	-27.0	80.9	4.3%
Royal Devon & Exeter NHS FT	7.4	-2.8	22.0	4.3%
University Hospitals Plymouth Trust	0.0	-22.4	25.6	4.7%
Northern Devon Healthcare NHS Trust	0.0	-14.1	10.0	4.6%
Torbay and South Devon NHS FT	4.6	-3.8	20.0	4.1%
Devon Partnership Trust	1.6	0.3	7.9	4.0%
Livewell Southwest	1.1	1.1	4.2	3.6%
Total	**-12.3**	**-68.7**	**170.6**	

To deliver this and deal with the significant performance challenges to address, including eliminating 52-week waits, meeting core national standards for cancer (2-week and 62-day waits) and improving A&E performance, requires system-wide transformation and maximum focus on delivery throughout 2019/20.

Progress towards our financial target will be monitored robustly with variable financial impact assessment undertaken by commissioner and providers.

To deliver the CCG element of the System plan set out above, detailed expenditure, savings and efficiency plans for the CCG have been presented to the CCG Finance Committee, and will form the basis for the monthly finance reporting to Governing Body.

The summarised CCG Expenditure plan for Approval is set out below

NHS Devon CCG	15N	
Financial Position		
Revenue Resource Limit		
£ 000	2018/19	2019/20
Recurrent	1,629,649	1,881,834
Non-Recurrent	41,537	-
Total In-Year allocation	1,671,186	1,881,834
Income and Expenditure		
Acute	851,329	897,199
Mental Health	186,810	200,436
Community	266,309	264,835
Continuing Care	108,965	112,637
Primary Care	224,429	224,432
Other Programme	20,986	16,395
Primary Care Co-Commissioning	-	160,996
Total Programme Costs	**1,658,827**	**1,876,930**
Running Costs	21,111	22,496
Contingency	-	9,409
Total Costs	**1,679,938**	**1,908,834**

Action:

The Governing Body is asked to

- Note the STP context and key deliverables contained in the 2019/20 Operating Plan
- Approve the CCG Financial Plan for the year

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: Thursday 27th June 2019

Dates of Committees covered in this report: 20th June 2019

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

Chair's Name and Title: Brian Mackness, Non-Exec Director (Finance)

Contact Details:

Reports discussed and assurances received

- **Risk Register report**
- **Devon CCG Monthly Finance report**
- **GB Quality & Performance report**
- **19/20 Operational Financial plan and budgets**

Reports received and noted

- **Risk Register report**
- **Devon CCG Monthly Finance report**
- **GB Quality & Performance report**
- **Single Source Waivers**

Risk Register Review (changes and areas of concern)

- **No risks were recommended for closure**
- **One new risk to be added to the register**

Committee Decisions

- **Agreed to extend the procurement policy until the September committee**

Recommendations for Governing Body

- **Approval of the 19/20 Operational Financial Plan**

Recommendations for other Committees
•
Terms of Reference or other committee effectiveness issues
•

Management of Conflict of interests:

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

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: FINANCIAL PERFORMANCE REPORT					
Date of committee: 27th June 2019 **Date report produced:** 20th June 2019					
Author (s) Name and Title: **Finance, Business Intelligence and Contracting Directorate** **Contact Details:** Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting)			**Supporting Executive:** John Dowell **Name and Title:** Director of Finance **Contact Details:** **Report Approved by:** **Name and Title:** John Dowell, Director of Finance **Date** 20th June 2019		
Public or Private (Governing Body only):			**Public**	✓	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**		**Information** ✓
Does this report place individuals at the centre?			**Yes**	✓	**No**

Executive Summary:

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

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

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

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

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

At this early stage of the year limited data has been received, so unless otherwise stated contract/service performance is reported in line with the plan/budget for 2019/20.

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

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

None

Key recommendations and actions requested:

The Governing Body is asked to note the month 2 position as at 31st May 2019 and the level of risk to delivery of the CCG's control total.

Reference to other documents or accompanying papers:

n/a

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

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

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

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

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

NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Month 2 – 2019/20

Contents

Appendices

1. Executive Summary

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

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

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

Since the initial assessment The Devon System has been through an intensive programme, supported by NHSE&I colleagues, to reach an acceptable position in relation to financial performance against control total. This has seen a rapid improvement in the gross system deficit from £115m to £70m (a distance of £27m from control total) based on significantly increasing the level of ambition in our plan and accelerating the pace of change in the transformation programmes the System is undertaking. This revised plan remains draft while we await NHSE&I's approval. Within the system plan the CCG submitted a Financial Plan for 2019/20 which sets out a forecast deficit to 31st March 2020 of £27m. Within this the CCG has a savings target of £81m which includes the £45m anticipated improvement through accelerating transformation programmes as described above. All parties in the system recognise the challenge this represents and are committed to developing a detailed risk share between NHS partners to enable all parties to recognise individual contributions to the shared risk of delivery.

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

Financial Position

This report sets out the financial performance of the CCG to the end of May 2019 (month 2 management accounts).

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

	Planned Deficit £'000	Actual Deficit £'000	Variance to plan £'000
Year to date position	4,500	4,500	0
Forecast Outturn	27,000	27,000	0

There are no significant variances to report at Month 2 other than the risk to deliverability of the as set out below and in later sections.

Savings Plan

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

Risk

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

STP Plan

The CCG's plans sit within an overall plan for the STP which has a deficit of £69.8m (excluding anticipated Transformation Funding) with a savings plan of £166.3m. The plan is based on an agreed set of block contracts but with a large proportion of the savings predicated on joint working to reduce cost within those contracts through an accelerated transformation programme.

Should the system deliver its planned deficit position providers are expecting to receive £56.4m of Transformation funding resulting in an overall STP deficit position of £13.4m.

2. Financial Assurance Dashboard

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

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

- Financial plan
- In Year Financial performance

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

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	4.5	4.5	0.0%	RED
3	Forecast Outturn in year deficit	27.0	27.0	0.0%	RED
4	QIPP - Year To Date Delivery (% achieved)	-5.6	-3.2	57.1%	RED /AMBER
5	QIPP - Forecast Outturn Delivery	-80.9	-80.1	99.0%	GREEN
6	Running Costs	25.4	22.6	88.9%	GREEN
7	Risk adjustment to deficit (% of allocation)	0.0	39.5	2.1%	AMBER/ GREEN
8	Cash Position (% drawn down)	16.7%	16.1%	96.6%	GREEN
9	BPPC (% paid - value)	95%	99.8%	105.0%	GREEN

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

3. Detailed Financial Performance

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

Month 02 May	DEVON CLINICAL COMMISSIONING GROUP					
	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES						
Acute Services	155,939	155,939	0	935,636	935,636	0
Mental Health Services	33,406	33,406	0	200,437	200,437	0
Community Health Services	40,121	40,204	1	240,724	240,724	0
Complex Care	19,406	19,406	0	116,432	116,432	0
All Other Healthcare	2,346	2,263	0	8,553	8,552	-1
Primary Care Services						
Prescribing	32,332	32,331	0	193,990	193,990	0
Other Primary Care	30,825	30,825	0	190,474	190,474	0
Primary Care Subtotal	63,157	63,156	0	384,464	384,464	0
Subtotal	314,374	314,374	0	1,886,245	1,886,244	-1
CORPORATE						
Running Costs	3,765	3,765	0	22,589	22,589	0
TOTAL COMMISSIONED SERVICES	318,139	318,139	0	1,908,834	1,908,834	-1
Allocation excl b/fwd position	313,639	318,139	4,500	1,881,834	1,908,834	27,000
2018/19 Surplus/Deficit	4,500	-	4,500	27,000	-	27,000

There are no significant variances to report at Month 2 other than the risk to deliverability of the as set out below and in later sections.

When set against our available in year revenue resources of £1,882m for Devon CCG the expenditure plan results in an overspend of £27m.

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

3.1 Acute Services

The CCG 2019/20 activity planning with providers has been submitted to NHSE. The four providers in Devon are forecasting variable growth in activity for 2019/20.

The highest area of growth is for elective activity, which is designed to maintain sustainable RTT waiting list sizes and to significantly reduce the number of patients waiting over 40 weeks, minimising the risk of 52-week breaches.

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

The table below presents the activity and financial savings by provider for each transformation scheme.

2019/20: Activity & Financial Reductions

		STP		TSD		UHP		RDE		NDHT	
Transformation Action	Scheme	Act	£k	Act	£k	Act	£k	Act	£k	Act	£k
Reducing activity growth	Ortho Bunion threshold	253	£ 969	64	£ 251	93	£ 384	72	£ 256	24	£ 78
	Ortho shoulder threshold	28	£ 164	8	£ 45	4	£ 24	10	£ 63	6	£ 32
Implementation of ICM	Reduce 19/20 growth in urgent care to 0.45%	2,675	£ 4,500	-	£ -	1,175	£ 2,000	1,000	£ 1,700	500	£ 800
Outpatient transformation	1st:fup reduction (improving to best in Devon)	101,015	£ 6,566	15,385	£ 1,000	41,923	£ 2,724	18,354	£ 1,193	25,354	£ 1,648
Intensity gradient	Inpatient to daycase	1,132	£ 2,264	300	£ 600	42	£ 85	322	£ 644	467	£ 935
	Day case to opa	4,000	£ 3,000	1,000	£ 750	1,000	£ 750	1,000	£ 750	1,000	£ 750

Across the system this will mean reducing activity by 14% for follow-up outpatients and 2% for elective inpatients in 2019/20, with growth for day cases reduced from 4% to 2% and emergency admissions from 5% to 3%.

The table below presents the scheme reductions by POD across the STP

STP: Activity Planning Submission - POD Activity Reductions

Activity Line	STP	RDE	NDHT	UHP	TSDFT
Total Consultant Led Outpatient Attendances	**- 101,015**	**- 18,354**	**- 25,354**	**- 41,923**	**- 15,385**
Consultant Led First Outpatient Attendances					
Consultant Led Follow-Up Outpatient Attendances	- 101,015		- 25,354	- 41,923	- 15,385
**Total Outpatient Appointments with Procedures	4,000	1,000	1,000	1,000	1,000
Total Elective Admissions	**- 4,281**	**- 1,082**	**- 1,028**	**- 1,097**	**- 1,072**
Total Elective Admissions - Day Case	- 3,121	- 750	- 555	- 1,051	- 764
Total Elective Admissions - Ordinary	- 1,160	- 332	- 473	- 46	- 308
Total Non-Elective Admissions	**- 2,675**	**- 1,000**	**- 500**	**- 1,175**	**-**
Total Non-Elective Admissions - 0 LoS	- 1,338	- 500	- 250	- 588	-
Total Non-Elective Admissions - +1 LoS	- 1,337	- 500	- 250	- 587	-

**Susbset of OPA

The outpatient appointments with procedures has activity increases due to shifting settings of care

Activity figures are linked to the delivery of performance improvement, particularly in reducing long waits for RTT and cancer. The table below shows the 2018/19 outturn and the 2019/20 plan at STP level. Having been through a system check and challenge process around our planned acute demand and activity growth assumption, we have identified improvement opportunity (a maximum of £19.4m) that could be achieved. The CCG planned levels of reduction against these plans, for each Provider to deliver, align to transformation schemes.

CCG: 2019/20 Activity Plan

Activity Line	CCG Activity Plan				Planned Reductions	CCG Revised Activity Plan		
	18/20 FOT	19/20 plan	Growth (v)	Growth (%)		19/20 plan	Growth (v)	Growth (%)
Total Referrals (General and Acute)	356,488	367,878	11,390	3.2%		367,878	11,390	3.2%
GP Referrals (General and Acute)	231,767	239,976	8,209	3.5%		239,976	8,209	3.5%
Other Referrals (General and Acute)	124,721	127,902	3,181	2.6%		127,902	3,181	2.6%
Total Consultant Led Outpatient Attendances	1,032,108	1,063,875	31,767	3.1%		962,860	-69,248	-6.7%
Consultant Led First Outpatient Attendances	347,158	356,545	9,387	2.7%		356,545	9,387	2.7%
Consultant Led Follow-Up Outpatient Attendances	684,950	707,330	22,380	3.3%	-101,015	606,315	-78,635	-11.5%
*Total Outpatient Appointments with Procedures	237,117	244,483	7,366	3.1%	4,000	248,483	11,366	4.8%
Total Elective Admissions	158,609	164,328	5,719	3.6%		160,047	1,438	0.9%
Total Elective Admissions - Day Case	132,908	138,020	5,112	3.8%	-3,121	134,899	1,991	1.5%
Total Elective Admissions - Ordinary	25,701	26,308	607	2.4%	-1,160	25,148	-553	-2.2%
Total Non-Elective Admissions	135,693	142,148	6,455	4.8%		139,473	3,780	2.8%
Total Non-Elective Admissions - 0 LoS	40,399	44,841	4,442	11.0%	-1338	43,503	3,104	7.7%
Total Non-Elective Admissions - +1 LoS	95,294	97,307	2,013	2.1%	-1337	95,970	676	0.7%
Total A&E Attendances excluding Planned Follow Ups	453,158	464,482	11,324	2.5%		464,482	11,324	2.5%
Type 1 A&E Attendances excluding Planned Follow Ups	293,328	297,816	4,488	1.5%		297,816	4,488	1.5%
Other A&E Attendances excluding Planned Follow Ups	159,830	166,666	6,836	4.3%		166,666	6,836	4.3%

**Please note outpatient procedures are a subset of total outpatients*

CCG Referrals Summary

Below is a summary of the CCG referrals for Month 1

NHS Devon CCG Referrals to Consultant Led Clinics - Summary Position for Month 1 2019

Summary Position

Provider	Referral Source	2018/19	2019/20	Variance	% Variance
NHS Devon CCG Total	GP/Dental	17,770	17,504	-266	-1.5%
	Other	9,179	9,686	507	5.5%
	Total	**26,949**	**27,190**	**241**	**0.9%**
ASI Referrals for reporting period (Apr) based on unbooked DRSS Deferred Referrals	***as at Jun 07th :***		597		
Royal Devon & Exeter	GP/Dental	6,119	6,590	471	7.7%
	Other	2,361	2,490	129	5.5%
	Total	**8,480**	**9,080**	**600**	**7.1%**
University Hospitals Plymouth	GP/Dental	4,729	5,041	312	6.6%
	Other	2,422	2,600	178	7.3%
	Total	**7,151**	**7,641**	**490**	**6.9%**
Torbay & South Devon FT	GP/Dental	3,675	3,253	-422	-11.5%
	Other	3,455	3,526	71	2.1%
	Total	**7,130**	**6,779**	**-351**	**-4.9%**
Northern Devon Heathcare	GP/Dental	2,096	1,690	-406	-19.4%
	Other	670	847	177	26.4%
	Total	**2,766**	**2,537**	**-229**	**-8.3%**
Other	GP/Dental	1,151	930	-221	-19.2%
	Other	271	223	-48	-17.7%
	Total	**1,422**	**1,153**	**-269**	**-18.9%**

Month 1 shows a flat referral position for the CCG although there is growth of 8.4% for GP 2ww referrals but this is offset with a reduction in routine.

2WW Routine Split

	2WW				Routine			
Referral Source	**2018/19**	**2019/20**	**Variance**		**2018/19**	**2019/20**	**Variance**	
GP	4,981	5,102	121	2.4%	12,752	12,390	-362	-2.8%
Dentist	23	11	-12	-52.2%	14	1	-13	-92.9%
Consultant	322	558	236	73.3%	4,500	4,719	219	4.9%
Other	87	152	65	74.7%	3,058	2,808	-250	-8.2%
A&E	102	158	56	54.9%	1,110	1,291	181	16.3%
Grand Total	**5,515**	**5,981**	**466**	**8.4%**	**21,434**	**21,209**	**-225**	**-1.0%**

The rolling 12-month view of referrals shows the growth specialities consistent across the providers is; T&O, Dermatology and Gynaecology.

UHP Rolling 12 Months Top 5 Specialties By Volume		
Specialty	Rolling 12 Months Volume	Rolling 12 Months Variance
Trauma & Orthopaedics	10,872	**17.30%**
Ophthalmology	10,188	-1.10%
Gynaecology	8,604	-5.30%
Dermatology	7,243	**24.80%**
Ear, Nose & Throat (ENT)	6,539	-0.60%

RD&E Rolling 12 Months Top 5 Specialties By Volume		
Specialty	Rolling 12 Months Volume	Rolling 12 Months Variance
Ophthalmology	14,476	-0.70%
Trauma & Orthopaedics	15,153	**0.90%**
Dermatology	11,581	**3.70%**
Ear, Nose & Throat (ENT)	10,055	**2.40%**
Gynaecology	9,790	**5.00%**

TSDFT Rolling 12 Months Top 5 Specialties By Volume		
Specialty	Rolling 12 Months Volume	Rolling 12 Months Variance
Trauma & Orthopaedics	10,414	-7.90%
Ophthalmology	9,275	-2.70%
Dermatology	7,502	**8.30%**
Ear, Nose & Throat (ENT)	7,138	**3.70%**
Gynaecology	6,589	-1.70%

NDHT Rolling 12 Months Top 5 Specialties By Volume		
Specialty	Rolling 12 Months Volume	Rolling 12 Months Variance
130 - Ophthalmology	4,769	-7.90%
330 - Dermatology	3,531	**8.80%**
100 - General Surgery	3,520	**10.30%**
502 - Gynaecology	3,382	**6.30%**
110 - Trauma & Orthopaedics	2,998	-0.40%

3.2 Mental Health Services

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

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

3.3 Community Health Services

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

3.4 Placements

At this early stage in the year the forecast is on budget however there is underlying risk that will require robust financial management over the coming months. The key risks relate to the CHC QIPP savings target of £5m that is embedded within the budget where further detailed plans are required to meet the full challenge and there is inherent risk around the assumption that the number of eligible clients will drop again this year.

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

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

3.5 Primary Care Services

Delegated Primary Care Commissioning

On 1st April 2019 Devon CCG took on the formal responsibility for primary care commissioning from NHS England. This means that the CCG is now responsible for a budget of £162m to commission GP services in Devon.

Primary Care Prescribing

It is too early in the year to accurately forecast expenditure, and the position has been reported at breakeven for both accrued year to date and forecast outturn. Work is currently under way to finalise the QIPP plans, with financial amounts allocated against each scheme. We are planning to start reporting against this plan for M03 to provide the assurance needed. The Data group is assisting with this to insure we are now consistently reporting across all areas and one source is used as appropriate.

It remains too early to understand the impact of price concessions, and subsequent tariff changes are having on the position, and it is assumed these are within planning assumptions, helping to inform a breakeven position.

Other Primary Care Services

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

3.6 All Other Healthcare

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

3.7 Running Costs

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

The forecast outturn at month 2 is estimated at £22.6m which would be an underspend of £2.8m when compared to the £25.4m allocation received.

3.8 Resource Allocation

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

	NEW Devon CCG	SD & Torbay CCG	Devon CCG
Planned revenue resources	£'000	£'000	£'000
Final allocation after place based pace of change	1,257,424	433,048	1,690,472
Other funding pace of change	2,191	475	2,666
Total recurrent revenue resources	**1,259,615**	**433,523**	**1,693,138**
Recurrent adjustments			1,486
Primary care commissioning			161,805
Running costs allocation			25,405
Total revenue resources			**1,881,834**
Total forecast expenditure			1,908,834
Total revised planned overspend 2019/20			(27,000)
B/fwd 2018/19 deficit	(170,460)	(14,548)	(185,008)
Cumulative planned overspend			(212,008)

4. QIPP/Systems Savings Plan

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

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

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

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

This means that for the CCG, although the total 2019/20 QIPP savings required is £80.9m, the transformational savings plans (i.e. not contractualised) within this amount to £37.0m. All parties in the system recognise the £37.0m challenge and are

committed to developing a detailed risk share between NHS partners to enable all parties to recognise individual contributions to the shared risk of delivery.

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

QIPP Delivery	Plan	Upside Forecast	Upside Risk	Downside Forecast	Downside Risk
Description	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Demand/activity management and transformation programmes	37,500	27,500	10,000	10,500	27,000
Reduction in spend on individual patient placements	2000	2,000	0	1,000	1,000
Joint commissioning	7,000	3500	3,500	0	7,000
Continuing healthcare	5,000	5,000	0	3,000	2,000
Primary care prescribing	8,000	8,000	0	4,000	4,000
Allocations/income	10,000	10,000	0	5,000	5,000
Further benchmarking opportunities	3,896	2,500	1,396	0	3,896
Non-rec opportunities	6,000	6,000	0	6,000	0
Procurement/contracting savings post merger	500	500	0	500	0
Running costs	1,000	1,000	0	1,000	0
Total QIPP	**80,896**	**66,000**	**14,896**	**31,000**	**49,896**

Future reports will provide more detail of the savings made to date as well as the estimated forecast savings for the CCG.

5. Risks

The assessment of financial risk at month 2 is estimated at £39.5m as follows.

Devon CCG		Month 2
Risk	**Description**	**£'000**
Acute Services	Latest assessment of the level of risk attached to the activity and transformation programmes being developed with system partners for delivery in 19/20. Monitoring arrangements and an appropriate risk share mechanism are being refined and implemeted	24,500
Mental Health Services	Potential risk of not delivering in full the target set for the reduction in cost of out of area placements.. There is a process for monitoring and managing this area and the arranegements in place	500
Community Healthcare Services	Reassessment of opportunities which were explored and delivered against in 19/20 but at present don't exist for this financial year.	7,000
Continuing Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arrenegmnts are in place through the Control Centre and this will be proactively managed during the year	1,000
Primary Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arramgements are in place to monitor delivery but the latest assessment doesn't meet the required target.	2,000
Primary Care Delegated Commissioning	Initial assessment in advance for full financial due diligence of the potential risks which may materialise in the next two years. This is currently being discussed and developed further with NHS England	1,500
Other Programme Services	Continuing assessment of opportunities for mitigating against some of the risk which exists in the CCG plan, including non-recurrent solutions and limiting existing exposure to cost pressures	7,000
Total Risk		**43,500**
Mitigations	**Description**	**£'000**
Acute Services	Potential sources of funding to mitigate opening plan risk being agreed with system partners	-2,000
Other Programme Services	Initial reassessment of opening plan risks and potential mitigating solutions	-2,000
Total Mitigations		**-4,000**
Total unmitigated risk		**39,500**

The scale of the unmitigated risk represents a significant challenge to the CCG delivering its plan for 19/20. Further work on mitigations either through acceleration of transformation programmes or other risk sharing mechanism are being considered by all partners in the Devon STP with a view to reducing the risk exposure to the CCG.

In addition, a detailed action plan is being prepared to provide assurance to the CCG Governing Body that all opportunities are being explored to address the challenge.

6. Other Financial Information

6.1 Statement of Financial Position

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

The CCG's position at 31st May 2019 is shown in appendix 1.

6.2 Capital

As part of financial planning the CCG had requested £168k of capital for business as usual projects, to include IT infrastructure. However, NHS England have informed the CCG that the bid for the resource was not approved and hence the CCG will need to deal with this accordingly.

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non NHS Creditors - % of bills paid within target	91.98%	99.63%
NHS Creditors - % of bills paid within target	91.49%	99.82%

The target of 95% has not been met for the number of invoices paid within 30 days. This looks to be due to the merger of the two CCGs. Legacy organisations invoices had to be re-scanned, coded and paid via Devon CCGs ledger which resulted in a delay in the process. It is our aim to ensure that that the CCGs performance gets back on track as the year progresses.

6.4 Cash

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

7 Recommendations

The Governing Body is requested to:

Note and review the month 2 year to date performance and the forecast year end position including the current risks around delivery of the CCG's control total.

Appendices

Appendix 1: Statement of Financial Position

AS AT 31 MAY 2019	DEVON CCG		
STATEMENT OF FINANCIAL POSITION	**OPENING**	**ACTUAL**	**MOVEMENT**
	£000's	£000's	£000's
NON CURRENT ASSETS			
Property Plant Equipment	0	3,118	3,118
Intangible Assets	0	10	10
Investment Properties	0	-	-
Trade & Other Receivables	0	0	0
Other Financial Assets	0	-	-
Total Non Current Assets	0	3,128	3,128
CURRENT ASSETS			
Inventories	0	328	328
Trade & Other Receivables - NHS	0	3,933	3,933
Trade & Other Receivables - Non NHS	0	12,165	12,165
Other Current Assets	0	-	-
Cash & Cash Equivalents	0	3,349	3,349
Non-current Assets held for Sale	0	-	-
Total Current Assets	0	19,775	19,775
Total Assets	0	22,903	22,903
CURRENT LIABILITIES			
Trade & Other Payables - NHS	0	- 23,375	- 23,375
Trade & Other Payables - Non NHS	0	- 113,811	- 113,811
Other Liabilities	0	- 978	- 978
Borrowings / Cash in Transit	0	- 23,002	- 23,002
Provisions	0	- 231	- 231
Total Current Liabilities	0	- 161,397	- 161,397
Total Assets less Current Liabilities	0	- 138,494	- 138,494
NON-CURRENT LIABILITIES			
Trade & Other Payables	0	-	-
Other Financial Liabilities	0	- 95	- 95
Total Non Current Liaibilities	0	-	-
Total Assets Employed	0	- 138,589	- 138,589
FINANCED BY TAXPAYERS EQUITY			
General Fund	0	138,589	138,589
Total Taxpayers' Equity	0	138,589	138,589

Appendix 2: Cash

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

Measure	Month 2
CCGs must operate within their Maximum Cash Drawdown (MCD) *The MCD is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,904.431m for Devon CCG the year.*	16.1% of the MCD has been utilised as at month 2 (16.7% is expected based on a straight-line trajectory at month 2).
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 £11,729 for May.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has not met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

NHS
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Clinical Commissioning Group

GOVERNING BODY

Report title: Locality Reports				
Date of committee: 27 June 2019 **Date report produced: 14 June 2019**				
Author (s) Name and Title: **Dr John Womersley, Northern Locality Representative** **Dr Simon Kerr, Eastern Locality Representative** **Dr David Greenwell and Dr Matthew Fox, Southern Locality Representatives** **Dr Shelagh McCormick, Western Locality Representatives**		**Supporting Executive: Dr Paul Johnson, Name and Title: Clinical Chair** **Contact Details: paul.johnson4@nhs.net** **Report Approved by: Locality Clinical Lead Representatives, Directors and Lay Members** **Date: 14 June 2019**		
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 these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Western and Southern Devon Localities.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				

Key recommendations and actions requested:
The Governing Body are asked to receive and note the contents of the locality reports,
Impact on Strategic Objectives
Commission Safe and Effective Services **Develop Strategic commissioning plans which improve the physical and mental health of the population** **Work in partnership with the wider health and care system to commission integrated and personalized care** **Make best use of 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	See individual reports	
Equality		
Resource and Finance		
Legal		
Engagement and Consultation		
Risk		

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

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Locality update report

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

Key achievements/progress

Eastern GP practices have established 11 primary care networks (PCN) with identified Clinical Directors (CD). These GP's have now met together for the first time 12th June at a refreshed Eastern GP collaborative board.

Invitations have been sent to PCN CD's to attend the next Eastern locality delivery group on July 3rd and the meeting is proposed to further explore joint working between primary and secondary care, health and social care. Planned care and A+E delivery board meetings continue and it's hoped to develop a local care partnership executive group from emergent clinicians and managers from these three locality group meetings.

3 member forum engagement meetings are planned for July to further explore urgent care provision, ambulance services and the potential for commissioning an additional alternative patient transport service.

Locality clinicians met again June 19th with clinical colleagues from the Northern locality and commissioning managerial leads at the joint locality preparatory board. The board spent some time exploring commissioning and provision concern with respect to cardiology.

The locality has 6 GP clinical sessions per week engaged and is working with HR to recruit a further 3 x 2 sessions with one "strategic clinical adviser" from each it's three districts both to support the forums within these districts and to enhance the clinical contribution to the commissioning of mental health, urgent care and preventative services

I represented the locality at STP collaborative board, integrated commissioning executive and Clinical cabinet during this month.

I now have oversight of reports from “some” commissioning leads in the locality regarding their achievements, progress, priorities & concerns and have had the opportunity to report some of these within this report.

Key priorities for the next three months

Recruitment of 3 locality strategic clinical advisers, one from each of the three district forum footprints.
It’s hoped these individuals might be ready to begin on an interim basis perhaps early in September.

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

Prepare for a joint GP members forum on Sept 18th to explore the opportunities digital technology can bring to health provision in east with engagement of primary, secondary clinical and managerial colleagues to attend.

Begin preparation for Governing body (GB) development and “showcase” for November in E. locality.

Further develop this monthly report to be of most use to GB.

Issues of concern or risk

Lack of co-ordinated and directed clinical commissioning time in the locality.

CCG exec clarity with regard to proposed and expected support from CCG to PCN clinical directors. E.g.: Understanding of whether “CCG initiated” PCN visits would be a good idea to discuss, referral/demand, prescribing, quality/safety management

On-going concerns re cardiology and community based secondary mental health services .

Out of area acute mental health bed usage remains a concern but has been consolidated through the procurement by DPT of 16 male beds at Cygnet, Taunton

Support required from CCG/system or barriers to progress

HR support to engage 3 strategic clinical advisors

Primary care commissioning support for greater clarity re working with new PCN’s

Further engagement of commissioning managerial leads with respect to helping to populate this GB report on a monthly basis.

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Locality update report

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

Key achievements/progress

- **Health coach with expertise in mental health appointed** – will offer targeted coaching to those with mental health issues.
- **Personal wheelchair budgets** implemented, with CHC offer now consistent with the rest of the CCG.
- **52-week wait** performance currently exceeding trajectory
- **End to end reviews of 12-hour breaches** completed
- South A&E Delivery Board revised ToRs and merged with the Trust's Patient Flow board to oversee **ED performance improvement** plans.
- **Winter review** completed, themes have informed wider Devon plan for winter 19/20.
- **Trusted assessor**: 21 homes now signed up. Excellent feedback from homes - other home managers hearing feedback now requesting to sign up.
- **TSDFT IT issues** – report presented to System Improvement Board detailing issues, but further assurance sought around future resilience
- **Local Care Partnership arrangements** – local delivery group membership refreshed and discussions held with clinical leads and partner organisations to agree structure of LCP and how it will fit within existing meetings architecture
- **Clinical leadership roles –** proposals drafted for further input with CCG leads

Key priorities for the next three months

- Formal feedback due from ECIST and NHSI work with TSDFT – will inform **performance improvement plan**
- Evolve and support **Local Care Partnership arrangements** – July/August
- Liaise with and support **development of PCNs** ensuring alignment with integrated community teams and evolving community mental health offer – clinical directors to be invited to LCP development workshop
- Confirming **local clinical commissioning expertise** to support key pieces of work – end of June
- Roll out of **social prescribing** framework in alignment with PCNs
- **Extend the personal budget** offer to people subject to S117 aftercare in mental health

Issues of concern or risk

- **TSDFT performance** and financial position remain a key concern. Feedback due from ECIST and NHSI expected to flag further performance concerns.
- **Dawlish MIU** operating reduced hours, inability to retain staff an ongoing issue which may lead to Trust requesting to reduce service even further.
- **Teignmouth Health and Wellbeing centre** public consultation delayed whilst business case and bid for purchase of land submitted. Decision due 7th July.
- **Dartmouth health and wellbeing centre** development is reliant on resolving GP practice relocation issues.
- **IG issues** stalling the implementation of One Devon dataset and risk stratification (STP-wide), core to the implementation of the ICM. ICM exec leads have agreed actions to unblock.
- **PCNs** potential for unplanned and uncoordinated working if not fully engaged with CCG

Support required from CCG/system or barriers to progress

- **Unblocking of IG issues** which are delaying progress on risk stratification model at STP level. (Action agreed at ICM exec leads meeting 6th June to ensure their IG leads resolve issues and prioritise)
- Likely that TSDFT performance will require exec-level focus and assurance, in partnership with NHSEI.

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Locality update report

Locality:	Northern
Period covered by update:	June 19
Locality clinical representative:	John Womersley
Locality executive lead:	Andrew Millward
Locality non-executive representative:	Charlotte Burrows

Key achievements/progress

- The Moorings mental health crisis café has had a very positive reception since opening in April 2019. There may be an opportunity to access additional Devon iBCF funding to expand the Moorings to further test out demand. This could enable consideration of opening additional hours and days.

- The Deep-Dive into Care Home data, cross-referencing Acute and 999, to identify causes for Northern outlying Care Home data has concluded that the increased admissions from care homes in NHDT is due to North Devon having a greater number of care home relative to other localities rather than a service deficit in the North.

- Strong sustained engagement continues with the Holsworthy Community Involvement Group and we are developing cross border collaborative opportunities with Kernow.

- One Northern Devon has elected to run a development day as soon as practicable to explore its role in the evolving requirements for Local Care Partnerships.

- As part of the development of the STP social prescribing programme and the new GP contract One Northern Devon and the four local Primary Care Networks are now working in partnership to deliver the programme.

- The Planned Care Programme in the North continues working to align with the priorities in the Long-term plan and priorities identified within the

Peninsula Clinical Service Strategy (PCSS). We now have clarity on the key deliverables within the Planned Care programme for 19/20 and these will include Demand Management, PCSS related projects and delivery of the national performance standards.

- The Northern sub-group of the STP Diabetes Transformation Steering Group has reviewed NDHT sustainability business case with clinical and operational leads at the Trust to ensure alignment and delivery of the Diabetes Strategy outcomes and to ensure sustainability of the initiative.

Key priorities for the next three months

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

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

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

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

- Great emphasis on co-produced data-sets that allow shared emphasis on the correct variances to manage. This has particular relevance in the Urgent Care arena.

- Engage with emerging PCNs and Clinical Directors on diabetes transformation plan.

- NHS Devon CCG now has responsibility for commissioning sexual violence therapeutic services for residents of Devon and Torbay. From 1 April 2019,

North Devon Healthcare Trust has been commissioned in-line with NHSE guidance to provide Sexual Violence and Therapeutic Services. NHS Devon CCG has received notification of additional £40k per annum to support this work. To increase capacity, sustainability and viability of a range of providers a procurement exercise will be undertaken to identify a suitable organisation to take forward delivery against the additional funds.

Issues of concern or risk

- NDHT's sensitivity to small changes in demand destabilising ED performance and flow through the hospital continues to be a challenge.

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

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

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

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

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

Support required from CCG/system or barriers to progress

- Early resolution to Community Urgent Care Strategy outcome.

- Many reports are compiled to cover the Northern and Eastern Localities combined. This makes local analysis, learning and planning more difficult. With the planned move to Local Care Partnerships we would request the localisation of reports whenever possible.

- Continued support required from CCG to support recruitment of locality clinicians to support delivery of the operating plan for 19/20 and the long-term plan.

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Locality update report

Locality:	Western
Period covered by update:	To 19th June 2019
Locality clinical representative:	Dr Shelagh McCormick
Locality executive lead:	Jo Turl
Locality non-executive representative:	Nick Ball

Key achievements/progress

- Primary Care Network Development
- Integrated Care Model (e.g. diabetes, respiratory, enhanced health in care homes, LTC health coach pilot, strength and balance to reduce frailty/falls) with refresh of priority programmes
- Children's Procurement – Implementation
- Improved Access
- Finalised specification for procurement of an Integrated Care Partnership Agreement of inclusion of Mannamead into Mayflower for 19/20 and successful communications

Key priorities for the next three months

- Joint support offer to general practice in Plymouth
- Agreement and contractualisation of ICM delivery in 19/20 with Livewell Southwest
- Primary Care Networks including early development of enhanced primary care teams and alignment of existing social prescribing programme and resources with Devon-wide approach and PCN engagement
- Integrated Care Partnership Procurement
- Integrated Care Model (5 priority programmes: Primary and community integration; multi-morbidity including LTC, frailty and dementia; population health management; wellbeing hubs; enhanced health in care homes)
- Implementation of demand plans through AEDB
- Population health management (Devon-wide and local projects)
- System pharmacy support offer to PCNs

Issues of concern or risk

- Emergency Department
- Operational Plan delivery
- Diagnostics
- Primary Care Provision
- Improved Access
- Pharmacy Workforce
- Population health management
- Social Prescribing provision
- ICP procurement

Support required from CCG/system or barriers to progress

- Resolution to information governance issues preventing rollout of population health management (Devon Linked Data Set)
- Request for progress update on equity workstream
- Resource to enable bridging of Social Prescribing workforce between end of funding from iBCF and establishment of new service developed by PCNs

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GOVERNING BODY

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

Date of Governing Body:

Dates of Committees covered in this report: 2nd May (ratified minutes) 6th June

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

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

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

Reports discussed and assurances received

- Members of the Committee discussed the following reports:

Finance Report

Ben Chilcott attended the Committee meeting. No Finance report for month 1. Ben presented to the group on Primary Care Delegation. Ben presented slides to the group showing information on the 18/19 allocation and forecast and the 19/20 allocation and forecast. Jo Turl thanked the Finance Team for their hard work in getting us to the current financial position.

Estates Update

Clive Shore attended the meeting via teleconference and presented slides to update the group on the preparation of a Primary Care investment plan.

Judy Hargadon asked Clive to return to PCC on a regular basis to keep the group up to date with progress.

Workforce Update

Pam Smith attended and Paula Knowles joined via Skype to update the group on workforce priorities for Primary Care. The group discussed recruitment and retention of medical and non-medical staff and Paula informed the group of various projects being undertaken to improve recruitment.

Primary Care Networks

Mark Procter reported on the Primary Care Networks paper, with the following key points:

- 31 applications have been received. All approved
- One practice has asked not to be in a network. One month to find a solution to this.

Primary Care Operational Group

Members of the Committee reviewed decisions made a Primary Care Operational Group and members endorsed the decisions made.

Primary Care Highlight Delivery Status

Gill Munday attended the Committee on behalf of Paul Baker and presented the Primary Care Highlight report with the following highlights:

- Paul Johnson congratulated the team on the increased use of e-consult
- Improved Access - Gill reported consistently high uptake across the patch and the team are working hard on 111 booking. Gill reported some technical issues which are out of our control
- Workforce Programme – the group discussed the recruitment of newly qualified GPs and how this can be encouraged and measured.

Mannamead Surgery Update

Mark Procter gave assurance that work is ongoing. Access Health is due to take over the Practice from 1st July. Pastoral support from LMC has been very helpful. Mark reported that Access Health are to take over before the end of the 6 month notice period and this will help with procurement timeline. Partners were happy with this approach.

Jo Turl thanked the team for their significant work. She also thanked LMC, Comms and Procurement

Reports received and noted

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

LMC Negotiation Meeting Outcome Report – Mark Procter reviewed the paper with the group with no actions.

Locality Flash Reports – Members noted the locality flash reports

Contracting Report – Mark Procter presented the contracting report. Members noted the temporary closure information and three new CQC reports, two of which were reported as ‘outstanding’ and one ‘good’. Paul Johnson congratulated these practices.

Forward Planner – Members reviewed and noted the Committee forward planner and agreed that Estates and Workforce should be reported to PCC on a regular basis.

Risk Register Review (changes and areas of concern)

- The Risk Register was reviewed by members with one elevation on risk this month. It was agreed to close two risks 09 and 68 and combine in a new risk 108

Committee Decisions

- The Committee endorsed decisions made at Primary Care Operational Group

Recommendations for Governing Body

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

Management of Conflict of interests:

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