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

Microsoft Teams

30 July 2020 13:30 - 30 July 2020 16:00

AGENDA

#	Description	Owner	Time
1	Patient Experience Presentation	Non-Exec Lay Member Public and Patient Involvement	13:30
2	Welcome and Apologies Verbal	Chair	13:45
3	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 15 July 2... 6	Chair	13:50
4	Minutes of last meeting and action log Paper 1 Draft Public GB minutes 18.06.2020 v2 PJ comm... 11 2 Master Action Log - PUBLIC v2 nc.xlsx 23	Chair	13:55
5	Chair's Report Paper 1 cover sheet chair's report.docx 24 Chairs Report July 2020 Draft.docx 26	Chair	14:00
6	Accountable Officer's Report Paper 1 Cover sheet template (002) AO Report Public Jul... 28 2 AO Report Public July 2020.docx 30 3 Appendix 1 - Cover sheet July 20 Devon CCG.do... 34 4 Appendix 1 - Restoration and Transformation GB... 36	Director of Finance	14:10
7	PROGRAMMES OF WORK		14:30

#	Description		Owner	Time
7.1	Devon Ethical Framework		Director	
	1 JulyGB_EthicsFrontSheet.docx	51		
	2 DevonEthicsPaperForOrganisationalBoards_v1.6...	54		
	AppendixA_DevonEthicalFramework_2.0_19.07.20...	58		
	AppendixB_DevonGuidance_AllocationAndWithdra...	70		
	AppendixC_Engaging on the Devon Ethical Frame...	79		
	AppendixD_Recommendations_EthicsEngagement...	87		
8	FINANCE, PERFORMANCE AND QUALITY			14:50
8.1	Month 3 Finance Report		Finance Director	
	Paper			
	1 FPC_Report_FPC_Month 3_FINAL_2020-21 (GB...	93		
	2 FPC_Report_FPC_Month 3_FINAL_2020-21 (GB...	96		
8.2	Performance and Quality Report		Chief Operating Officer/ Chief Nurse	
	Paper			
	Governing Body Public Performance Report 30 July...	113		
9	GOVERNANCE			15:15
9.1	NHS Devon CCG Constitution		Board Secretary	
	Paper			
	1 Paper for GB - constitution feedback from NHSE....	133		
	2 NHS Devon CCG constitution v3 25.06.20 NHSE...	137		
10	COMMITTEE CHAIR'S REPORTS			15:25
10.1	Remuneration and Strategic Workforce Committee		Chair of Remuneration and Strategic Workforce Committee	
	Paper			
	1 Rem Com Chairs Report - public 30.07.2020 v1n...	226		
	2. Appendix 1 ICS Chief Executive and AO of the C...	229		

#	Description		Owner	Time
10.2	Finance Committee Paper [P] Finance Committee Chair Report 16 July 2020 v2....	236	Chair of Finance Committee	
10.3	Audit Committee to include risk register Paper [P] 0. Audit Committee Chair Report 08.07.20 (V2).doc... [P] 1. Appendix 4 COVID Risk Register v1.11 16_25 Ju... [P] 2. Appendix 2 Corporate Risk Register Significant_... [P] 3. Audit committee ToR July 2020 approved.docx [P] 4. Appendix 5 Assurance Framework June 2020.xl... [P] 5. Risk Management Framework V6 - approved 080... [P] 5.1 Twelve Steps to Risk Management v2.pdf	240 243 248 255 265 283 318	Chair of Audit Committee	
10.4	Primary Care Committee Paper [P] Committee Chair Report - Public PCC - July 2020.d...	320	Chair of Primary Care Committee	
10.5	Quality Assurance Committee Paper [P] QAC Part 1 Chair Report July 2020 v2.docx	323	Chair of Quality Assurance Committee	
11	LOCALITY UPDATES			16:00
11.1	Northern, Eastern, Southern and Western Paper [P] 0 Locality Updates Cover Sheet.docx [P] 1 Northern Locality Report July 2020 V3.docx [P] 2 Locality Update Report - Eastern June.July 2020.... [P] 3. NHS Devon CCG WL Update Report - July 2020.... [P] 4 NHS Devon CCG - South Locality Update Report...	328 330 334 337 339	Locality Triumvirate	

Declaration of Interests Register - Governing Body, NHS Devon Clinical Commissioning Group
Report generated by the governance team on 15 July 2020

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Allcorn	Darryn	CCG and System Chief Nursing Officer Shared role with Phillip King to 20 June 2020 Caldicott Guardian	Member of Governing Body Member of Quality Assurance Committee Senior Leadership Team (SLT) CCG Executive Team Meeting Member of Devon JCEG	Honorary Associate Professor University of Exeter Seconded to NDHT		11/05/2020		09/07/2020	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Appleby	Gaynor	Non Executive Lay Member (Allied Health Professional)	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee Member of Remuneration and Workforce Committee	CQC Specialist Advisor Therapy Lead for Health and Social Care for North Devon		01/11/2019		05/05/2020	Non Financial	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Atherton	Glynis	Non Executive Lay Member- Quality Geographical remit - Eastern	Member of Governing Body Member Quality Assurance Committee (Chair) Member Primary Care Commissioning Committee Member of Remuneration and Workforce Committee (Chair)	Consultancy for FORCE cancer charity – not CCG funded but has a relationship with RD&E hospital Trustee for St. Margaret's Hospice, Somerset Volunteer for Hospiscare, Exeter – helping at events and proof reading applications to charitable trusts Volunteer for University of Exeter – mentoring students Member of the Labour party		14/05/2019		21/05/2019	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geographical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 , Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		10/05/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Blackford	Derek	Deputy Chief Finance Officer	Attendee of Audit Committee (Deputy for CFO) Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Member of Vacancy Control Panel	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Non Executive Lay Member - Patient and Public Involvement Geographical remit - Northern	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Member Primary Care Commissioning Committee (PCCC)	Self-Employment business consultant from September 2019 Associate for Research In Practice Feb 2020 Associate for Research In Practice Supplier/Associate for SWAHSN (Feb 2020) Associate for Devon Communities Together		04/04/2019		13/05/2020	Financial/Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt	Partner is employed by Livewell Southwest in position of influence	26/09/2017		15/10/2018	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Coles	Anna	Director of Integrated Commissioning Seconded to CCG to Associate Director of Commissioning (Western)	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019		12/03/2019				Plymouth City Council
	Davis	Alison	Associate Non-Executive Lay Member	Attendee of Governing Body	Plymouth City Council – Foster panel Chair Torbay Council- Foster panel Chair Pathway Care Fostering- Ashburton- Independent Reviewing Officer University of Exeter – student mentor Somerset County Council- casual employee		19/10/2019		19/10/2019	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015				Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Member of Primary Care Commissioning Committee (PCCC) Strategic Commissioning Programme Board	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	19/06/2018	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body A & E Delivery Board (SD&T)	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher GP Locality Clinical Director Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	28/07/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay and South Devon NHS Foundation Trust
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration and Workforce Committee(Non exec rem) Member of Devon JCEG	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	08/11/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Hargadon	Judy	Non Executive Lay Member - Primary Care and Prevention Geograhical remit - Southern	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) (Chair) Member of Remuneration and Workforce Committee		Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	10/03/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Harris	Penny	Management Consultant	Attendee of Governing Body Senior Leadership Team (SLT) Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Strategic Commissioning Programme Board	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training		23/07/2019	24/07/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	KERR Darnley Ltd
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body (Chair) Member of Remuneration and Workforce Committee Transition Sub Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	GP Partner, Cricketfield Surgery (ceased December 2019) Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Clinical Chair NHS Devon CCG 1 March 2017 Church Warden Holy Trinity Church Spouse works in emergency department at RDE and for Exeter Medical School Primary Care Network - Templar Care Network		21/08/2015	04/10/2018	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kennedy	Nick	Secondary Care Doctor	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) QEIA Panel Member of Audit Committee Member of Devon JCEG	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer Partner, Staplegrove Anaesthetists LLP, Taunton Partner Blackdown Orthopaedic and Spinal Services, Taunton Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of Data safety monitoring committee (DSMC), The GAP study (safety of gabapentin) United Hospitals Bristol Member of national Independent Funding Request Panel NHS England Non-Executive Director GO-OP, GO-OP is a Multistakeholder Co-operative Society (Somerset Rules), registered under the Co-operative and Community Benefit Societies Acts. GO-OPGO-OP will be the UK's first co-operatively owned and run Train Operating Company Introduced PPE supplier (Orthofix International) to Devon CCG. Company part owned by my cousin Non-Executive Director of a start up limited company called LinkExec, an online business aimed at promoting start up businesses and investors. April 2020		26/09/2017	11/06/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Member of Integrated Commissioning Executive (ICE) Attendee Remuneration and Workforce Committee Attendee of Audit Committee Member Strategic Commissioning Programme Board	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Lees	Sarah	Representative of Director of Public Health for Plymouth City Council	Member of Governing Body (Deputy) Member of Primary Care Commissioning Committee (PCCC)	School Governor, College Road Primary School, Plymouth	Husband is an employee of Livewell Southwest	10/11/2017		Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Manton	Sonja	Director of Strategy Interim Director of Commissioning. Northern, Eastern and South Devon and Torbay	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Transition Sub Committee Senior Leadership Team (SLT) Member of Quality Assurance Committee Attendee Audit Committee Member of Devon JCEG	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit from 1st Nov 2018	03/04/2017	09/10/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Governing Body Clinical Lead – Western Locality Chair of Western Primary Care Partnership	Member of Governing Body Member of Quality Assurance Committee Clinical Cabinet QEIA Panel STP Collaborative Board Remuneration and Workforce Committee (Non exec rem) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG)	Elected member, South West Regional Council of BMA Occasional Locum (self-employed) at Access Health Ltd Plymouth. GP Appraiser (NHS England) Working at Church View Surgery as self-employed sessional GP Elected to the Medical managers Committee of the BMA from September 2019	Partner is Medical Secretary and Board member of Devon LMC Partner is GP Partner, Church View Surgery, Plymstock Partner is Clinical Director of Mewstone Primary care Network(PCN)	26/09/2017	25/09/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Director of Communications and HR functions NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	04/03/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Pearson	Virginia	Chief Officer for Communities, Public Health, Environment and Prosperity/Director of Public Health, Devon County Council System Director of Population Health and Wellbeing, Devon STP	Co-opted Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Member of Integrated Commissioning Executive (ICE) Strategic Commissioning Programme Board	Member, STP Directors Group Member, STP Programme Delivery Executive Group Member, Devon Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Association of Directors of Public Health Member, British Medical Association Honorary Clinical Professor, University of Exeter College of Medicine and Health		02/02/2017	22/04/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council
	Pearson	Nick	Head of Communications and engagement	Senior Leadership Team (SLT) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for Director of Communications)	Member of the Labour Party Member of the Exeter City Supporters Trust	Spouse is owner of Pearson Creative	13/01/2017	14/08/2019	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. Will not be commissioned by employee	NHS Devon CCG
	Polak	Tracey	Public Health Consultant (Devon Council) Honorary Clinical Associate Professor – University of Exeter Medical School	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Northern and Eastern Preparatory Group	Honorary contract with Exeter University	Spouse: Deputy Chief Nursing Officer and Interim Director of Quality Assurance (July 2019) Devon CCG	24/10/2017	21/01/2019	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee Audit Committee CCG Executive Team Meeting Senior Leadership Team (SLT) Strategic Commissioning Programme Board Member of Remuneration and Workforce Committee Working with Industry Group	No interests declared		22/03/2019	25/06/2020				NHS Devon CCG
Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Attendee of Remuneration and Workforce Committee Strategic Commissioning Programme Board	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	07/09/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Tetley	Piers	Associate Director of HR and OD	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel	No interests declared			16/10/2018				NHS Devon CCG
Thompson	Sarah	Interim Chief Operating Officer	Member Governing Body Member of Senior Leadership Team (SLT) Member of Integrated Commissioning Executive (ICE)	Managing Director SF Thompson Consulting Limited (Not trading) Volunteer for Redbourn Care Group and the Redbourn Community Volunteers in response to the COVID-19 pandemic		22/01/2020	21/04/2020	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Turl	Jo	Director of Commissioning - Western	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting Strategic Commissioning Programme Board			13/08/2015	03/09/2019	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee (Chair)	Co-opted Councillor on Budleigh Salterton Town Council (Independent Member – non-political)	Son employed by Care Quality Commission as an Information Analyst	16/10/2019	26/11/2019	Indirect interest		Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Webber	Lorraine	Associate Chief Nursing Officer Deputy Caldicott Guardian	Member of Quality Assurance Committee A & E Delivery Board QEIA Panel Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Member of Governing Body CCG Executive Team Meeting Member of Vacancy Control Panel Working with Industry Group Member of Devon JCEG	No interests declared		14/03/2017	09/07/2020				NHS Devon CCG
Wheller	Kevin	Locality Chief Finance Officer (Northern & Eastern)	Attendee of Audit Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Northern and Eastern Preparatory Group Working with Industry Group		Spouse is employed as a finance manager at Castle Place Surgery in Tiverton. The Surgery is operated by the Royal Devon & Exeter NHS FT	22/10/2015	25/01/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

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

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting
DRAFT minutes held in PUBLIC

Date: 18 June 2020 Time: 13:00 – 15:45PM

Location: Via Microsoft Office Teams (this meeting was also recorded sound and vision)

Item	Discussion	*Action*	
1	**Welcome and Apologies** PJ, chair welcomed everyone to the meeting and noted although the meeting was not live it would be available on our website for view but hoped that if any members of the public watching would find it a valuable experience. Apologies were noted as detailed below. • VP – Tracey Polak deputy PJ noted that this was the last Governing Body that TP would be attending representing DCC Public Health and thanked her for bringing challenge to have the right conversations and discussions for the population of Devon. On behalf of the Governing Body he wished TP all the very best for her for the future.		
2	**Register of Interest (ROI)** The members reviewed the ROI and there were no new or amended declarations made. No conflicts were declared against the agenda **The Governing Body received and noted the ROI.**		
3	**Minutes of the last meeting** PJ led a page by page review of the minutes of the meeting held on 30 April 2020 and it was agreed these were a true and accurate record of the meeting. There were no open actions for review.		
4	**Chair's Report** PJ took his report as read but highlighted the extent that people have gone above and beyond and adapted to new ways of working where things have been done differently and so well. This had been echoed in other meetings such as Overview and Scrutiny of DCC and Devon MPs have also been supportive. He thanked the public in the display of rainbows and posters in windows and Thursday evening applause. **The Governing Body received and noted the contents of the Chair's Report.**		
5	**Accountable Officer's Report**		

	There was nothing further to add to this report, but the ST reminded the Governing Body that the CCG had redeployed 120 people which included external agencies. A project team has also been set up to make sure that workplaces are safe and fit for a return to work. ST noted Test and Trace and by the end of June the county council and other local authorities will need to submit local outbreak management plans for the County of Devon. DCC and Torbay will submit a joint plan, with Plymouth submitting a separate one. There are several groups required under the local outbreak management plan such as Health Protection board which Directors of Public Health will chair, and an engagement group will be led by local authorities. ST and PJ will be members of these groups providing NHS support. ST drew attention to care homes and CCG trainers for infection control training offered to care homes across our areas and thanked the nursing and quality team who supported this with the target being met. ST noted activity on social media has reached over a million people and we have worked with our partners to deliver briefings and webinars and shared information with our staff to keep them informed. ST referred to NHS oversight Framework where Devon CCG has received confirmation that following a review by the regional team, it has been allocated to Segment 2, targeted support as agreed with the CCG and regulators. Previously the CCG had been placed in legal directions and ST was pleased to report this improved trajectory. JH referred to the issues with Personal Protective Equipment (PPE) and asked for an update. ST responded and explained the makeup of the Local Resilience Forum (LRF) which is chaired by the police as a statutory body which come together when incidents occur. Representatives include the police, fire, health and local authorities. Whilst the LRF is looking to stand down the PPE cell locally, the CCG felt the need to keep the PPE cell open whilst standing up services and the CCG will continue to monitor to ensure our providers including primary care have enough PPE. The CCG can go back to the LRF for further support if required. NB queried the death rate and the number of proportionate rates of those affected for Devon which appear to be consistent in average for England but compared to the whole of UK the rates appear to be double and asked if we had an understanding how Ireland Wales and Scotland are depressing their death rates. ST was not able to confirm the reasons for differing death rates but would take this as an action to follow up. **<u>ACTION 1</u>** **ST to explore the reasons for differences in death rates for Devon compared to the whole of the UK.** SK raised a capacity issue with phlebotomy which is rapidly developing.ST responded to confirm that this issue is being reviewed regionally by the out of hospital cell. The CCG is aware of this capacity however it was not sure of the solutions at the moment.		
6	**Future planning** ST has been working with the executive directors looking at our priorities as we move into phase 3 anticipated on 1 August. It was discussed and agreed at an executive development session that there is a need to set out the CCG's priorities to understand our population and utilise research and best evidence to set priorities locally that are important		

	for the population for Devon. This may mean setting up the organisation structure in a different way and ST referred to the commissioning cycle. This will be to make sure that we can suitably support localities and have enough knowledge and can provide commissioning expertise. ST noted that future planning would be discussed again next week at a further development session and confirmed there was an intention to bring a proposal and discussion document to the Governing Body for consideration. ST explained the benefits for the population and referred to the Joint Strategic Needs Assessment (JSNA) and the clinical effectiveness team. The CCG will focus on items that come from the National Institute of Clinical Evidence (NICE) and we will monitor these and look for best evidence. GAth wondered when our commissioning intentions would be reviewed and refreshed as part of future planning and ST answered to confirm that this would be done over the next couple of months and would also be part of the proposal and discussion document that would be brought to the Governing Body. NK was supportive of evidence-based decision making and mentioned a value-based approach looking at outcomes and overall value and asked if this was something the CCG was looking into as part of our ongoing thinking. ST responded and described how we will take finance and value for money forward and he explained the population health management process analysis and cost effectiveness and NK was reassured by this. SK asked about population health management and the use of data and the standing back up of Quality and Outcomes Framework (QoF). JT referred to the latest letter received detailing phase 2 which gives a clear message to use clinical judgement and noted that QoF was not completely stood down but recognised that some time was diverted to respond to the pandemic and confirmed that we are awaiting further national guidance. **The Governing Body received and noted this verbal update on future planning.** *Liz Cosford (LC) joined the meeting.*		
7	**Covid and Mental Health in Devon -presentation** PJ welcomed LC to the meeting and noted that both LC and JW would co present this item. JT opened and set the context. LC referred to the purpose slide and drew attention to the six questions detailed regarding Covid-19 and mental health. The learning has been reviewed and she mentioned evidence published by Lancet Psychiatry 2020 and summarised the impact and consequences. LC noted the ripple effect of Covid-19 and the impact on mental health of our population and the expectation of demand on our services. She drew attention to the predictions graph and explained the needs of our population. JW spent time going through in detail slide 11 'What do we know' national trends and needs in existing mental help service users. Phase 1 included a repurposed response and Livewell Southwest and Devon Partnership Trust (DPT) have implemented a prioritisation common purpose framework. A system response has comprised of: • restructured inpatient provision • four mental health hubs		

- psychological therapies moved to digital and telephone platform
- maintained children and young people's mental health services
- restructured team resilience for community mental health services

LC noted that phase 2 is moving towards recovery and stepping up of non Covid services and we are compliant in seven areas out of 8.

LC described phase 3 and what are we doing next. She summarised and warned the Governing Body that mental health needs are likely to increase significantly in the light of Covid and we have strong evidence to support this. She anticipated needs and demand will increase over a period time. LC noted that the CCG had operated effectively and is now working together in an integrated way to prepare and deliver the phase 3 ask.

JW noted it was important in going forward that our links with voluntary sectors continue to support with demand and LC confirmed that the CCG has started to do a stock take with our voluntary sector partners around the services they can provide to help with demand.

PJ thanked LC and JW for a comprehensive presentation which demonstrated some really good work and noted that this is a growing concern that we may face. JT noted that Improving Access to Psychological Therapies (IAPT) can be made through a self-referral route.

On behalf of the Governing Body PJ asked for effective engagement and communication with the wider public to be an Integral part of plan especially for some people coping with less severe mental health as part of the pandemic.

CB suggested that the voluntary sector should be reflected in our commissioning priorities in going forward. JT agreed that we need to build on our commissioning work and that the community and voluntary sector is valuable and that we should treat them as part of the system and plan for demand in all services not just mental health.

LC confirmed perinatal mental health is being assessed along with needs and we are reviewing our learning and looking into this in detail.

AD wondered if we have the capacity to meet demand for Children and Young Peoples services especially when children return to school. JT reported that a bid was submitted pre Covid-19 system wide to support mental health for children linked to schools. She was pleased to report that we were successful in this bid and additional support for schools in the Northern Locality and there is an opportunity for further bidding to extend this.

DG highlighted some good things that have come out of the pandemic and referenced the mental health direct line for patients in crisis.

GT gave examples of two cases and the impacts of Covid and that these cases may not have made self referrals for mental health support. He asked about third party referrals and LC confirmed this was important and this would be fed into future planning. JT referenced the first response service which will enable third parties to contact them, and the advantage of this commissioned service is not just to support the individual but the wider family and network.
SMC wondered if we are quantifying mental health issues in our staff due to the pandemic including GPs. IAPT services has now been opened to health and social care staff across Devon and through that process there will be some quantifying potential to understand their issues and support for them. AM noted that we are making sure we are checking in regular

	with staff and there is a national support line for staff however we do need to look at who is taking up the offer and to see if there is more we should be doing. **<u>ACTION 2</u>** **AM to link with HR to check the quantity of staff that have access the national support line. Post meeting update this review has been completed by each directorate.** It was noted that the Local Medical Committee (LMC) offer pastoral support for GPs and clinical practice and PJ noted that reports have identified an increase in demand. PJ asked about the significant risks to delivering/ managing an increase in mental health concerns in the community. It was acknowledged that the initial risks are will we be able to meet demands locally. We will need to have robust and efficient plans in place across providers and build upon our connections with voluntary sector for early interventions. **The Governing Body received and noted the contents of the Mental Health in Devon presentation.** *Jo Turl, David Greenwell and Philip King left the meeting.*		
8	**Discharge Update** STh presented this report and noted that the discharge cell had been established following national guidance in March 2020 and remains operating 7 days per week. Its value has been about bringing localities to work together and has allowed forging strong relationships with providers and a single version of the data they are mutually reviewing and considering supporting trusts by drawing on expertise for blockages. From March to May the system has held an average of 65% bed occupancy and since end of May this has been challenging. We have now moved to focus on locality hospital plans for out of hospital care to understand what is needed for business as usual and surge planning and this will be on a phased basis and the first of the plans are being developed. National guidance has been used as a steer for the discharge work, and we are mindful and worked carefully with providers to get the balance right. STh noted that discharge cell doesn't have clinical representation however the CCG is working with providers in support trusts in clinical decision making and we are starting to focus on the element of capacity planning work. GApp raised concern around community and 7-day services and STh explained that national policy and discharge applies to providers and commissioners and part of our work for capacity planning for 7 day working where practical and meaningful. There is also a focused piece of work on flows in the hospital and work has commenced on this. GT asked if there was plan for one set of financial figures and performance data, and ST said it was an aspiration and ambition to achieve a single set of agreed data. On behalf of the Governing Body PJ thanked STh and the discharge cell for their work. **The Governing Body received and noted the update on the discharge cell.**		
9	**Recovery, Transformation and Service Change** ST gave an overview and noted that there are three elements of the process:		

	• 6 providers meet every two weeks and agree what services to stand back up • Individual conversations are underway with smaller providers on how to stand up their services and adhere to infection control and digital platforms • Phase 3 letter expected, and we will need to see how that accords to our long-term plan and whether there will be a need for any changes ST declared that a return is submitted to the region on a weekly basis and he noted that the latest return was very detailed. He explained the process of review which goes to the executive team meeting every week. The process includes clinical involvement and input on specialties such as urgent care and mental health. ST confirmed that a formal report will be developed and presented to a future Governing Body. **The Governing Body received and noted the verbal update on recovery, transformation and service change.**		
10	**Month 2 Finance Report** JD stressed that we are in unprecedented times from a financial point of view and we are still working in the environment from the government that all costs incurred will be reimbursed for the period that the framework is applied to. We have been set an indicative plan by NHS England and the numbers are reported against this plan and not against the operational plan agreed prior to the incident period. We have been careful to ensure we are recording the additional costs incurred directly to the incident response, including the fast discharge scheme. With our colleagues in the local authorities we have been working to ensure the right services are in place whilst remaining clear on the costs and for first two months of the incident period we will have spent £3.6 million pounds to support initiatives. Another significant cost relevant to Covid has been the support for the care homes sector one which has been to provide financial stability. JD referred to the summary table on page 74 section which details the expenditure and an explanation on variances. JD highlighted that our biggest risk is uncertainty and what happens beyond the first 4 months of the financial framework for the incident response. Our rate of expenditure is being observed and the first few months has indicated that we are on course to spend £80m higher than our allocation and there is more work to be undertaken to understand this and as we exit the emergency period we will have a better understanding of what our forecast expenditure will be. PJ wondered what the impact on expenditure has been with stepping down non Covid activity and JD confirmed this has been mixed. Although some services have been stepped down in main NHS providers this hasn't made a difference to the rate of spending for some cases and for those services that have stepped down, we have ceased payment. For the independent sector capacity was nationally commissioned for a period of Covid response and these funds has been taken off us and is now commissioned centrally. JD stressed that it was important to recognise where we are financially, and that further work is needed to understand what our expenditure will look like and we know that expenditure will be covered for the first four months of the year in responding to the incident.		

	JH referred to section 4 and the Nightingale Exeter. JD clarified that the Nightingale Exeter during the set-up period the costs were being charged to the CCG, but ongoing costs will be recovered by the Royal Devon and Exeter (RDE) who will run this unit operationally. JD noted the priority is to ensure that money has not been an obstacle to make the right service response to the incident and there will be a period of new normal to review the implications of costs. JH urged that we must not be slow in addressing financial balance issues. NK asked if we have confidence that spend has not been unreasonable during the response to the incident. JD was confident that the CCG will be reimbursed and linked to the controls and checking before costs were made and we have had good governance on spending decisions made. SK queried prescribing and why there has been an under achievement and the standing down a number of nonessential activities to provide extra resource. ST explained that we have reprioritised our pandemic response and we will now be taking the opportunity to work to get our finances back on track. PJ asked the Governing Body to remember the place the CCG was in when we were told to prepare for an overwhelming demand on our whole system not knowing whether it was going to become reality or not and actions we took then were within that context. **The Governing Body considered, reviewed and noted the contents of the month 2 financial report and the forecast four-month position including the current risks.**		
11	**Performance and Quality Report** STh noted that this report builds on the last report presented and is significant in setting out the quantifying clinical impact for last month of 19/20 and the first period of 20/21. The paper details improvements for some targets in A&E attendance which has been due to the public not coming forward for treatment. 52 weeks has shown a deterioration in performance as well as diagnostics. In moving forward from April 2020 national guidance required us to maintain oversight of constitutional standards but no hands-on performance management role through to the end of July. The unvalidated data reaffirms the deterioration in performance and we are keeping a firm focus on what happens going forward and we are waiting for further national policy to reset our approach in a more positive way. DA drew attention to some elements from previous months and note there has been significant learning to take forward and good areas of practice such as working collaboratively. We have seen challenges around quality and safety There is work to be done around mental health elements and a need to triangulate the learning. Other areas have seen investments such as Healthcare Acquired Infections (HAI) prevention and infection control. The cell approach has supported care homes which has seen a system driven method. Going forward we need to look at how we will work with our providers in a different way to focus on quality and performance, and because of lockdown Safeguarding has been impacted with domestic abuse and the wider element of child and adolescent harm.		

	GT asked whether if performance had not deteriorated in some areas and we had done more activity what impact that would have had on financial numbers. JD responded to say that would not have made any difference financially as there had been a redeployment of staff into our partner organisations and was not financial flows and the financial figures will reflect system performance figures. PJ wondered about non emergency activity deterioration and are these figures proportionate to what has been seen elsewhere a national picture. ST answered that the CCG has started to look at national comparisons and Devon has seen less impact than elsewhere with some variation. STh informed the Governing Body that were expecting further guidance on performance and this was expected in early July. **The Governing Body received and noted the contents of the Quality and Performance Report**		
12	**Proposal for Commissioning Committee** GS referred to the terms of reference and the purpose of this paper was for a proposal for a new committee which had been previously discussed at a development session of the Governing Body. • This will ensure we have good oversight of our commissioning decisions • To ensure that these decisions are made in a robust way with evidence of good practice and data • Make sure good clinical input of all our clinical decisions at the development stage GS noted that this proposal to establish this new committee which would feed into Governing Body. CB wondered if there had been any thought for a non- executive lay member to be part of the membership of this committee structure to bring impartiality and a different voice and perspective strengthen equality and diversity in the remit of the committee. ST responded to confirm this was a decision-making committee and felt appropriate to allow the Governing Body for assurance however he agreed to look at strengthening the remit of the committee. NB drew attention to a recent paper released from NHS England and the role of audit committees (AC), which puts increased emphasis on the role of the AC in looking at the governance of other committees. This formalisation of the AC's role may negate the need to have non-executive on the membership of the commissioning committee. ST explained the decision-making process which sits outside non-executive governance and the new committee. NB queried as to why the chair of this committee would be a non-GB member and ST said the reason for this was about succession planning to make sure that the next level of clinical leaders coming forward have experience of chairing and our decision-making process. **Following discussion, the Governing Body unanimously agreed to:** • **The formation and establishment of the commissioning committee** • **Agreed to the Terms of Reference (ToRs) including the additional element of strengthening equality and diversity** • **Agreed the membership, and agreed for the chair role to be reviewed by the audit committee in 6 months' time**		

13	**Ambulance Joint Commissioning Committee (AJCC) ToRs** GS presented the revised AJCC ToRs, which were approved in January 2020 however since this meeting there have been some changes. These have been highlighted and circulated to the voting members of the Governing Body electronically outside of the formal Governing Body meeting and approved. The Governing Body and approved and ratified the AJCC ToRs. PH was concerned that section 9.5 and 11 need to be linked so there is no question any decision abstract without total budgets agreed for spending on the ambulance service made and she would raise this at the next AJCC committee meeting for clarification. **Post meeting update: PH has confirmed** the ToRs has an overriding clause 11 that requires all funding requests including new developments to be within the context of the contract agreement and this was confirmed by the legal team.		
14	**Primary Care Committee** There was nothing to add or highlight regarding this report.		
15	**Quality Assurance Committee** GAth brought the Governing Body's attention to the financial support item from the April meeting and the Autism project and whether that would continue. She also referred to an item from the March meeting and this was in relation to patient experience presentation from a woman who had two terminations of pregnancy. Her experience for both occasions were very different, and the Quality Assurance Committee raised concerns around the attitude by staff and the way she was treated in two different settings. It was acknowledged that there was a need for some training across Devon as the issues were around attitude, approach, culture, dignity and respect rather than facilities and a need to DA was aware of this patient experience situation and provided and assured the Governing Body that pathways have been changed and significant learning has been taken on board and we will make sure that this situation is not repeated across our providers. DA agreed to raise this with the Chief Nursing Officers across the system and will also link in with the local maternity services. DA took a commitment to ensure the learning and pathways of the patient are fed back. The Governing Body acknowledged the bravery of the patient in sharing their experience. **The Governing Body received and noted the contents of the Quality Assurance Committee Chair's Report.**		
16	**Audit Committee Report** **There was nothing to add to the report.** GS noted that attached to the report was the Covid-19 and Corporate Risk Register and highlighted to the Governing Body that the Covid-19 Covid Risk Register attached to this report was not reviewed by Committee as it is being constantly updated. **The Governing Body received and noted the contents of the Audit Committee Report.**		
17	**Locality Updates** **Northern**		

	There was nothing to add to the report, however JWo re-emphasised that it was heartening to see the collaboration and cooperation and partnership working during our response to the incident and the speed and way things have been done. **Eastern** There was nothing to add to the report. SK also noted the increased collaboration of work including virtually and there had been some good examples of joint working and more to be done. There are exciting new changes and willingness from the RDE to do things in a different way and this was a positive movement for the Eastern locality. **Southern** SMa highlighted the key achievements, service changes and local issues. She recognised this period had cemented integration into action and the importance of locality working but this has demonstrated this has seen unintended consequences elsewhere in the system. There is Devon wide approach for ED services to ensure patients get the care they need and how they redesign the departments in a different way to understand increase in demand levels. It was noted that the Southern Locality regular meetings have been recently reinstated. **Western** SMC echoed the themes in West elsewhere. She reminded the Governing Body of the GP and Practice nurse workforce which has been an historical issue pre Covid and remained during our response to Covid. As we move towards higher levels of activity that will cause some problems. SMC raised concerns around the flu vaccinations in and this will be a risk and warned the Governing Body in the Western Locality they will need some support with that. JW was pleased to see suicide prevention work in the Northern Locality as a key area of work but noticed this had not been included in the other locality reports. ST commented that public health and local authorities are the leads for suicide prevention and the CCG is looking to stepping back up their involvement in this workstream. TP reported that a suicide Audit has been undertaken is being finalised and there will be recommendations coming out from that in the next few months. GT praised the four-locality update report but was worried about the reduce capacity into Emergency Departments (ED) and will GPs pick up the fall out due to social distancing. SK responded that this is indeed a concern for ED at the RDE Exeter. Innovative ideas are being explored including looking to see if calls could be diverted through to the 111 clinical assessment service (CAS) with clinicians answering calls for triage. **The Governing Body received and noted the contents of the Locality Update Reports.**		
18	**Any other business** The Chair noted that a question came in late from a member of the public relating to Continuing Healthcare (CHC) and there were specific technical aspects to this question. A response was not provided at this meeting, but there would be a formal written response initially and if the member of the public would still like this to be raised at a Governing Body this would be done next time.		

	The chair thanked everyone for their enthusiasm and contributions which demonstrated the approach we are taking as a CCG for the health and wellbeing of our population at this time.		
19	The meeting closed at 15:45 pm		

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*
Alison Davis (AD) **	Associate Non-Executive Director, Devon CCG
Andrew Millward (AM) **	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Darryn Allcorn (DA) **	Chief Nurse, NHS Devon CCG
David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Gaynor Appleby (GApp) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT) **	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG
James Wooldridge (JW) **	Associate Non-Executive Director, Devon CCG
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Womersley – Dr (JWo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF) A (in absence of DG)	Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **	Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **	Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) **Chair** **	Clinical Chair, Devon CCG
Penny Harris – (PH) **	Director, Devon CCG
Philip King (PK) **	Interim Chief Nurse
Ruth Harrell - Dr (RH) **	Director of Public Health, Plymouth City Council
Sarah Thompson (STh) **	Chief Operating Officer, Devon CCG
Simon Kerr – Dr (SK) **	Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc) **	Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST) **	Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **	Interim Director of Commissioning – North, East and South, Devon CCG
Tracey Polak (TP) (for VP) **	Assistant Director Public Health, Devon County Council
Virginia Pearson – Dr (VP) A	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) ** **Minute Taker**	Executive Assistant, Devon CCG
Liz Cosford (LC) ** **item 7 only**	Associate Director for Mental Health and South Devon Commissioning, Devon CCG

Minutes approved	Date:	Signed by chair:

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**		**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential order	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action is very clear to the owner and the committee members	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertakenYes/No confirmation if all actions		This will be the lead or person to whom the action was designated	Confirmation that committee that raised the action is content the action has been completed	Confirmation if action complete
1	18-Jun-20	ST to explore the reasons for differences in death rates for Devon compared to the whole of the UK.	30-Jul-20	Simon Tapley					**OPEN**

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GOVERNING BODY

Report title: Chair's Report				
Date of committee: 30 July 2020 **Date report produced: 21 July 2020**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive:** **Name and Title:** **N/A** **Contact Details:** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date: 21 July 2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

- Introduction
- Annual General Meeting
- Completion of Nightingale Exeter
- Local Outbreak Engagement Boards
- Clinical Senate
- Integrated Care System Leadership

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

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

N/A

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

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

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

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GOVERNING BODY – CHAIRS REPORT

1. Introduction

Our Annual General Meeting earlier this month marked an opportunity for us to pause and reflect on the first year of Devon CCG and celebrate all the good work that the teams have done and the collaborative success with our partner organization. I would like to reiterate what I said at the AGM and thank all the staff, whose skills and hard work we celebrated.

I would like to particularly thank Simon Tapley who, as our Accountable Officer, has worked tirelessly leading the CCG with authority and vision to ensure that no matter what environment we are operating in, the values of the CCG are upheld and we meet our responsibility in making the best use of our resources to ensure the best possible services are provided to meet the needs of the people of Devon.

2. Annual General Meeting

As already mentioned, the Annual General Meeting was held on 2 July and like so many of our meetings now was done virtually. We were joined by a number of members of the public as well as some local GPs and members of our staff. As well as celebrating the success of the previous year, we were also able to describe the work the CCG has done to support our NHS providers and local authorities during the Covid-19 pandemic.

3. Completion of Nightingale Exeter

On 6 July I represented the CCG at the formal presentation of the completion of the Nightingale facility in Exeter. The team, led by Philippa Slinger, have delivered a facility that is able, should the need arise, to provide extra critical care capacity in support of our acute hospitals. In the meantime, the extra CT scanning capacity that it can provide will be much welcomed extra diagnostics capacity.

4. Local Outbreak Engagement Boards

All three local authorities have established the required governance structures to monitor local Covid-19 cases and manage any outbreaks. I represent the CCG on all three Local Outbreak Engagement Boards which are chaired by the council leaders and draw wide representation together including local councilors, patient representatives and health organisations.

5. Clinical Senate

The South West Clinical Senate met on 16 July to discuss lessons learnt during the pandemic. This echoed much of the conversations we have had as an organisation and with our partners,

with a clear desire to persist with the beneficial changes and not revert back to previous ways of working, but also an understanding that digital and remote is not the complete answer and many clinical interactions and decisions will require face to face consultations.

6. ICS Leadership

As detailed later in this agenda, there is a need to establish substantive leadership of the Devon STP in readiness to becoming an Integrated Care System in 2021. I am working closely with NHS England and Suzi Leather, STP Independent Chair, to ensure we get the right leadership with the necessary skills and experience to progress our path towards integration.

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GOVERNING BODY MEETING

Report title: Accountable Officer's Report				
Date of committee: 30 July 2020 **Date report produced: 21 July 2020**				
Author (s) Name and Title: Simon Tapley, Accountable Officer Andrew Millward, Director of Communications and HR Dr Sonja Manton, Executive Director and SRO for Integrated Care Partnership (Western Devon) Jo Turl, Director of Commissioning Molly Bishop, Executive Assistant to Accountable Officer		**Supporting Executive:** **Name and Title:** Simon Tapley, Accountable Officer **Report Approved by:** **Name and Title:** Simon Tapley, Accountable Officer **Date** 21 July 2020		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				
Executive Summary: This report contains updates on: • CCG response to COVID-19 • Restoration and transformation • Think 111 First • Integrated Care Partnership in Western Devon				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				

This report is for information only.
Impact on Strategic Objectives
We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
Appendix 1 – Restoration and Transformation
Does this report have implications in any of the areas highlighted below?

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

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

NHS
Devon
Clinical Commissioning Group

Accountable Officer's Report

1. CCG Response to COVID-19

With the prevalence of the COVID-19 virus in Devon, the response of the CCG and the Devon Health and Care System has been reviewed recently to allow resources to be redeployed to support the restoration of services whilst balancing business as usual.

The co-ordination meetings within the CCG and with System partners are now held with reduced frequency. The Devon System Gold calls are now only to be held when there are specific issues requiring escalation or co-ordination across the System and other incident related calls are also now less frequent.

The Devon, Cornwall and Isles of Scilly (DCIoS) Local Resilience Forum (LRF) multi-agency emergency response co-ordinating meetings, in which the CCG participated, have now been stood down. DCIoS LRF were the first LRF in the country to stand down from Major Incident response, handing responsibility for the pandemic response over to the recently established Health Protection Boards (HPBs), led by Local Authority Directors of Public Health. The CCG is represented on the HPBs by the CCG's Accountable Officer.

Whilst the scale of response has been reviewed and reduced in some areas, the CCG's incident co-ordination function has been maintained, in alignment with national requirements, to be able to initiate a response within 15 minutes of receiving a call or email. Preparations are in place to ensure that, should there be further outbreaks, or a second pandemic wave occur, that the full incident response may be re-established in short order.

The structure and size of the CCG's Incident Management Team and supporting Cells has been reviewed several times over the period of the incident and adjustments made to respond to emerging issues and risks. The most recent review has looked at how the necessary incident related functions may be covered going forward as the CCG re-establishes its services and returns significant numbers of staff to their permanent posts.

Recently, the Clinical Cell, Primary Care Cell, Communications Cell and HR Cell have been stood down and their residual work has been absorbed within the CCG's normal team structures.

The Discharge and Access to Out of Hospital Services Cell is working towards standing down on 1 August 2020 with its functions transferring to the CCG's Locality Teams.

Work continues, through the Restoration and Transformation Cell, to co-ordinate the system in restoring services and ensuring that beneficial new practices and processes, adopted during the response to date, are integrated into the System's operations for the benefit of patients.

The PPE Cell is changing its operational model from delivery to collection of PPE by 1 August 2020, due to the loss of support from the Devon and Cornwall 4x4 Reserve as their volunteers return to their employment.

The ongoing incident management arrangements remain under regular review to ensure proportionate deployment of resource to manage our COVID response.

Nightingale Hospital

The Nightingale Hospital was been completed and handed over to its host, the Royal Devon and Exeter NHS Foundation Trust. The CT scanner is being used to help local GPs and hospitals provide people with safer and faster access to tests for a range of conditions, including cancer. Further work is ongoing to determine the best use of the facility going forward.

Returning to CCG offices

On 11 May 2020, the UK Government published its roadmap for coming out of lockdown. As part of this, they released national guidance to support safer working in the office.

A CCG recovery group was set up to consider the actions from this guidance, entitled: "Working safely during COVID-19 in offices and contact centres".

A report providing assurance that the CCG has implemented the relevant COVID-safe measures in line with government guidelines will be provided to the Executive team on 31 July 2020.

A number of operational processes have been implemented to protect employees and others from the risk of coronavirus infection. These include:

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

- COVID outbreak protocol for CCG.

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

There is regular engagement with our Staff Partnership Forum, along with communications to the workforce through staff briefings.

Official guidance on the government's plans for returning to the workplace continues to emerge, with a recent announcement that staff can now return to the workplace, if safe to do so.

Our plan as a CCG is to enable staff to start to return to offices in August, subject to line management approval, and more widely in September 2020.

Given the reduction is desk space necessary to implement the new guidelines, a new booking system is being worked on with Delt to help Directorates plan for staff working in our offices.

2. Restoration and Transformation

As described, as we move into the next phase of the COVID-19 response we have prepared a paper to update the Governing Body on:

- The work undertaken in phase 2 of the COVID-19 pandemic response;
- The CCG's service restoration process;
- The planning underway in relation to phase 3 of the response.

This paper is attached as **Appendix 1.**

3. Think 111 First

"Think 111 first" aims to redefine and improve urgent care pathways by ensuring that patients receive the right care in the most appropriate setting with the lowest level of risk of acquiring a hospital or health care related (nosocomial) infection. This need has always been present, but has been brought into focus during the COVID-19 pandemic, particularly given the following considerations:

- Reduced capacity within the Emergency Department due to requirements for social distancing;

- To ensure people's needs can be responded to within nationally agreed timeframes;
- To ensure bed occupancy rates meet the national requirements in case of a further peak;
- To maximise the use of capacity to respond to winter pressures and plan for surge.

Taking learning from the Cornwall and Isles of Scilly Health and Care Partnership, who are an early adopter in this approach, NHS Devon CCG will be seeking to understand the learning from this to build upon areas of good practice for our population. To take forward this work, a Programme Board has been established and the first meeting is taking place at the end of July. We have also identified Philippa Slinger as the lead Chief Executive for this work on behalf of the Devon system.

4. Integrated Care Partnership in Western Devon

In March 2020, it was agreed to postpone the contract start date for the new Integrated Care Partnership in Western Devon to 1 April 2021, to allow focus on managing the response to COVID. We have been taking stock of the learning and experiences during this period and have used this as an opportunity to consider how we may wish to strengthen the ambitions and expectations of the new partnership and whether there are benefits that the local population and wider system can experience sooner from this integrated offer, particularly as we prepare for winter this year. The work to progress the collective review of the specification and outcomes framework with the preferred bidder and the due diligence process has commenced.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY MEETING

Report title: Devon System Covid-19 Restoration & Transformation Planning – phase two outputs and phase three planning				
Date of committee: 30th July 2020 **Date report produced: 17th July 2020**				
Author (s) Name and Title: **John Finn,** **Associate Director of Commissioning** **Northern & Planned Care and Cancer**		**Supporting Executive: Simon Tapley** **Name and Title: Chief Operating Officer** **Contact Details:** **Report Approved by:** **Name and Title: Simon Tapley** **Chief Operating Officer** **Date**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The purpose of this paper is to update the Governing Body on:

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

none

Key recommendations and actions requested:
To note the information included in the report.

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

Reference to other documents or accompanying papers:
No additional accompany papers

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

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

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NHS
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Devon System COVID-19 Restoration & Transformation Planning - phase two outputs and phase three planning

Introduction

The purpose of this paper is to update the Governing Body on:

- The work undertaken in phase 2 of the COVID-19 pandemic response;
- The CCG's service restoration process;
- The planning underway in relation to phase 3 of the response.

Phase 2 COVID-19 requirements

1. On the 29th April 2020, NHS England wrote to all NHS organisations thanking NHS teams for the remarkable response to the greatest global emergency in our history. The letter noted that every patient needing hospital care, including ventilation, has been able to receive it.

2. The letter set out actions required as part of a second phase of the NHS response to COVID19, based on the assumption that there would continue to be cases of COVID19 and the need to ensure that the NHS fully stepped up non-COVID urgent services within the following 6 weeks.

3. The letter also asked that each organisation considered what routine non-urgent elective services could be stood up whilst maintaining capacity to deal with COVID19 cases but recognising the need to factor in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies.

4. The letter also asked for organisations to consider the learning from the response to the crisis and how the innovations could continue.

5. NHS England laid out 43 objectives to be completed by the 12th June 2020 which came under the following areas:

    - Urgent & Routine care
    - Cancer
    - Cardiovascular Disease, Heart Attacks & Stroke

- Women & Children's Services
- Primary Care
- Community Services
- Mental health and Learning Disability & Autism Services
- Screening & Immunisations
- Reduce the risk of cross-infection and support the sage switch-on of services by scaling up the use of technology-enabled care

6. NHS England also included an emphasis on health and wellbeing arrangements for staff.

Devon CCG's response in Phase 2

7. The CCG had already set up at team to co-ordinate the COVID19 Restoration and Transformation planning for the CCG. The Restoration and Transformation team worked with groups which were already established, to deliver usual business work programmes to review the actions required and to ensure that everything was in place to deliver all the NHSE expectations by the 12th June 2020.

8. An example of this is for Cancer actions, where the Restoration & Transformation Team are working with the Cancer Alliance team to ensure that all the actions required are delivered.

9. Many of the actions had already been considered by the group and were either in place or plans were in place for their delivery.

10. There are plans in place to deliver all the NHSE requirements laid out in the letter of 29th April 2020 and confidence that these will be delivered.

Current situation in Devon

11. The following services have been available throughout the crisis, although they may have been delivered in different ways to ensure safe delivery of services for patients:……

    - Access to GP services
    - Community pharmacy
    - Urgent Optometry
    - Urgent hearing services
    - Urgent hospital services including cancer, diagnostics and emergency services
    - Mental health
    - Women & Children's Services

12. An important success story for phase 2 resolution has been the approach to the utilisation of the independent sector capacity as part of the national contract arrangement. It has been recognised regionally that we have been one of the most productive systems in terms of use of independent sector activity and this has served us well as we are entering phase three.

13. Patients who have needed urgent health services have received that care.

14. Some of the actions which are taking place to meet the expectations of NHSE as part of phase 2 are:

    - Strengthening the capacity in out of hours services including 111
    - Communication campaigns to encourage people who should be seeking emergency or urgent care
    - Review of patients waiting for treatment to ensure those patients requiring time-critical treatment are prioritised
    - Enhanced discharge planning to ensure timely, safe and appropriate discharge
    - Prioritisation of acute cardiac surgery and other time-critical cardiology services
    - Further support to care homes including identifying a clinical lead for each care home and setting up weekly virtual “care home round” of residents needing clinical support
    - Prioritisation of home visits where there is a safeguarding concern
    - Preparing for possible longer-term increase in demand for mental health services
    - Enhance psychological support for all NHS staff who need it

15. Moving forward some services will need to be delivered differently to account for the impact of PPE, social distancing etc and to ensure that services are delivered safely for patients.

16. Some non - urgent services have already started to offer routine services. The delivery of these services will be prioritised for patients with the highest clinical need. These include some services within the following areas:

    - Physiotherapy & podiatry services across Devon
    - Audiology
    - Community Health Visiting
    - Some vasectomy clinics
    - Hospice at Home
    - Speech and Language therapy
    - Outpatient clinics
    - Fertility clinics

17. There have been many transformative, positive changes in the way that healthcare has been delivered across Devon and we plan to ensure we learn from this and embrace these changes moving forward alongside considering

whether and how some patients may be disenfranchised by new ways of working.

18. A good example of the accelerated changes is an increase in non-face to face appointments in primary care, mental health services and secondary care outpatients. This has been supported by embracing the use of digital technology including the use of e-Consult in GP practices and Consultant Connect and Attend Anywhere in psychological therapy services (IAPT) and outpatient clinics.

19. This has meant that patients have been able to continue to access health services safely during the crisis without having to travel to healthcare sites.

20. Further examples include:

    - The launch of a free for all parenting programme, this is a digital package to support parents from birth to 19 which includes free courses which are available for all parents in Devon
    - e-Consult is a service now offered by all practices in Devon, where GPs and other primary care staff offer online consultations to their patients
    - The autism service for young people has moved to online assessment where possible and have noticed an increase in the number of families engaging in the service. Online videos and resources and a family education/support programme has been made available to those waiting for diagnosis as well as those with a diagnosis

21. There is a focus to ensure that mental health services can plan to deal with increased demand due to the impact of COVID19 on the health population in Devon.

22. The communications team have launched a publicity campaign, “NHS is here for you,” to ensure that patients still access care in current times and know that the NHS is still available.

23. Across the system we have set up a system restoration group co-chaired by Alison Wilkinson and John Finn to support restoration of services, embedding learning from Covid and ensuring barriers to restoration are highlighted and acted upon.

24. This group will also lead the Phase 3 Recovery.

25. Details of services that have been re-instated are collated by the CCG each week, ensuring system oversight of activity being undertaken in each of our providers. This information is shared with the system restoration group regularly. There is a clear process set up for non-acute providers to send in requests for service restore to be authorised by the CCG and to ensure that services are restored safely and in line with commissioning intentions

26. The ability to stand down services in the run up to a potential spike in Covid is clearly articulated in our system wide plans

System Restoration Group Members

Organisation	Lead	Job title
Devon Clinical Commissioning Group	John Finn/ Alison Wilkinson	Associate Director of Commissioning
Royal Devon & Exeter Foundation Trust	Phil Luke	Deputy Chief Operating Officer
University Hospitals Plymouth Trust	Sarah Brampton	Director of Finance
Torbay & South Devon Foundation Trust	Adel Jones	Director of Transformation
Northern Devon Healthcare Trust	Jill Canning	Deputy Chief Operating Officer
Devon Partnership Trust	Phil Mantay	Director of Finance & Strategy
Devon County Council	Tim Golby	Associate Director of Commissioning
Livewell Southwest	Katherine Chilcott	Interim Director of Financing
Plymouth City Council	Emma Crowther	Strategic Commissioning Manager
Torbay Council	Chris Lethbridge	Strategic Commissioning Officer
SWAST	Tracy Jolly	Clinical Lead
Devon Doctors	Ryan Hewitt	Director of Transformation
Local Medical Council	Bob Fancy/ Mark Sandford-Wood	Chief Executive Officer/ Medical Secretary

Impact of covid on healthcare activity during Phase 2 response

GP referrals

Devon's referral rate is currently around 70% of normal. "Normal" being same time last year.

27. The information below is an activity description of what happened in Phase 2. It does not align to July performance

28. There is an upward trend, from a low point of 10% of normal in mid-April. This is shown below as daily referral volumes for the period 16 March 2020 to 16 June 2020.

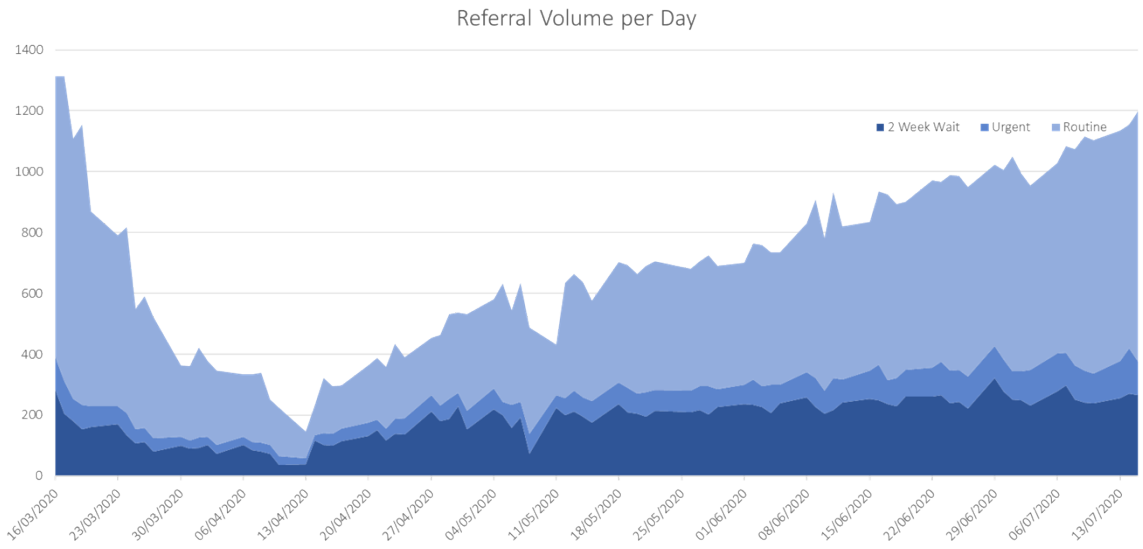

Figure 1. DRSS Daily Referrals Report

Elective activity

Elective waiting times

52 week waits more than quadrupled March 2020 to May 2020. May is the most recent validated position.

	Jan	Feb	Mar	Apr	May
NDHT	12	8	7	41	131
RDE	82	67	102	253	494
TSD	80	42	53	93	192
UHP	127	120	126	231	411
Totals	301	237	288	618	1228

29. More generally, 18ww RTT incomplete pathway breaches increased 20% from March 2020 to April 2020 from 25,241 to 30,408. That is accompanied by a decrease in the denominator by 4.4%, from 94,760 to 90,579 incomplete pathways March to April. April RTT performance is therefore at 66.5%l. Those figures, from the table below, are a provider view of pathways. Devon CCG patients account for 27,381 of the 30k April breaches and c.82k of the c.90k total April incomplete pathways

	2019/20												2020/21
	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL
Breaches	19015	18597	19136	19852	20926	21350	21121	21259	21787	21791	22396	25241	30408
Total	92215	95238	96319	96979	98176	97636	97368	96283	96899	95777	96157	94760	90579
Performance	79.4%	80.5%	80.1%	79.5%	78.7%	78.1%	78.3%	77.9%	77.5%	77.2%	76.7%	73.4%	66.4%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Over 52 week wait	203	195	227	268	368	349	345	328	281	301	237	288	618

30. Work is ongoing and will continue into Phase 3 to understand waiting lists in terms of categories of clinical risk rather than simply waiting time. The Royal College of Surgeon's et al categories of risk are generally in use throughout Devon's acute providers. This is intended to enable better system, rather than organisational, response to that overall risk. These categories are as follows:

- Priority level 1a Emergency - operation needed within 24 hours
- Priority level 1b Urgent - operation needed with 72 hours
- Priority level 2 Surgery that can be deferred for up to 4 weeks
- Priority level 3 Surgery that can be delayed for up to 3 months
- Priority level 4 Surgery that can be delayed for more than 3 months

31. Work is ongoing to understand how the clinical risk categories shown can be seen within those waiting time figures led by Dr Claire Hooper

32. Work is ongoing to understand a population and GP practice view of patients impacted by delay to treatment.

Urgent Care activity

33. Urgent care summary

- Source Covid-19 System Pressures Dashboard

As at 22/6/2020	Since 01 March, system DAILY volumes			
Attendances type 1	Now rising towards previous year normal (currently near 90% of last year's levels)			
	Min	403	on 24/03/2020	
	Max	900	on 02/03/2020	
	7day latest Av	739		
Emerg Admissions	Now rising to pre-COVID levels			
	Min	170	on 29/03/2020	
	Max	456	on 09/03/2020	
	last 7 day Av	351		
ED Attendances daily latest per Trust	Below last year's levels but rising , see below works in progress on demand management			
	Trust	This Year	Last Year	Comparison
	NDHT	124	136	91%
	RD&E	234	277	84%
	UHP	271	281	96%
	TSDFT	192	221	87%
	TOTAL	821	915	90%

- Lengths of stay >7 days remain around 60% of pre- COVID levels with active discharging and restricted activity

Work in progress

- The Royal College of Emergency Medicine (RCEM) Position Statement COVID-19: Resetting Emergency Department Care (6TH May) necessitated a South West Regional response to improve Demand Management and support the aim of ED attendances 25% below pre-COVID levels.
- As detailed in the Urgent care demand management strategy key points are:

- Prioritising 111 and 999 as only points of entry
- Supporting 111 and primary care to adjust to this as a method of flow control
- Now piloted in Trelisk and Portsmouth, and being led at system level in Devon

Examples of learning through Covid

34. **Primary care**

- Stratify and contact high risk/shielded patients ensuring they know how to access primary care services
- Continuing to identify and refer patients acutely to cardiac and stroke services throughout COVID/continuing pushing comms to this effect
- Ensuring clear messaging to patients regarding accessing general practice
- Delivery of webcams to all practices
- Enabling of eConsult to all practices
- Care homes package of support – including accessing digital technologies and sharing digital guide
- StarLeaf video consultation platform now available for all practices, which has option to include BSL interpreters in the consultation
- Establishment of sites for patients with and without Covid-19 throughout Devon (for use in hours and OOH)
- Sourcing/provision of PPE
- Funding for localities/PCN half day sessions for COVID learning/consideration of ongoing management of patients
- Flu cell planning/coordinating delivery of flu vaccination programme

35. **Mental Health**

- The MHLDA Cell was established on 08/04/2020 as a key mechanism to bring together leaders from the CCG, LA, Public Health, MHLDA providers, the police and ambulance service. The function of the cell was to:
  ensure MHLDA support, care and treatment operates in line with guidance
  respond to challenges, escalate and accelerate
  review impact of service change

- One aspect of our learning in mental health at this point in time is about the level of demand there is for urgent mental health care provision and the positive impact this has on our system partners. In response to national direction across Devon STP Urgent Mental Health Assessment Hubs were established and the roll out of our 24/7 crisis response telephone line was accelerated.

- Within weeks of COVID being identified as a Level 4 incident Urgent Mental Health Assessment Hubs had been established, one in each locality, near to or co-located with emergency department provision. The Hubs were implemented so that people in mental health crisis could access mental health treatment/ assessment when they had an urgent need to safely, given the additional risks posed by COVID and; at the same time, take pressure out of ED's during COVID.

- Interim intelligence identifies that the Urgent Mental Health Assessment Hubs vary in terms of their utilisation by geography and time of day/week. Early

indications are that the Hubs are greatly valued by acute care providers, the police and ambulance service; system partners would wish to retain the provision. A review is being undertaken of the Hubs in July, this will also need to consider challenges in terms of service quality- for example, getting safe access to the hub, the suitability of the hub environment, service user dignity and experience; and also reflect challenges in terms of sustainability of workforce, estate arrangements and finance.

- The planned roll out of our 24/7 crisis response telephone line (First Response) has been accelerated, now, whatever your age, if you are experiencing a mental health crisis in Devon you can speak to someone who can help with signposting, immediate tele-coaching or arrange for you to have a face to face assessment, depending on what response you need. The 24/7 crisis response telephone line is currently managing around 250 calls/ day across the Devon and are valued by service users have we evidence of this? and system partners including the police and ambulance service. The post implementation review will need to consider the available evidence in regard to quality impact (safety, outcomes and experience), system impact (impact on partners and strategic ambitions) and sustainability (in terms of staffing, estates, finance etc.).

- In addition to implementing all of the overarching NHS guidance, restructuring inpatient and community provision and delivering new services at unprecedented pace, mental health and learning disability providers have led the way in terms of rapidly adopting digital technologies. Livewell South West have embedded a number of digital offerings which operate across the range of services they provide. Devon Partnership Trust are the biggest adopter of 'Attend Anywhere' in the South West. Our mental health providers uptake of digital and telephony based treatment and care has meant the vast majority of services have continued to provide care and treatment, albeit differently, throughout COVID. Around one third of the use has been generated by the IAPT teams (DPT Attend Anywhere) who, across Devon, moved to an exclusive digital and telephony based model almost immediately. Again, the extent to which it is possible and desirable to retain this change will be determined as part of a post implementation review reflecting quality of impact, system impact and sustainability.

- The MHLDA Cell has supported and enabled co-ordination and delivery of care and treatment for people with mental health problems throughout COVID. The MHLDA Cell reflected as part of its discussion about recovery and restoration that some of the most impactful changes have been possible as a result of increased collaboration and partnership working and that this was in part attributable to the involvement of a broader range of partners, i.e. the police and ambulance services. In this context our mental health providers have also been able to develop shared approaches such as joint planning for surge bed management. Overall, the MHLDA Cell has created a more robust platform for future collaboration and it is working to understand how, as we adjust to the requirements and expectations of Phase 3, we can retain the energy and collaboration which the MHLDA Cell has instilled.

36. **Learning Disability & Autism Services**

- Continued focus on reducing inpatient care by;
    - Completion of 'virtual' Care Treatment Reviews
    - Maintaining patient flow and timely discharge from DPT Additional Support Unit (ASU)
    - Individual care co-ordination with oversight and discharge planning oversight by fortnightly tracker meetings
    - Analysis of future bed usage requirements, meeting 28th July 2020.
    - HR process to recruit Housing Lead post (Torbay Council) to implement capital housing projects and long term housing solutions to support discharge.

- Engagement with provider market recommenced 6th June 2020, relaunch of 'Test of Change' procurement (17th July 2020) to enable greater resilience in community provider market.
- Reflection of 'lessons learned' from COVID-19 resulted in development of an enhanced service specification for Test of Change project and a review of role and function of Primary Care Liaison nurses.
- Learning disability mortality reviews (LeDeR) recovery plan developed.
- Restart of Annual Health Checks (AHC) launched
    - Lessons learned from AHC, commencement of pilot in Plymouth to provide enhanced training to community providers to enable earlier identification of physical health issues
    - Stratification of risk factors to establish appropriateness of face to face visits or virtual checks.
- Autism Implementation Group led by DCC commenced June 2020.

37. **Local Maternity Services**

- One of the key positive changes in Local Maternity Services has been the launch of a free for all parenting programme, this is digital package to support parents from birth to 19 which includes free courses which are available for all parents in Devon

- Phase 3 of restoration will have an emphasis on vulnerable and BAME communities.

CCG Restoration process

38. As has been reported to the Governing Body previously, the CCG introduced a service change process at the start of the pandemic response, to ensure that, when services were stood down, providers had undertaken an initial Quality and Equality Impact Assessment (QEIA) on the change and that the CCG understood the potential risks to different patient cohorts and mitigating actions being taken. Note that this is not the full pre-COVID QEIA process but

is intended to continue to prompt active consideration and management of quality and equality risks while standing services down at the significant scale and pace required by NHS England's directives.

39. In parallel to the system restoration work detailed above in response to Simon Stevens' letter, the CCG has established a restoration approval process, which mirrors the service change process. Requests come into a central point and are shared with relevant colleagues for review and approval. Requests must detail the service being stepped up, how any innovation employed during Phase 1 has been retained, confirmation that PPE requirements can be met, measures being taken to ensure social distancing and details of any interdependencies to other services. A short form QEIA is also required.

40. Each request is scrutinised by a relevant group of experts within the CCG, including the Patient Safety and Quality team (through business as usual, since the Clinical Cell was stood down), finance and contracting, if there is an impact on contractual terms, GPs, the Devon Referral Support Service (DRSS) and commissioners, as necessary, depending on the type of service, QEIA and interdependencies highlighted.

41. To date, more than thirty requests have been received, both from independent providers and from NHS partners in relation to specific services, such as wheelchairs and fertility.

Phase Three Planning

42. We are now moving into a phase 3 response where more routine healthcare services will be stood up and plan to use the same Restoration & Transformation Team and ways of working used in phase 2 to take this forward.

43. The pre-existing financial and performance issues in the Devon system remain material to our system planning. Value for money, benchmarking of costs, benchmarking of performance recovery and a reduced cost base all remain necessary.

44. In particular, while the immediate COVID-19 response sprang from the necessity of doing what is needed with less regard to expense, Phase 3 *Restoration & Transformation* requires a proportionate focus on the financial contribution made by the new ways of working that have recently emerged as well as those that the reset will put in place.

45. Foreseeable phases of the NHS response envisage the ongoing presence of COVID-19, and therefore a separation of some services and continued IPC.

46. Whilst, at time of writing, the national guidance on Phase 3 planning has yet to be received and is not anticipated until mid-July, the NHSE/I regional team have shared a set of planning principles and have given an indication of their expectations. The document sets out that:

*"Phase 3 will require an **operational and winter plan**, jointly developed and owned by all partners within the **health and care system**, based on the principle of **'system by default'** with **shared local priorities and objectives**, including investments, and **continued joint working** across organisations."*

47. The document goes on to confirm the requirements for a Plan to:

- reflect the **changing social compact** with the public with health and social care and support public confidence, building for the future.

- confirm key principles and the approach taken to identify **system priorities** that will help improve the **quality of and access to care** and **improve outcomes** for the local population, explaining how these have changed due to Covid-19.

- be grounded in local knowledge of **population needs** with a strong emphasis on reducing **health inequalities**, both those existing pre-Covid and new ones as a result of Covid-19:

    - setting out what action is being taken and how the restoration, recovery and transformation of services will ensure that health inequalities are reduced, taking into account public and patient access in the context of Covid-19.

    - supported with appropriate Equality Impact Assessments to ensure that equality of service access and outcomes are addressed across each system, including digital inclusion where greater use of digital technology is planned.

- include actions to **reduce and mitigate potential harm** as a result of Covid-19, including patients that are waiting to access services and patients that have not accessed services or had reduced access to services.

- set out clearly how health and care providers and commissioners within the **system** will continue to work together to provide **integrated services** that meet public/patient needs in the context of covid-19, outlining how services will be **delivered and configured** to **optimise outcomes** in the ongoing pandemic.

- identify the local **learning** to date in the Covid-19 pandemic. The **opportunities** to **do things smarter** or **transform more rapidly** should be highlighted. particularly in terms of **new ways of working, roles and responsibilities** for delivery of future integrated services.

- set out the approach to ongoing **clinical and patient/citizen involvement and engagement.**

- be **flexible** ('a live plan') and include a proposed approach and processes/actions for dealing with **possible future Covid-19 disease peaks and changing assumptions**. Plans should promote and deliver increased flexibility in workforce roles. Plans should quantify PPE and testing requirements but should assume these will be met. Plans must be clear about the process and

'trigger points' for stepping up and stepping down services, including risk mitigation.

- describe the high-level **governance arrangements** in place to deliver the plan, including a description of key risks and mitigating actions in place. Governance arrangements should ensure **quality and safety considerations** are incorporated.

- articulate **demand, capacity, activity and workforce** projections over time and in the face of localised Covid-19 outbreaks in an **internally consistent way**: describing practical solutions to reduce gaps by 31 December 2020 with a clear articulation of how each individual scheme addresses the constraints and what additional activity it will deliver, key risks and mitigating actions. It must clearly show the integration changes due to Covid-19 and the opportunities presented by the pandemic, particularly in terms of new ways of working, roles and responsibilities for delivery of future integrated services.

- evidence a **clear link** between anticipated demand, the physical and workforce capacity required to deliver it and the **financial implications** including both revenue and capital.

- **Financial plans** should set out key assumptions and should assume that the following continue until 31 March 2021:

    - Block contracts
    - Nationally funded independent sector capacity; and
    - Current discharge funding arrangements

- Systems should provide an update of the **workforce plan** for 2020-21.This should highlight key assumptions on **health & wellbeing, capacity building (supply & demand), sharing what is good and codesigning the future** as a result of Covid-19 and actions being taken in risk mitigation, particularly around whether available **capacity can deliver projected activity, attendance management including sickness, annual leave and flexible working, BAME and other vulnerable groups risk management and opportunity scoping.**

48. In response to the principles, work has now commenced gathering information on demand, capacity and activity projections for the rest of the 2020/21 financial year, to ensure that the system is in a good position to respond to the guidance, when received. Demand projections assume a gradual increase in emergency activity back to 100% of 19/20 levels, but an ongoing lower rate of referrals for elective activity and A&E attendances.

49. As part of the Phase 2 Stocktake, systems submitted bids for capital funding for specific initiatives to create additional capacity to support urgent care and elective recovery. It is not yet clear whether all, some, or any of the bids have been successful, but the regional team have asked Systems to plan for various scenarios, including modelling the impact of a loss of independent sector and/or Nightingale capacity and the improvement in activity and performance which would result from utilisation of the capital funding. These bids are being worked up in detail, in order that the relative benefits of each in terms of capacity and performance improvement are understood.

Conclusion

The Governing Body is asked to note the contents of this report, specifically:

a) The work done in phase 2 of the pandemic response;

b) The planning underway for phase 3.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: *Devon Ethical Framework* and associated *Guidance on the Allocation and Withdrawal of Organ Support* and/or Treatments during the COVID19 pandemic				
Date of committee: 30 July 2020 **Date report produced: 17 July 2020**				
Author (s) Name and Title: **Adam Carrick** **Head of Planned Care, Northern & Eastern Localities**		**Supporting Executive:** **Name and Title: Penny Harris, Director** **Contact Details:** **Report Approved by:** **Name and Title: Penny Harris, Director** **Date 17 July 2020**		
Public or Private (Governing Body only):	**Public**	☑	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

There is an absence of national guidance on the withdrawal or withholding of treatments, if this were ever required during the pandemic. Legal advice received by the CCG regarding ethical decision-making and the lawful withholding or withdrawal of treatment has indicated the necessity for common, system-level policies amongst Devon's providers and commissioner, supported by proportionate engagement.

A common Ethical Framework has been drawn up by the Devon Ethical Reference Group, along with Guidance on the allocation & withdrawal of organ support or treatments. Public Engagement on these documents took place during June and July 2020 and has been taken into account.

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:

Discussed and recommended by the system level group, the Devon Ethical Reference Group.

Shared at system level with NHSE/I SW Regional Ethics Group.

The legal advice relating to Ethical Decision making and the allocation and withdrawal of treatment was discussed in the private Governing Body session in June 2020, along with the drafts of the Framework and Guidance. These were considered in private session as they were pre-public engagement drafts and not for approval at that time.

Key recommendations and actions requested:

a) To approve the Devon Ethical Framework (Appendix A) for use in this organisation.
b) To approve the Devon guidance on allocation and withdrawal of treatment (Appendix B) for use in this organisation.
c) To note the Public Engagement Report (Appendix C).
d) To note the Recommendations adopted by the Devon Ethical Reference Group following Public Engagement (Appendix D) and which have been reflected in the Ethical Framework and Guidance.
e) To note that once the Framework and Guidance documents have been approved by all organisations, Devon CCG Comms & Engagement Team will work with provider teams to produce common patient-facing materials working with groups and individuals identified during their Public Engagement.

Impact on Strategic Objectives

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

Appendix A: Devon Ethical Framework

Appendix B: Guidance on the Allocation and Withdrawal of Organ Support or Treatments

Appendix C: Public Engagement Report

Appendix D: Recommendations following public engagement, adopted within the Framework and Guidance.

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

	If Yes, please give details	**No**
Quality of Services	This work arises from in extremis pandemic impacts on Quality/Access	Yes
Health Inequalities	This work explicitly highlights health inequalities in pandemic context	Yes
Equality (staff or public)	This work notes both staff and public equality issues arising from COVID	Yes
Resource and Finance	This work covers unlikely scenarios of insufficient clinical resource.	Yes
Legal	This work has been subject to legal advice.	Yes
Engagement and Consultation	This work has been subject to a public engagement exercise.	Yes
Risk	This work explicitly links ethical responses during COVID to system states of escalation and escalation triggers.	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.

Together for Devon

Health and care working in partnership with local communities in Plymouth, Torbay and the rest of the county

Board Paper: *Devon Ethical Framework* and associated *Guidance on the Allocation and Withdrawal of Organ Support* and/or Treatments during the COVID19 pandemic

This paper is circulated to all Health & Social Care Boards within the Devon system.

Recommendations:

a) To approve the Devon Ethical Framework (Appendix A) for use in its organisation.
b) To approve the Devon guidance on allocation and withdrawal of treatment (Appendix B) for use in its organisation.
c) To note the Public Engagement Report (Appendix C).
d) To note the Recommendations adopted by the Devon Ethical Reference Group following Public Engagement (Appendix D) and which have been reflected in the Ethical Framework and Guidance.
e) To note that once the Framework and Guidance documents have been approved by all organisations, Devon CCG Comms & Engagement Team will work with provider teams to produce common patient-facing materials working with groups and individuals identified during their Public Engagement.

Briefing:

1. There is not currently a common, Ethical Framework for health and care organisations in response to the COVID-19 pandemic.

2. Additionally, there is no NHS guidance for the specific scenarios of allocation and withdrawal of organ support or treatment. Various guidance exists from professional bodies addressing only specific aspects of those scenarios.

3. Practically, Devon's populations are served by more than one organisation. Some facilities are shared. Some staff are shared. Consistency is required in decision-making support and in the ethical underpinning of clinical and organisational decisions, particularly where Nightingale provision is invoked or other shared system arrangements are established.

4. Decision-making guidance and processes relating to the withholding or withdrawal of treatment or organ support due to insufficient resources

need to reflect the COVID-19 multi-organisational states of escalation, and the escalation triggers for the sharing of critical healthcare resources across Devon and more widely.

5. The Devon Ethical Reference Group (DERG) is an advisory group convened to consider issues in relation to the COVID-19 pandemic which arise at the Devon system level. All local health and care organisations have had representation on the group which drew up this document. Membership includes Healthwatch and external ethicists and medico-legal advisors. The DERG Membership is included at the end of this document.

6. The DERG has devised two policy documents:

    - Devon Ethical Framework (Appendix A)
    - Devon Guidance on the Allocation & Withdrawal of Organ Support and/or Treatment (Appendix B)

7. It is recognised that some healthcare organisations in Devon have already established their own ethics infrastructure and ethics support for frontline staff, though this is not universal.

8. The Devon Ethical Framework provides a frame of reference wherever an organisation has reached in the establishment of its ethics arrangements. Crucially, its adoption across Devon's health and care organisations provides a common, transparent approach for the whole of Devon's population.

9. Despite the very low likelihood of Devon's capacity for mechanical ventilation or other vital treatments not meeting demand, explicit Guidance on the Allocation and Withdrawal of Organ Support and/or Treatments, common to all Devon's organisations, was deemed necessary for the following reasons:

    - To explicitly cover the scenario of withdrawal or withholding of treatment, in extremis. Difficult decisions may have to be made if there are insufficient resources to offer treatment to all patients who could benefit from it. It is important that the advice available to clinicians charged with making these decisions is clear, defensible and non-discriminatory.
    - To explicitly require that discussions over the withdrawal or withholding of treatment due to insufficient local resources are integrated with escalation processes for accessing Devon and Regional resources.
    - To explicitly set out the necessity for appropriate End of Life care where treatments or support are withdrawn or withheld.

- To set out a consistent practice to be adopted where there is disagreement with the treatment plan, from the patient, their family or a clinician involved in their care.
- To bring a consistent, lawful approach on all of these aspects to the Board of each of the organisations involved to enable clarity for patients and staff.

10. Legal advice received on these documents identifies that Boards should consider and sign-off such policies explicitly. For Devon, each organisational Board should agree a common policy.

11. To support lawful policy implementation, there has been a need for to be proportionate engagement with Devon's population about such policy and guidance. Devon Clinical Commissioning Group has undertaken this public engagement on behalf of all organisations in the local system and with the public participation of clinicians from University Hospitals Plymouth, the Royal Devon & Exeter Foundation Trust and Devon CCG.

12. The engagement process and the key themes arising from it are described in the Summary Engagement Report included at Appendix C. The Devon Ethical Reference Group (DERG) has derived a number of Recommendations from that engagement process (Appendix D). Those Recommendations have been incorporated within these final versions Devon Ethical Framework and the Guidance on Allocation & Withdrawal.

13. The South West Regional Ethics Group, which runs under the auspices of NHSE/I, is aware of and supportive of this work.

Membership of Devon Ethical Reference Group

Glynis **Atherton**	NHS Devon Clinical Commissioning Group (CCG), Non-Executive Director. Former Chief Executive of Hospiscare.
Prof Tom **Baldwin**	Emeritus Professor of Philosophy, University of York
Adam **Carrick**	NHS Devon CCG. Head of Planned Care Commissioning. Secretary to the Devon Ethical Reference Group.
Dr Rob **Dyer**	Torbay & South Devon NHS Foundation Trust (T&SDFT), Medical Director. Devon Sustainability & Transformation Partnership (STP), Medical Director.
Prof Emily **Jackson**	Professor of Medical Law & Ethics, London School of Economics.
Dr Paul **Johnson**	NHS Devon CCG, Chair; and representing primary care.
Prof Lord Richard **Harries** of Pentregarth	Emeritus Professor of Divinity; former Bishop of Oxford.
Prof Richard **Huxtable**	Director of Centre for Ethics & Medicine, Bristol Medical School. Trustee, UK Clinical Ethics Network.
Dame Suzi **Leather** (Chair)	Independent Chair of Devon Sustainability & Transformation Partnership (STP).
Prof David **Mabin**	Royal Devon & Exeter Foundation Trust (RD&EFT). Co-Chair of RD&EFT and Northern Devon District Hospital (NDDH) Ethics Committee.
Mr Paul **McArdle**	University Hospitals Plymouth. Assistant Medical Director. Ethics Lead for Plymouth integrated health system.
Dr Maung **Oakaar**	Livewell South West. Interim Medical Director/Director of Medical Education.
Dr Colm **Owens**	Devon Partnership NHS Trust (DPT). Chair of DPT Ethics Committee.
Sally **Parker**	NHS Devon CCG. Equality, Diversity & Inclusion Lead.
Dr Virginia **Pearson**	Devon County Council. Chief Officer for Communities, Public Health, Environment & Prosperity.
Nick **Pennell**	Healthwatch Plymouth and SW Clinical Senate Citizens' Assembly.
Dr Sam **Waddy**	University Hospitals Plymouth, Medical Lead South West Critical Care Network.

Devon-wide ethics framework – alignment to COVID-19 response

version 2.0, 19/07/2020

In brief

The infectious outbreak of COVID-19 and the resulting pressures on healthcare staff, services and society presents both uncertainty and foreseeable ethical considerations. These require a very active ethical approach for the sake of supporting staff, discharging organisations' statutory and ethical duties, and to reassure the populations we serve at this difficult time.

Although COVID-19 is the epicentre of the current crisis, its impacts span the entirety of healthcare, not just care provided in relation to COVID-19.

Some best practices for the NHS have been provided by the region. Local supplementation of these is required, for the additional, foreseeable, consequential and difficult choices that are arising in the care of patients in COVID-19 and non COVID-19 healthcare. Some of these decisions will affect the whole Devon health system and so an ethics infrastructure that spans the whole system but supports organisations' individual duties is required.

It is of course imperative that the Devon Ethical Framework enables exceptionally timely decision-making at the frontline and in organisations, without constant reference to another authority. It must be thorough in the frame of reference and the consistency it brings for Devon's population. It must provide for system-level decisions where these are required and enable timely consideration of complex issues.

Devon's Ethical Framework has three elements: Ethical Principles; Ethics Groups; and Decision-Making Tools.

The British Medical Association has helpfully produced ethical and legal guidelines in the current crisis[1]. They assert that it is extremely unlikely that challenges to the care provided and decisions made during the pandemic will be upheld where those decisions are:

- reasonable in the circumstances
- based on the best evidence available at the time
- made in accordance with government, NHS or employer guidance
- made as collaboratively as possible
- designed to promote safe and effective patient care as far as possible in the circumstances

[1] British Medical Association (3 April 2020). *COVID-19 – ethical issues. A guidance note.* Retrieved 3 April 2020.

The Devon Ethical Framework seeks to ensure that these criteria are met and that they are embedded into all aspects of decision-making and decision-making groups.

The Devon Ethical Framework is intended for health and care organisational ethics committees and groups in Devon which are providing assurance to their own Board. It is left to organisations to communicate the necessary elements and available support to their staff as appropriate. The Ethical Framework may be of wider, public interest. It will be made publicly available and provided to Council Leaders.

It is noted that relevant national guidance is being published and republished rapidly during the pandemic. This may well continue. Inclusions or gaps within that guidance may influence the work of the Devon Ethical Reference Group (DERG).

An ethical framework for adult social care has been published nationally[2, 3] . It has the same underpinning as the Devon Ethical Framework. Both are derived from the Department of Health & Social Care (2017) *Pandemic flu planning information for England and the devolved administrations, including guidance for organisations and businesses.*

The latest review date for this document by the Devon Ethical Reference Group is 31 January 2021.

Derivation of the Framework

1. Ethical principles and practices are, of course, not new to the COVID-19 situation.

2. Clinical decisions should continue to be guided by the principles of GMC Good Medical Practice[4,5], the standards and guidance of the relevant professional bodies and the available evidence. Clinical teams have a responsibility for decisions about their patients. Organisations have a responsibility for ensuring good governance in the decisions they make.

[2] DHSC (19 March 2020) *Responding to COVID-19: the ethical framework for adult social care*. https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care/responding-to-covid-19-the-ethical-framework-for-adult-social-care. Retrieved 29 April 2020.
[3] For a Local Authority, consideration of the *ethical framework for adult social care* is a component of implementing Care Act Easements in relation to duties under the Care Act (as those duties stood prior to amendment by the Coronavirus Act). For the avoidance of doubt, for adult social care, the *ethical framework for adult social care* takes precedence over the Devon Ethical Framework.
[4] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice. Retrieved 17 April 2020
[5] https://www.gmc-uk.org/ethical-guidance/ethical-hub/covid-19-questions-and-answers

3. The law which covers medical treatment also continues to apply. That means, for example, that patients who have capacity have the right to refuse unwanted treatment, and that – in the absence of a binding advance directive, or a lasting power of attorney for health and welfare – decisions for patients who lack capacity are made by their clinicians, in their best interests, following consultation with family and carers about what they would have wanted.

4. The Devon Ethical Framework as a whole has been developed:

    - with the input of an expert advisory committee and local organisations;
    - following a period of active public engagement;
    - and taking account of the relevant UK pandemic guidance[6].

5. Incorporating these various perspectives, special attention has been given to:

    - Ways of managing ethical demands, especially if resources are not sufficient to meet the population's clinical needs.
    - The importance of communicating and engaging with patients, families and carers on an individualised basis.
    - The duty to support medical staff and all those who contribute to the provision of healthcare services.
    - The importance of avoiding unconscious bias when dealing with potentially vulnerable groups, including patients and staff with a disability or from BAME communities.

6. The description of Ethics Groups provides for the system level and distributed decision-making that necessarily takes place across many settings of care. Resources and support for local ethics committees are available from the UK Clinical Ethics Network[7].

7. The need for decision-making tools will evolve based on rapid gap analysis of the availability and sufficiency of published guidance and issues raised by frontline staff and organisational ethics committees from across the health and social care system.

Ethical Principles

8. These Principles are adopted from the relevant UK pandemic planning guidance. They were developed by the Committee on Ethical Aspects of

[6] UK Government (2017). *Pandemic flu planning information for England and the devolved administrations, including guidance for organisations and businesses.* Retrieved 4 April 2020.
[7] http://www.ukcen.net/covid-19/. Accessed 08 April 2020.

Pandemic Influenza (2007), updated in 2017. They are cited as source material in the recent BMA guidance note on COVID-19 ethical issues[8].

9. These will guide the Devon system, organisations and individuals making decisions, making policy and applying policy in a pandemic context. For clinicians, in the context of individual patient decisions, the ethical principles should be considered alongside their own professional codes.

The Ethical Principles are framed within a fundamental principle of ***Equal concern and respect***. This means that:

- Everyone matters.
- Everyone matters equally – but this does not mean that everyone is treated the same.
- The interests of each person are the concern of us all, and of society.
- The harm that might be suffered by every person matters, and so minimising the harm that a pandemic might cause is of central concern.

Using the Principles

10. The principle of Equal Concern & Respect draws together a number of ethical principles. Using the principles systematically as a checklist can help ensure that the full range of ethical issues is considered.

11. Good ethics require good facts. Ethical decision-making should be informed by the evidence available at the time. Evidence might become available later which would lead to a different decision but this alone is not sufficient reason for judging a previous decision to have been ethically inappropriate.

The individual principles

12. Sometimes, there will be tension both within and between these principles – in weighing different sorts of harm, and in trying both to minimise harm and to be fair.

13. There are often no absolutely right answers. A judgement may have to be made on the priority to be given to each element of a principle (such as the potential impact of different types of harm) and to the principles themselves in the context of circumstances.

14. Sometimes, use of the principles may indicate that more than one possible decision would be ethically justifiable and would accord with the fundamental principle of equal concern and respect. In such a case, the principle of good decision-making (below) should be used to decide which

[8] British Medical Association (3 April 2020). *COVID-19 – ethical issues. A guidance note.* Retrieved 3 April 2020, page 4.

one to take. To a large extent, this should simply be viewed as normal practice but with a recognition that the current context could bring decision-fatigue and additional strains. In that context, ethical decision-making support will be available if needed, both in organisations and for the system as a whole.

Respect.

This means:

- Keeping people as informed as possible.
- Giving people the chance to express their views on matters that affect them.*
- Respecting people's personal choices about their treatment and care.**
- When people are not able to decide, those who have to decide for them take decisions based on the best interests of the person as a whole rather than just based on their health needs.

People's choices about their treatment and care are very important. This does not mean that they are entitled to have treatment that those caring for them consider would not work or is not suitable for them.

Where resources are constrained, it may not be possible to provide all the treatment that people would like and that might benefit them. In such difficult circumstances, decisions should be guided by a patient's capacity to benefit from the intervention.

*When asked about this Ethical Principle, members of the public were keen to emphasise that 'giving people a chance to express their views on matters that affect them' may require individualised approaches and practical consideration of communication difficulties. Reasonable Adjustments to enable a person with a disability to fairly access healthcare is a legal requirement.

**A key component of the principle of Respect that has been emphasised in our public engagement is care and attention to maintaining a patient's dignity throughout their care and treatment.

Minimising the harm a pandemic could cause

During a pandemic, some harm is likely to be unavoidable and choices between harms are likely to be inevitable. An individual's capacity to benefit from treatment considered alongside explicit aims in the health system are helpful in this regard. Those aims are:

- To save the maximum number of lives.
- Judgements of the social value of individual lives should not be made.**
- To prevent or reduce irreversible harm.

- To alleviate other suffering.

Where there is a decision that a treatment is not clinically appropriate there is not an obligation to provide it, but the reasons should be explained to the patient and other options explored.

Where the appropriate clinical decision may be to withdraw life prolonging or life sustaining treatment the intention should be to neither hasten nor postpone death. At this point end of life care, including appropriate psychological, social and spiritual support, must be provided.

**When consulted, members of the public were keen to support this principle but were wary of how it might apply in practice. Specifically, people with lived experience of a disability were keen to highlight the reality of unconscious bias and to make explicit in the Framework that we are all susceptible to unconscious assumptions which may influence our decisions. In the case of clinical decisions, the members of the public who were consulted were supportive of clinical practice where important decisions are tested with multiple colleagues and especially with the patient themselves and, when appropriate, those close to them.

Fairness
This means:

- Everyone matters equally; people should be treated as individuals and not discriminated for or against.
- People with an equal chance of benefitting from health or social care resources should have an equal chance of receiving them – however, it is not unfair to ask people to wait, if they could get the same benefit from an intervention at a later date.

So, in considering a particular decision, a first question might be: how could harm be minimised? Then it is necessary to ask: Would it be fair to do this? Could the same outcome be achieved in a fairer way?

This involves thinking about the interests of everyone who may be affected by the decision. There need to be good reasons to treat some people differently from others, which the decision-maker should be prepared to explain. As with all of these Principles, this applies equally to patients with and without COVID-19.

If a situation arises where resources are overwhelmed across a whole healthcare system and it is not possible to offer the treatments by moving resources or moving patients then the treatments offered will have to be allocated fairly on the basis of the capacity of individuals to benefit from the treatment offered. Practically if the benefit gained is only likely to be marginal

the resource would be offered to a patient where the benefit gained is likely to be more substantial.

Working together

This means:

- Working together to plan and to respond.
- Helping one another.
- Taking responsibility for our own behaviour, for example, by not exposing others to risk.
- Being prepared to share information (for example, on the effects of treatment) that will help others.

This principle spans all kinds of working together: with patients and families, within and between teams, within and between organisations.
Means of communication should be clear and account for particular communication difficulties and situational stresses.

Reciprocity

The principle of reciprocity is based on the concept of mutual exchange. Therefore, if people are asked to take increased risks, or face increased burdens, during a pandemic, they should be supported in doing so. The risks and burdens should be minimised as far as possible.

For example, staff should be equipped to reduce the risks and burdens, notably through the provision of required training and the provision of necessary personal protective equipment.

Analysis has been undertaken in the course of the pandemic which describes increased COVID-19 transmission and mortality risks for members of BAME communities in particular[9]. These risks are reported to increase with age, obesity, co-morbidities, deprivation and male gender and are likely to be heightened further where multiple risk factors exist[10]. Health & Care organisations should ensure that occupational risk assessments are conducted for their staff[11]. Occupational risk assessment should take account of periods of heightened risk, notably during the observance of religious festivals[12].

[9] South Asian Health Foundation (2020), *COVID-19 in Black, Asian and Minority Ethnic Populations: an evidence review and recommendations*. Retrieved 08 July 2020.
[10] Ibid., p27. *Figure 1: Factors associated with COVID-19 transmission and mortality*.
[11] *A Risk Reduction Framwork for NHS staff at risk of COVID-19 infection* (2020) has been produced by the South Asian Health Foundation (SAHF) which aligns to the above cited SAHF recommendations. Retreived 08 July 2020.
[12] NHS Muslim Network & the British Islamic Medical Association (2020). *COVID-19 and Ramadan: how to support staff who may be fasting*. Retrieved 15 July 2020.

Keeping things in proportion

This means:

- Decisions on actions that may affect people's daily lives, or the care they may receive, will be proportionate to the risk and to the benefits that can be gained.
- Those responsible for providing information will neither exaggerate nor minimise the situation and will give people the most accurate information that they can in a medium or format appropriate to their communication needs.
- Where there are resource constraints, patients should receive the best care possible, while recognising that there may be a competing obligation to the wider population.

Flexibility

This means that:

- Plans will be adapted to take into account new information and changing circumstances. This is a feature of good decision-making and a means of responsively upholding the ethical principles in an evolving situation.
- People will have as much chance as possible to express concerns about or disagreement with decisions that affect them.

Good decision-making

Good decisions are about being accountable for the decisions taken or not taken. Good decisions involve reasonableness. This means they should be:

- Rational
- Based on evidence
- The result of a process, taking into account how quickly a decision has to be made, the circumstances in which it is made and the potential for the decision to be actively reviewed in the light of new information.
- Practical – what is decided should have a reasonable chance of working.

Respect for this principle involves openness and transparency. This means those that make decisions will:

- Consult those concerned as much as possible in the time available.
- Be open about what decisions need to be made and who is responsible for making them.

- Be as open as possible about what decisions have been made and why they were made

Good decision-making is inclusive – this means decisions will:

- Involve people as much as possible in aspects of planning that affect them.
- Take into account all relevant views expressed.
- Take into account any disproportionate impact of the decision on particular groups of people.
- Try to ensure that no group is excluded from becoming involved.

Some people find it harder to access communications or services than others, and decision-makers need to think about how these people can express their views and have a fair opportunity to get their needs for treatment or care met.

Records should be kept of decisions taken and the justification for them. This matters for accountability, but such records can also help people learn from experience in order to respond to further pandemic waves, or to a different pandemic in the future.

Ethics Groups

15. At the core of the ethics infrastructure in Devon are organisational-level ethics groups and committees set up under their organisational governance to offer advice on issues arising in those settings and to plan for foreseeable scenarios within their sphere of responsibility. These will provide ethical support to their staff and assurance to their Boards.

16. It is necessary that organisational ethics infrastructures have a flexible approach and are designed to be readily accessible to offer timely support when required. This must also acknowledge that such groups can offer advice about ethical decision-making but the responsibility for such decision-making lies with the relevant professionals: embedded in day-to-day professional practice and day-to-day governance.

17. The organisational ethics groups will typically be able to advise on the ethical dimensions of patient care in cases involving:

    - Complex decisions around withdrawal of care.
    - Situations where clinical decision makers feel uncomfortable with the application of national guidance.
    - Challenging decisions around escalation planning and ceilings of treatment.

- Complex decisions related to patient discharge due to high clinical demand.
- Challenges related to reduced ability to provide normal standards of care, in particular in the community or for patients at the end of their lives.
- Issues in relation to novel treatments

18. Where uncertainty, complexity or disagreement remains after advice has been sought from an organisational ethics group, then the organisational ethics group may choose to seek advice from the Devon Ethical Reference Group.

19. This Group may also be approached where the decision to be made or issues arising involve multiple organisations or have other system or population level consequences. Additionally, some frontline decision-making will require a consistent approach to be designed, agreed and put in place to enable consistency across Devon's population and to support parity amongst different groups of patients.

20. The Devon Ethical Reference Group can be contacted via Devonstp.Ethics@nhs.net or on 01392 675124. These methods of contact will be monitored in accordance with the pandemic escalation status of the Devon system and publicised to the relevant local organisations.

21. The Devon Ethical Reference Group will:

- ensure that a consistent set of Ethical Principles is in place and communicated.
- seek to anticipate ethical considerations for feasible scenarios which are not yet the focus of system or organisational work and which may need guidance or other planning.
- provide advice on scenarios and issues which have a system or multi-organisational impact.
- be available to rapidly offer advice on cases with an ethical dimension where these cannot be resolved within organisations.

22. Some impacts and decision-making associated with the current crisis are organisational; some are within a local healthcare system; and some are regional. The ethics infrastructure spans all of these levels to provide advice and support where it is needed.

23. *Figure 1*, below, depicts the Regional, Devon and local ethics groups. The groups are advisory. There is no line of accountability between them. Sharing of information and support flows both ways for the sake of fairness and consistency across the populations served.

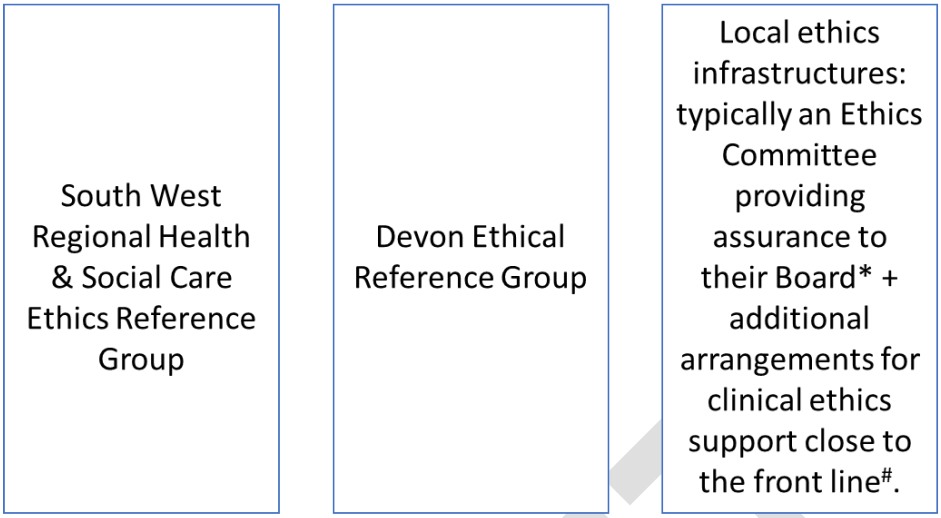

Figure1: Ethics infrastructure

*local ethics Committees may be shared between organisations or span integrated care organisations where governance allows.
known front line support arrangements within the region include rapidly convened Clinical Ethics Groups and on-call rotas of pairs of experienced clinicians able to offer advice.

Ethical Decision-making tools

24. Decision-making tools will result from a gap analysis and on the advice of the Devon Ethical Reference group and other stakeholders.

25. At the present time a gap in national guidance regarding critical care triage and potential discontinuation of critical care treatment has been noted and guidance to fill this particular gap is being prepared.

Key sources:

British Medical Association (3 April 2020). *COVID-19 – ethical issues. A guidance note.* Retrieved 3 April 2020.

General Medical Council. *Coronovirus: your frequently asked questions*. Retrieved 27 April 2020.

General Medical Council (2019). *Good Medical Practice*. Retrieved 17 April 2020.

The Hastings Center (16 March 2020). *Ethical Framework for Health Care Institutions Responding to Novel Coronavirous SARS-CoV-2 (COVID-19) – guidelines for institutional ethics services responding to COVID-19*. Retrieved 31 March 2020.

NHS England & Improvement South West. (7 April 2020). *Interim Advice for Clinicians Regarding a Shared Ethical Approach to Treatment and Referral Decisions During COVID-19 Pandemic*

Scottish Government (2 April 2020). *COVID-19 Guidance: Ethical Advice and Support Framework*. Retrieved 8 April 2020.

UK Clinical Ethics Network (UKCEN). http://www.ukcen.net/covid-19/. Retrieved 07 April 2020.

UK Government (2017). *Pandemic flu planning information for England and the devolved administrations, including guidance for organisations and businesses.* Retrieved 4 April 2020.

World Health Organization (2016). *Guidance for managing ethical issues in infectious disease outbreaks.* Retrieved 31 March 2020.

Allocation and withdrawal of organ support and/or treatments during COVID-19 pandemic

Overview

According to our current understanding of the COVID-19 pandemic, with sufficient adherence to hygiene and social distancing measures and sufficient COVID-19 testing, contact tracing and isolation, Devon is unlikely to experience the scenario where there is a shortage of mechanical ventilation. Although the likelihood of such a shortage is low, it is ethically and legally important to prepare for such difficult decision-making.

Where resources of any kind for seriously ill patients become constrained, we should maximise consistency between healthcare providers and across regions using local and regional escalation status and protocols. Mechanical ventilation is the key example used in this document. However, consideration of insufficient resources may occur in other settings. For example, in primary care, in deciding when and whether a deteriorating patient might benefit from hospital assessment and treatment.

Importantly, all patients who would normally be considered for treatment outside of the current COVID-19 crisis remain eligible for treatment. However, if there is scarcity of healthcare resource, treatment decisions would need to be based on more utilitarian principles than in normal times in order to provide the greatest medical benefit for the greatest number of people.

Although it is an unlikely scenario, lawfully withholding or withdrawing treatment could be required if the healthcare system were to be completely overwhelmed, and where local and regional coordination of resources still proves insufficient to meet the needs of seriously ill patients.

This would represent an additional consideration, on top of the more usual clinical focus on doing what is in an individual patient's best interest, because of the need to take account of the interests of the wider population of patients.

Doing so will be stressful. Crucially, there must be real-time support for teams making these challenging decisions with patients and their families, as well as ongoing services for the emotional wellbeing of the full range of staff involved.

Discrimination in treatment decisions based on irrelevant characteristics is unacceptable and may be unlawful. Best use of resources, such as ventilators, is a relevant consideration. 'Best use' in this context means maximising the prospects of a positive outcome based upon an individual assessment of the patients concerned and their capacity to benefit from clinical intervention. This applies equally to patients who do and do not have COVID-19.

Factors to consider include: likelihood of recovery, likely length of time to make that recovery and, of the greatest importance, the capacity of a patient to recover to a quality of life which is acceptable to the patient.

Please note that members of the public consulted on this document, were supportive of the principle of capacity to benefit from treatment and to recover to a quality of life which is acceptable to the patient but were cautious about its application in practice. Specifically, a number of members of the public with a disability were keen to explicitly raise their lived experience of unconscious bias in order that it can be openly discussed if healthcare providers and frontline staff are using this Guidance. In the case of clinical decision making, the people consulted were reassured by clinical practice where important decisions are tested with multiple colleagues, with the patient themselves and, where appropriate, with those close to them.

These considerations are not limited just to the commencement of interventions. In exceptional circumstances, the withdrawal of life-sustaining treatment may be necessary in order to maximise the beneficial treatment outcomes for the population as a whole. These difficult decisions need sensitivity, compassion, clarity, consistency, oversight and support.

For clinical teams making these challenging decisions, timely ethics support will be made available via local clinical ethics groups. Local hospitals will define and communicate how that support can be accessed. Any clinician, patient or patient's recognised representative can query treatment decisions and withdrawal of treatment decisions and seek wider ethical input. Where they wish, if ethical issues are not reconciled locally, an organisation may seek advice from the Devon Ethical Reference Group.

This document:

- Provides principles for allocation and withdrawal of treatment.
- Provides patient-specific considerations for assessment and review of patients receiving organ support.
- Sets out that decisions based on scarcity must be informed by the treatment resources feasibly available in the wider health and care system, not just within an individual organisation.
- Reinforces that the capacity for a patient to benefit from clinical intervention must be individually assessed.

The latest review date for this document by the Devon Ethical Reference Group is 31 January 2021.

Principles for system-wide clinical best practice

1. Best practices are gathered here for the sake of promoting consistency, fairness and openness for all seriously ill patients, not just those with COVID-19.

2. It is taken as a given that many or all of the practices included here will already be current, compassionate clinical practice.

3. Essentially, i) do your best; ii) treat people fairly; iii) there will be ethical help available; iv) keep excellent contemporaneous notes; v) notice when you or your colleagues may need help and ask for that help; iv) appropriate emotional support will be made available for healthcare workers and those involved in triage/decision-making processes.

Clarity about age and/or disability in this guidance

1. The Devon system endorses and adopts the following statements from the British Medical Association and the Intensive Care Society:

2. *"Under our guidance, the fact that someone is above a particular age, or that they have a pre-existing medical condition is not, in itself, a factor that should be used to determine access to intensive treatment. Similarly, someone with a disability should not have that disability used by itself as a reason to withhold treatments, unless it is associated with worse outcomes and a lower chance of survival. A decision to exclude from treatment everyone above a particular age, or with a disability, would be both unacceptable and illegal."* (British Medical Association, 2020).[1]

[1] British Medical Association (April 2020). *Statement/briefing about the use of age and/or disability in our guidance*. Retrieved 4 May 2020.

3. *"It is recognised that a factual assessment of likely benefit may take into account age, frailty and comorbidities, but the guidance emphasises that every assessment must be individualised on a balanced, case by case, basis and may inform clinical judgement but not replace it. The effects of a comorbidity on someone's ability to benefit from critical care should be individually assessed. Measures of frailty should be used with care and should not disadvantage those with stable disability."* (Intensive Care Society et al., 2020)[2]

4. Further, although the BMA and ICS statements and this DERG guidance take as their key context the availability of intensive organ support, the same non-discriminatory ethical and legal principles apply to any treatments for seriously ill patients.

Allocation and withdrawal decisions

5. Crucially, ventilation, staffing and other resources for Devon's seriously ill patients must be considered on a system-wide basis. Organ support or treatment should not be restricted or withheld in one hospital where it can feasibly be accessed in another, including outside of Devon using regional co-ordination mechanisms set up for the pandemic.

6. For this reason, hospitals must make known to the staff involved the processes and triggers for accessing resources outside of their own institution.

7. Where resources are sufficient, usual clinical decision-making practices remain in place.

8. Where resources are insufficient for the number of patients, inappropriate continuation of support for a patient who is unlikely to survive their stay may have the effect of denying necessary support to other patients.

9. The duration of ventilation for an individual patient must not be too brief. It should remain in line with what is reasonably known at the time about the natural history of the patient's condition. This remains the same whether their condition is COVID-19 or another pathology.

10. Where resources are insufficient to meet demand, it is best practice to seek multiple, senior clinical views in deciding on the allocation or withdrawal of treatment and for this to include clinicians not involved in the direct care of those patients. Local organisations should put in place a system enabling timely access to ethical opinion.

11. Where possible, it is desirable to create a separate triage team. This is intended to enhance objectivity, avoid conflicts of commitment and minimise the moral distress of the clinicians providing treatment. This does not preclude clinicians involved in the patient's care being part of those triage discussions: it is important for all involved that a clear understanding of the patient's condition, prognosis and wishes are reliably conveyed.

12. In the event of sustained pressure on health services and high volumes of triage decisions having to be made, organisations should have regard to decision fatigue and compassion fatigue and combat these through appropriate staff support and staff rotas which reduce the likelihood of sustained periods of exposure to such decision making.

13. The ethical and legal principles around decisions to withdraw organ support are the same as the same as those relating to the withholding of support.

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[2] Intensive Care Society (May 2020). *Clinical Guidance: assessing whether COVID-19 patients will benefit from critical care, and an objective approach to capacity challenges*. Guidance endorsed by the Royal College of Physcians (London), Scottish Intensive Care Society, Welsh Intensive Care Society, All-Wales Trauma and Critical Care Network and the National Critical Care Networks of England. Retrieved 6 May 2020.

14. Thresholds for admission to ICU or withdrawal of support may have to change over the course of the pandemic if the shortfall between supply of resources and demand varies. Under extreme pressure, requiring triage, the focus will become that of delivering the greatest medical benefit to the greatest number of people.

15. There must be no categorical exclusion criteria (such as age). Capacity to benefit remains the key consideration in the scenario where the availability of a treatment or of organ support is insufficient for the number of patients.

16. Where restriction of ICU access takes place, it could be the case that a patient predicted to benefit from only a short stay on ICU should be taken ahead of a patient predicted to require organ support for many days or weeks.

17. Such decisions, may be finely balanced clinically and ethically. There may be more than one interpretation of the facts. In the event of such a decision having to be made, the principles of good decision-making must be upheld, with no decision falling to a single individual, all decisions being rational and evidence based, and their rationale being transparent and recorded.

18. Records regarding treatment choices and the allocation, review and discontinuation of critical care must be kept and form part of the patient's clinical record. This will include the decision made, parameters considered in the decision (including any influence of the lack of resources) and communication with the patient and family. Hospital ethics groups and committees must record their decisions also.

Patient specific considerations

19. The law which normally applies to medical treatment continues to apply. That means, for example, that patients who have capacity have the right to consent to, or refuse, the medical treatment which they are offered. Patients who might lose capacity in the future can make binding advance decisions to refuse unwanted medical treatment. If a patient wishes to refuse life-prolonging treatment in advance, their decision must be in writing and witnessed, and they must be specific about exactly what treatment is refused. Patients can also choose someone else to make medical decisions for them if they lose capacity, by giving one or more people Lasting Power of Attorney for health and welfare decisions. If a patient lacks capacity, staff should try to find out if they have made an advance decision or if they have given someone Lasting Power of Attorney over health and welfare decisions. In the absence of a valid and applicable advance decision, or a Lasting Power of Attorney, clinicians must treat patients who lack capacity in their best interests, taking seriously the views of those close to the patient about what the patient would have wanted.

20. Advance care planning continues to be good practice, so it is important for clinicians to give patients the opportunity to express preferences about their care.

21. Hospital survival is not the only outcome measure to be considered – longer-term survival and change in quality of life may be more meaningful and more important to the patient and family.

22. A decision not to provide organ support, eg invasive ventilation, does not mean that other less invasive support (eg CPAP) should not be used for the patient. Such a ceiling of support, if appropriate, should be included in the patient's escalation plan.

23. Ventilation and other organ support can be prolonged and distressing and should not be undertaken without due consideration of the likely benefit or harm to the patient. It should not be undertaken if it is only likely to delay death for a short period, rather than enable recovery.

24. While there must be no blanket exclusions of patients based upon their characteristics, on a case-by-case basis, it is relevant to consider whether the patient's comorbidities affect their capacity to benefit from treatment or organ support. Comorbidities may impact both the chances of surviving the acute illness in the short term and the likelihood of recovery to a quality of life which is acceptable to the patient.

25. No single scoring system of acute physiological disturbance or chronic health conditions/frailty is recommended as a stand-alone tool for decision-making in individual patients as none are validated for an individual's prediction of outcome, but they can be useful to inform clinical judgements.

26. Reasonable Adjustment is both a legal requirement and a compassionate act to ensure that some people with additional needs have equal access to health care. It may be appropriate to make reasonable adjustments to the way that assessments are undertaken for patients with disabilities. For example, that could include permitting a learning disabled patient or a patient with a serious mental health condition to be accompanied by a carer even if additional persons are generally not permitted as part of social isolating or infection control rules.

Support to patients and families

27. Public consultation on this Guidance showed than a common concern for some people is the role that families and those close to a patient might play in treatment decisions. Staff should be aware of the potential anxiety associated with the misunderstanding that families may be required to decide on treatment options.

28. Staff should be able to clearly describe to patients and to those close to them that it is the patient's own preferences that are considered by clinicians who will decide upon the feasible clinical courses of action. Those close to the patient may support the patient in this if the patient clearly wishes but this is with a view to understanding the patient's own preferences.

29. Representatives of some BAME communities consulted on this Guidance wished to convey that those close to a patient may be overseas and in other times zones. Reasonable effort should be made to facilitate the social support the patient wishes to draw upon, including facilitating the time and technology to achieve this.

30. The particular circumstances of COVID-19 may mean that if mechanical ventilation does not lead to recovery for a patient there may be less time to ready a family for the withdrawal of that support.

31. When first discussing the use of mechanical ventilation with patients and families, it is necessary as good practice to talk through the patient's treatment plan, including that ventilator use will not be open-ended and may need to be brought to an end. The expected effects and burden of ICU support will form part of that discussion.

32. There is an expectation that all patients admitted to hospital will have an escalation plan discussed and documented as near as possible to the time of admission.

33. The continuation of ventilation should be informed by regular review of each ICU patient.

34. Patients and their families should be made aware where resource limitations may cause treatment standards to deviate from the normal standard of practice.

35. Throughout a patient's care and treatment, active steps to preserve and enhance their dignity and to maintain their privacy should be taken.

36. If ventilation is discontinued, expert comprehensive palliative care is imperative.

37. Providing comfort at the end of life when patients may be in isolation is of course difficult. Wherever possible, and where Personal Protective Equipment (PPE) stocks allow, family members of patients near death should be granted compassionate use of PPE so that they can be with the dying patient if they wish.

38. Where this is not possible, families should be permitted and helped to use video conferencing technologies in ways that do not compromise the duties of confidentiality and dignity in respect of other co-located patients. While the patient's condition may not allow interaction, the family may be helped by being virtually at the patient's bedside. This choice should be discussed in advance as part of treatment planning.

39. When consulted on this guidance, members of the public and from BAME communities in particular noted the important role of timely access to interpreters and made a clear distinction between using translated materials and having interpreters available.

40. Professional, independent interpretation services must be made available. Reasonable effort should be made to enable the patient's choice of professional interpreter.

41. In common with all staff and family members, professional interpreters may be subject to unconscious bias too. Staff are asked to be alert to this possibility and if necessary seek clarification of precisely what a patient has said rather than summaries of it.

42. An additional consideration raised during consultation on this Guidance is where the primary carer is a child. Members of the public wished two aspects of that scenario to be conveyed to staff: the burden on the child; and not overlooking the child when seeking to understand the preferences of an incapacitated patient.

Disagreements with treatment

43. A patient or their close family may disagree with a treatment decision.

44. Members of the public who were consulted on this Guidance wanted to convey to staff that groups of people who are already disadvantaged in their access to health care may find it difficult to disagree with a treatment decision or to express their choices. Staff should be aware that this may be more likely for members of BAME communities (especially newly settled members of those communities), Gypsy Travellers, people with a disability and people without a family or social support network; and that coexistence of multiple factors may increase this risk further. In these cases, extra effort may need to be made to ensure informed consent and to establish the patient's preferences.

45. The law provides mechanisms for the resolution of disputes, in rare cases where agreement cannot be reached through discussion or mediation. Applications can be made to the Court of Protection for declarations as to what is in an incapacitated patient's best interests, for example. Before taking such a step, the Medical Director should follow the Trust's process for accessing advice from the Trust's lawyers, and families can contact a solicitor.

46. More usually, disagreements can be resolved directly with the clinical team. Members of the public consulted about this Guidance wished to convey to staff that patients may be concerned about the timeliness with which a disagreement about treatment can feasibly be resolved. Trusts should ensure that clinicians have extremely timely access to further clinical opinion and same day access to ethical advice if required. In the unlikely event that resolution cannot be reached swiftly, the

least restrictive option for treatment should be undertaken while the situation is resolved, ie while resolution of a disagreement is still pending the treatment undertaken should be one that least precludes different treatment options being taken for the patient in the future..

47. A clinician may disagree with a treatment decision.

48. In this circumstance, a discussion allowing all clinical staff involved in the care of the patient (at least two senior clinicians) should be convened by or on behalf of the Medical Director of the relevant organisation. The aim will be to reach a mutually acceptable solution. Ultimately, the Medical Director will hold responsibility for the decision reached. The clinicians will likely be a combination of consultants from the relevant specialties, all professional groups, nursing and ICU. It is assumed that the Medical Director or their representative would not be involved in the patient's direct care.

49. If disagreement persists, the hospital's own ethics infrastructure shall provide for an escalation to the local organisation's ethics committee for advice. The Devon Ethical Reference Group (DERG) is available should an organisational ethics committee wish to invite a further perspective. The DERG's contact details are Devonstp.ethics@nhs.net or 01392 675124.

50. Any member of clinical staff has the right to challenge formally the decision of the Trust. There should be a route to do so through the Trust's policies and procedures.

51. While the withholding or withdrawal of treatment can be lawful, as described in this guidance, individual clinicians should have the right to legal advice separate to the Trust through their own medical indemnity organisation.

Key Sources:

Birmingham Women and Children's Hospital Foundation Trust (April 2020). *Ethically acceptable decision making for COVID and Non-COVID treatment during COVID-19 pandemic*. Unpublished draft.

British Medical Association (3 April 2020). *COVID-19 – ethical issues. A guidance note.* Retrieved 29 April 2020.

Christian, M.D. et al. on behalf of the Task Force on Mass Critical Care (2014). *Triage: care of the critically ill and injured during pandemics and disasters: CHEST consensus statement*. Retrieved 4 April 2020.

Intensive Care Society (5 May 2020). *Clinical Guidance: Assessing whether COVID-19 patients will benefit from critical care, and an objective approach to capacity challenges*. Retrieved 5 May 2020.

NHS England & Improvement South West. (7 April 2020). *Interim Advice for Clinicians Regarding a Shared Ethical Approach to Treatment and Referral Decisions During COVID-19 Pandemic*

NICE (9 April 2020). *NG159: COVID-19 rapid guideline: critical care in adults.* Retrieved 11 April 2020.

Royal Devon & Exeter Foundation Trust (21 April 2020). *Guidelines for the escalation and provision of support for critically ill patients during the COVID-19 pandemic.* Unpublished draft.

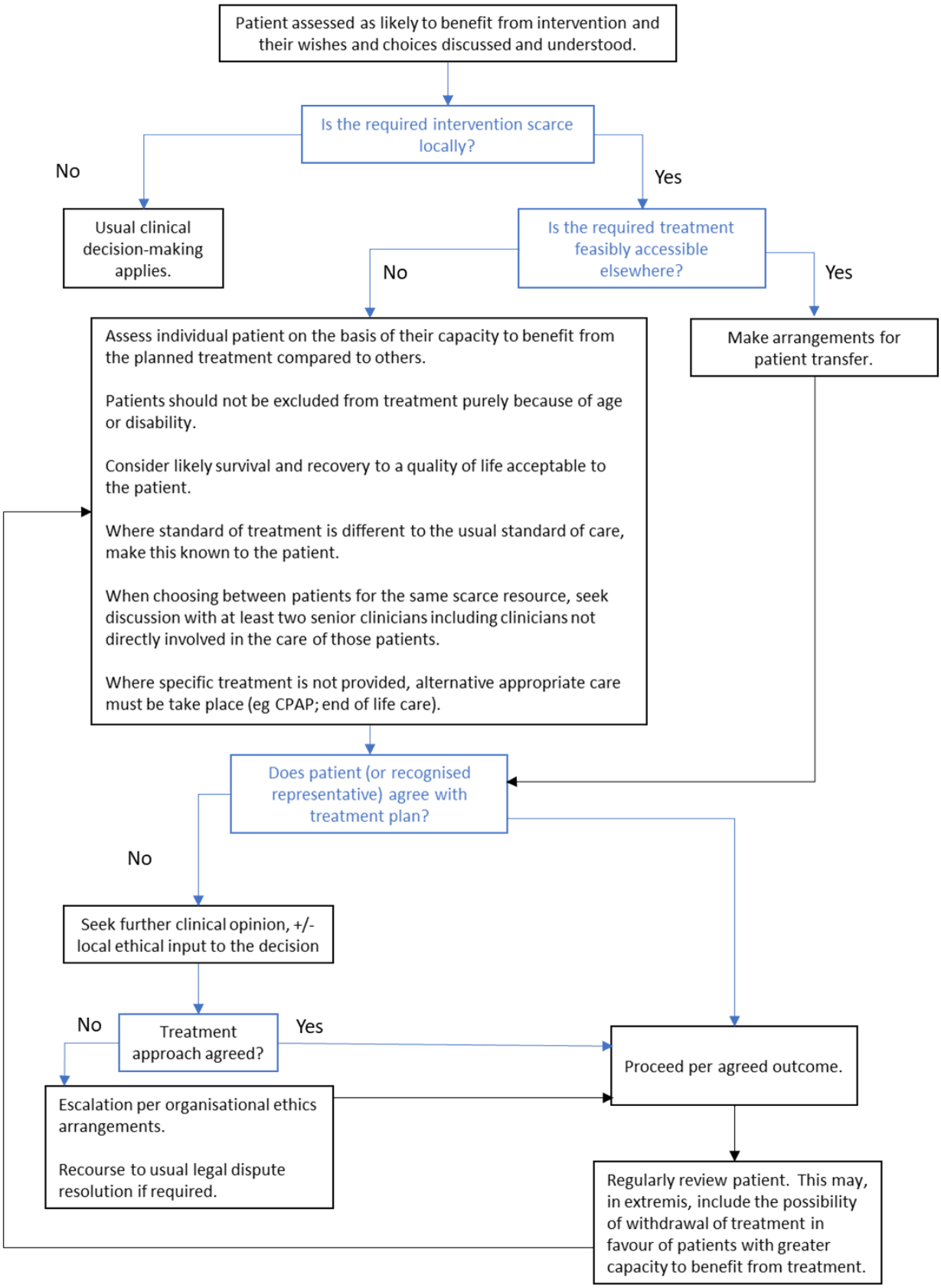
UK Government (2017). *Pandemic flu planning information for England and the devolved administrations, including guidance for organisations and businesses.* Retrieved 4 April 2020.

White, D.B. (27 March 2020). *A framework for rationing ventilators and critical care beds during the COVID-19 pandemic*. JAMA. doi:10.1001/jama.2020.5046

World Health Organization (2016). *Guidance for managing ethical issues in infectious disease outbreaks*. Retrieved 31 March 2020.

Appendix 1:

Treatment allocation and withdrawal at times of scarce availability



Appendix C: Engaging on the Ethical Framework for Devon
Engagement report
July 2020

Background and Context

Two documents have been developed by the Devon Ethical Reference Group (DERG) designed to support the NHS manage the Coronavirus pandemic. These are:

- The Devon-wide Ethical Framework
- Decision-making guidance on the allocation and withdrawal of organ support and/or treatments during the COVID-19 pandemic

(Hereafter these will be referred to as the documents or Framework and the Guidance).

A summary document was also developed.

The Devon Ethical Reference Group (DERG) is a panel made up of expert ethicists, hospital doctors and GPs; specialists in mental health, community services and public health; healthcare commissioners and lay members.

It is hoped that there will not be a need to implement these polices. However, if the need does arise, it is important that due consideration has been made with those could be affected.

To this end, a period of engagement has been undertaken to seek the views of the public about these two important documents.

This report provides an outline of the engagement that was undertaken and a summary of the feedback that was received.

You can find out more about this project on the Together for Devon website HERE[1]

Purpose of the engagement

The purpose of the engagement was to seek the views of the public on the framework and the guidance, thus allowing the DERG to develop recommendations for improvements or amendments on them.

There were five key objectives that this engagement set out to achieve, these are listed below.

[1] https://www.togetherfordevon.uk/get-involved/devon-ethical-framework/

Engagement Objectives

1. To provide an opportunity for the people of Devon to review the Framework and Guidance and provide feedback on them

2. To identify and explore any areas of concern from a public perspective, not previously considered by the DERG, about the documents,

3. To target engagement at that groups at greater risk from COVID

4. To support the DERG project team to develop a set of recommendations about the documents based on the feedback received

5. To provide a feedback report to those who contributed to the engagement (and the wider public) on how their contributions have been used.

Engagement approach

This qualitative approach to engagement was structured around a set of four questions.

The questions were designed to prompt discussion, drive conversation in order to explore people's views and gain meaningful insight.

In partnership with the DERG, following four questions were developed:

- **Question 1**
  In these circumstances, do you think any group is unfairly disadvantaged in either the framework or the guidance? If so, please set out your reasons below

- **Question 2**
  In practice, there may be areas of disagreement when implementing the framework or guidance. For example, between clinicians, or between families and clinicians.

  Do you think the framework and guidance allow for these areas to be adequately explored and resolved?

- **Question 3**
  Do you think the framework and guidance cover all the areas you would expect it to? Have any areas been missed?

- **Question 4**
  What else would you like to tell us?

Engagement methods

The engagement had four elements, each designed to target a different audience and meet a different engagement objective:

1. Devon Virtual Voices Panel

The NHS Devon CCG hosts an online panel of 1700 members, called the Devon Virtual Voices Panel (VVP). The panel has been recruited to be a demographic representation of the people of Devon. This platform was used in order to gain a representative view about the Framework and the Guidance from the people of Devon.

You can find out more about the panel by visiting the CCG website HERE[2]

The VVP were sent the Framework and Guidance (including the summary document), and the questions to respond to in a survey format.

The survey was open for responses between 17 June and 3 July 2020 (16 days)

2. Focus Groups

Three separate focus groups were held with representatives of those deemed to be most at risk from COVID-19, namely:

- People over the age of 65
- Black and Minority Ethnic (BAME) community
- People with disabilities

All the focus groups were structured around the agreed questions and lasted for a maximum of 1hr 30mins.

With their links to the community, the CCG worked in partnership with Healthwatch and Living Options Devon to identify participants for the focus groups.

The CCG's request to Healthwatch and Living Options was for them to source five or six people for each of the focus groups, who were service users, supporting organisations, volunteers or relevant interested parties.

Support from the following organisation was also received:

- Hikmat Devon CIC
- Plymouth and Devon Racial Equality Council

The CCG also requested that the Healthwatch Chair act as an independent chair for each of the focus groups. This was agreed to and the same Chair was present for all three focus groups.

[2] https://devonccg.nhs.uk/get-involved/current-projects/devon-virtual-voices-panel

- **Focus group – People over the age of 65**
  This focus group took place on 30 June, 2.00pm – 3.30pm with five members of Devon over 65 community. Attendees included Healthwatch volunteers and members of the public, some with former NHS experience.

- **Focus group – Black, Asian and Minority Ethnic (BAME) community**
  This focus group took place on 2 July, 10.00am – 11.30am with five members of Devon's BAME community. Attendees included service users, care workers and members of BAME organisations

- **Focus groups – People with disabilities**
  This focus group took place on 2 July, 2.00pm – 3.30pm. Attendees included service users with physical disabilities, people with learning disabilities, and members of disability support organisations.

3. Together for Devon Website

The framework, Guidance and questions were also published on the Together for Devon website on 17 June 2020. Responses were invited via email returns of a downloadable survey. This was the same survey sent to the VVP.

Links were sent to all potential respondents for information and sharing.

4. Live webinar

The final engagement method was a pre-planned, registration only, live webinar. This took place on Friday 10 July, 11.00am – 12.00pm.

Invitations to register were sent to all VVP members, all focus groups members (attending and not) and to organisations supporting the groups targeted for the focus groups.

The webinar was hosted and chaired by the DERG members and supported by CCG engagement.

The DERG panel representatives were:

- Dame Suzi Leather – Webinar Chair, Chair Devon Ethical Reference Group / Independent Chair, Devon STP
- Dr Paul Johnson – Clinical Chair, NHS Devon CCG
- Sam Waddy, Medical Lead, South West Critical Care Network
- Lisa Bartram – Consultant Physician – Royal Devon and Exeter NHS Foundation Trust
- Professor Richard Huxtable - Professor of Medical Ethics and Law and Director of the Centre for Ethics in Medicine, University of Bristol

The aim of the webinar was to present back the feedback received so far, address any key issues, and set out the next steps for the feedback and the documents.

Summary of feedback

Responses

A total of 76 people shared their views during the engagement process.

- Virtual Voices Panel – 53 responses
- People over 65 – five attendees
- Black, Asian and Minority Ethnic community – five attendees
- People with a disability – six attendees

A further 7 people attend the live webinar, alongside those who had already contributed during the engagement (the webinar had 20 participants in total).

Demographic breakdown

Group	Number of respondents	Demographic Breakdown
Virtual Voices Panel	53	**Gender** 31 males (58%) / 20 Females (38%) 2 not recorded (4%) **Ethnicity** 50 White British (94%) / 3 not recorded (6%) **Age** • Under 22 – 0% • 22-35 – 8% • 36 – 50 – 8% • 51 – 65 – 30% • 66 – 75 – 43% • 76 – 87 - 9% • 1 not recorded – 2%
People over 65	5	**Age** All attendees over the age of 65 (100%) **Gender** 3 males (60%) / 2 females (40%)
Black, Asian and Minority Ethnic	5	**Age** 5 not recorded **Gender** 5 females (100%)
Group	**Number of respondents**	**Demographic Breakdown**
Disability (including people with a Learning Disability)	6	**Age** 6 not recorded **Gender** 1 male (16%) / 5 females (84%)

Engagement outcomes

General comments on the engagement

An overwhelming majority of people, given the topic on which engagement was taking place, were hugely positive about the Framework and the Guidance being comprehensive, well researched and inclusive.

Those engaged recognised the importance of the documents and were grateful that such a complex and sensitive subject was being considered in a public forum, and that they had been offered the opportunity to be involved in such a piece of work.

Key Themes

The table below provides a summary of the key themes arising from the engagement. The full feedback dataset is available upon request from the CCG Communications & Engagement Team.

The feedback has been grouped into key theme areas, then summaries of these key themes have been developed.

Theme area	Key Theme summaries
Patient Communication	- Need for patient facing documents - Clear language - Access to trained interpretation not just translation - Accessibility of documents - Measures to support communication
Socialisation of framework and guidance	- Socialisation of framework and guidance - Adequate time for public to understand the documents - Adequate time for interpretation and accessibility, especially for those with learning disabilities - People from BAME backgrounds and those with disabilities can be reluctant to seek medical care because of a fear that they will be treated unfairly due to their background or condition - Recognition of the impact cultures/religions can have on healthcare, such as issue around Ramadan - Anxiety over limited access to support needs or reasonable adjustments (translation, BSL etc) for informed consent - Desire for better relationships between communities and the NHS
Unconscious bias	- Acknowledgement of unconscious bias in the documentation and the implementation - There is a perception that despite equality being cited in the documentation, this will not be reflected in reality.
Statutory advocacy	- Lack of reference to statutory advocacy and support for those without family or support network. - Recognition of the importance of the rights of inclusion for carers.

	- Access to support networks considering restriction during COVID, including disparate families, advocacy services etc
Supporting staff	- Support for staff making decisions, and guard against decision fatigue, and/or PTSD - Impact on BAME frontline staff
End of Life	- Incorporating existing EOL choices, especially when making decisions in a limited timeframe
Family Involvement	- Support for those with no family network (see also statutory advocacy), or those stuck in a Power of Attorney situation More prominence given to the inclusion of family conversations
Privacy and dignity	- Privacy and dignity developed much further in the guidance and framework
Time limit on decisions	- Provision to challenge welcomed, but more detail on how to object is needed - Clarity on how much time is allocated for the decision-making process and what, if any, time limit exists on appeals.
Monitoring Implementation	- When implemented, how will consistency be monitored across the system? - Mechanisms in place to update and maintain the documents
Other Comments of note	- Whether to consider a formal scoring system, appropriately weighted to consider a range of issues clearly explaining why decisions are being made - The “duty to guide” needs more explanation and understanding - Concerns over “as much as possible” statements in the documents

Next steps

- The CCG’s engagement team will continue to work in partnership with the DERG to develop recommendations based on the feedback that has been received.

- Following the approval of the recommendations by the DERG, this report along with the final versions of the Framework and Guidance will be shared with all those involved in the engagement, and published on the Together for Devon website

- The CCG's engagement team will provide any required support to the DERG to deliver any communication and engagement recommendations arising from this work.

Nellie Guttmann – Senior strategic engagement manager
Jon Sewell – Strategic engagement manger

Communications and engagement team
NHS Devon CCG
July 2020

Appendix D

Recommendations following Public Engagement on the Devon Ethical Framework and on Guidance on the Allocation and Withdrawal of Organ Support and/or Treatment

Introduction

1. A public engagement conducted for the Devon Ethical Reference Group on behalf of the health and care organisations in Devon took place during June and July 2020.

2. The engagement exercise sought views on the Devon Ethical Framework ('The Framework) and on the Devon Guidance on Allocation & Withdrawal of Organ Support and/or Treatments ('The Guidance').

3. The following Recommendations are derived from the responses elicited in that exercise. Responses came from individual survey responses, focus groups and organisations representing different sections of the public.

4. A report summarising the public engagement exercise and including all of the detailed responses and themes has been produced by the Devon CCG Communications & Engagement Team and has informed these recommendations.

5. The Recommendations relate to one or more of a number of aspects of the documents. Each Recommendation is followed by an annotation as follows:

    - **"F"** – an amendment is required to the Devon Ethical Framework.
    - **"G"** – an amendment is required to the Devon Guidance on the Allocation & Withdrawal of Organ Support or Treatment.
    - **"I"** – particular considerations that are required in the Implementation of the Framework and or Guidance, rather than just noted in the documents themselves. These should influence spans issues such as staff training, supporting and the responsibilities of individual health organisations.

6. The public engagement exercise also elicited a wide range of issues, many illustrative of existing health inequalities. These may direct future work for the Devon Ethical Reference Group and/or the organisations within the Devon health and care system. These will be collated and presented to the DERG for its August 2020 meeting.

Recommendations

Unconscious biases

7. There was strong support for the emphasis within in the Framework and Guidance for:

    - individualised assessments.
    - adherence to the principle of an individual's capacity to benefit from treatment.
    - the consideration not just of survival from treatment but recovery to a quality of life that was *acceptable as judged by the patient*.

    However, although the requirement that a patient's post-recovery quality of life should be judged by the patient's own criteria in every case, there was concern about unconscious biases, to which we are all susceptible, affecting treatment decisions. This view was particularly resonant amongst some disabled respondents to the public engagement. In addition to the existing emphasis in the Guidance on decisions being considered amongst multiple clinicians, it is recommended that:

    a. The prospect of unconscious bias should be explicitly mentioned in the Framework and Guidance along with the fact that this is of concern to some people with lived experience of discrimination. **[F.G.I.]**
    b. In the event of extreme pressure on critical services, the potential for decision fatigue and compassion fatigue should be noted and influence the scheduling of staff rotas, debriefing exercises and staff support. **[G.I.]**
    c. For seriously ill patients admitted to hospital, their preferences and choices should be understood reasonably early in their admission. **[G.I.]**
    d. For seriously ill patients not admitted to hospital, their preferences and choices should be understood reasonably early in their illness. **[G.I.]**

The role of families and carers

8. The Guidance should more clearly highlight the role of families and carers in supporting patient's preferences and choices. **[G].** However, this is not a straightforward point:

9. Differing views were received about the role of families and carers. For some, families and carers were seen as pivotal in supporting the patient and helping to establish the patient's choices and preferences. Others expressed their concerns that their families and carers would not necessarily understand their preferences or advocate in their best

interests. It became clear that there is a general misunderstanding about the role families may be allowed to take and that they may have a role in treatment decisions which is not the case. That misunderstanding provoked anxiety for a number of respondents. Wherever possible, the staff involved in the patient's care should create time with the patient alone to sensitively try to establish whose opinions they consider helpful and important. Staff should be aware of the potential misunderstanding about the role of those close to the patient and seek to sensitively clarify this. **[G.I.]**

10. Members of some BAME communities emphasised that those who are close to a patient may potentially be overseas and in different times zones. Staff should be aware of this and where wish to seek social from abroad make reasonable efforts to facilitate this with time, technology or both. **[G.I.]**

11. Concern was expressed where the primary carer may be a child. The concern covered the burden for the child and the need not to overlook the input of a child who is a carer when seeking to understanding the preferences of an incapacitated patient. Attention to this circumstance should be noted in the Guidance and its an its implementation. **[G.I.]**

Interpreters

12. Members of some communities conveyed their experience that some interpreters may not share the ethical stance in the Framework and Guidance. In common with any staff or family member, interpreters may be susceptible to unconscious bias.

    e. NHS staff should be made aware that this potential issue exists and is of concern to some patients. **[G.I.]**
    f. Professional interpreting services should be used. **[G.I.]**
    g. Where possible, a patient's preferred professional interpreter should be used. **[G.I.]**

13. The psychological support offered to NHS staff should also be made available to interpreters working with patients and families who are facing treatment allocation and withdrawal decisions. **[I]**

Disagreements with treatment decisions

14. Although it was generally recognised that disagreements with treatment decisions were likely to be rare, and rarer still those that could not be readily resolved between, that difficult circumstance attracted notable attention in the public engagement. In particular, whether and how resolution of disagreements could be thoroughly explored and still be timely enough if clinically urgent. Timescales and should referenced in the

Guidance and be made clear in patient versions materials as part of the implementation of the Guidance. **[G.I.]**

15. Although there is provision for disagreements with treatment decisions, there was consistent feedback that some patients may feel less able than others to raise their disagreement.

    Focus Groups suggested that this may particularly impact people who are reluctant to seek medical care or to know what care they are entitled to. It was fed back during the engagement that some members of BAME communities and some patients with a disability may be at an increased risk of not querying treatment decisions. The same risk was raised for patients without a family or a social support network, particularly those who do not meet the threshold for statutory advocacy services.

    Be clear that some patients may need increased support and multiple opportunities to ask questions about their care and in particular to raise any disagreement. **[G.I.]**

Links to statutory and legal processes

16. The ways in which the Guidance links to statutory and legal processes is not sufficiently clear or explicit. The relevant legal processes should be clearly referenced in the Guidance and in patient-facing versions. **[G.I.]**

17. Be clearer about the legal requirement for Reasonable Adjustments and make sure that this is differentiated from issues of mental capacity. Aside from its legal implications, Reasonable Adjustment should be seen as compassionate best practice required for properly informed consent **[G.I.]**

Risks for staff

18. Concern was expressed at the heightened risk of a worse outcome from COVID for staff members from certain BAME communities. Coinciding with Devon's public engagement, the South Asian Health Foundation has issued a recommendation for mandatory occupational risk assessment for staff[1]. This should be seen as a preventative measure and is adopted in the DERG's recommendations. Its mandatory nature is distinct from a line management led, discretionary occupational risk assessment which is believed to be so far the case in some organisations. **[G.I.]**

[1] South Asian Health Federation (July 2020), *COVID-19 in Black, Asian and Minority Ethnics Populations: an evidence review and recommendations from the South Asian Health Federation*. Retrieved 08 July 2020.

19. Concern was expressed in the engagement as to whether Muslim staff are at heightened risks at or around Ramadan due to physiological effects of fasting. Guidance on Ramadan and COVID-19 has been produced for staff by NHS England in conjunction with the NHS Muslim Network and the British Islamic Medical Association[2]. This should be promoted to chaplaincies, line managers and staff in a timely way ahead of Ramadan. **[I.]**

Accessibility of the documentation

20. The Framework and Guidance documents are written to support a common organisational policy in Devon and parity in the protocols for frontline staff. The public engagement exercise confirmed that for many members of the public the language in the documents is not entirely clear. The final, signed-off versions of the documents should be accompanied by more accessible versions, in clearer language, developed with the input of members of the public. **[I]**

21. Making the documents more accessible and understandable for the public includes their translation into additional languages. Additional languages include British Sign Language. **[I]**

22. In the unlikely event where services are overwhelmed and the Guidance is therefore required, patients whose first language is not English must have access to interpreters, not just to translated documents. **[I]**

Wording and emphasis

23. Greater prominence should be given in the Guidance to preserving and enhancing a patient's dignity during their care and treatment. **[F.G.I.]**

24. At times, the role of patient preferences and choices could be read as an after thought in the way the document is constructed. Give greater prominence to the role of patient preferences and choices while remaining clear about the precedence of clinical treatment recommendations. **[G.I.]**

Timeliness of publication

25. While the Guidance covers scenarios that are unlikely to arise, people who may be affected by it should have time to consider it. Ensure creation of patient versions of support materials and the publication of final versions of documents within 1 month of their sign-off of the Framework and Guidance by Trusts. Sooner if COVID-19 trajectories were to rapidly worsen.

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[2] NHS Muslim Network & British Islamic Medical Association (2020), *COVID-19 and Ramadan: how to support staff who may be fasting. Retrieved 15 July 2020.*

Review period for the documents

26. It was noted in the feedback that the evidence regarding COVID-19 is emerging and the trajectory of the pandemic is not certain, therefore a clear review period for the document is necessary. Maximum six month review period to be applied by the Devon Ethical Reference Group; though sooner if circumstances dictate. Within that review, only changes of material significance to take place, in recognition of the practicalities of having to agree changes through the separate governance of each of Devon's health and care organisations. **[F.G.]**

27. To reduce the likelihood of revisions to the documents, continue to reference the need for Trusts and clinicians to stay appraised of the emerging evidence rather than embed it at a point in time in the Guidance or Framework. **[F.G.]**

Key feedback not incorporated

28. The public engagement received feedback from some respondents that a clinical scoring tool might be incorporated into the Guidance to attempt to objectively assess a patient's capacity to benefit from treatment and their likely recovery. Since no such tools are validated for COVID-19, none has been incorporated into the guidance. Additionally, such tools risk giving rise to inequities and discrimination for groups of patients with shared characteristics.

29. Some language was thought not to be forceful enough. In particular, it was suggested that "must" could be used in place of the more equivocal "should". However, "should" has been retained in the Framework and Guidance documents to reflect the advisory nature of ethical reference groups. "Must" has generally been reserved for factual statements relating to legal duties.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 30th July 2020 **Date report produced: 21st July 2020**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date: 21st July 2020**		
Public or Private (Governing Body only):	**Public**		**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

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

The report details the financial position to the 30th June 2020 and includes reference to the impact of the COVID19 pandemic and the financial consequences for the CCG during 2020/21.

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

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

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

On the above basis the CCG has received an allocation of £682.0m, including £11.6m for COVID19 related expenditure, for the period to 31st July 2020 together with an expectation that budgets are set within the parameters stipulated by the NHSE Model. Excluding the COVID19 funding, the allocation is roughly £20m higher than the previously in year planned allocation which recognises (subject to the revised 20/21 modelling) the underlying deficit position of the CCG.

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

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

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

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

None.

Key recommendations and actions requested:

The Governing Body is requested to:

Consider, review and discuss the month 3 year to date performance and the forecast four month position including the current risks.

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

N/A

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

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

NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 3 – 2020/21

Contents

Appendices

1. Executive Summary

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

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

Financial Position

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

June 2020 (Month 3)	Budget £'000	Actual £'000	Variance £'000	Additional Allocation £000	Revised Variance £'000
Year to date position	514,123	528,647	14,524	-14,524	0
Four months forecast	681,633	699,700	18,067	-18,067	0

The year to date and FOT variances arise mainly form additional costs linked to the COVID19 pandemic (£18.6m YTD to 30th June and £22.1m FOT to 31st Jul). These costs are detailed in section 4.

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

Savings Plan

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

Risk

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

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

STP Plan

The STP planning process was put on hold in March. The CCG and STP partners are anticipating that the current financial regime may extend beyond the 31st July but will be addressing the next steps through the restoration and recovery programme.

2. Financial Assurance Dashboard

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

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

- Financial plan
- In Year Financial performance

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

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	10.1	14.5	143.7%	RED
3	Forecast Outturn deficit to 31st July	13.5	18.1	134.1%	RED
4	Running Costs	7.2	7.5	104.6%	RED
5	Risk adjustment to deficit (% of allocation)	0.0	0.0	0.0%	GREEN
6	Cash Position (% drawn down)	25.0%	32.9%	131.6%	RED
7	BPPC (% paid - value)	95.0%	100.0%	105.2%	GREEN

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

3. Detailed Financial Performance

The year to date financial position to the 30th June 2020 by main service heading is as follows. The current year forecast is the forecast to the 31st July.

2020/21 FINANCE BOARD REPORT	DEVON CLINICAL COMMISSIONING GROUP									
FOR THE PERIOD FROM 01 APRIL 2020 TO 30 JUNE 2020	Year To Date					Current Year Forecast				
Month 03 June	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES										
Acute Services	229,734	226,932	33	226,965	-2,770	306,303	301,444	33	301,477	-4,826
Mental Health Services	52,734	53,023	472	53,494	761	70,175	70,625	598	71,223	1,048
Community Health Services	71,120	69,732	7,613	77,345	6,224	93,645	93,174	9,557	102,731	9,086
Placements	33,661	32,364	1,245	33,609	-52	44,390	42,608	1,718	44,326	-64
All Other Healthcare	15,748	12,071	2,986	15,057	-691	20,017	14,203	3,445	17,648	-2,369
Primary Care Services										
Prescribing	50,146	55,403	2,269	57,672	7,525	66,862	74,504	2,392	76,896	10,035
Delegated Commissioning	40,929	43,018	-	43,018	2,089	54,572	57,311	-	57,311	2,739
Other Primary Care	15,445	12,390	3,624	16,015	570	19,528	16,566	4,013	20,579	1,051
Primary Care Subtotal	106,520	110,811	5,893	116,704	10,184	140,962	148,381	6,405	154,786	13,824
Commissioned Services Subtotal	509,517	504,933	18,242	523,174	13,657	675,492	670,435	21,757	692,192	16,699
CORPORATE										
Running Costs	4,606	5,155	317	5,472	867	6,141	7,177	331	7,508	1,368
EARMARKED RESERVES AND CONTINGENCIES										
Earmarked Reserves	-	-	-	-	-	-	-	-	-	-
Contingency	-	-	-	-	-	-	-	-	-	-
Other Reserves	-	-	-	-	-	-	-	-	-	-
Reserves Subtotal										
TOTAL COMMISSIONED SERVICES	514,123	510,088	18,559	528,647	14,524	681,633	677,612	22,088	699,700	18,067
Allocation excl b/fwd position	-514,123	-510,088	-18,559	-528,647	-14,524	-681,633	-677,612	-22,088	-699,700	-18,067
2019/20 Surplus/Deficit					-					-

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

3.1 Acute Services

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

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

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

The underspend of £2.8m at Month 3 and forecast underspend of £4.8m relates to reduction of Non-contract activity compared to the budget set. The underspend is offset by some small variances in other contracts where the budget does not match the commitments.

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

3.2 Mental Health Services

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

In 2020/21 the CCG had planned to invest £11.9m (5.63% increase) in Mental Health Services. Whilst the temporary financial arrangements are in place and planning on hold the proposed investments are on hold, but with the expectation that MHIS will still be honoured over the course of the remainder of the financial year.

At month 3 there is an overspend of £0.8m for all mental health services with a forecast overspend of £1.0m. Some of this relates to costs incurred in relation to the response to the pandemic and are covered in section 4.

The other variances are driven mainly by the temporary budget setting process when compared to actual commitments the largest of which relates to Learning Disability placements where the budget compared to commitments and other pressure presents a £0.5m adverse variance at Month 3 projected to be £0.8m after 4 months.

There is also a FOT overspend on CAMHS commitments projected to be £0.2m after 4 months where the budget does not reflect the full year effect of commitments made in 19/20.

3.3 Community Health Services

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

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

The majority of the year to date overspend of £6.2m and projected overspend of £9.1m relate to COVID19 costs detailed in section 4. The remaining variance covers the following areas.

The budget received for the contact with Livewell Southwest does not reflect the level of growth and investment agreed during the original planning round including the full year effect of contract variations in 19/20. This presents an overspend of £1.3m year to date and a projected variance of £1.8m.

The budget received for the Better Care Fund does not reflect that national agreements regarding uplifts and gives rise to an overspend of £1.4m year to date and a forecast of £1.9m.

3.4 Placements

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

This area in total is forecast to underspend by £0.1m for the period to 31st July. This is largely as a result of exceptional costs during the current pandemic (uplifts to market rates) and variance between NHSE/I budget setting model verses local plan but offset by client number reductions and additional budget received from NHSE/I for Covid costs.

The following table provides an analysis of the forecast variance.

Placements FOT Variance	
Variance Type	**£m**
Additional Covid related costs e.g. fee uplifts	1.5
Additional Budget for Covid costs M1&2	-1.5
Budget variances (NHSE/I model vs local plan) & profiling	1.0
Non delivery of QIPP savings plan	0.8
Cost reduction due to client number movements (partly Covid related)	-2.9
FNC Uplift over and above plan assumption	1.0
Total	- 0.1

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

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

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

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

3.5 All Other Healthcare

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

Overspending recorded in this area relates solely to COVID19 specific costs and in particular the setup of the Nightingale Hospital in Exeter. The remaining variances that offset these costs are as a result of the budget setting methodology compared to actual commitments.

3.6 Primary Care Services

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

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

Prescribing

The Month 3 Prescribing figure is reported as a £7.5m overspend year to date £10.0m overspent by Month 4. The methodology used to set the budget did not take account of non-recurrent benefits achieved in 19/20 which resulted in a lower opening budget than anticipated. The position is further worsened by the following in year pressures.

- £3m underachievement on the set QIPP plan of £9m, as COVID19 has prevented work on this for the first 4 months.
- The final March prescribing costs showed an increase of £2m not provided for in 19/20 or the budget methodology.
- Warfarin spend at £492k due to changes for patients during COVID19
- Category M and No Cheaper Stock Obtainable (NCSO) costs predicted to add pressures of £2.5m.

Delegated Commissioning

The £2.1m year to date and £2.7m forecast overspends are as a result of the budget methodology not accurately reflecting the recurrent commitments and pressures anticipated in 20/21.

Other Primary Care

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

3.7 Running Costs

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

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

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

The CCG's allocation for 2020-21 was set to reduce from £25.4m last year to £22.4m for this financial year but as part of the framework set for this period to 31st July this has been revised. The CCG is reporting expenditure for the 4 months at £7.5m, of which £0.3m are specific short-term costs in relation to COVID19.

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

3.8 Resource Allocation

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

Planned revenue resources	£'000
Allocation after place based pace of change	1,759,720
Primary care commissioning	170,193
Running costs allocation	22,411
Recurrent adjustments	-1,768
COVID19 non-recurrent allocation	11,592
Non recurrent adjustments (Months 5 to 12)	-1,280,516
Total revenue resources to month 4	**681,632**

The resources include a non recurrent COVID19 allocation, received at month 3, but excludes the assumed additional allocation to cover the overspend position reported. The high level parameters under which the allocation was set are as follows:

Plan modelled as follows:

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

4. COVID19 Specific Costs

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

The CCG has incurred costs of £18.6m to date and is predicting costs of £22.1m by the end of the 4-month period.

COVID 19 Comittment Analysis	YTD £m	FOT £m
Nightingale Hospital	2.0	2.1
CHC - Market Enhancements	1.6	2.2
Prescribing	2.3	2.4
Primary Care	3.4	3.8
PPE, Staffing and other costs	2.1	2.2
	11.4	12.8
Hospital Discharge		
Devon CCG	0.4	0.4
Devon Council	4.4	5.9
Plymouth Council	1.4	1.9
Livewell Southwest (Social Care)	0.9	1.1
	7.2	9.3
Total	18.6	22.1

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

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

The impact of the national initiative to ensure the care sector remains stable during the COVID19 period has had a consequently effect on the cost care packages funded through Continuing Care Homes. We continue to work without Local Authorities on the developing strategies for the market management of the care home sector.

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

In addition to these measures a national initiative to speed up discharge from Hospital and reduce the burden of assessment on decisions supporting discharge NHSE and Local Authority's regulators agreed a hospital discharge programme supported by £1.3bn of NHSE funding. It allows Local Authorities to reclaim the cost of discharge packages and enhanced costs of care to prevent hospital admissions to be reclaimed via the CCG.

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

5. Risks

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

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

As the financial framework beyond July is unknown there is a risk that the exit run-run rate exceeds the remaining allocation for the financial year.

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 30th June 2020 is shown in appendix 1.

6.2 Capital

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

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non NHS Creditors - % of bills paid within target	99.57%	99.92%
NHS Creditors - % of bills paid within target	97.63%	100.00%

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

6.4 Cash

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

7 Recommendations

The Governing Body is requested to:

Consider, review and discuss the month 3 year to date performance and the forecast four-month position including the current risks.

Appendices

Appendix 1: Statement of Financial Position

AS AT 30 JUNE 2020	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	1,952
Intangible Assets	3
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	1,955
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	5,603
Trade & Other Receivables - Non NHS	22,111
Other Current Assets	-
Cash & Cash Equivalents	11,838
Non-current Assets held for Sale	-
Total Current Assets	39,951
Total Assets	41,906
CURRENT LIABILITIES	
Trade & Other Payables - NHS	92,522
Trade & Other Payables - Non NHS	- 113,640
Other Liabilities	- 8,069
Borrowings / Cash in Transit	- 10,065
Provisions	-
Total Current Liabilities	- 39,252
Total Assets less Current Liabilities	2,654
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 89
Total Non Current Liaibilities	-
Total Assets Employed	2,565
FINANCED BY TAXPAYERS EQUITY	
General Fund	- 2,565
Total Taxpayers' Equity	- 2,565

Appendix 2: Cash

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

Measure	Month 3
CCGs must operate within their expected annual cash drawdown requirement. *The expected annual cash drawdown requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,979.275m for Devon CCG the year.*	32.9% of the MCD has been utilised as at month 3 (25.0% is expected based on a straight-line trajectory at month 3). Over utilisation is due to the requirement by NHS England to pay Providers one month's block payment in advance.
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £7,446 for June.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has not met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

Appendix 3: Operating Expenditure

2020/21 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2020 TO 31 MAY 2020 Month 02 May	DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
ACUTE CARE										
NHS Royal Devon & Exeter Foundation Trust	69,078	69,078	-	69,078	-0	92,104	92,104	-	92,104	-
NHS University Hospitals Plymouth NHS Trust	57,091	57,091	-	57,091	-0	76,121	76,121	-	76,121	-0
NHS Northern Devon Healthcare Trust	30,220	30,220	-	30,220	-0	40,294	40,294	-	40,294	-
NHS South Devon Healthcare Foundation Trust	50,564	50,564	-	50,564	0	67,419	67,419	-	67,419	0
NHS Taunton and Somerset	2,413	2,413	-	2,413	0	3,218	3,218	-	3,218	0
NHS South Western Ambulance Trust	12,624	12,624	-	12,624	0	16,832	16,832	-	16,832	-0
Independent Sector	519	302	-	302	-217	691	673	-	673	-19
Other Acute	7,225	4,640	33	4,673	-2,553	9,624	4,783	33	4,816	-4,808
Subtotal	229,734	226,932	33	226,965	-2,770	306,303	301,444	33	301,477	-4,826
PLACEMENTS										
Continuing Healthcare	30,626	29,005	928	29,933	-693	40,390	38,020	1,446	39,466	-924
Funded Nursing Care	2,726	3,233	123	3,356	630	3,593	4,188	245	4,434	840
Individual Patient Placements	309	126	194	320	11	407	400	27	427	20
Subtotal	33,661	32,364	1,245	33,609	-52	44,390	42,608	1,718	44,326	-64
COMMUNITY & NON ACUTE										
Livewell Southwest	12,523	12,370	1,423	13,793	1,270	16,428	16,495	1,744	18,239	1,812
Royal Devon and Exeter Community	14,684	14,684	-	14,684	-0	19,578	19,578	-	19,578	-0
Northern Devon Healthcare Community	7,653	7,653	-	7,653	-0	10,204	10,204	-	10,204	-
South Devon Healthcare Community	17,628	17,628	-	17,628	-	23,503	23,503	-	23,503	-
Children and Families Health Devon	2,900	2,908	-	2,908	9	3,866	3,878	-	3,878	12
MIU Contracts	195	214	-	214	19	260	286	-	286	26
Plymouth Integrated Fund	2,682	2,338	1,754	4,092	1,410	3,242	3,118	1,900	5,019	1,776
Better Care Fund_Devon CC	9,168	7,917	4,436	12,353	3,185	11,646	10,556	5,913	16,469	4,823
Better Care Fund Torbay	566	824	-	824	258	755	1,098	-0	1,098	343
Other Community Services	3,122	3,196	-	3,196	74	4,162	4,457	-	4,457	294
Subtotal	71,120	69,732	7,613	77,345	6,224	93,645	93,174	9,557	102,731	9,086
MENTAL HEALTH SERVICES										
Devon Partnership NHS Trust	32,486	32,486	-	32,486	0	43,314	43,314	-	43,314	0
Livewell MH Services	9,614	9,614	-	9,614	-	12,819	12,819	-	12,819	-0
Children and Families Health Devon	2,643	2,643	-	2,643	-	3,525	3,525	-	3,525	0
Individual Patient Placements	6,597	6,743	382	7,125	529	8,689	8,992	508	9,500	811
Other Mental Health	1,394	1,536	90	1,626	232	1,828	1,975	90	2,065	237
Subtotal	52,734	53,023	472	53,494	761	70,175	70,625	598	71,223	1,048

2020/21 FINANCE BOARD REPORT	DEVON CLINICAL COMMISSIONING GROUP									
FOR THE PERIOD FROM 01 APRIL 2020 TO 31 MAY 2020	Year To Date					Current Year Forecast				
Month 02 May	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
OTHER COMMISSIONED SERVICES										
NHS 111	933	905	-	905	-27	1,243	1,207	-	1,207	-36
Integrated Urgent Care Service	223	110	-	110	-113	297	147	-	147	-150
Hospices	2,108	1,954	16	1,970	-138	2,805	2,717	16	2,733	-72
Patient Transport Services	2,078	2,147	43	2,190	111	2,756	2,839	43	2,881	125
All Other Commisionned Services	10,407	6,955	2,928	9,883	-525	12,916	7,294	3,386	10,680	-2,235
Subtotal	15,748	12,071	2,986	15,057	-691	20,017	14,203	3,445	17,648	-2,369
PRIMARY CARE										
Prescribing	50,146	55,403	2,269	57,672	7,525	66,862	74,504	2,392	76,896	10,035
Enhanced Services	3,510	3,734	-	3,734	223	4,680	4,978	-	4,978	298
Delegated Commissioning	40,929	43,018	-	43,018	2,089	54,572	57,311	-	57,311	2,739
GP Out Of Hours	3,850	3,394	313	3,708	-142	5,029	4,516	313	4,829	-200
Other Primary Care	8,084	5,262	3,311	8,573	489	9,819	7,071	3,700	10,771	952
Subtotal	106,520	110,811	5,893	116,704	10,184	140,962	148,381	6,405	154,786	13,824
TOTAL COMMISSIONED SERVICES	509,517	504,933	18,242	523,174	13,657	675,492	670,435	21,757	692,192	16,699
RUNNING COSTS										
Pay	3,463	4,031	276	4,307	844	4,618	5,743	310	6,053	1,435
Non Pay	1,166	1,125	41	1,166	-0	1,555	1,435	21	1,457	-98
Income	-24	-1	-	-1	23	-32	-1	-	-1	31
Subtotal	4,606	5,155	317	5,472	867	6,141	7,177	331	7,508	1,368
EARMARKED RESERVES AND CONTINGENCIES										
Earmarked Reserves										
Contingency										
Other Reserves	-	-	-	-	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-	-	-	-	-
NET TOTAL OPERATING COSTS	514,123	510,088	18,559	528,647	14,524	681,633	677,612	22,088	699,700	18,067
CCG Control Total	-514,123	-510,088	-18,559	-528,647	-14,524	-681,633	-677,612	-22,088	-699,700	-18,067
2020/21 Surplus/Defecit	-	-	-	-	0	-	-	-	-	-

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY MEETING

Report title: Quality and Performance Report April-May 2020 (Month 2)				
Date of Governing Body: 30th July 2020 **Date report produced:** 14th July 2020				
Author (s) Name and Title: Sarah F Thompson – Interim Chief Operating Officer Lorraine Webber – Associate Chief Nursing Officer & Deputy Caldicott Guardian Alison Wilkinson – Deputy Chief Operating Officer Kelvin Grabham – Associate Director of Business Intelligence		**Supporting Executive:** **Name and Title:** Sarah F Thompson – Interim Chief Operating Officer **Report Approved by:** **Name and Title:** Sarah F Thompson – Interim Chief Operating Officer Darryn Allcorn – Chief Nursing Officer **Date:** 14th July 2020		
Public or Private (Governing Body only):	**Public**	x	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The purpose of the paper is three-fold:

- To present the 1st April 2020 to 30th May 2020 (month 2) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.
- To present the quality and safety performance position for the period 1st April to 30th May 2020.
- To provide an update on the latest published national guidance on performance for the period 1st August 2020 to 31st March 2021.

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

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

Finance & Performance Committee on 16th July 2020.

Key recommendations and actions requested:

The Governing Body is asked to:

- Agree the 1st April 2020 to 30th May 2020 (month 2) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.
- Agree the quality and safety performance position for the period 1st April to 30th May 2020.
- Note the update on the latest position in relation to performance for the period 1st August 2020 to 31st March 2021.

Impact on Strategic Objectives

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

Appendix 1 – Performance Report

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

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

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

NHS Devon CCG
GOVERNING BODY (PUBLIC)
30th July 2020

Performance Report

1. Introduction

This paper builds on the last performance paper presented to the Governing Body on 18th June 2020. The purpose of the paper is three-fold:

- To present the 1st April 2020 to 30th May 2020 (month 2) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.

- To present the quality and safety performance position for the period 1st April to 30th May 2020.

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

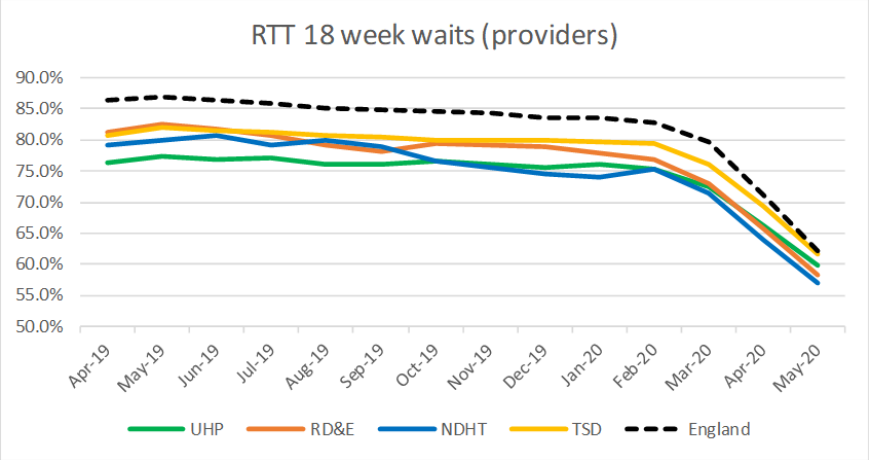
2. Constitutional Standards Performance from 1st April to 30th May 2020

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

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

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

Referrals to Treatment (RTT) Waiting Times
May validated data shows a further fall in RTT 18-week performance from 67.0% to 59.3% at STP level compared to the target of 92% and national performance of 62.2%.



Waiting lists continue to fall as referrals remain relatively low, although an increase is expected from July or August as referrals increase back towards expected levels and activity remains lower than pre-Covid volumes. The table below shows the RTT waiting list movement between April and May by provider:

	RD&E	NDHT	UHP	TSD
April	31,812	12,260	27,384	19,878
May	30,910	11,435	25,626	20,059
Variance	**-902**	**-825**	**-1,758**	**181**

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

	RD&E	NDHT	UHP	TSD
April	257	39	231	93
May	494	131	411	192
Variance	**237**	**92**	**180**	**99**

Diagnostic Waiting Times

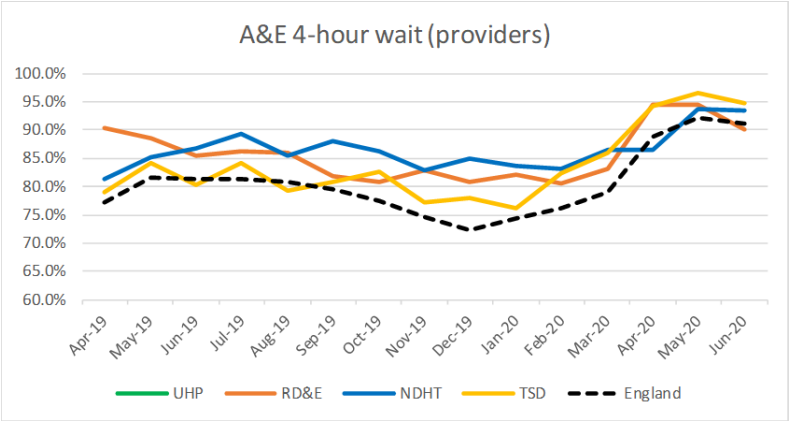
Diagnostic waiting times have also been significantly affected by the Covid-19 pandemic. April saw a large reduction in performance and although this flattened off for Torbay and South Devon NHS Foundation Trust (TSD), University Hospital Plymouth NHS Trust (UHP) and Northern Devon Healthcare NHS Trust (NDHT) in May, further falls at the Royal Devon and Exeter NHS Foundation Trust (RD&E) have further affected the STP position. The table below shows the number of patients seen within 6 weeks as compared to the national 99% target and the movement between April and May. The STP position of 43.9% remains well below the 99% target but is slightly better than the England position of 41.5%.

	RD&E	NDHT	UHP	TSD
April	68%	41%	53%	52%
May	37%	42%	54%	46%
Variance	**-31%**	**1%**	**1%**	**-7%**

Performance is monitored on a weekly basis and has improved as we go into July. Additional capacity is being stepped up for endoscopies in all acute trusts and CT scanning has now commenced in the Nightingale Hospital – trusts are currently discussing how the Nightingale activity will be recorded.

A&E Waiting Times

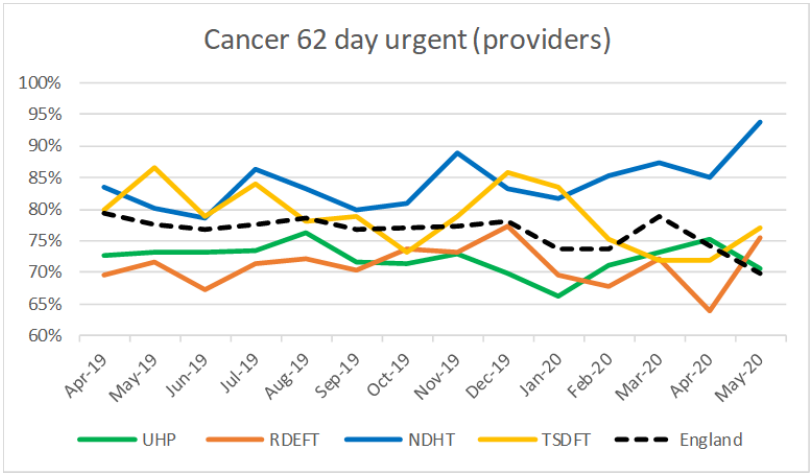
In contrast with the position against elective waiting times, performance against the A&E 4-hour wait target improved as a lower number of patients presented in emergency departments from late March and into April. Overall attendance volumes fell by 40% in April and, although they have been increasing during May and June, remain below expected levels. Performance across the STP in April was 94.4% and in May was 95.3%. June performance was 93.0% for all types and 91.3% for type 1 attendances, slightly down on the May position and below the 95% national target. The England position was 93.6%.



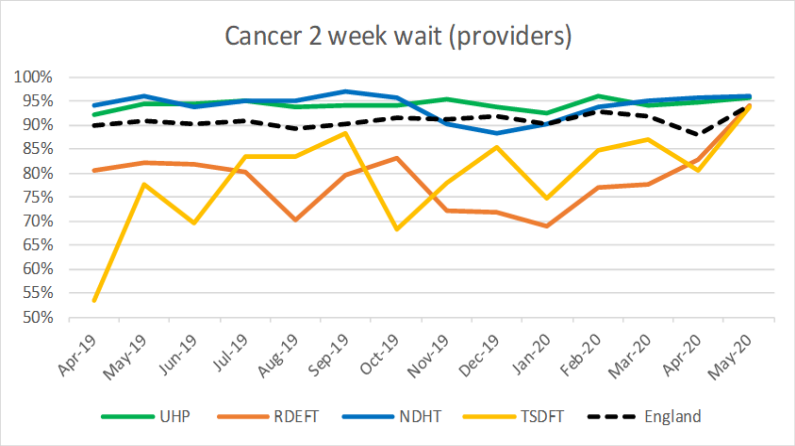
Cancer Waiting Times

Performance against the cancer waiting times standards remained relatively stable through the initial Covid-19 period and has improved in May.

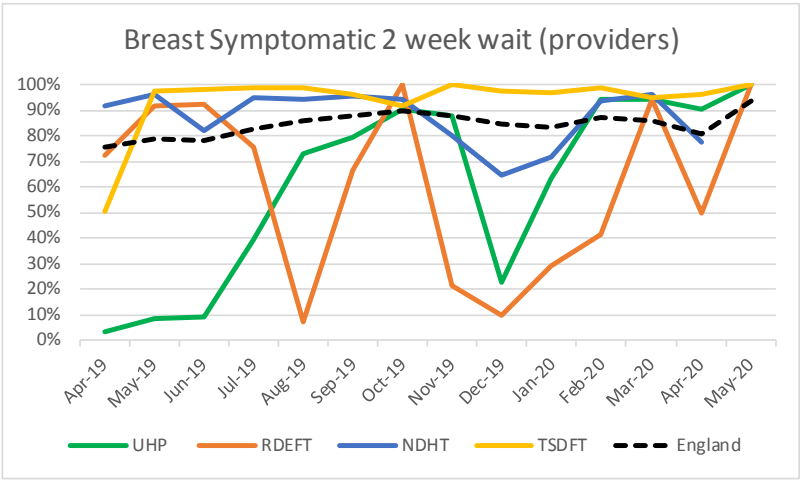
The STP position against the 62-day standard rose from 71.1% to 74.9%. Only NDHT achieved the 85% target at 93.8% but RD&E rose from 63.8% to 75.5% whilst TSD increased from 72.0% to 77.1%. However, UHP deteriorated slightly from 75.2% to 73.4%. Whilst the STP underperformed against target it remains above the national position of 69.9%.



Performance against the main two week wait standard rose above target to 94.7% in May, the first time the 93% standard has been achieved for over a year, with all providers meeting the target.



Breast symptomatic performance also increased above the 93% target in May with all providers achieving 100%.



3. Quality and Safety Performance for the period 1st April 2020 to 30th May 2020 (Month 2)

Urgent & Emergency Care – Whilst the overall picture for Emergency Department (ED) waiting times has improved, one decision to admit 12-hour breach was reported by UHP in April with no reported evidence of harm. Significant pressure on the 111 service with increased call volumes during April. Despite reduced call volumes reported during May at 88.79% of their forecasted call volume, there remained significant levels of call abandonment. This poor call answering position may lead to poor patient experience, although complaints to the service have reduced significantly during April and May.

Planned Care & Diagnostics – Pre COVID-19 escalated quality issues include long waiting times for elective care, with concerns and complaints evidencing suboptimal patients experience. Waiting times will be exacerbated by the pandemic. The CCG is seeking assurance from each provider, including the independent sector, that they have plans to

safely restore services, but also that providers have processes in place to check for harm due to long waits. Additionally, the CCG is supporting the development of a system approach to ensuring patient safety while waiting for treatments and ensuring our reviews of provider actions include patient experience of waiting list and delay. Detailed analysis of serious incidents occurring over a 12 month period, that included potential diagnostic delays and diagnostic reporting delays, was undertaken prior to the COVID-19 pandemic and on-going analysis is planned, to ensure providers have processes in place to identify risk and harm in all groups, including cancer care, diagnostics and cardiology.

Main provider Quality, Safety and Governance Committees have recommenced, attended by the CCG, where further evidence is provided on safe processes for managing restoration safely. The CCG leads the process of restoration of services for the system, ensuring quality and equality impact is considered.

However, this period has also seen huge advancement in innovative models that drive improved safety and experience. These include remote appointments, use of IT to monitor dermatological conditions, more patients self-monitoring blood pressure. The CCG is leading the transformational work across the system through the 'Restoration & Transformation Cell'.

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

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

Primary Care - The CCG Primary Care Quality Assurance Audit identified key improvement areas that will support quality surveillance and assurance across primary care moving forwards. These include an agreed quality data set that will provide assurance across the System, but also enable the CCG and partners to horizon scan for potential risks. This in conjunction with reviews and learning from individual practice challenges and closures experienced since becoming delegated commissioners of primary care (medical services), will aim to promote a responsive plan for oversight and early supportive interventions.

Care Home Support Model - The Care Home & Home Care Cell led by the CCG with membership from three Devon Local Authorities and CQC, continues to provide significant resource and support to community and social care settings and partners. Issues being managed currently include ensuring sufficient Personal Protective Equipment (PPE), FIT testing for staff where individuals receive aerosol generating procedures (AGP's), COVID testing resource to ensure an improved, but sustained, position within care homes and domiciliary care sectors. Training on infection prevention & control, Personal Protective Equipment (PPE) and swab testing is now extended to all domiciliary and supported living providers across Devon
Fortnightly webinar in partnership with the Care Quality Commission (CQC), Local Authorities and providers, with topical sessions and an interactive question & answer session continues.

Work across Primary Care and community health service providers to implement the COVID-19 Care Home Support Model set out by NHS England includes additional pharmacy input

and advice, a named clinical lead and clinical support through a weekly virtual 'check in', supporting with individualised care planning for residents.

A review of learning from national research undertaken by into varying COVID-19 impacts by local authority area has been undertaken by Devon County Council and shared with the Care home & Home Care Cell. Key findings from the evidence review are:

- Devon has experienced one of the lowest mortality rates in care homes due to COVID-19 in the country.
- During the COVID-19 period the proportion of deaths in care homes that were due to COVID-19 across Devon has been comparatively low.
- A lower proportion of care homes have reported outbreaks of COVID-19 in Devon than almost anywhere in the country.

Further analysis is now underway to understand these findings are as a result of low infection prevalence in the wider community, due to the characteristics of the care homes in Devon or due to the system approach we have taken together in supporting this sector.

4. Nursing and Quality Functional Performance from 1st April 2020

Quality Surveillance & Assurance

Throughout the COVID-19 response many CCG quality surveillance functions have continued despite limited access to the usual intelligence and information. Main provider Quality, Safety and Governance Committees have now recommenced, attended by the CCG. These committees shine a light on provider issues, risks and the actions they are taking to mitigate them. For example, long waits or gaps in staffing and recruitment issues; attendance provides the CCG with assurance on provider processes and the opportunity to communicate expectations of the CCG in seeking quality and safety experience. System work has begun to establish impact on services as a result of COVID-19, to seek an understanding of existing risk and harm, as well as inform future planning. As many provider functions begin to restore activity, the CCG is returning many of the deployed clinical and non-clinical staff within the nursing & quality directorate back into full restoration of safety systems and quality assurance. These staff support all restoration and transformation programmes across the system and the CCG in patient quality & safety functions whilst driving transformation and learning from innovation over the last 10 weeks.

Influenza Planning & Support Programme 2020/21

There are a number of potential challenges that will impact on this year's influenza (flu) programme across the patient/public and front-line healthcare worker vaccine programme. The CCG has therefore planned a system oversight group to support providers across Devon in the planning and delivery of this national programme.

Quality Equality Impact Assessments (QEIAs)

The CCG have developed concise QEIAS to support providers to step down and up services safely. This transformation is on-going, in order to support commissioning decisions and enable providers to have guidance and support on their service change plans. This includes learning around new ways of working and enabling a wide provider engagement with the process.

Hospital Acquired Covid 19 Infections

Continuous oversight of all Health Care Associated Infections (HCAI) against national targets for both acute and community settings occurs routinely. There is now an additional national

requirement for all hospital providers to also report Covid 19 positive cases where the onset of the infection was within the hospital setting. These are reviewed and regionally reported and discussed by NHS England with the CCG to ensure learning is identified. Currently, there are no evidence of cases of hospital acquired Covid 19 infections reported in Devon.

Safety Systems & Patient Experience
The national step down on the patient complaints process requirements made in March 2020 will be discontinued from July with complaints services expected to return to normal. The CCG has maintained the function throughout the pandemic and continues to support providers, there was a significant reduction in the number of contacts to the patient advice and complaints team which enabled two of the team to be redeployed to support the CCGs response to the pandemic. A review of the CCG Patient Advice and Complaints Team (PACT) is underway, and any recommendations will be reported through to QAC.

In April and May the CCG have received 159 cases of patient and staff feedback, 66 of which were health care professional feedback via the CCGs Yellow Card system. 5 formal complaints and 88 informal feedback cases. There are no particular trends or themes identified at this time.

The patient advice and complaints monitored those which could have related in some way to the COVID-19 pandemic. 33 of the informal feedback cases and 7 of the health care professional feedback cases were identified as having either a direct or indirect link to the pandemic.

In the same period, the CCG were notified of 60 potential or actual Serious Incidents (SIs). It is not possible at this stage to identify how many of these are linked to COVID-19. The Quality review template has been adapted to capture COVID-19 information related to SIs at the point of closure for auditable purposes.

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

Updated national guidance was published on 6th July ***Stepping back up of key reporting and management functions*** and this includes a section on reporting and assurance as follows:

"While we are keen to keep the data burden on trusts at an absolute minimum, we are now at a point in time where the need for certain data and our understanding of the impact of COVID-19 on particular areas has increased. Some collections will remain paused in the coming quarter; however, we have identified a small number of data collections that we need to re-instate, linked to our need to understand key aspects of delivery and clinical outcomes during the pandemic:

- ***National clinical audits and outcome review programmes (HQIP):*** *in order to support NHS recovery and NHS recovery, the Healthcare Quality Improvement Partnership (HQIP) will begin to work with national clinical audit and outcome review programme providers to identify key data items for collection from national clinical audits and outcome review programmes. This is in addition to intensive care, child mortality database and maternity audits, which have continued to collect data throughout the surge period.*

- ***Referral to treatment patient tracking list (RTT PTL):*** *with specific challenges in the restoration of elective care, the RTT PTL will enable national, regional and local oversight of waiting lists and waiting times, particularly for the longest waiting patients. While the return should continue to be provided at trust level, where primary accountability for PTL management continues to reside, we expect complementary work to be undertaken at a system level, to allow greater sharing of demand and capacity across system footprints.*

- ***Ambulance clinical outcomes (AmbCO):*** *reactivating AmbCO will mean the full suite of ambulance systems indicators (AmbSYS) will be in place. This will help our understanding of patients on urgent and critical care pathways such as those used to treat strokes, for example.*

Trusts were also asked to continue collecting data on the following mental health indicators, where capacity allowed:

- *Children and young people's eating disorders waiting time*
- *Physical health checks for people with severe mental illness*
- *Out of area placements.*

We are now confirming that these data collections resume as normal for the Q2 reporting period."

The CCG is working with providers to ensure that these requirements can be met across the Devon system.

A principles paper shared by the regional team highlights the need for Phase 3 plans to "be grounded in knowledge of population needs with a strong emphasis on reducing health inequalities" but does not set out any expectations around performance improvement.

Therefore, the CCG is progressing the piece of work referenced in the previous report, working with provider colleagues to look at the range of performance compliance that can be achieved using innovation and new ways of working and, in particular, at how a partnership approach might focus performance improvement on reducing inequalities.

6. Conclusion and Recommendation

Members of the Committee are asked to:

- Agree the 1st April 2020 to 30th May 2020 (month 2) Constitutional Standards performance position in line with national guidance published on the 28th March 2020 entitled *Reducing burden and releasing capacity on NHS providers and commissioners to manage the COVID-19 pandemic*.

- Agree the quality and safety performance position for the period 1st April to 30th May 2020.

- Note the update on the latest position in relation to performance for the period 1st August 2020 to 31st March 2021.

Appendix 1
Performance Report
July 2020

Performance and Quality indicators

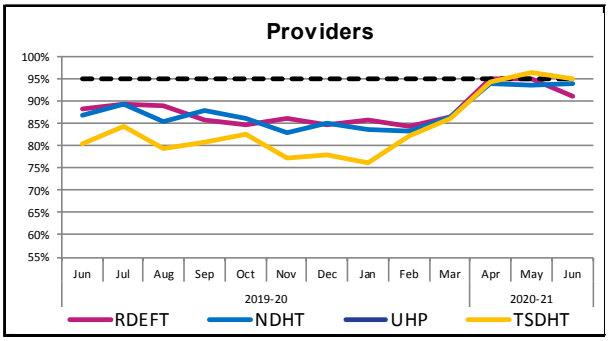
NHS Constitution Performance

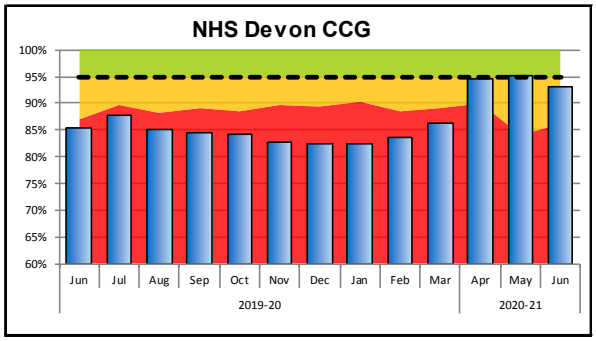
A&E Performance - Percentage of patients waiting less than 4 hours.

All types (including MIU and WiC)

Trust	Trajectory	June	2020/21
RDEFT	86%	91.2%	93.5%
NDHT	88%	93.8%	93.7%
UHP	N/A	N/A	N/A
TSDFT	82%	94.8%	95.3%

CCG	Trajectory	June	2020/21
NHS Devon	95%	93.0%	94.1%
ENGLAND		93.6%	93.2%

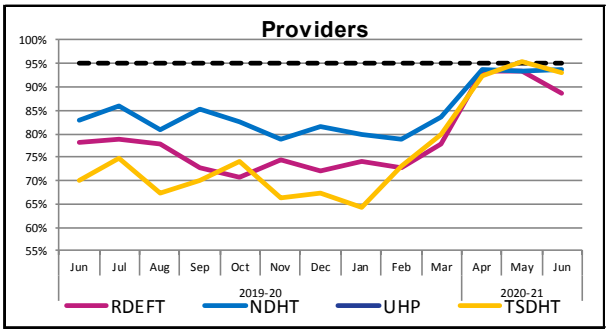


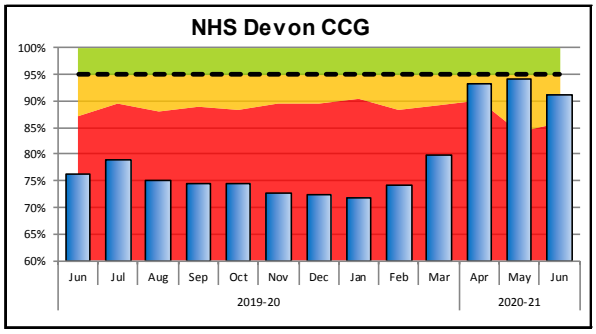


Type 1 A&E only

Trust	Trajectory	June	2020/21
RDEFT	86%	88.6%	91.5%
NDHT	88%	93.8%	93.7%
UHP	N/A	N/A	N/A
TSDFT	82%	93.1%	93.8%

CCG	Trajectory	June	2020/21
NHS Devon	95%	91.3%	92.8%
ENGLAND		91.2%	90.9%





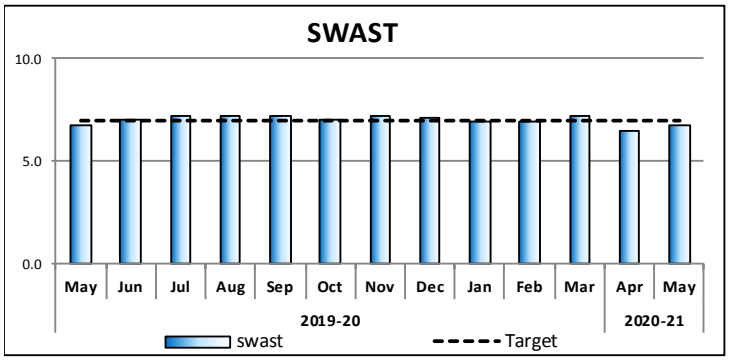
Performance Commentary

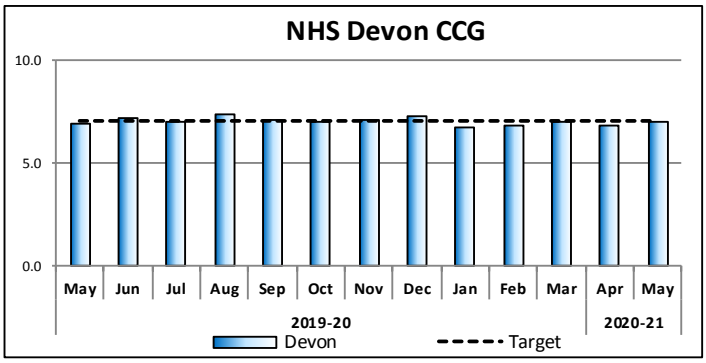
With attendance volumes remaining lower than expected (although they are increasing) performance remains comparatively good against the A&E 4-hour target across all providers.

The June STP 'all types' position was 93%, down from 95% in May and slightly under the national 95% target. TSD continued to see the highest level of performance at 94.8%, with NDHT at 93.8% and RD&E falling to 91.2%. Type 1 performance also remained relatively good at 91.3%, compared to the England position of 91.2%.

SWAST Cat 1 Mean response time

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



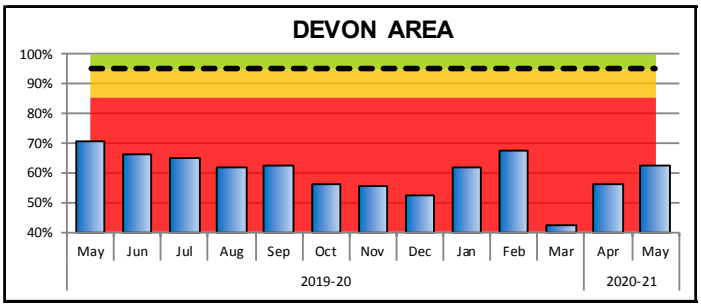


Performance Commentary

At STP level the 7-minute response time performance was within target in May at 7.0 minutes for Devon, slightly up from 6.8 in April.

NHS 111 answering calls within 60 Seconds

Trust	Target	May	2020-21
DEVON	95%	62.2%	59.7%
ENGLAND	95%	86.0%	76.2%



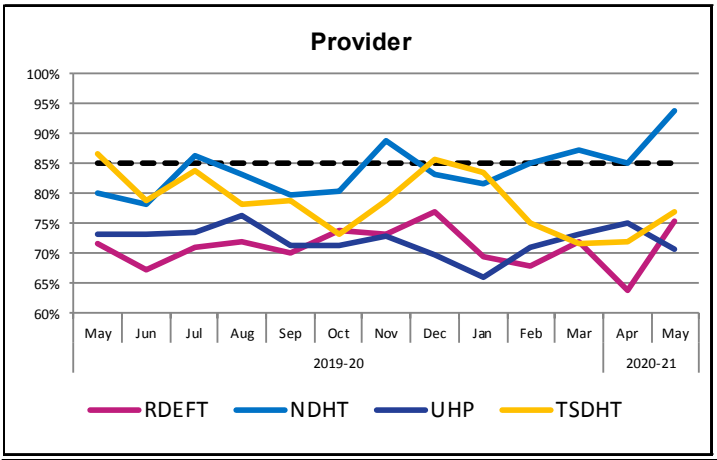
Performance Commentary

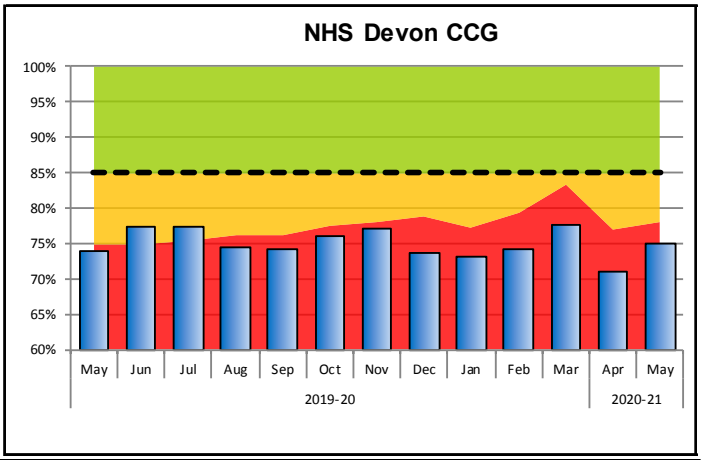
The proportion of calls answered within 60 seconds increased from 56.2% in April to 62.2% in May. However, performance remains well below the target of 95% and is the lowest in the South West.

Cancer 62 day Urgent Referral

Trust	Trajectory	May	2020/21
RDEFT	74.6%	75.5%	68.8%
NDHT	85.3%	93.8%	88.9%
UHP	73.4%	70.6%	73.2%
TSDFT	85.6%	77.1%	74.1%

CCG	Trajectory	May	2020/21
NHS Devon	78%	74.9%	72.8%
ENGLAND	85%	69.9%	69.9%



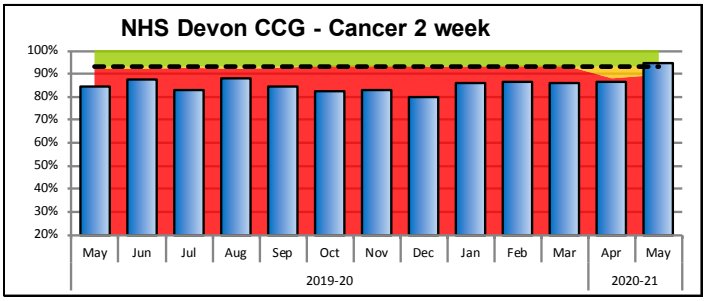


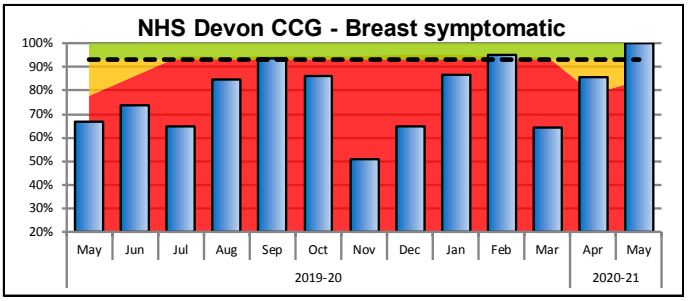
Performance Commentary

There was an increase in performance in May with the STP position rising from 71.1% to 74.9%. Only NDHT achieved the 85% target at 93.8%. RD&E rose from 63.8% to 75.5%, TSD rose from 72.0% to 77.1% but UHP deteriorated from 75.2% to 73.4%. Whilst the STP underperformed against target it remains above the national position of 69.9%.

Cancer Targets (May-2020)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	94.7%	94.2%	95.9%	95.7%	93.6%
93%	2 week breast	100.0%	100.0%	100.0%	100.0%	100.0%
90%	62 day screening	54.5%	75.0%		50.0%	33.3%
85%	62 day consultant	86.3%	75.0%		50.0%	33.3%
96%	31 day first	98.2%	98.4%	100.0%	96.7%	99.2%
94%	31 day surgery	93.0%	98.3%	87.5%	84.7%	96.2%
98%	31 day drugs	100.0%	100.0%	100.0%	100.0%	100.0%
94%	31 day radiotherapy	97.3%	99.2%		87.7%	98.2%





Performance Commentary

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

Performance against the main 2ww standard rose above target to 94.7%, the first time the 93% target has been achieved for over a year. All providers met the target.

Breast symptomatic performance also increased above the 93% target in May with all providers achieving 100%.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

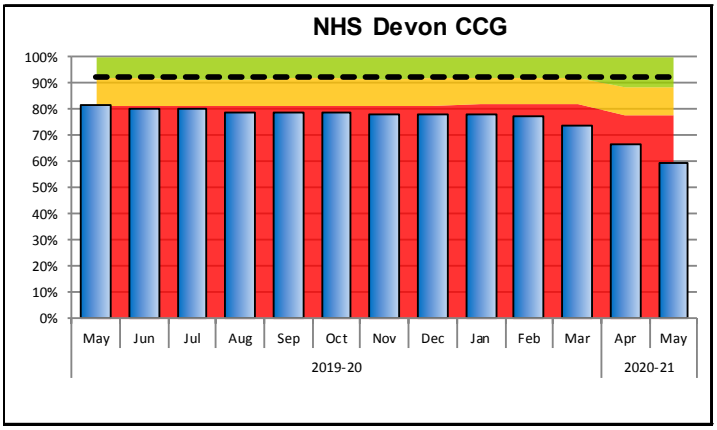
Trust	Trajectory	May	2020/21
RDEFT	77.4%	58.3%	62.1%
NDHT	75.0%	56.7%	60.4%
UHP	76.3%	59.2%	62.8%
TSDFT	80.0%	62.2%	65.7%

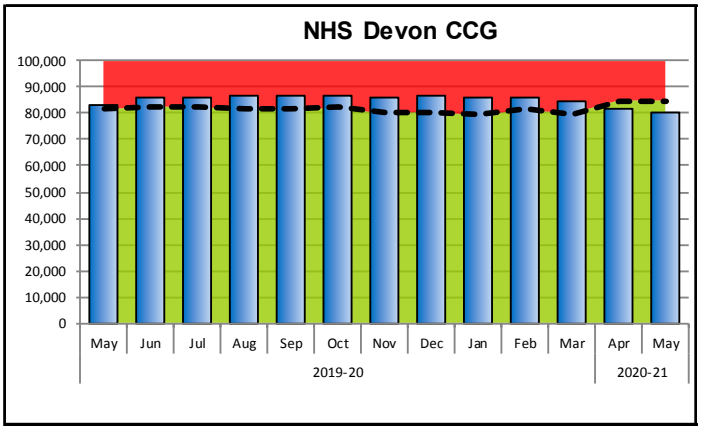
CCG	Trajectory	May	2020/21
NHS Devon	77.9%	59.3%	62.9%
ENGLAND	92.0%	62.2%	66.8%

RTT incomplete waits volume

Trust	Trajectory	May
RDEFT	33,783	30,910
NDHT	11,665	11,435
UHP	28,476	25,626
TSDFT	18,548	20,059

CCG	Trajectory	May
NHS Devon	81,536	80,555





Performance Commentary

The STP level RTT position continued to fall in May from 67.0% to 59.3% compared to the target of 92% and national performance of 62.2%. All providers saw a worsening position with UHP performance decreasing to 59.2%, RD&E at 58.3%, NDHT at 56.7% and TSD at 62.2%. All providers are under target and performance is expected to continue to decline when June data is released.

Waiting lists continue to fall as referrals remain relatively low, although an increase is expected from July or August as referrals increase back towards expected levels and activity remains lower than pre-Covid volumes.

RTT Incomplete Pathways long waiters

40-52 week waits

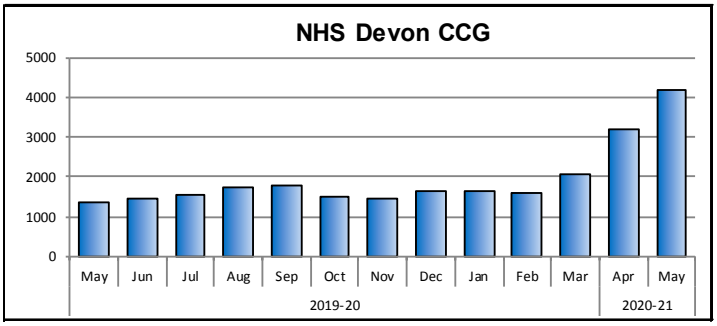
Trust	May	2020/21
RDEFT	1621	2878
NDHT	846	1430
UHP	1416	2579
TSDFT	788	1335

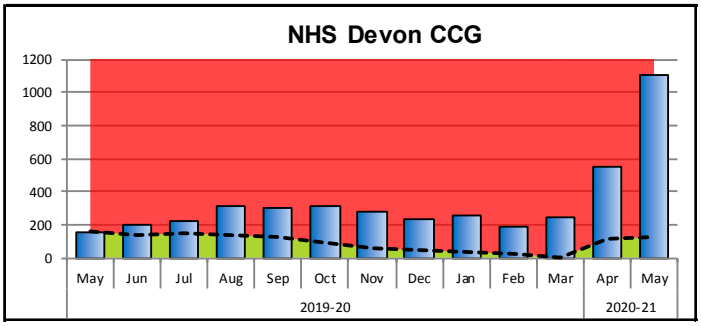
CCG	May	2020/21
NHS Devon	4190	7366

Over 52 week waits

Trust	Trajectory	May	2020/21
RDEFT	25	494	747
NDHT	8	131	172
UHP	49	411	642
TSDFT	103	192	285

CCG	Trajectory	May	2020/21
NHS Devon	163	1107	1661





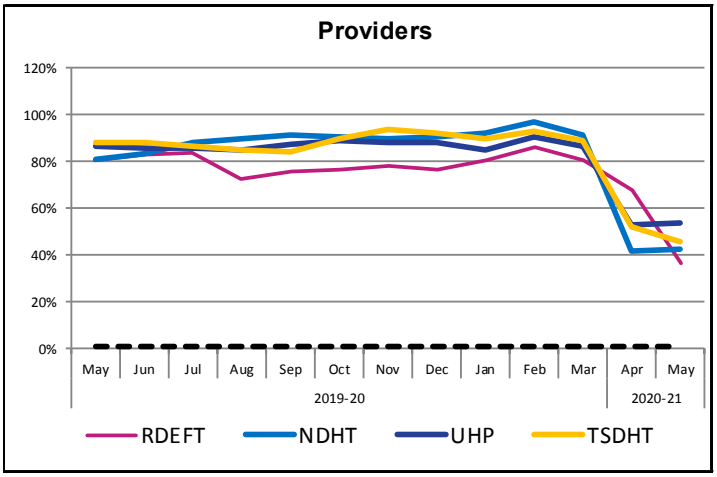
Performance Commentary

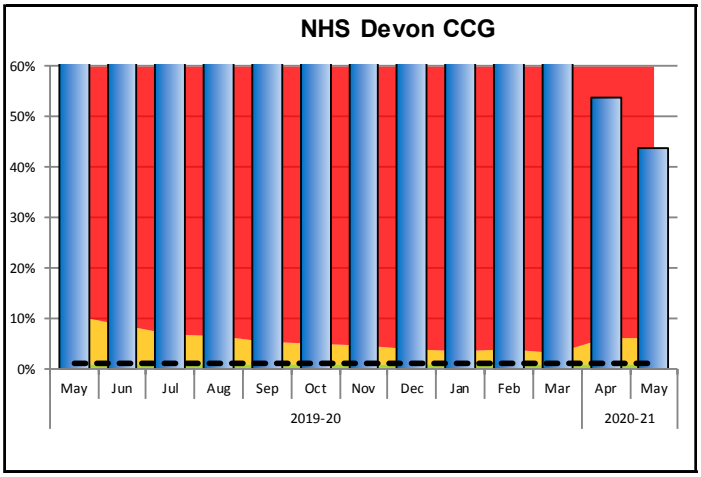
Over 52-week waits have continued to rise sharply. There were 249 people waiting over 52 weeks in March, rising to 585 in April and 1107 in May. All providers have seen an increase in breaches with RD&E rising to 494, UHP at 411, TSD at 192 and NDHT at 131. June is expected to show a further increase.

Diagnostic 6 week wait

Trust	Trajectory	May	2020/21
RDEFT	89.0%	36.7%	49.3%
NDHT	84.5%	42.4%	58.0%
UHP	93.3%	53.6%	46.7%
TSDFT	87.3%	45.8%	51.0%

CCG	Trajectory	May	2020/21
NHS Devon	89.4%	43.9%	48.5%
ENGLAND	99.0%	41.5%	42.8%





Performance Commentary

The STP position deteriorated further in May with 43.9% of patients being seen within the 6 weeks target compared to a national threshold of 99% and an England position of 41.5%.

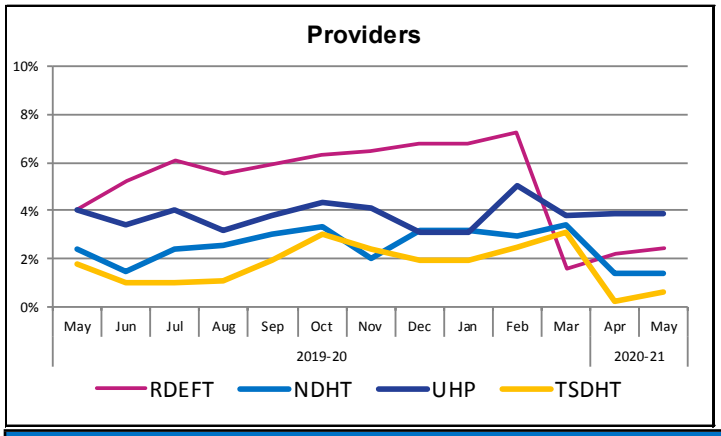
However, all providers except RD&E saw the majority of the fall in performance during April, with a flattening of the position in May. RD&E's reduction was slower, with a significant impact in May.

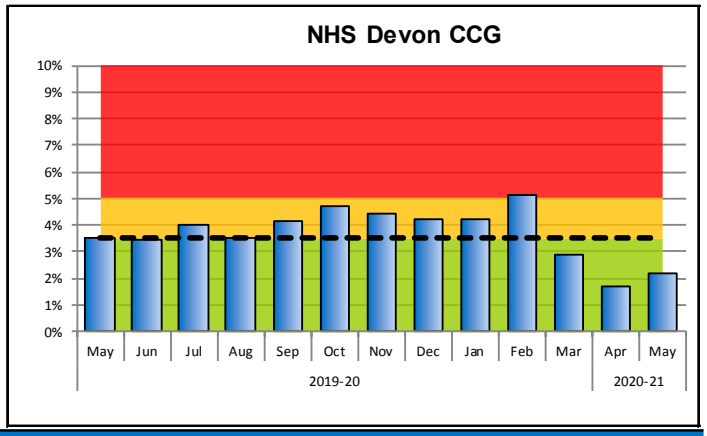
UHP performance was 53.6% in May, TSD at 45.8% NDHT at 42.4% and RD&E at 36.7%.

Acute Delayed Transfers of care

Trust	Target	May	2020/21
RDEFT	3.50%	2.4%	2.3%
NDHT	3.50%	1.4%	1.1%
UHP	3.50%	3.8%	2.5%
TSDFT	3.50%	0.6%	0.4%

CCG	Target	May	2020/21
NHS Devon	3.50%	2.20%	2.0%





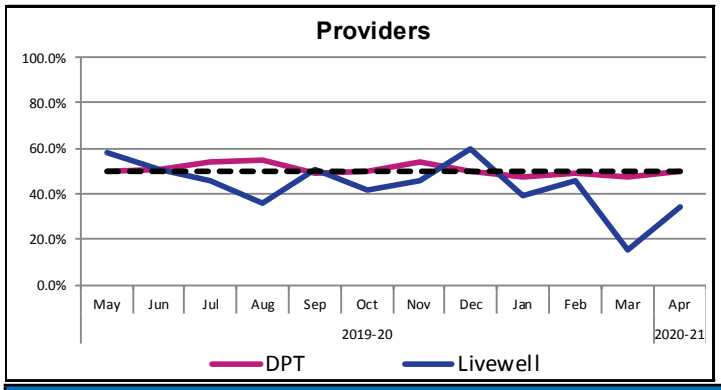
Performance Commentary

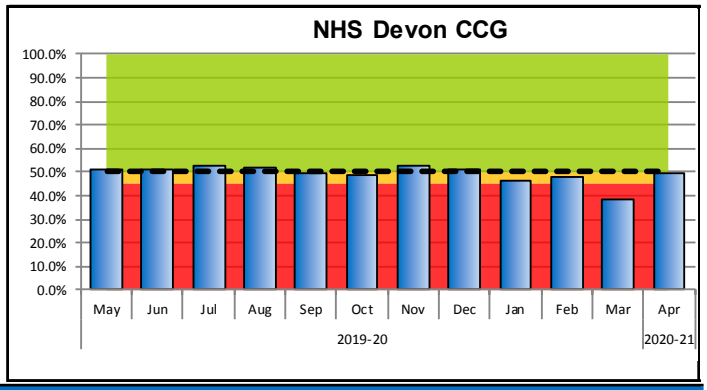
In May acute delayed transfers of care (DTOC) continued to be below the 3.5% target at 2.2%. All providers except UHP were within target.

IAPT Recovery rate

Trust	Target	April	2020/21
DPT	50%	49.5%	49.5%
LIVEWELL	50%	34.4%	34.4%

CCG	Target	April	2020/21
NHS Devon	50%	49.1%	49.1%





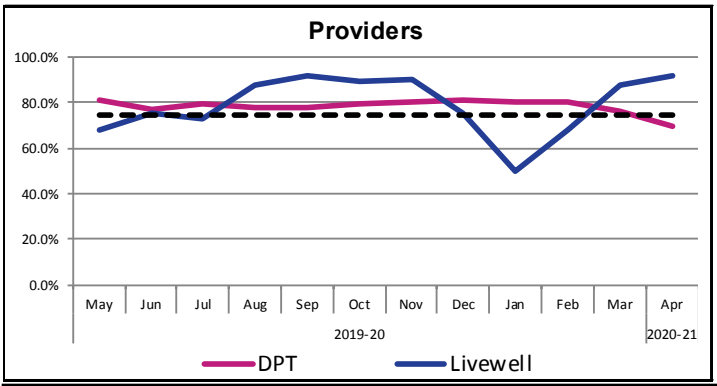
Performance Commentary

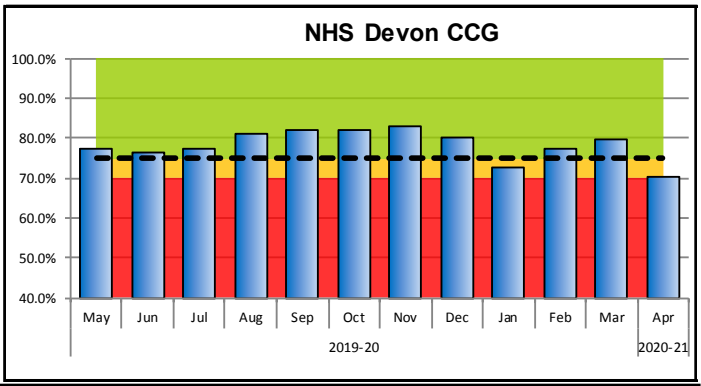
April IAPT recovery data shows performance very marginally under the 50% target at 49.1% for the STP. DPT were at 49.5% but Livewell continue to perform lower at 34.4%.

IAPT waiting 6 weeks

Trust	Target	April	2020/21
DPT	75%	69.4%	69.4%
LIVEWELL	75%	92.2%	92.2%

CCG	Target	April	2020/21
NHS Devon	75%	70.4%	70.4%



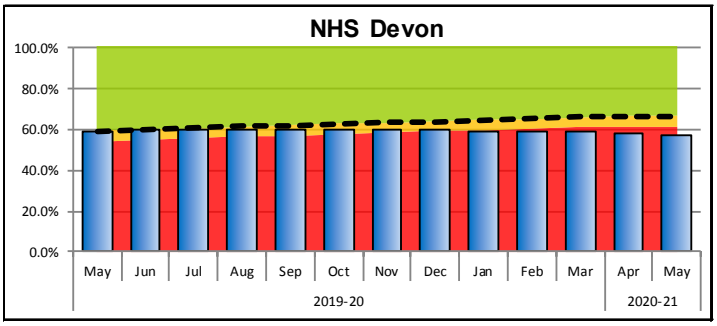


Performance Commentary

IAPT 6-week waits were below target in April at 70.4% for the STP against the 75% target. Livewell continue to perform well but DPT were below target at 69.4%.

Dementia Diagnosis Rate

CCG	Trajectory	May	2020/21
NHS Devon	67.0%	58.9%	58.9%
ENGLAND	67.0%	64.0%	64.7%



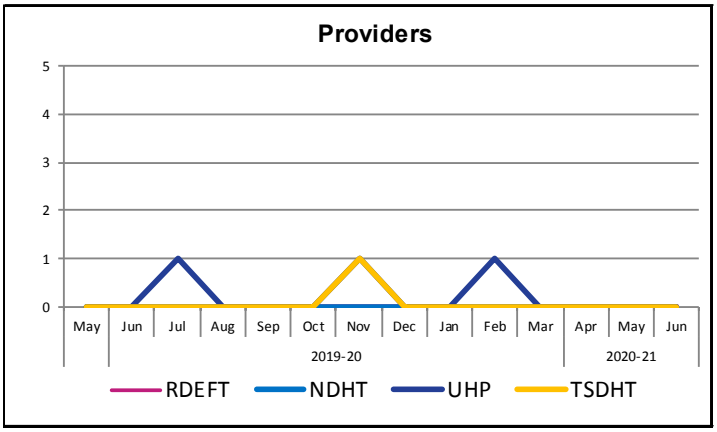
Performance Commentary

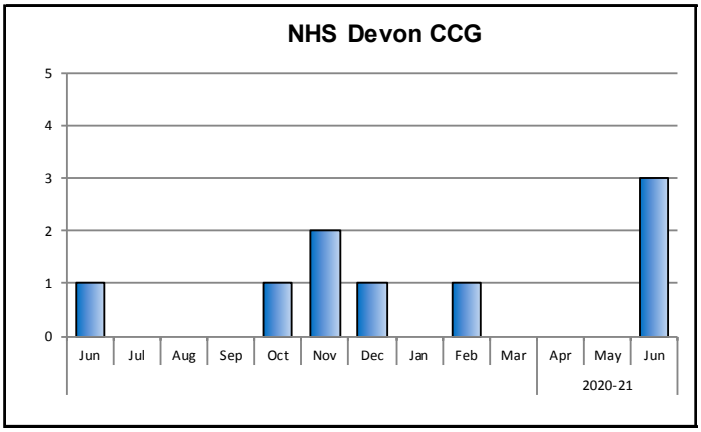
STP level performance remained static in May and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (42.2%), Mid Devon (51.1%) and Plymouth (56.5%). Conversely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

MRSA breaches

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

CCG	Target	June	2020/21
NHS Devon	0	3	3





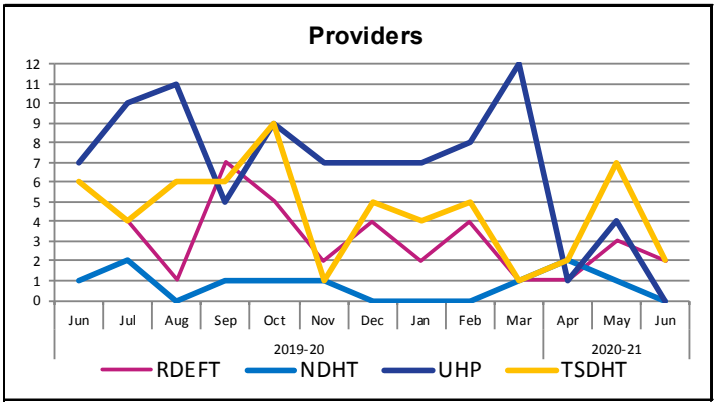
Performance Commentary

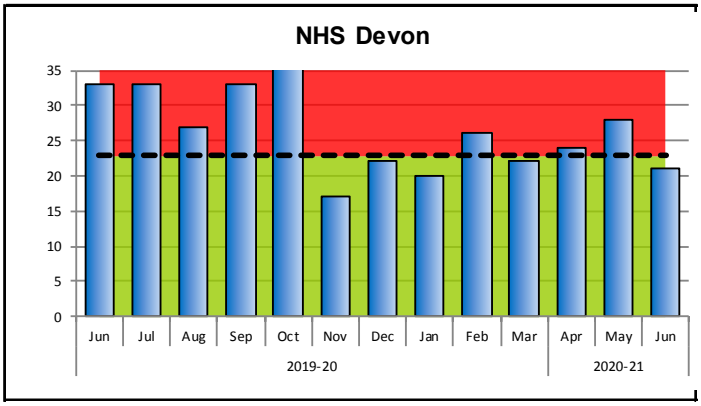
There were three reported cases of MRSA in June for the CCG but all were for out of area providers.

C-Diff breaches

Trust	Target	June	2020/21
RDEFT	<31	2	6
NDHT	<9	0	3
UHP	<63	0	5
TSDFT	<36	2	11

CCG	Target	June	2020/21
DEVON STP	<274	24	73





Performance Commentary

There were 2 C-Diff cases acquired within the Devon acute providers (both at RD&E) and 24 across the STP in June.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: NHS Devon CCG Constitution and supporting Governance Handbook amendments				
Date of committee: 30 July 2020 **Date report produced: 17 July 2020**				
Author (s) Name and Title: Clare Doble, Head of Governance **Contact Details: clare.doble@nhs.net**		**Supporting Executive:** **Ginny Snaith, Board Secretary** **Contact Details: g.snaith@nhs.net** **Report Approved by: As above** **Name and Title:** **Date 20 July 2020**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): This is ahead of written approval from NHS England, and, in anticipation of that approval, the constitution and governance handbook will then be made public and circulated to its members.				

Executive Summary:

1.1. The purpose of this paper is to feedback amendments from NHSE/I review of NHS Devon CCGs constitution, to ensure that both public documents are up to date and fit for purpose.

1.2. This paper will also provide clear direction of a future timeline and the process required to ensure that our constitution is reviewed in line with our obligations, no less than annually.

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:
Governing Body 30 January 2020
Key recommendations and actions requested:

The Governing Body are being asked to:

- Approve the amendments and visible track change minor iterations as requested by NHSE following their review during Q4 2019/20 and outlined in section 2 of this report.
- circulate the constitution, once formal approval received from NHSE, to its member practice representatives with a covering letter from the Chair, senior officers of the CCG, and ensure that the constitution and the supporting governance handbook is made publicly available on its website
- approve in principal the timeline for the next review of the constitution and inform the CCGs member practice representatives of rationale for this approach

Impact on Strategic Objectives

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

Reference to other documents or accompanying papers:

Appendix 1 Change history to NHS Devon CCG Constitution
Appendix 2 Change history to NHS Devon CCG Governance Handbook
Appendix 3 Impact Assessment as required by NHSE
Appendix 4 Letter to NHSE for request of constitutional change
NHS Devon CCG revised constitution
NHS Devon CCG revised Governance Handbook (inc Scheme of Reservation and Delegation)
NHSE revised model constitution

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

	If Yes, please give details	**No**
Quality of Services		
Health Inequalities		
Equality (staff or public)		
Resource and Finance		
Legal		
Engagement and Consultation	Engagement will be required with membership and stakeholders at the next review of the constitution as described in section 3 of this report	
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.

Report Title: NHS Devon CCG Constitution and Governance Handbook

1. Introduction

1.1 The Constitution for NHS Devon CCG underwent a planned review during Q3 2019/20 and the constitution was presented to the Governing Body in January 2020 who approved all amendments that were presented, ahead of submission to NHSE/I for review ahead of formal written approval.

1.2 NHSE/I was delayed in providing feedback due to the impact of Covid-19

2. Purpose of report

2.1 This paper is being presented to the Governing Body following NHS E/I feedback received on 25 June 2020. The revised draft constitution has been attached and includes visible track changes for ease.

2.2 have requested the following amendments to enable the constitution to be formally approved in writing by them – all other amendments previously presented to governing body in January 2020 were acknowledged as acceptable by NHSE/I. The additional amendments requested by NHSE/I include:

1) The naming convention of the Primary Care Committee to be reverted back to as previously written 'Primary Care Commissioning Committee' throughout the constitution and associated terms of reference – this is a standard naming convention from NHSE/I and a requirement under the revised model constitution
2) Remuneration and workforce committee (page 26, section 5.9.1.2) wording to revert back as previously written to read '*Only members of the Governing Body can be members on the Remuneration committee'*
3) Minor iterations to spelling or clarification shown within the constitution as visible track changes

2.3 As part of the review, the Audit Committee and Remuneration and Workforce Committee have had an opportunity to review their terms of reference as part of the annual committee effectiveness process. Minor amendments are shown as track changes which have been accepted by relevant committee and presented to Governing Body for approval through relevant Chairs reports.

3. Future process of engagement and approval

3.1 The next review of the constitution is set out in the timeline below for governing body awareness and approval. It must be brought to the Governing Body's attention that although this may seem quite quick to be reviewing the constitution and supporting governance handbook, it must be recognised that further considerations will need to be included in the next iteration in relation to the establishment of a sixth committee of the governing body which will be called the Commissioning Committee, inclusion of additional Executive roles, namely Chief Operating Officer, review of the scheme of reservation and delegation and establishment of Primary Care Networks and Local Care Partnership working. The latter two changes will require engagement with our GP membership and other stakeholders as well as continued support from our regulator.

3.2 Proposed timeline for review of constitution 2020:

Month	**Description of review**	**Oversight**
September 2020	General review of constitution with Board Secretary and Head of Governance – highlight any significant areas to	Dr Paul Johnson and Audit Chair Nick Ball

	change, sense check and update member practices and their representatives where necessary.	*(facilitated by Board Secretary / Head of Governance)*
October 2020	Present reviewed constitution to the clinical membership – to enable discussion with practice member representatives and receive feedback for changes/no changes to constitution Review and amend as directed	Member practice representatives *(facilitated by Dr Paul Johnson, Chair and GB Clinical GP/practitioner Representatives/Board Secretary)* *Head of Governance*
November/December 2020	Request approval from member practice representatives following engagement meeting	*Letter from Dr Paul Johnson Chair to member practice representatives (facilitated by Board Secretary)*
January 2021	Review changes and formalise documentation to NHS England – documentation will include the following: **Appendix 1 -** A revised NHS Devon CCG Constitution, with visible tracked changes - **Appendix 2 -** A detailed list of the tracked changes and where these have been approved - **Appendix 3 -** A completed impact assessment - **Appendix 4 –** list of electronic signatures or dates of sign off received and held by Governance from member practice representatives	Governing Body and Audit and Assurance Committee *(facilitated by Head of Governance)*
February 2021	Prepare final documentation and application to NHS England for review of constitution with covering letter from Dr Paul Johnson, Chair	NHS England *(facilitated by Head of Governance)*
March / April 2021	Receive feedback from NHSE	Governing Body *(facilitated by Head of Governance)*

4 Recommendations

The Governing Body are being asked to:

- Approve the amendments requested by NHSE following their review during Q4 2019/20 as outlined in section 2 of this report.
- circulate the constitution, once formal approval received from NHSE, to its member practice representatives with a covering letter from the Chair, senior officers of the CCG, and ensure that the constitution and the supporting governance handbook is made publicly available on its website
- approve in principal the timeline for the next review of the constitution and inform the CCGs member practice representatives of rationale for this approach

NHS DEVON
CLINICAL COMMISSIONING GROUP

CONSTITUTION

Version	Effective Date	Changes
Template	31 October 2018	Standard model for newly established CCG organisation – pending approval by NHS England
Draft V0.1	18 December 2018	Amendments from transition working group as mandated by Governing Body's in common (NHS NEW Devon CCG and NHS SDT CCG)
Draft V0.2	16 January 2019	Amendments from NHSE
Draft V0.3	23 January 2019	Amendments and additional information following NHSE review.
Draft V0.4	25 January 2019	Amendments and additional information following NHSE review.
Draft V0.5	28 January 2019	Amendments and additional information following NHSE review and feedback from member engagement
Draft V0.6	18 February 2019	Amendments and additional information following NHSE and Internal audit review and feedback from member engagement – Track changes
Draft V0.7	28 February 2019	Clean version for final review by NHSE following GB Sub-committee review.
Draft V0.8	13 March 2019	Formatted version
Draft V0.9	19 March 2019	Logo included. Map updated. Updated PCCC ToR.
V1.0	25 April 2019	Final version following approval at Governing Body
V1.1	14 October 2019	Minor amendments as described in record of amendments version 1.1 dated December 2019
V1.2	25 June 2020	Feedback from NHSE/I with minor iterations for governing body oversight ahead of formal approval from NHSE/I

CONTENTS

1 Introduction

1.1 Name

The name of this clinical commissioning group is NHS Devon Clinical Commissioning Group ("the CCG").

1.2 Statutory Framework

1.2.1 CCGs are established under the NHS Act 2006 ("the 2006 Act"), as amended by the Health and Social Care Act 2012. The CCG is a statutory body with the function of commissioning health services in England and is treated as an NHS body for the purposes of the 2006 Act. The powers and duties of the CCG to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to CCGs, as well as by regulations and directions (including, but not limited to, those issued under the 2006 Act).

1.2.2 When exercising its commissioning role, the CCG must act in a way that is consistent with its statutory functions. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to CCGs, including the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to CCGs take the form of statutory duties, which the CCG must comply with when exercising its functions. These duties include things like:

a) Acting in a way that promotes the NHS Constitution (section 14P of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Q of the 2006 Act);
c) Financial duties (under sections 223G-K of the 2006 Act);
d) Child safeguarding (under the Children Acts 2004,1989);
e) Equality, including the public-sector equality duty (under the Equality Act 2010); and
f) Information law, (for instance under data protection laws, such as the EU General Data Protection Regulation 2016/679 and the Freedom of Information Act 2000).

1.2.3 Our status as a CCG is determined by NHS England. All CCGs are required to have a Constitution and to publish it.

1.2.4 The CCG is subject to an annual assessment of its performance by NHS England which has powers to provide support or to intervene where it is satisfied that a CCG is failing or has failed to discharge any of our functions, or that there is a significant risk that it will fail to do so.

1.2.5 CCGs are clinically-led Membership organisations made up of general practices. The Members of the CCG are responsible for determining the governing arrangements for the CCG, including arrangements for clinical leadership which are set out in this Constitution.

1.3 Status of this Constitution

1.3.1 This Constitution is made between the Members of the CCG and has effect from 01 April 2019, when the CCG was established by NHS England.

1.3.2 Changes to this Constitution are effective from the date of approval by NHS England.

1.3.3 The Constitution will be published on the CCGs website www.DevonCCG.nhs.uk or can be obtained by writing to NHS Devon CCG, The Annexe, County Hall, Topsham Road, Exeter, Devon. EX2 4QD or by sending an email to

D-CCG.CorporateServices@nhs.net

1.4 Amendment and Variation of this Constitution

1.4.1 This Constitution can only be varied in two circumstances:

a) where the CCG applies to NHS England and that application is granted; and

b) where in the circumstances set out in legislation NHS England varies the Constitution other than on application by the CCG.

1.4.2 The Accountable Officer may periodically propose minor amendments to the Constitution and propose changes at the request of any Member representative or GB Member which is brought to their attention. These requests shall be considered and approved by the Governing Body.

In the following circumstances decisions shall be considered by the full Membership:

a. Changes are thought to have a material impact (this may include, but is not limited to composition of the Governing Body or change in geographical area)
b. Changes are proposed to the reserved powers of the Members (as outlined in the Scheme of Reservation and Delegation);
c. At least half (50%) of all the Governing Body Members formally request that the amendments be put before the Membership for approval.

1.5 Related documents

This constitution is also informed by a number of documents which provide further details on how the CCG will operate. With the exception of the Standing Orders and the Standing Financial Instructions, these documents do not form part of the constitution for the purposes of 1.4 above. They are the CCG's:

a) Standing Orders – which set out the arrangements for meetings and the selection and appointment processes for the CCG's Committees, and the CCG Governing Body (including Committees).

b) The Scheme of Reservation and Delegation – sets out those decisions that are reserved for the Membership as a whole and those decisions that

have been delegated by the CCG or the Governing Body

c) **Prime Financial Policies –** which set out the arrangements for managing the CCG's financial affairs.

d) **The CCG Governance Handbook –** which is available as described in section 1.3.3 above and includes, but is not limited to:

- Committee structure – operating model
- Committee terms of reference (excluding statutory committee terms of reference which are held in the Constitution Appendix 2)
- Scheme of Reservation and Delegation
- Standard Operating procedure for the arrangements for the election, selection and recruitment of senior officers of the Governing Body
- Governing Body Member roles and responsibilities
- Financial policies
- Standards of Business Conduct Policy – which includes the arrangements the CCG has made for the management of conflicts of interest
- Risk Management Framework Policy – which includes details of risk matrix and risk appetite for the CCG
- Health and Safety Policy – which includes details of incident management across the CCG in relation to any health and safety issues

1.6 Accountability and Transparency

1.6.1 The CCG will demonstrate its accountability to its Members, local people, the public, stakeholders and NHS England in a number of ways; we will meet our statutory requirements to:

a) publish our Constitution and other key documents including the CCGs Governance Handbook which can be found here www.DevonCCG.nhs.uk
b) appoint independent lay Members and non-GP clinicians to our Governing Body;
c) manage actual or potential conflicts of interest in line with NHS England's statutory guidance *Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017* and expected standards of good practice (see also part 6 of this Constitution);
d) hold Governing Body meetings in public (except where we believe that it would not be in the public interest);
e) publish an annual commissioning strategy that takes account of priorities in the health and wellbeing strategy;
f) procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers and publish a Procurement Strategy;
g) involve the public; in accordance with its duties under section 14Z2 of the 2006 Act; to ensure in all aspects of the CCGs business, the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG

h) When discharging its duties under section 14Z2, the CCG will ensure that it adheres to the Nolan Principles of Public Life and Standards for NHS Board Members which include:

Principle	Description
Selflessness / Responsibility	Holders of public office should act solely in terms of the public interest
Integrity	Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
Objectivity / Respect	Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
Accountability / Professionalism	Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
Openness	Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
Honesty	Holders of public office should be truthful.
Leadership	Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour whenever it occurs.

i) comply with local authority health overview and scrutiny requirements;
j) meet annually in public to present an annual report which is then published;
k) produce annual accounts which are externally audited;
l) publish a clear complaints process;
m) comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the CCG;
n) provide information to NHS England as required; and
o) be an active Member of the local Health and Wellbeing Board.

1.6.2 In addition to these statutory requirements, the CCG will demonstrate its accountability by:

a) holding regular ongoing engagement and involvement with our Member practices;
b) providing information to the public at large about the work of the CCG through our website and other means as appropriate

1.6.3 The Governing Body will ensure that the CCG continues to reflect the principles of good governance and is meeting its statutory obligations

1.7 Liability and Indemnity

1.7.1 CCG is a body corporate established and existing under the 2006 Act. All financial or legal liability for decisions or actions of the CCG, resides with the CCG as a public statutory body and not with its Member practices.

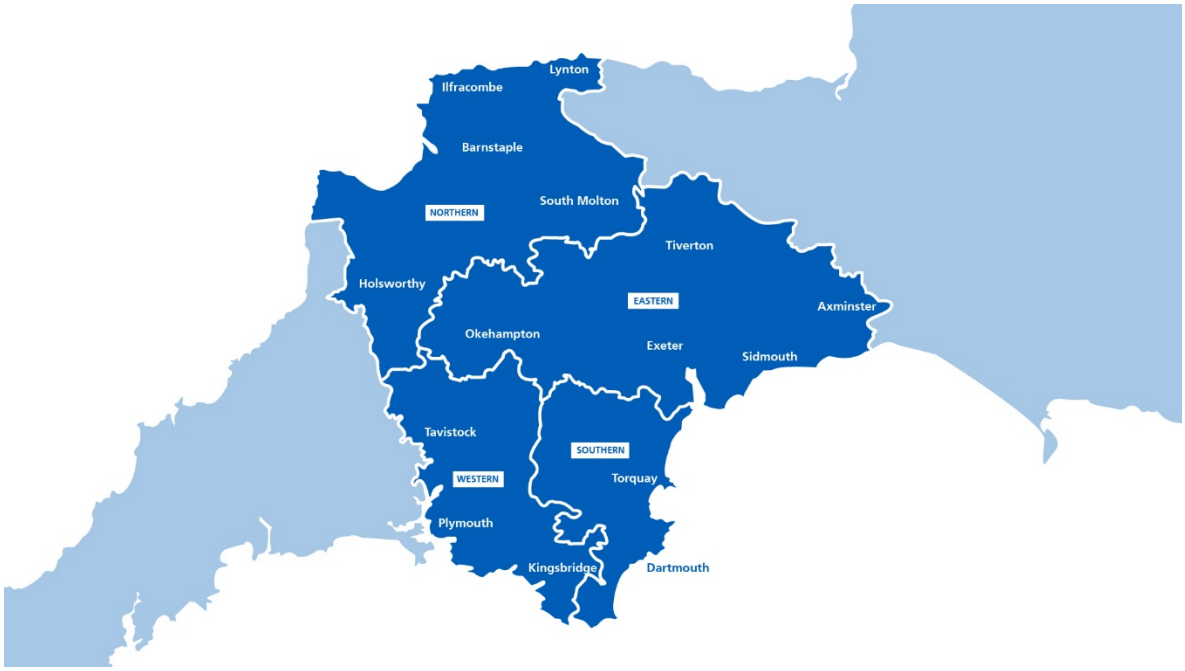
1.7.2 No Member or former Member, nor any person who is at any time a proprietor, officer or employee of any Member or former Member, shall be liable (whether as a Member or as an individual) for the debts, liabilities, acts or omissions, howsoever caused by the CCG in discharging its statutory functions.

1.7.3 No Member or former Member, nor any person who is at any time a proprietor, officer or employee shall be liable on any winding-up or dissolution of the CCG to contribute to the assets of the CCG, whether for the payment of its debts and liabilities or the expenses of its winding-up or otherwise.

1.7.4 The CCG will indemnify any Member practice representative, or other officer or individual exercising powers or duties on behalf of the CCG (excluding delivery of contracted primary care services), in respect of any civil liability incurred in the exercise of the CCG business, provided that the person indemnified shall not have acted recklessly or with gross negligence.

2 Area Covered by the CCG

2.1 The area covered by the CCG is shown in the map below.



2.2 The CCG population is approximately 1.2 million and is made up of registered patients of Member practices, served by eight District Councils as shown in the map above, who are led by three Local Authorities (two unitary and one county council) which are all fully coterminous and are supported by the registered primary care practice populations in Devon. The CCG has four main acute hospital sites which are Barnstaple, Exeter, Torquay and Plymouth. There is acknowledgement there are cross boundary patient flows and flexible cross border populations. The three local authorities include:

- Devon County Council;
- Torbay City Council (Unitary)and;
- Plymouth City Council (Unitary)

3 Membership Matters

3.1 Membership of the Clinical Commissioning Group

3.1.1 The CCG is a Membership organisation.

3.1.2 All practices who provide primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract in our area are eligible for Membership of this CCG.

3.1.3 The list of 126 practices which make up the Membership of the CCG is maintained and held by the corporate office and is available on our website and referenced in

our governance handbook through the CCG website – *please note the list below is updated only once a year and was last updated on 01 March 2020*
www.DevonCCG.nhs.uk

Practice Name	Address	Geography of Devon	Primary Network
Abbey Surgery	Abbey Surgery, 28 Plymouth Road, Tavistock, Devon. PL19 8BU	West Devon	West De
Adelaide Street Surgery	Adelaide Street Surgery, 20 Adelaide Street, Plymouth. Devon PL1 3JF	West Devon	Watersid Network
Albany Surgery	Albany Surgery, Grace House, Scott Close, Newton Abbot, Devon. TQ12 1GF	South Devon	Newton
~~Amicus Health~~	~~Amicus Health,~~ ~~Newport Street,~~ ~~Tiverton,~~ ~~Devon. EX16 6NJ~~	~~East Devon~~	
Ashburton Surgery	Ashburton Surgery, Eastern Road, Ashburton, Newton Abbot, Devon TQ13 7AP	South Devon	South Da Totnes
Axminster Medical Practice	Axminster Medical Practice, St Thomas Court, Church Street, Axminster. Devon EX13 5AG	East Devon	TASC
Barnfield Hill Surgery	Barnfield Hill Surgery, 12 Barnfield Hill, Exeter. Devon EX1 1SR	East Devon	Exeter C
Barton Surgery (Plymstock)	Barton Surgery, Horn Lane, Plymstock, Plymouth. Devon PL9 9BR	West Devon	Mewstor
Barton Surgery (Dawlish)	Barton Surgery, Barton Terrace, Dawlish. Devon EX7 9QH	South Devon	The Coa
Beacon Medical Group	Beacon Medical Group, Plympton Health Centre, Mudge Way, Plymouth. Devon PL7 1AD	West Devon	Beacon Group
Beaumont Villa Surgery	Beaumont Villa Surgery, 23 Beaumont Road, Plymouth. Devon PL4 9BL	West Devon	Pathfield Group

Bideford Medical Centre	Bideford Medical Centre, Abbotsham Road, Bideford. Devon EX39 3AF	North Devon	Torridge
Black Torrington Surgery	Blake House, Black Torrington, Beaworthy. Devon EX21 5QE	North Devon	Holswort and Surr Villages
Blackdown Practice	Blackdown Practice, Station Road, Hemyock, Cullompton. Devon EX15 3SF	East Devon	Culm Va
Bovey Tracey and Chudleigh Practice	Bovey Tracey and Chudleigh Practice, Le Molay-Littry Way, Bovey Tracey, Devon. TQ13 9QP	South Devon	Newton
Bow Medical Practice	Bow Medical Practice, Iter Cross, Junction Road, Bow, Near Crediton. Devon EX17 6FB	East Devon	Mid Dev Healthca
Bradworthy Surgery	Bradworthy Surgery, The Square, Bradworthy. Devon EX22 7SY	North Devon	Holswort and Surr Villages
Bramblehaies Surgery	Bramblehaies Surgery, College Road, Cullompton. Devon EX15 1TZ	East Devon	Culm Va
Brannam Medical Centre	Brannams Medical Centre, Kiln Lane, Barnstaple. Devon EX32 8GP	North Devon	Barnstap
Brunel Medical Practice	Brunel Medical Practice, St Albans Road, Babbacombe, Torquay. Devon TQ1 3SL	South Devon	Torquay
Buckfastleigh Medical Centre	Buckfastleigh Medical Centre, Bossell Road, Buckfastleigh, Devon. TQ11 0DE	South Devon	South Da Totnes
Buckland Surgery	Buckland Surgery, 1 Raleigh Road, Newton Abbot. Devon TQ12 4HG	South Devon	Templer Network
Budleigh Salterton Medical Practice	Budleigh Salterton Medical Practice, 1 The Lawn, Budleigh Salterton. Devon EX9 6LS	East Devon	WEB
Budshead Medical Practice	Budshead Medical Practice, 433 Budshead Road, Plymouth. Devon PL5 4DU	West Devon	Sound

Caen Medical Centre	Caen Medical Centre, Caen Street, Braunton, North Devon. Devon EX33 1LR	North Devon	North De
Castle Gardens Surgery	Castle Gardens Surgery, Castle Hill Gardens, Great Torrington, Torrington. Devon EX38 8EU	North Devon	Torridge
Castle Place Practice	Castle Place Practice, Kennedy Way, Tiverton. Devon EX16 6NP	East Devon	Tiverton
Catherine House Surgery	Catherine House Surgery, The Plains, Totnes. Devon TQ9 5HA	South Devon	South Da Totnes
Chagford Health Centre	Chagford Health Centre, Chagford, Newton Abbot. Devon TQ13 8BW	East Devon	North Da
Channel View Surgery	Channel View Surgery, 3 Courtenay Place, Teignmouth. Devon TQ14 8AY	South Devon	The Coa
Chelston Hall Surgery	Chelston Hall Surgery, Old Mill Road, Torquay. Devon TQ2 6HW	South Devon	Torquay
Cheriton Bishop Surgery	The Surgery, Cheriton Bishop, Devon. EX6 6JA	East Devon	Mid Dev Healthca
Chiddenbrook Surgery	Chiddenbrook Surgery, Threshers, Crediton. Devon EX17 3JJ	East Devon	Mid Dev Healthca
Chilcote Surgery	Chilcote Surgery, Hampton Avenue, Torquay. Devon TQ1 3LA	South Devon	Baywide
Chillington Health Centre	Chillington Health Centre, 8 Orchard Way, Chillington, Kingsbridge. Devon TQ7 2LB	South Devon	South Ha
Church View Surgery	Church View Surgery, 30 Holland Road, Plymouth. Devon PL9 9BN	West Devon	Mewstor
Clare House	Newport Street, Tiverton, Devon. EX16 6NJ	East Devon	Tiverton
Claremont Medical Practice	Claremont Medical Practice, Claremont Grove, Exmouth. Devon EX8 2JF	East Devon	WEB

Clock Tower Surgery	Access Health, Wat Tyler House, King William Street, Exeter, Devon. EX4 6PD	East Devon	Exeter C
Coleridge Medical Centre	Coleridge Medical Centre, Canaan Way, Ottery Saint Mary. Devon EX11 1EQ	East Devon	HOSMS
College Surgery Partnership	College Surgery Partnership, Willand Road, Cullompton. Devon EX15 1FE	East Devon	Culm Va
Combe Coastal Practice	Combe Coastal Practice, 18 St Brannock's Road, Ilfracombe. Devon EX34 8EG,	North Devon	North De
Compass House Medical Centre	Compass House Medical Centre, King Street, Brixham. Devon TQ5 9TF	South Devon	Baywide
Corner Place Surgery	Corner Place Surgery, 46 A Dartmouth Road, Paignton. Devon TQ4 5AH	South Devon	Paignton Brixham
Cranbrook Medical Practice	Access Health, 169 Younghayes Road, Cranbrook, Exeter. Devon EX5 7DR	East Devon	Outer Ex
Cricketfield Surgery	Cricketfield Surgery, Cricketfield Road, Newton Abbot. Devon TQ12 2AS	South Devon	Templer Network
Croft Hall Medical Practice	Croft Hall Medical Practice, 19 Croft Road, Torquay. Devon TQ2 5UA	South Devon	Torquay
Dartmouth Medical Practice	Dartmouth Medical Practice, 35 Victoria Road, Dartmouth. Devon TQ6 9RT	South Devon	South Ha
Dean Cross Surgery	Dean Cross Surgery, 21 Radford Park Road, Plymouth. Devon PL9 9DL	West Devon	Mewstor
Devon Square Surgery	Devon Square Surgery, 44 Devon Square, Newton Abbot. Devon TQ12 2HH	South Devon	Templer Network
Devonport Health Centre	Devonport Health Centre, 53 Damerel Close, Devonport, Plymouth. Devon PL1 4JZ	West Devon	Watersid Network
Elm Surgery	Elm Surgery, 123 Leypark Walk, Plymouth. Devon PL6 8UF	West Devon	Sound

Estover Surgery	Estover Surgery, Leypark Walk, Plymouth. Devon PL6 8UE	West Devon	Sound
Foxhayes Practice	Foxhayes Practice, 117 Exwick Road, Exeter. Devon EX4 2BH	East Devon	Exeter W
Fremington Medical Centre	Fremington Medical Centre, 11/13 Beards Road, Fremington, Barnstaple. Devon EX31 2PG	North Devon	Barnstap
Friary House Surgery	Friary House Surgery, Friary House, Beaumont Road, Plymouth. Devon PL4 9BH	West Devon	Sound
Haldon House Surgery	Haldon House Surgery, 37-41 Imperial Road, Exmouth. Devon EX8 1DQ	East Devon	WEB
Hartland Surgery	Hartland Surgery, 66 The Square, Hartland, Bideford. Devon EX39 6BL	North Devon	Torridge
Heavitree Practice	Heavitree Practice, South Lawn Terrace, Exeter. Devon EX1 2RX	East Devon	NEXUS
Hill Barton Surgery	Hill Barton Surgery, 1 Lower Hill Barton Road, Exeter. Devon EX1 3EN	East Devon	NEXUS
Honiton Surgery	Honiton Surgery, Marlpits Lane, Honiton. Devon EX14 2NY	East Devon	HOSMS
Ide Lane Surgery	Ide Lane Surgery, 25 Ide Lane, Exeter. Devon EX2 8UP	East Devon	Outer Ex
Imperial Surgery	Imperial Surgery, 47-49 Imperial Road, Exmouth. Devon EX8 1DQ	East Devon	WEB
Isca Medical Practice	Isca Medical Practice, 38 Polsloe Road, Exeter. Devon EX1 2DW	East Devon	NEXUS
Kingskerswell and Ipplepen Medical Practice	Kingskerswell and Ipplepen Medical Practice, School Road, Kingskerswell. Devon TQ12 5DJ	South Devon	Newton
Kingsteignton Medical Practice	Kingsteignton Medical Practice, 4 Whiteway Road, Kingsteignton, Newton Abbot. Devon TQ12 3HN	South Devon	Templer Network

Knowle House Surgery	Knowle House Surgery, 4 Meavy Way, Plymouth. Devon PL5 3JB	West Devon	Drake M Alliance
Leatside Surgery	Leatside Surgery, Babbage Road, Totnes. Devon TQ9 5JA	South Devon	South Da Totnes
Lisson Grove Medical Centre	Lisson Grove Medical Centre, 3-5 Lisson Grove, Plymouth. Devon PL4 7DL	West Devon	Drake M Alliance
Litchdon Medical Centre	Litchdon Medical Centre, Landkey Road, Barnstaple. Devon EX32 9LL	North Devon	Barnstap
Lynton Health Centre	Lynton Health Centre, Burvill Street, Lynton. Devon EX35 6HA	North Devon	North De
Mannamead Surgery	Mannamead Surgery, 22 Eggbuckland Road, Plymouth. Devon PL3 5HE	West Devon	Mayflow
Mayfield Medical Centre	Mayfield Medical Centre, 37 Totnes Road, Paignton. Devon TQ4 5LA	South Devon	Paignton Brixham
Mayflower Medical Group	Access Health, Ernesettle Green, Plymouth. Devon PL5 2ST	West Devon	Mayflow
Mid Devon Medical Practice	Mid Devon Medical Practice, Cannington Road, Witheridge, Tiverton. Devon EX16 8EZ	East Devon	Mid Dev Healthca
Modbury Health Centre	Modbury Health Centre, Poundwell Meadow, Modbury, Ivybridge. Devon PL21 0QL	West Devon	South Ha
Moretonhampstead Health Centre	Moretonhampstead Health Centre, Embleford Crescent, Moretonhampstead, Newton Abbot. Devon TQ13 8LW	East Devon	North Da
Mount Pleasant Health Centre	Mount Pleasant Health Centre, Mount Pleasant Road, Exeter. Devon EX4 7BW	East Devon	NEXUS
New Valley Practice	New Valley Practice, Newcombes, Crediton. Devon EX17 2AR	East Devon	Mid Dev Healthca
North Road West Medical Centre	North Road West Medical Centre, 167 North Road West, Plymouth, Devon. PL1 5BZ	West Devon	Drake M Alliance

Northam Surgery	Northam Surgery, Bay View Road, Northam, Bideford. Devon EX39 1AZ	North Devon	Torridge
Norton Brook Medical Centre	Norton Brook Medical Centre, Cookworthy Road, Kingsbridge. Devon TQ7 1AE	West Devon	South Ha
Oakside Surgery	Oakside Surgery, Guy Miles Way, Plymouth. Devon PL5 3PY	West Devon	Sound
Okehampton Medical Centre	Okehampton Medical Centre, East Street, Okehampton. Devon EX20 1AY	East Devon	North Da
Old Farm Surgery	Old Farm Surgery, 67 Foxhole Road, Paignton. Devon TQ3 3TB	South Devon	Paignton Brixham
Park View Surgery	Park View Surgery, 34 Ford Park Road, Mutley, Plymouth. Devon PL4 6NU	West Devon	Park Vie
Pathfields Practice	Pathfields Practice, Mudge Way, Plymouth. Devon PL7 1AD	West Devon	Pathfield Group
Pembroke House Surgery	Pembroke House Surgery, 266 Torquay Road, Paignton. Devon TQ3 2EZ	South Devon	Baywide
Peverell Park Surgery	Peverell Park Surgery, Outland Road, Plymouth. Devon PL2 3PX	West Devon	Watersid Network
Pinhoe Surgery	Pinhoe Surgery, Pinn Lane, Pinhoe, Exeter. Devon EX1 3SY	East Devon	Outer Ex
Queens Medical Centre	Queens Medical Centre, 6 Queen Street, Barnstaple. Devon EX32 8HY	North Devon	Barnstap
Raleigh Surgery	Raleigh Surgery, 33 Pines Road, Exmouth. Devon EX8 5NH	East Devon	WEB
Redfern Health Centre	Redfern Health Centre, Shadycombe Road, Salcombe. Devon TQ8 8DJ	West Devon	South Ha
Roborough Surgery	Roborough Surgery, 1 Eastcote Close, Roborough, Plymouth. Devon PL6 6PH	West Devon	Drake M Alliance

Rolle Medical Partnership	Rolle Medical Partnership, Claremont Grove, Exmouth. Devon EX8 2JF	East Devon	WEB
Ruby Country Medical Group	Holsworthy Medical Centre, Dobles Lane, Holsworthy, Devon. Devon EX22 6GH	North Devon	Holswor and Surr Villages
Sampford Peverell Surgery	Sampford Peverell Surgery, 29 Lower Town, Sampford Peverell, Tiverton. Devon EX16 7BJ	East Devon	Culm Va
Seaton and Colyton Medical Practice	Seaton and Colyton Medical Practice, 148 Harepath Road, Seaton, Devon. EX12 2DU	East Devon	TASC
Sid Valley Practice	Sid Valley Practice, Blackmore Drive, Sidmouth. Devon EX10 8ET	East Devon	HOSMS
South Brent Health Centre	South Brent Health Centre, Plymouth Road, South Brent. Devon TQ10 9HT	West Devon	South Da Totnes
South Lawn Medical Practice	South Lawn Medical Practice, South Lawn Terrace, Exeter. Devon EX1 2RX	East Devon	NEXUS
South Molton Medical Centre	South Molton Medical Centre, East Street, South Molton. Devon EX36 3BZ	North Devon	North De
Southernhay House Surgery	Southernhay House Surgery, 30 Barnfield Road, Exeter. Devon EX1 1RX	East Devon	Exeter C
Southover Medical Practice	Southover Medical Practice, Bronshill Road, Torquay, Devon. TQ1 3HD	South Devon	Torquay
Southway Surgery	Southway Surgery, 33 Rockfield Avenue, Plymouth. Devon PL6 6DX	West Devon	Sound
St Leonards Practice	St Leonards Practice, Athelstan Road, St Leonards, Exeter. Devon EX1 1SB	East Devon	Exeter C
St Levan Surgery	St Levan Surgery, 350 St Levan Road, Plymouth. Devon PL2 1JR	West Devon	Watersid Network
St Neots Surgery	St Neots Surgery, 1 North Prospect Road, Plymouth. Devon PL2 3HY	West Devon	Watersid Network

St Thomas Medical Group	St Thomas Medical Group, Cowick Street, Exeter. Devon EX4 1HJ	East Devon	Exeter W
Stoke Surgery	Stoke Surgery, Belmont Villas, Plymouth. Devon PL3 4DP	West Devon	Watersid Network
Tavyside Health Centre	Tavyside Health Centre, Abbey Rise, Tavistock. Devon PL19 9FD	West Devon	West De
Teign Estuary Medical Group	Teign Estuary Medical Group, 3 Carlton Place, Teignmouth. Devon TQ14 8AB	South Devon	The Coa
Teignmouth Medical Practice	Teignmouth Medical Practice, 2 Den Crescent, Teignmouth. Devon TQ14 8BG	South Devon	The Coa
Topsham Surgery	Topsham Surgery, Holman Way, Topsham, Exeter. Devon EX3 0EN	East Devon	Outer Ex
Torrington Health Centre	Torrington Health Centre, New Road, Great Torrington, Torrington. Devon EX38 8EL	North Devon	Torridge
Townsend House Medical Centre	Townsend House Medical Centre, 49 Harepath Road, Seaton. Devon EX12 2RY	East Devon	TASC
Wallingbrook Health Centre	Wallingbrook Health Centre, Back Lane, Chumleigh. Devon EX18 7DL	North Devon	Mid Dev Healthca
Wembury Surgery	Wembury Surgery, 51 Hawthorn Drive, Wembury, Plymouth. Devon PL9 0BE	West Devon	Mewstor
West Hoe Surgery	West Hoe Surgery, 2 Cliff Road, Plymouth. Devon PL1 3BP	West Devon	Watersid Network
Westbank Practice	The Limes Surgery, Church Stile, Exminster. Devon EX6 8DF	East Devon	Outer Ex
Whipton Surgery	Whipton Surgery, 378 Pinhoe Road, Exeter. Devon EX4 8EG	East Devon	Exeter C
Wonford Green Surgery	Wonford Green Surgery, 129A Burnthouse Lane, Exeter. Devon EX2 6NF	East Devon	Exetr Cit

Wooda Surgery	Wooda Surgery, Clarence Wharf, Barnstaple Street, Bideford. Devon EX39 4AU	North Devon	Torridge
Woodbury Surgery	Woodbury Surgery, Fulford Way, Woodbury, Exeter. Devon EX5 1NZ	East Devon	WEB
Wycliffe Surgery	Wycliffe Surgery, 8 Cattedown Road, Plymouth. Devon PL4 0BZ	West Devon	Drake M Alliance
Wyndham House Surgery	Wyndham House Surgery, 32 Fore Street, Silverton, Exeter. Devon EX5 4HZ	East Devon	Culm Va
Yealm Medical Centre	Yealm Medical Centre, Market Street, Yealmpton, Plymouth. Devon PL8 2EA	West Devon	Mewstor
Yelverton Surgery	Yelverton Surgery, Westella Road, Yelverton. Devon PL20 6AS	West Devon	West De

3.2 Nature of Membership and Relationship with CCG

3.2.1 The CCG's Members are integral to the functioning of the CCG. Those exercising delegated functions on behalf of the Membership; including the Governing Body, remain accountable to the Membership.

The CCG has established a system of local place based governance, through which the Membership can provide input and influence on commissioning. These arrangements are set out in more detail in the CCG Governance Handbook.

3.3 Speaking, Writing or Acting in the Name of the CCG

3.3.1 Members are not restricted from giving personal views on any matter. However, Members should make it clear that personal views are not necessarily the view of the CCG.

3.4 Members' Rights

3.4.1 Members' rights are described further either in the Standing Orders which are detailed in Appendix 3 of this Constitution and/or the CCG Governance Handbook and include:

- calling and attending a general meeting of the Members;
- submitting a proposal for amendment of the Constitution
- putting themselves forward for election to the Governing Body
- Approving the process of recruitment of the Chair (and/or other Members) of

the Governing Body
- Removing the Chair (and/or other elected Members) of the Governing Body
- participating in the development of the CCGs corporate governance documents, including the CCG Governance Handbook.

3.4.2 The CCG has elected no less than four clinical Members to reside on the Governing Body each elected clinical Member has a vote on the Governing Body and will act as a conduit to the Governing Body for each nominated practice Member representative of the CCG. Member practice representatives are listed in the CCG Governance Handbook.

3.5 Members' Meetings

3.5.1 Meetings of the Members shall be held at such times and in such manner as is outlined in the Standing Orders and in the CCG Governance Handbook.

3.6 Practice Representatives

3.6.1 Each Member practice has a nominated lead healthcare professional who represents the practice in the dealings with the CCG. This individual will be known as the Member practice representative.

3.6.2 CCGs are clinically led Membership organisations made up of general practices. The CCG is therefore, constituted and empowered by its Membership.

4. Arrangements for the Exercise of our Functions.

4.1 Good Governance

4.1.1 The CCG will, at all times, observe generally accepted principles of good governance. These include:

a) Adoption of public and private governance to ensure best practice;

b) Undertaking regular governance reviews;

c) Adoption of standards and procedures that facilitate speaking out and the raising of concerns;

e) The Good Governance Standard for Public Services;

f) The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles';

g) The seven key principles of the NHS Constitution;

h) Listening and responding to constructive formally appointed Non-Executive Lay Members views to ensure healthy dialogue at all levels of management in the CCG.

i) Relevant legislation including such as the Equality Act 2010; and

j) The standards set out in the Professional Standard Authority's guidance 'Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England'.

4.2 General

4.2.1 The CCG will:

a) Comply with all relevant laws, including regulations;
b) Comply with directions issued by the Secretary of State for Health or NHS England;
c) Have regard to statutory guidance including that issued by NHS England; and
d) Take account, as appropriate, of other documents, advice and guidance.

4.2.2 The CCG will develop and implement the necessary systems and processes to comply with (a)-(d) above, documenting them as necessary in this Constitution, its Scheme of Reservation and Delegation and other relevant policies and procedures as appropriate.

4.3 Authority to Act: the CCG

4.3.1 The CCG is accountable for exercising its statutory functions. It may grant authority to act on its behalf to:

a) Any of its Members or employees;
b) Its Governing Body;
c) A Committee or Sub-Committee of the CCG;

4.4 Authority to Act: The Governing Body

4.4.1 The Governing Body may grant authority to act on its behalf to:

a) Any Member of the Governing Body;
b) A Committee or Sub-Committee of the Governing Body;
c) A Member of the CCG who is an individual (but not a Member of the Governing Body); and
d) Any other individual who may be from outside the organisation and who can provide assistance to the CCG in delivering its functions

5 Procedures for Making Decisions

5.1 Scheme of Reservation and Delegation

5.1.1 The CCG has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the CCG Governance Handbook and is available as described in section 1.3.3 of this Constitution and on the CCG website www.DevonCCG.nhs.uk ~~.~~

5.1.2 The CCG's SoRD sets out:

a) Those decisions that are reserved for the Membership as a whole;

b) Those decisions that have been delegated by the CCG, the Governing Body or other individuals.

5.1.3 The CCG remains accountable for all of its functions, including those that it has delegated. All those with delegated authority, including the Governing Body, are accountable to the Members for the exercise of their delegated functions.

5.2 Standing Orders

5.2.1 The CCG has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:

a) Conducting the business of the CCG;
b) The appointments to key roles including Governing Body Members;
c) The procedures to be followed during meetings; and
d) The process to delegate powers.

5.2.2 A full copy of the Standing Orders is included in appendix 3. The Standing Orders form part of this Constitution.

5.3 Standing Financial Instructions (SFIs)

5.3.1 The CCG has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD which is held outside of the Constitution in the CCG Governance Handbook.

5.3.2 A copy of the SFIs is included at Appendix 4 and forms part of this Constitution. Financial limits and delegations are held in the CCG Governance Handbook.

5.4 The Governing Body: Its Role and Functions

5.4.1 The Governing Body has statutory responsibility for:

a) Ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance (its main function); and for
b) Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme established.

5.4.2 The detailed procedures for the Governing Body, including voting arrangements, are set out in the Standing Orders.

5.5 Composition of the Governing Body

5.5.1 This part of the Constitution describes the make-up of the Governing Body roles. The CCG has designated 19~~7~~ voting Members to its Governing Body. The Governing Body is supported by Non-Executive Lay Members who represent the

voice of the public. Further information about the individuals who fulfil these roles can be found on our website www.DevonCCG.nhs.uk

5.5.2 The National Health Service (Clinical Commissioning Groups) Regulations 2012 set out a minimum Membership requirement of the Governing Body of:

a	The Clinical Chair	Statutory requirement – voting Member
b	The Accountable Officer	Statutory requirement – voting Member
c	The Chief Finance Officer (also known as the Director of Finance)	Statutory requirement – voting Member
d	A Secondary Care Specialist	Statutory requirement – voting Member
e	A Registered Nurse (also known as the Chief Nursing Officer)	Statutory requirement – voting Member
f	Two Lay Members (also known as Non-Executive Lay Members), one of whom will Chair the Audit Committee and the other will Chair the Remuneration and Workforce Committee	Statutory requirement – voting Member

5.5.3 The CCG has agreed the following additional Members:

g	A third Non-Executive Lay Member, who is the Chair or Vice Chair of the Primary Care Commissioning Committee	Additional voting Member
h	A fourth Non-Executive Lay Member, who will provide support for quality and safety as required to the Governing Body.	Additional voting Member
i	A fifth Non-Executive Lay Member, Patient and Public Engagement	Additional voting member
j	A sixth Non-Executive Lay Member, Allied Health Professional	Additional voting member
k	No less than four additional Locality Clinical Representatives from within the CCG geographical area	Additional voting Member
l	No more than four additional Clinical or Non-Clinical Executive Directors appointed by the Governing Body	Additional voting Members

5.5.4 One of the formally appointed Non-Executive Lay Members, shall be nominated as Vice Chair of the Governing Body and this will be visible on the CCG website www.DevonCCG.nhs.uk

5.5.5 If the CCG chooses to appoint a clinician for the role of the Accountable Officer, then they will be known as the Clinical Leader. If the Accountable Officer is not a clinician a Clinical Chair will be selected/elected and will be known as the Clinical Leader.

5.5.6 Details of the roles and responsibilities of Governing Body Members are outlined in the CCG Governance Handbook.

5.6 Additional Attendees at the Governing Body Meetings

5.6.1 The CCG Governing Body may invite other person(s) to attend all or any of its meetings, or part(s) of a meeting, in order to assist it in its decision-making and in its discharge of its functions as it sees fit. Any such person may be invited by the chair to speak and participate in debate but may not vote.

5.6.2 The CCG Governing Body will regularly invite the following individuals to attend any or all of its meetings as attendees who are non-voting:

a) **2 x Associate Non-Executive Lay Member.** The Associate NED role is a 'step up' role aimed to attract potential Non-Executive Director candidates who do not yet have (sufficient) Board-level experience, or currently do not have the required availability – but have the ability and potential to succeed in a Board level role. The Associate Non-Executive Director (Associate NED) role will support the Governing Body succession strategy and achieve a balance of Board level skills. For the avoidance of doubt, Associate Non-Executive Directors are not Directors of the CCG or Governing Body Board members and do not have the associated rights or liabilities.

b) Local authority representatives, specifically Public Health in accordance with Section 14W of the NHS Act within the CCG local geography. This representation would be from Devon County Council, Plymouth City Council and Torbay Council as described in section 2.2 of this Constitution.

5.7 Appointments to the Governing Body

5.7.1 The process of appointing GPs to the Governing Body, the selection of the Chair, and the appointment procedures for other Governing Body Members are set out in the Standing Orders within the Governance Handbook.

5.7.2 Also set out in Standing Orders are the details regarding the tenure of office for each role and the procedures for resignation and removal from office.

5.8 Committees and Sub-Committees

5.8.1 The CCG may establish Committees and Sub-Committees of the CCG.

5.8.2 The Governing Body may establish Committees and Sub-Committees of the CCG

5.8.3 Each Committee and Sub-Committee established by either the CCG or the Governing Body operates under terms of reference and Membership agreed by the CCG or Governing Body as relevant. Appropriate reporting and assurance mechanisms must be developed as part of agreeing terms of reference for Committees and Sub-Committees.

5.8.4 With the exception of the Remuneration and Workforce Committee, any Committee or Sub-Committee established in accordance with clause 5.8 may consist of or include persons other than Members or employees of the CCG.

5.8.5 All Members of the Remuneration and Workforce Committee will be Members of the CCG Governing Body.

5.9 Committees of the Governing Body

5.9.1 The Governing Body will maintain the following statutory or mandated Committees:

5.9.1.1 **Audit Committee:** This Committee is accountable to the Governing Body and provides the Governing Body with an independent and objective view of the CCG's compliance with its statutory responsibilities. The Committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a Lay Member who has qualifications, expertise or experience to enable them to lead on finance and audit matters and Members of the Audit Committee may include people who are not Governing Body Members.

5.9.1.2 **Remuneration and Workforce Committee:** This Committee is accountable to the Governing Body and makes recommendations to the Governing Body about the remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the CCG.

The Remuneration and Workforce Committee will be chaired by a lay Member other than the Audit chair and only Members of the Governing Body may be Members of the Remuneration Committee.

5.9.1.3 **Primary Care Commissioning Committee:** This committee is required by the terms of the delegation from NHS England in relation to primary care commissioning functions. The Primary Care Commissioning Committee reports to the Governing Body and to NHS England. Membership of the Committee is determined in accordance with the requirements of *Managing Conflicts of Interest: Revised statutory Guidance for CCGs 2017*. This includes the requirement for a Lay Member Chair and a Lay Vice Chair.

None of the above Committees may operate on a joint committee basis with another CCG.

The terms of reference for each of the above committees are included in Appendix 2 to this Constitution and form part of the Constitution.

The Governing Body may from time to time establish a number of other Committees to assist it with the discharge of its functions. These Committees are set out in the SoRD and further information about these Committees, including

terms of reference, are published on the CCG website www.DevonCCG.nhs.uk and available in the CCG Governance Handbook.

5.10 Collaborative Commissioning Arrangements

5.10.1 The CCG wishes to work collaboratively with its partner organisations in order to assist it with meeting its statutory duties, particularly those relating to integration. The following provisions set out the framework that will apply to such arrangements.

5.10.2 In addition to the formal joint working mechanisms envisaged below, the Governing Body may enter into strategic or other transformation discussions with its partner organisations, on behalf of the CCG.

5.10.3 The Governing Body must ensure that appropriate reporting and assurance mechanisms are developed as part of any partnership or other collaborative arrangements. This will include:

a) Reporting arrangements to the Governing Body, at appropriate intervals;
b) Engagement events or other review sessions to consider the aims, objectives, strategy and progress of the arrangements; and
c) Progress reporting against identified objectives.

5.10.4 When delegated responsibilities are being discharged collaboratively, the collaborative arrangements, whether formal joint working or informal collaboration, must:

a) Identify the roles and responsibilities of those CCGs or other partner organisations that have agreed to work together and, if formal joint working is being used, the legal basis for such arrangements;
b) Specify how performance will be monitored and assurance provided to the Governing Body on the discharge of responsibilities, so as to enable the Governing Body to have appropriate oversight as to how system integration and strategic intentions are being implemented;
c) Set out any financial arrangements that have been agreed in relation to the collaborative arrangements, including identifying any pooled budgets and how these will be managed and reported in annual accounts;
d) Specify under which of the CCG's supporting policies the collaborative working arrangements will operate;
e) Specify how the risks associated with the collaborative working arrangement will be managed and apportioned between the respective parties;
f) Set out how contributions from the parties, including details around assets, employees and equipment to be used, will be agreed and managed;
g) Identify how disputes will be resolved and the steps required to safely terminate the working arrangements;
h) Specify how decisions are communicated to the collaborative partners.

5.11 Joint Commissioning Arrangements with Local Authority Partners

5.11.1 The CCG will work in partnership with its Local Authority partners to reduce health and social inequalities and to promote greater integration of health and social care for its entire population.

5.11.2 Partnership working between the CCG and its Local Authority partners might include collaborative commissioning arrangements, including joint commissioning under Section 75 of the 2006 Act, where permitted by law. In this instance, and to the extent permitted by law, the CCG delegates to the Governing Body the ability to enter into arrangements with one or more relevant Local Authority in respect of:

a) Delegating specified commissioning functions to the Local Authority;
b) Exercising specified commissioning functions jointly with the Local Authority;
c) Exercising any specified health-related functions on behalf of the Local Authority.

5.11.3 For purposes of the arrangements described in 5.11.2, the Governing Body may:

a) Agree formal and legal arrangements to make payments to, or receive payments from, the Local Authority, or pool funds for the purpose of joint commissioning;
b) Make the services of its employees or any other resources available to the Local Authority; and
c) Receive the services of the employees or the resources from the Local Authority.
d) Where the Governing Body makes an agreement with one or more Local Authority as described above, the agreement will set out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties, and the legal basis for such arrangements;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including payments towards a pooled fund and management of that fund;
- Contributions from each party, including details of any assets, employees and equipment to be used under the joint working arrangements; and
- The liability of the CCG to carry out its functions, notwithstanding any joint arrangements entered into.

5.11.4 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.11.2 above.

5.12 Joint Commissioning Arrangements – Other CCGs

5.12.1 The CCG may work together with other CCGs in the exercise of its Commissioning Functions.

5.12.2 The CCG delegates its powers and duties under 5.12 to the Governing Body and all references in this part to the CCG should be read as the Governing Body, except to the extent that they relate to the continuing liability of the CCG under any joint arrangements.

5.12.3 The CCG may make arrangements with one or more other CCGs in respect of:

a) Delegating any of the CCG's commissioning functions to another CCG;
b) Exercising any of the Commissioning Functions of another CCG; or
c) Exercising jointly the Commissioning Functions of the CCG and another CCG.

5.12.4 For the purposes of the arrangements described at 5.12.3, the CCG may:

a) Make payments to another CCG;
b) Receive payments from another CCG; or
c) Make the services of its employees or any other resources available to another CCG; or
d) Receive the services of the employees or the resources available to another CCG.

5.12.5 Where the CCG make arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

5.12.6 For the purposes of the arrangements described above, the CCG may establish and maintain a pooled fund made up of contributions by all of the CCGs working together jointly pursuant to paragraph 5.12.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

5.12.7 Where the CCG makes arrangements with another CCG as described at paragraph 5.12.3 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working including details of:

a) How the parties will work together to carry out their commissioning functions;
b) The duties and responsibilities of the parties, and the legal basis for such arrangements;
c) How risk will be managed and apportioned between the parties;
d) Financial arrangements, including payments towards a pooled fund and management of that fund;
e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

5.12.8 The responsibility of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.12.1 above.

5.12.9 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.12.1 above.

5.12.10 Only arrangements that are safe and in the interests of patients registered with Member practices will be approved by the Governing Body.

5.12.11 The Governing Body shall require, in all joint commissioning arrangements, that the lead Governing Body Member for the joint arrangements:

a) Make a quarterly written report to the Governing Body;
b) Hold at least one annual engagement event to review the aims, objectives, strategy and progress of the joint commissioning arrangements; and
c) Publish an annual report on progress made against objectives.

5.12.12 Should a joint commissioning arrangement prove to be unsatisfactory, the Governing Body of the CCG can decide to withdraw from the arrangement but has to give six months' notice to partners to allow for credible alternative arrangements to be put in place, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

5.13 Joint Commissioning Arrangements with NHS England

5.13.1 The CCG may work together with NHS England. This can take the form of joint working in relation to the CCG's functions or in relation to NHS England's functions.

5.13.2 The CCG delegates its powers and duties under 5.13 to the Governing Body and all references in this part to the CCG should be read as the Governing Body, except to the extent that they relate to the continuing liability of the CCG under any joint arrangements.

5.13.3 In terms of either the CCG's functions or NHS England's functions, the CCG and NHS England may make arrangements to exercise any of their specified commissioning functions jointly.

5.13.4 The arrangements referred to in paragraph 5.13.3 above may include other CCGs, a combined authority or a Local Authority.

5.13.5 Where joint commissioning arrangements pursuant to 5.13.3 above are entered into, the parties may establish a Joint Committee to exercise the commissioning functions in question. For the avoidance of doubt, this provision does not apply to any functions fully delegated to the CCG by NHS England, including but not limited to those relating to primary care commissioning.

5.13.6 Arrangements made pursuant to 5.13.3 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

5.13.7 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 5.13.3 above, the CCG shall develop and

agree with NHS England a framework setting out the arrangements for joint working, including details of:

a) How the parties will work together to carry out their commissioning functions;
b) The duties and responsibilities of the parties, and the legal basis for such arrangements;
c) How risk will be managed and apportioned between the parties;
d) Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

5.13.8 Where any joint arrangements entered into relate to the CCG's functions, the liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 5.13.3 above. Similarly, where the arrangements relate to NHS England's functions, the liability of NHS England to carry out its functions will not be affected where it and the CCG enter into joint arrangements pursuant to 5.13.

5.13.9 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

5.13.10 Only arrangements that are safe and in the interests of patients registered with Member practices will be approved by the Governing Body.

5.13.11 The Governing Body of the CCG shall require, in all joint commissioning arrangements that the lead Governing Body Member for the joint arrangements make:

a) Make a quarterly written report to the Governing Body;
b) Hold at least one annual engagement event to review the aims, objectives, strategy and progress of the joint commissioning arrangements; and
c) Publish an annual report on progress made against objectives.

5.13.12 Should a joint commissioning arrangement prove to be unsatisfactory the Governing Body of the CCG can decide to withdraw from the arrangement but has to give six months' notice to partners to allow for credible alternative arrangements to be put in place, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

6 Provisions for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14O of the 2006 Act, the CCG has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made

by the CCG will be taken and seen to be taken without being unduly influenced by external or private interest.

6.1.2 The CCG has agreed policies and procedures for the identification and management of conflicts of interest.

6.1.3 Employees, Members, Committee and Sub-Committee Members of the CCG and Members of the Governing Body (and its Committees, Sub-Committees, Joint Committees) will comply with on the recording and monitoring of conflicts of interest, by adhering to the CCGs Standards of Business Conduct Policy. Where an individual, including any individual directly involved with the business or decision-making of the CCG and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CCG considering an action or decision in relation to that interest, that must be considered as a potential conflict and is subject to the provisions of this Constitution and the CCGs Standards of Business Conduct Policy.

6.1.4 The CCG has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the CCG's governance lead, their role is to:

a) Act as a conduit for GP practice staff, Members of the public and healthcare professionals who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers of the CCG to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and Members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Declaring and Registering Interests

6.2.1 The CCG will maintain registers of the interests of those individuals listed in the CCG's policy.

6.2.2 The CCG will, as a minimum, publish the registers of conflicts of interest and gifts and hospitality of decision making staff at least annually on the CCG website and make them available at our headquarters upon request.

6.2.3 All relevant persons for the purposes of NHS England's statutory guidance *Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017* and *Best Practice Update on Conflicts of Interest Management: Call to action for CCGs 2019* must declare any interests. Declarations should be made as soon as reasonably practicable and by law within 28 days after the interest arises. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.2.4 The CCG will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually. All persons required to, must declare any interests as soon as reasonably practicable and by law within 28 days after the interest arises.

6.2.5 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the CCG will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The CCG's published register of interests states that historic interests are retained by the CCG for the specified timeframe and details of whom to contact to submit a request for this information.

6.2.6 Activities funded in whole or in part by third parties who may have an interest in CCG business such as sponsored events, posts and research will be managed in accordance with the CCG policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.3 Training in Relation to Conflicts of Interest

6.3.1 The CCG ensures that relevant staff and all Governing Body Members receive training on the identification and management of conflicts of interest and that relevant staff undertake the NHS England Mandatory training.

6.4 Standards of Business Conduct

6.4.1 Employees, Members, Committee and Sub-Committee Members of the CCG and Members of the Governing Body (and its Committees, Sub-Committees, Joint Committees) will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should: Act in good faith and in the interests of the CCG;

a) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
b) Comply with the standards set out in the Professional Standards Authority guidance - *Standards for Members of N HS Boards and Clinical Commissioning Group Governing Bodies in England; and*
c) Comply with the CCG's Standards of Business Conduct, including the requirements set out in the policy for managing conflicts of interest which is available on the CCG's website www.DevonCCG.nhs.uk and will be made available on request.

6.4.2 Individuals contracted to work on behalf of the CCG or otherwise providing services or facilities to the CCG will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the CCG's Standards of Business Conduct policy.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006
Accountable Officer (AO)	An individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act, appointed by NHS England, with responsibility for ensuring the group: Complies with its obligations under: Sections 14Q and 14R of the 2006 Act, Sections 223H to 223J of the 2006 Act, Paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006, and Any other provision of the 2006 Act specified in a document published by the Board for that purpose; Exercises its functions in a way which provides good value for money.
Area	The geographical area that the CCG has responsibility for, as defined in part 2 of this Constitution
Chair of the CCG Governing Body	The individual appointed by the CCG to act as chair of the Governing Body and who is usually either a GP Member or a Lay Member of the Governing Body.
Chief Finance Officer (CFO)	A qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance and who is a Member of the Governing Body.
Clinical Commissioning Groups (CCG)	A body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act.
Committee	A Committee created and appointed by the Membership of the CCG or the Governing Body.
Committees in Common	If a Committee meets at the same time, in the same location, as another CCG's committee, it is referred to legally as meeting as 'Committees in Common'. Such Committees in Common maintain a common agenda, but maintain their own attendance, minutes, action and decision logs allowing each Committee to retain transparent records of their own governance arrangements and outcomes.
Governing Body	The body appointed under section 14L of the NHS Act 2006, with the main function of ensuring that a Clinical Commissioning Group has made appropriate arrangements for ensuring that it complies with its

	obligations under section 14Q under the NHS Act 2006, and such generally accepted principles of good governance as are relevant to it.
Governing Body Member	Any individual appointed to the Governing Body of the CCG
Healthcare Professional	A Member of a profession that is regulated by one of the following bodies: The General Medical Council (GMC) The General Dental Council (GDC) The General Optical Council; The General Osteopathic Council The General Chiropractic Council The General Pharmaceutical Council The Pharmaceutical Society of Northern Ireland The Nursing and Midwifery Council The Health and Care Professions Council Any other regulatory body established by an Order in Council under Section 60 of the Health Act 1999
Joint Committee	Committees from two or more organisations that work together with delegated authority from both organisations to enable joint decision-making. This is different from Committees in Common
Lay Member	A Lay Member of the CCG Governing Body, appointed by the CCG. A Lay Member is an individual who is not a Member of the CCG or a healthcare professional (as defined above) or as otherwise defined in law. For purposes of NHS Devon CCG, Lay Members are known formally by title as Non-Executive Lay Members.
Member/ Member Practice	A provider of primary medical services to a registered patient list, who is a Member of this CCG.
Member practice representative	Member practices appoint a healthcare professional to act as their practice representative in dealings between it and the CCG, under regulations made under section 89 or 94 of the 2006 Act or directions under section 98A of the 2006 Act.

NHS England	The legislation refers to the NHS Commissioning Board and this is the legal name for NHS England. The NHS Commissioning Board has changed its operational name to 'NHS England'.
Primary Care Network	A primary care network (PCN) consist of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations.
Primary Care Commissioning Committee	A Committee required by the terms of the delegation from NHS England in relation to primary care commissioning functions. The Primary Care Commissioning Committee reports to NHS England and the Governing Body
Professional Standards Authority	An independent body accountable to the UK Parliament which helps Parliament monitor and improve the protection of the public. Published *Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England* in 2013
Registers of Interests	Registers a group is required to maintain and make publicly available under section 14O of the 2006 Act and the statutory guidance issues by NHS England, of the interests of: • the Members of the group; • the Members of its CCG Governing Body; • The Members of its Committees or Sub-Committees and Committees or Sub-Committees of its CCG Governing Body; and its employees.
SFI	Standing Financial Instructions (Appendix 4)
SO	Standing Orders (Appendix 3)
SoRD	Scheme of Reservation and Delegation – held outside of the Constitution in the CCG Governance Handbook
STP	Sustainability and Transformation Partnerships – the framework within which the NHS and local authorities have come together to plan to improve health and social care over the next few years. STP can also refer to the formal proposals agreed between the NHS and local councils – a "Sustainability and Transformation Plan".
Sub-Committee	A Committee created by and reporting to the Governing Body.
Sub Group / Working Group	A sub group or working group is a meeting of experts who report to a sub committee of the governing body to assist in discharging the sub committee's duties

Appendix 2: Committee Terms of Reference

NHS Devon Clinical Commissioning Group
Audit Committee
Terms of Reference

1. Constitutional Obligations

1.1 The Clinical Commissioning Group's Governing Body hereby resolve to establish a Committee of the Governing Body known as the Audit Committee. The Committee is established in accordance with Devon Clinical Commissioning Group's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

1.2 These terms of reference set out the Membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's Constitution and standing orders.

1.3 The Audit Committee is an assurance Committee of the Governing Body and has the ability to execute any powers assigned to it by the Governing Body and those specifically delegated in these terms of reference and/or through the CCGs Constitutional Scheme of Reservation and Delegation.

1.4 The Local Audit and Accountability Act 2014 (the Act) requires every 'relevant authority' to appoint an 'Auditor Panel' to exercise functions set out in the Act (part 3, section 9). The Governing Body has resolved to nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, Paragraph 1 of the 2014 Act and details of the Auditor Panel responsibilities and purpose are encompassed within the Audit Committee's terms of reference in line with the Act.

2. Purpose

2.1 The purpose of the Audit Committee is to assist the CCG in delivering its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide evidence-based assurance to the Governing Body that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Financial statements are prepared in a timely fashion, and give a true and fair view of the financial position of the CCG for the period in question
- Affairs are managed to secure economic, efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities Governing bodies can – if they choose – nominate a 'subset' of the Audit Committee to act as the Auditor Panel. If a subset is used, there must be at least three

Members with a majority who are independent and non-executive Members of the Governing Body. (HFMA briefing December 2015)

2.2 It is the responsibility of the Committee to make recommendations to the Governing Body on determinations about the assurances received surrounding any internal or external audit findings and probity issues on behalf of the CCG.

2.3 It shall support the objectives of the CCGs Governing Body as outlined in the Operational Plan and provide assurances to the Governing Body that these are being met and considered.

2.4 It will promote a whole system culture of continuous improvement, ensuring that assurance and probity sits at the heart of health and social care locally, whether provided by NHS or non-NHS providers.

2.5 It will seek assurance that the CCG is fulfilling its statutory duties through continuous monitoring and this will be detailed in the organisation's annual governance statement and annual report, under the relevant Acts, and current national guidance.

2.6 The Committee is authorised by the CCG Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the Committee.

2.7 The Committee is authorised by the CCG Governing Body to obtain external legal or other independent professional advice and to secure the attendance of advisers with relevant experience and expertise if it considers this necessary.

2.8 The Committee is responsible for the approval of the Annual Financial Statements and Annual Governance Statement prior to submission to the CCG Governing Body.

3. Responsibilities

The responsibilities of the Committee can be categorised as follows:

3.1 Governance, Internal Control and Risk Management
The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisation's core objectives.

3.1.1 In particular, the Committee will review the adequacy and effectiveness of:

a) All risk and control related disclosure statements (in particular the Annual Governance Statement and any declarations of external compliance), together with any accompanying Head of Internal Audit Opinion, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the CCG Governing Body
b) The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
c) The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.

d) The policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authoirty (NHSCFA).

3.1.2 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective risk assurance framework to guide its work and that of the audit and assurance functions that report to it. To enable this, the Audit Committee will have sight of the full risk assurance framework no less than four times a year to enable it to report on its assurances of internal control and the process of risk management throughout the organisation to the Governing Body.

3.1.3 The Audit Committee shall review the findings of other significant assurance functions through effective relationships with other key Committees so that it understands processes and linkages and will receive assurance that these Committees are working effectively through the annual Committee effectiveness reviews. However, these other Committees must not usurp the Committee's role.

3.1.4 The Committee will review the Finance and Performance reporting and Quality reporting to the Governing Body at each meeting. The Committee will challenge the content of the report and seek assurance that it is based on sound systems of control and that there are appropriate action plans in place to mitigate the risk areas. This will provide the opportunity for detailed scrutiny of the performance of the CCG prior to this being presented to the Governing Body.

3.1.5 Where timeliness is of the essence in managing a significant risk or issue, the Chair of the Committee will be informed of an issue by the quickest possible means (e.g. verbally) and this will be acted upon in accordance with the risk management strategy and risk escalation processes of the CCG.

3.2 Auditor Panel

3.2.1 The Auditor Panel for NHS Devon CCG forms a subset of the Audit Committee and shall comprise of the core Membership of the Audit Committee. This Membership consists of at least 3 Members with a majority who are independent and recognised as non-executive lay Members of the Governing Body.

3.2.2 The Auditor Panel is a non-executive lay Member Committee and has no executive powers other than those specifically delegated in these terms of reference. In line with the requirements of the Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 (regulation 6) each Members independence must be reviewed against the criteria laid down in the regulations[2].

3.2.3 The Auditor Panel chairperson and/or Members of the panel can be removed in line with rules agreed by the Governing Body.

2 If a specially established panel is nominated with new Members (i.e. not from the existing Audit Committee, a full recruitment process must be followed in line with Regulation 3. This means that any prospective Members who are not on the Governing Body must be appointed in response to an advertised vacancy and after submitting an application.

3.2.4 The Auditor Panel's chairperson shall formally state at the start of each meeting that the Auditor Panel is meeting in that capacity and NOT as the Audit Committee.

3.2.5 Auditor Panel business shall be identified clearly and separately on the agenda and Audit Committee Members shall deal with these matters as Auditor Panel Members NOT as Audit Committee Members.

3.2.6 The Auditor Panel's functions are to:

a) Advise the CCG's Governing Body on the selection and appointment of the external auditor. This includes:
b) Agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules;
c) Making a recommendation to the Governing Body as to whom should be appointed;
d) Ensuring that any conflicts of interest are dealt with effectively;
e) Advise the CCG's Governing Body on the maintenance of an independent relationship with the appointed external auditor
f) Advise (if asked) the CCG's Governing Body on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable;
g) Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor;
h) Advise the CCG's Governing Body on any decision about the removal or resignation of the external auditor.

3.3 External Audit

3.3.1 The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management responses to their work. This will be achieved by:

a) Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Governing Body when appropriate)
b) Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
c) Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
d) Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Governing Body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
e) Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

3.4 Internal Audit

3.4.1 The Committee shall ensure that there is an effective internal audit function established by management that meets the Public sector internal audit standards, 2017 and provides appropriate independent assurance to the Committee, Accountable

Officer and CCG Governing Body.

This will be achieved by:

a) Consideration of the provision of the Internal Audit service and costs involved,
b) Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
c) Considering the major findings of internal audit work (and managements response) and ensuring coordination between the internal and external auditors to optimise the use of audit resources;
d) Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
e) Monitoring the effectiveness of internal audit and carrying out an annual review

3.5 Counter Fraud and Bribery

3.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority (NHSCFA) standards and shall review the outcomes of work in these areas.

3.5.2 The Committee shall also ensure that there is a counter fraud specialist within the CCG and that policies and procedures for all work related to fraud are in place while also ensuring that procedures are in place which ensure that it cannot be guilty of any bribery or corruption. The Committee will receive reports from the Local Counter Fraud Specialist on current investigations.

3.6 Financial Reporting

3.6.1 The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

3.6.2 The Committee should ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

3.6.3 The Committee shall review the annual report and financial statements before submission to the Governing Body, focusing particularly on:

a) The wording in the annual governance statement and other disclosures relevant to the Terms of reference of the Committee;
b) Changes in, and compliance with, accounting policies, practices and estimation techniques;
c) Unadjusted mis-statements in the financial statements;
d) Significant judgements in preparation of the financial statements
e) Significant adjustments resulting from the audit
f) Letters of representation
g) Explanations for significant variances

3.7 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial,

clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

3.8 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

4. Membership

The core Membership of the Audit Committee shall be:

The following Members have voting rights:

- (Chair) Non-Executive Lay Member – who has qualifications expertise or experience to enable them to lead on finance, probity, governance and audit matters enabling them to express an informed view about discharge of the CCG functions
- Two additional Non-Executive Lay Member representatives
- Registered Nurse
- Secondary Care Consultant

The following attendees do not have voting rights:

GB locality clinical representative

Under the NHS (CCG Groups) Regulations 2012, (14) Audit Committee (3) The following are disqualified from Membership of a CCG's Audit Committee:

(a) the Chair of the CCG's Governing Body

(b) the CCG's Chief Finance Officer

Attendees do not have voting rights and include:

The Chief Finance Officer/Director of Finance, Governance representative, Head of Internal Audit, the local counter fraud specialist (LCFS) and representatives from external audit shall normally attend meetings. At least once a year the Committee Members should meet privately with the external and Internal Auditors without any senior officer present.

The Accountable Officer and CCG Chair can attend any Committee meeting but cannot be the Chair of the Audit Committee.

The Accountable Officer/Chief Officer does not have voting rights, and, should be invited to attend and discuss at least annually with the Audit Committee the process for assurance that supports the CCGs input into the annual governance statement. He or she should also attend when the Committee considers the CCG input into the draft Internal Audit plan and Annual Accounts.

The Chair of the Committee may co-opt any non-voting Clinicians, Executive or Managing Directors, nominated deputies and lead managers as appropriate and

particularly, when the Committee is discussing areas of risk or operation that are the responsibility of that attendee.
Note: When a Committee Member is unable to attend, a nominated formal deputy with sufficient authority must attend in their place. Deputies will have the decision making and voting rights of the person he/she is representing.

5. Quorum

5.1 A quorum of the Audit Committee and the Auditor Panel shall be two of the Non-Executive Lay Members and one clinical Member.

5.2 A decision put to a vote at the meeting shall be determined by a majority of the votes of independent Members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

5.3 People invited to attend, or those in attendance to the Committee do not have the right to vote.

5.4 If the Committee Chair is absent then the Members of the Committee will select a chair for that meeting from the voting Members present – this will be overseen by the most senior officer responsible for governance as the Chair needs to be an independent representative of the CCG.

6. Register of Interests

6.1 The Register of Interest will be reviewed at each Audit Committee meeting in line with the NHS Audit Committee Handbook.

6.2 Members will be asked by the Chair of the Audit Committee to declare any interests at the beginning of each meeting. If a Member feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

6.3 **Auditor Panel**. Conflicts of interest must be declared and recorded at the start of each meeting of the Auditor Panel. Auditor Panel register of interest must be maintained by the panels chairperson and submitted to the Governing Body in accordance with the CCGs standards of business conduct policy. If a conflict of interest arises, the chairperson may require the affected Auditor Panel Member to withdraw at the relevant discussion or voting point.

7. Frequency of Meetings

7.1 The Audit Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per annum at appropriate times in the reporting and audit cycle which must be documented in the corporate calendar and aligned to provide assurance in a timely manner to Governing Body. The Governing Body, Accountable Officer, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

7.2 The Head of Internal Audit, representative or external audit and counter fraud specialist have a right of direct access to the Chair of the committee.

7.3 The Auditor Panel will usually meet on the same day as the Audit Committee, either before or after dependent upon availability of Members and governance arrangements. The Auditor Panel's chairperson may invite executive directors and others to attend depending on the requirements of each meeting's agenda. These invitees are not Members of the Auditor Panel.

7.4 The Committee has agreed that in the interest of expediency or when there are few items to be discussed that business of the committee can be conducted by e-mail and the actions/decision will be recorded by the Administrator for purposes of transparency and recording. Where a discussion is required, all Members must respond, and the administrator will oversee this to ensure that all Members are accounted for.

8. Reporting arrangements

8.1 The Committee Chair shall report formally to the CCGs Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the public meeting of the CCGs Governing Body. The Committee shall make recommendations to the CCGs Governing Body on any area within its remit where action or improvement is needed.

8.2 The Committee is authorised by the CCG Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

8.3 The Committee may require the attendance at its meetings of any officer of the CCG and the production of any document.

8.4 The Committee is authorised by the CCG Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8.5 The Auditor Panel is a sub group of the Audit Committee and is authorised by the Governing Body to carry out the functions specified at 3.2.6 and can seek any information it requires from any employees or relevant third parties. All employees are directed to co-operate with any request made by the Auditor Panel.

8.6 The Auditor Panel is authorised by the Governing Body to obtain outside legal or other independent professional advice (for example, procurement specialists) and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such 'outside advice' must be obtained in line with the organisations existing rules (e.g. legal framework policy).

8.7 Minutes and reports of the meetings will be produced and held by the Administrator of the Committee, accessible to the Chair, core Membership and the Director responsible for the corporate function. Extracts from Minutes will be made public as appropriate under the freedom of information act.

9. Statutory Functions, Committee Oversight and KPIs (Internal Monitoring)

9.1 The Governing Body has delegated the following authorities to the Audit Committee:

• Authority to establish sub-groups
• Provision of an independent and objective view of the CCG's systems of internal control, information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance, risk, quality and performance management systems underpinned by the assurance framework
• Appoint Internal Auditors
• Approve the internal audit plan
• Review financial policies
• Approval of the CCGs risk management framework and risk assurance framework

9.2 The Committee will undertake an annual review of the performance and effectiveness of the CCG Governing Body associated sub-committees to ensure that the Committee structure and work plans reflect the current and future needs of the CCG Governing Body.

9.3 In addition, the Committee will review the work of other sub-groups within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. These may include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Public Sector Audit Appointments Ltd, National Audit Office, Financial Reporting Council) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal College, accreditation bodies).

9.4 The reviews will be spread throughout the year with an Annual Report produced by the Committee for the Governing Body.

10. Administration

10.1 The Committee and its sub group shall be supported administratively by its Administrator his or her duties in _this respect _will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the Chair to prepare reports to the Governing Body
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example, with the internal/external auditors, Auditor Panel or local counter fraud specialists
- Maintaining records of Members appointments and renewal dates
- Advising the Committee on pertinent issues/areas of interest/policy developments
- Advising the Auditor Panel on pertinent issues/areas of interest/policy developments

- Ensuring that action points are taken forward between meetings
- Ensuring that Committee Members receive the development and training they need.
- Ensuring that panel Members receive the development and training they need
- Providing appropriate support to the Chairperson and Panel Members

10.2 Following each meeting, the Administrator will:

- Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by Members.
- Maintain a record of decisions taken for transparency through each Audit Chairs report
- Maintain a log of summary written reports provided to Governing Body from formal meetings.

11. Review

An annual effectiveness review will be undertaken by the Head of Governance as good governance practice and to ensure compliance with the Annual Governance Statement.

These Terms of Reference will be reviewed on an annual basis or sooner if required through the Head of Governance with recommendations made to the CCGs Governing Body for approval via the Audit Chair.

END

NHS Devon Clinical Commissioning Group
Remuneration and Workforce Committee
Terms of Reference

1. Constitutional Obligations

1.1 The Remuneration and Workforce Committee of NHS Devon Clinical Commissioning Group is established in accordance with its Constitution, standing financial instructions, standing orders and scheme of delegation.

1.2 These terms of reference set out the Membership, remit, responsibilities and reporting arrangements of the Committee.

1.3 The Remuneration and Workforce Committee of 'the CCG' is a Non-executive Committee of the Governing Body and has no executive powers other than those specifically delegated in this Terms of Reference or through the Constitutional scheme of delegation. Only members of the Governing Body can be members on the Remuneration committee.

2. Purpose

2.1. The purposes of the Remuneration and Workforce Committee is to provide assurance and oversight of all aspects of strategic people management and organisational development; recommending the appointments, determinations regarding matters of remuneration to the Governing Body, fees and other allowances for employees and for people who provide services to the CCG, and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS Pension Scheme. The Remuneration and Workforce Committee has clear delegations for decision making which are set out in the Scheme of Reservation and Delegation.

Responsibilities

3. Responsibilities

3.1 The Remuneration and Workforce Committee will apply best practice in the decision-making processes, for example, when considering individual remuneration, the committee will:

- Comply with current disclosure requirements for remuneration;
- On occasion seek independent advice about remuneration for individuals,
- Ensure that decisions are based on clear and transparent criteria.
- Assure 'the CCG' Governing Body on the approval process for recruiting and appointing Governing Body and other Executive Team Members, including any interim or off- payroll arrangements.

- Ensure all arrangements are in line with NHS England/DH/SoS/HMRC directions e.g. 02.06.15 Financial Controls Letter, CCG Remuneration Gateway Publication 03656 etc.
- Make recommendations to Governing Body on any proposed remuneration and terms of service for clinical and non-clinical Governing Body Members, taking into account any national or local guidance as necessary, so as to ensure that the individual is fairly rewarded for their individual contribution to the CCG, whilst having proper regard to 'the CCG' circumstances and performance. This shall include all aspects of salary (including any performance related elements or bonuses), provisions for other benefits and any other contractual terms.
- Assure 'the CCG' Governing Body on pay policy and any annual award for all employees of 'the CCG' including, pensions, remuneration, fees, travelling or other allowances payable to employees and to other persons providing services to 'the CCG'. This includes overseeing the implementation of appropriate contractual arrangements for staff and clinicians, including the proper calculation and scrutiny of termination payments, excluding ill health and normal retirement, taking into account such national guidance as is appropriate.
- Monitor and assure on succession planning for the Executives residing on Governing Body and VSM senior team Members, to ensure there is a process for identifying and developing internal staff and clinicians with the potential to fill key leadership positions in 'the CCG' in accordance with NHSE Guidance, 'the CCG' Constitution, standing orders and any associated documentation, whilst taking into account the challenges and opportunities facing 'the CCG', and what skills and expertise are therefore needed in the future.
- Ensure that all provisions regarding disclosure of remuneration, including pensions, are fulfilled.
- Consider any payments, in addition to salary, for very senior managers (VSM) and where appropriate ensure that any approvals are sought such as seeking HM Treasury approval as appropriate and bringing these to the attention of the governing body for approval.
- Provide assurance to the Governing Body on the CCG's arrangements for strategic people management and Organisational Development including the management of risks relating to these areas.
- Ensure that the CCG is meetings its obligations in relation to reporting on workforce issues including (but not limited to) senior pay and equality and diversity (including gender equality).
- At the request of the accountable officer, to advise on exceptional payments to staff outside of the Governing Body.
- Ensure that the CCG has the appropriate governance arrangements for the recruitment, employment and remuneration of "hosted" staff on behalf of other organisations.
- Oversight of HR policy development, approval and implementation – The Committee will approve the following policies; Disciplinary, Performance Management, MARS Scheme and Family Matters.
- The Committee has authority to establish Sub-Committees.
- The Committee has full authority to commission any reports or surveys it deems necessary to help it fulfil the remit outlined above.
- Oversee performance management of the Accountable Officer.
- The committee will not discuss Non-Executive Lay Member remuneration or succession planning of these positions. This will be discussed at a meeting convened by the NHS Devon CCG Chair and most appropriate senior officer(s),

guided by the national framework and with support from HR and Governance. The Business Manager for REMCO will formally note the minutes and any actions in accordance with section 11 of these terms of reference.

4. Membership

The core Membership of the Remuneration and Workforce Committee shall be:

- Four ~~Three~~ Non-Executive Lay Members*
- Secondary Care Doctor
- CCG Chair (Non-voting)
- Governing Body ~~GP~~ Clinical Representative

*The Chair of Remuneration Committee cannot be either the CCG Chair or the Audit Chair.

Agenda and minutes will be shared with all Non-Executive Lay Members to enable them to offer comment and consideration, ahead of the committee meeting, to support the Chair and the core Members of the Committee in their decision making.

The Accountable Officer will be invited to meetings, where their remuneration is not being discussed, but will not be a voting member.

The Associate Director of Human Resources and Board Secretary will be in attendance in an advisory role to support the Remuneration and Workforce Committee in its work, but do not form part of the Membership. On occasions when they cannot attend, the Director of Communications and Human Resources may attend in their place.

Additionally, other individuals may be invited to attend for all or part of the meeting, providing their own remuneration or terms of service are not being discussed.

In addition, external advisors can be called upon as required by the Chair of the Committee.

The Chair may request any external advisors clinical or senior officer to attend should their presence be required to assist the Members of the Committee. Any such invited attendees will be asked to verbally declare any interests to ensure no conflict of interest exists upon their attendance.

5. Quorum

5.1 A minimum of three Non-Executive Lay Members and a Clinical Representative will constitute a quorum.

5.2 A decision put to a vote at the meeting shall be determined by a majority of the votes of Members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

5.3 People invited to attend the Committee do not have the right to vote.

5.4 If the Chair is absent then the Members of the Committee will select a chair for that meeting from the Non –Executive Lay Members present, this cannot be the CCGs Audit Chair or CCG Chair, this will be overseen by governance to ensure that no conflicts of interest arise, and that the committee remains quorate.

6. Register of Interests

6.1 Members and attendees will be asked by the Chair of the Remuneration and Workforce Committee to declare any interests at the beginning of each meeting. If a Member or attendee feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

7. Frequency of Meetings

7.1 The Remuneration and Workforce Committee will meet at least once a year to discharge its duties with extraordinary meetings held as required and in line with the corporate calendar.

7.2 The Remuneration and Workforce Committee has agreed that in the interest of expediency or when there are few items to be discussed that business of the committee can be conducted by e-mail and the actions/decision will be recorded by the Administrator for purposes of transparency and recording. Where a discussion is required, all Members must respond, and the administrator will oversee this to ensure that all Members are accounted for.

8. Reporting Arrangements

8.1 The Remuneration and Workforce Committee Chair shall report formally to the Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the confidential meeting of 'the Governing Body. The Remuneration and Workforce Committee shall make recommendations to the Governing Body on any area within its remit where action or improvement is needed.

8.2 Minutes and reports of the meetings will be confidential. The committee minutes may be shared with voting Members of the Governing Body, the senior officer of governance and the Associate Director of HR & OD, for NHS Devon CCG.

8.3 Extracts from minutes will be made public as appropriate.

9. Risk Reporting

9.1 Where timeliness is of the essence in managing a significant risk or issue, the Chair of the Remuneration and Workforce Committee will be informed of

an issue by the quickest possible means (e.g. verbally) and this will be acted upon in accordance with the CCGs risk management framework.

10. Statutory Functions, Committee Oversight and KPIs (Internal Monitoring)

10.1 The Remuneration and Workforce Committee shall act in accordance with the scheme of reservation and delegation to ensure Constitutional compliance. Any deviation from this must be brought to the attention of the most senior officer of Governance.

11. Administration

11.1 The Committee will be formally minuted by a designated administrator. Agendas and papers will be available ~~three~~ five working days before the meeting is scheduled to take place. A formal attendance and action and decisions log will be held and reported to each meeting.

12. Review

12.1 An annual effectiveness review will be undertaken by the Head of Governance as good governance practice and to ensure compliance with the Annual Governance Statement of internal control.

12.2 These Terms of Reference will be reviewed on an annual basis or sooner if required with recommendations made to the Governing Body for approval by the Chair of the Remuneration and Workforce Committee.

END

NHS Devon Clinical Commissioning Group
Primary Care Commissioning Committee
Terms of Reference

1. Constitutional Obligations

1.1 The Clinical Commissioning Group's Governing Body hereby resolve to establish a Committee of the Governing Body known as Primary Care Commissioning Committee.

1.2 These terms of reference set out the Membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's Constitution and standing orders.

2. Introduction

2.1 Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 1 to these Terms of Reference to NHS Devon CCG.

2.3 The CCG has established the NHS Devon CCG Primary CareCommissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

3. Statutory Framework

3.1 NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

3.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

3.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2)

3.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act.

3.5 The Committee is established as a committee of the Governing Body of each named CCG in accordance with Schedule 1A of the "NHS Act".

3.6 The Members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

4. Role of the Committee

4.1 The Committee has been established in accordance with the above statutory provisions to enable the Members to make decisions on the review, planning and procurement of primary care services in Devon, under delegated authority from NHS England.

4.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Devon CCG, which will sit alongside the delegation and terms of reference.

4.3 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

4.4 The specific obligations of the CCG with respect to the delegated functions are set out in section 6 and schedule 2 of the Delegation Agreement and include:

1) Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contract including:

a) the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach / remedial notices, and removing a contract);
b) Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
c) Local incentive schemes as an alternative to the national Quality Outcomes Framework (QOF) (including the design of such schemes);
d) 'Discretionary' payments (e.g., returner/retainer schemes);
e) Commissioning urgent care for out of area registered patients.

2) Planning the primary medical services provider landscape in Devon, including considering and taking decisions in relation to:

a) The establishment of new GP practices (including branch surgeries) in the area, and the closure of GP Practices;
b) Approving practice mergers;
c) Managing GP practices providing inadequate standards of patient care;
d) The procurement of new Primary Medical Services Contracts;
e) Dispersing the lists of GP practices;
f) Agreeing variations to the boundaries of GP practices; and
g) Co-ordinating and carrying out the process of list cleansing in relation to GP practices.

3) Decisions in relation to the management of poorly performing GP Practices including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

4) Decisions in relation to the Premises Costs Directions Functions.

4.5 The CCG will also carry out the following activities:

- To plan, including needs assessment, primary care services in Devon;
- To undertake reviews of primary care services in Devon;
- To co-ordinate a common approach to the commissioning of primary care services generally;
- To manage the budget for commissioning of primary care services in Devon.

4.6 The Primary Care Operational Group will review operational contractual issues impacting on primary care delivery working within approved frameworks and decision-making authority from the Primary Care Commissioning Committee.

5. Geographical Coverage

5.1 The Committee will comprise the NHS Devon CCG area.

6. Membership

6.1 The Membership of the Committee shall be:

The Committee shall consist of the following voting members:
Non-Executive Lay Member with responsibility for Primary Care
Non-Executive Lay Member with responsibility for Patient Care
Non-Executive Lay Member with responsibility for Allied Health Professionals
Independent Secondary Care Consultant (Non-Executive Role)
Chief Finance Officer/Director of Finance
Executive Director with responsibility for Primary Care
Associate Director with responsibility for Primary Care
Chief Nursing Officer (covering nursing and quality assurance)
Director of Public Health (also representing the Health and Wellbeing Boards) –

one nominated rep on behalf of all three local authorities The Chair of the Committee shall be the Non-Executive Lay Member with responsibility for Primary Care. The Vice Chair of the Committee shall be the Non-Executive Lay Member with responsibility for Patient Care. **Non-voting Membership will be:** 2 Governing Body GP representatives Strategic Clinical Advisor for Primary Care LMC Advisor CCG Chair (open invitation to attend) CCG Audit Chair (open invitation to attend) CCG Quality Assurance Committee Chair (open invitation to attend) Lay member for Patient and Public Involvement Healthwatch representative (Devon area) Deputy Director of Primary Care CCG Contracting representative CCG Communications representative
The Chair of the Committee may co-opt any non-voting Clinicians, Executive or Associate Directors, nominated deputies and lead managers as appropriate and particularly, when the Committee is discussing areas of risk or operation that are the responsibility of that attendee.
Note: When a Committee Member is unable to attend, a nominated formal deputy with sufficient authority must attend in their place. Deputies will have the decision making and voting rights of the person he/she is representing.

NB: HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

6.2 The CCG will notify NHS England of all primary care commissioning committee meetings at least seven (7) days in advance of such meetings and NHS England will be entitled to attend such meetings at its discretion.

7. Meetings and Voting

7.1 The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each Member representative no later than 3 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

7.2 Each voting Member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of Members present but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

8. Quorum

8.1 The committee is quorate when at least four voting Members are present

8.2 If a committee Chair and Vice Chair are absent, then the Members of the Committee will select a Chair for that meeting from the Members present – this will be agreed in advance by the residing Chair and Director responsible for corporate governance.

8.3 Where agreed with the Chair, Members of the Committee may participate in meetings by telephone, by the use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting using these methods shall be deemed to constitute presence in person at the meeting.

8.4 Anyone deputising for a voting Member will have the voting Members right to vote.

8.5 Invited Members, or those in attendance to the Committee do not have the right to vote

9. Meetings

9.1 The Committee will meet as required to conduct its business, and will meet, normally monthly, in line with the corporate calendar.

9.2 The Committee has agreed that in the interest of expediency or when there are few items to be discussed that business of the Committee can be conducted by e-mail and the actions/decision will be recorded by the Secretary for purposes of transparency and recording. Where a discussion is required, all Members must respond, and the administrator will oversee this to ensure that all Members are accounted for.

9.3 Meetings of the Committee shall:

a) be held in public, subject to the application of 23(b);
b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

9.4 Members and attendees will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a Member or attendee feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

9.5 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

9.6 The Committee may delegate tasks to such individuals, sub-committees or individual Members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation,

are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

9.7 The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

9.8 Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution and Governance Handbook.

9.9 The Committee will present its minutes to NHS England and the Governing Body of NHS Devon CCG each month for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

9.10 The CCG will also comply with any reporting requirements set out in its Constitution.

9.11 These Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

10. Accountability of the Committee

10.1 For the avoidance of doubt, in the event of any conflict between the terms of the Delegation and Terms of Reference and the Standing Orders or Standing Financial Instructions of any of the Members, the Delegation will prevail.

11. Procurement of Agreed Services

11.1 The CCG will make procurement decisions as relevant to the exercise of its delegated authority and in accordance with the detailed arrangements regarding procurement set out in the delegation agreement. In doing so the CCG will comply with public procurement regulations and with statutory guidance on conflicts of interest.

12. Decisions

12.1 The Committee will make decisions within the bounds of its remit.

12.2 The decisions of the Committee shall be binding on NHS England and NHS Devon CCG.

13. Administration

13.1 The Committee and its sub group shall be supported administratively by its Administrator his or her duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the Chair to prepare reports to the Governing Body
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair
- Maintaining records of Members appointments
- Ensuring that action points are taken forward between meetings
- Providing appropriate support to the Chairperson and Committee Members

14. Review

An annual effectiveness review will be undertaken by the Head of Governance as good governance practice and to ensure compliance with the Annual Governance Statement.

These Terms of Reference will be reviewed on an annual basis or sooner if required through the Head of Governance with recommendations made to the CCG's Governing Body for approval.

END

Appendix 3: Standing Orders

1. STATUTORY FRAMEWORK AND STATUS

1.1 Introduction

1.1.1 These Standing Orders have been drawn up to regulate the proceedings of the NHS Devon Clinical Commissioning Group so that the CCG can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the CCG is established.

1.1.2 The Standing Orders, together with the CCG's Scheme of Reservation and Delegation[52] and the CCG's Prime Financial Policies/SFIs[53], provide a procedural framework within which the CCG discharges its business. They set out:

a) The arrangements for conducting the business of the CCG;

b) The appointment of Member practice representatives;

c) The procedure to be followed at meetings of the CCG, the Governing Body and any Committees or sub-committees of the CCG or the Governing Body;

d) The process to delegate powers; and

e) The declaration of interests and standards of business conduct.

1.1.3 These arrangements must comply and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate[54] of any relevant guidance.

1.1.4 The Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs have effect as if incorporated into the CCG's Constitution. CCG Members, employees, Members of the Governing Body, Members of the Governing Body's Committees and sub-committees, Members of the CCG's Committees and sub-committees and persons working on behalf of the CCG should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs may be regarded as a disciplinary matter that could result in dismissal.

1.2 Schedule of matters reserved to the Clinical Commissioning Group and the Scheme of Reservation and Delegation

1.2.1 The 2006 Act (as amended by the 2012 Act) provides the CCG with powers to delegate the CCG's functions and those of the Governing Body to certain bodies (such as Committees) and certain persons. The CCG has decided that certain decisions may only be exercised by the CCG in formal session. These decisions

52 See CCG Governance Handbook

53 See Appendix 4 entitled Standing Financial Instructions

54 Under some legislative provisions the Group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.

and also those delegated are contained in the CCG's Scheme of Reservation and Delegation which is held in the CCGs Governance Handbook and can be obtained by the relevant contacts outlined in Section 1.3.3 of this Constitution.

2. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESS

2.1 Composition of Membership

2.1.1 Section 3 of the CCG's Constitution provides details of the Membership of the CCG and the Member practice role.

2.1.2 Section 5 of the CCG's Constitution provides details of the governing structure used in the CCG's decision-making processes as well as outlining certain key roles and responsibilities within the CCG and its Governing Body.

2.2 Key Roles

2.2.1 These Standing Orders set out how the CCG will appoint the voting individuals of the Governing Body.

2.2.2 Section 5.4 of the CCG's Constitution sets out the key role of the Governing Body whilst section 5.5 outlines the composition of the CCG's Governing Body. These Standing Orders set out how the CCG appoints individuals to these key roles and are further supported by a standard operating procedure held by our HR Department and published here www.DevonCCG.nhs.uk

All Governing Body individuals are to be appointed in accordance with the 'Clinical Commissioning Group Governing Body Members: Role outlines, attributes and skills' October 2012 https://www.england.nhs.uk/wp-content/uploads/2012/09/ccg-Members-roles.pdf

2.3 Nomination, Eligibility, Appointment, Re-appointments and Terms of Reference

2.3.1 People who are ineligible for nomination to any of the Governing Body roles include anyone who is:

- MPs, MEPs, Members of the London Assembly, and local councillors (and their equivalents in Scotland and Northern Ireland);
- Members including shareholders of, or partners in, or employees of commissioning support organisations;
- A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

  a) in the United Kingdom of any offence,

  b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence

in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine;

- a person subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986(33), sections 56A to 56K of the Bankruptcy (Scotland) Act 1985(34) or Schedule 2A to the Insolvency (Northern Ireland) Order 1989(35) (which relate to bankruptcy restrictions orders and undertakings);
- a person who within the period of five years immediately preceding the date of the proposed appointment has been dismissed (other than because of redundancy), from paid employment by any of the following: the Board, a CCG, SHA, PCT, NHS Trust or Foundation Trust, a Special Health Authority, a Local Health Board, a Health Board, or Special Health Board, a Scottish NHS Trust, a Health and Social Services Board, the Care Quality Commission, the Health Protection Agency, Monitor, the Wales Centre for Health, the Common Services Agency for the Scottish Health Service, Healthcare Improvement Scotland, the Scottish Dental Practice Board, the Northern Ireland Central Services Agency for the Health and Social Services, a Regional Health and Social Care Board, the Regional Agency for Public Health and Wellbeing, the Regional Business Services Organisation, Health and Social Care Trusts, Special health and social care agencies, the Patient and Client Council, and the Health and Social Care Regulation and Quality Improvement Authority;
- A healthcare professional who has been subject to an investigation or proceedings, by any regulatory body, in connection with the person‘s fitness to practise or any alleged fraud, the final outcome of which was suspension or erasure from the register (where this still stands), or a decision by the regulatory body which had the effect of preventing the person from practising the profession in question or imposing conditions, where these have not been superseded or lifted;
- a person disqualified from being a company director; and
- a person who has been removed from the office of charity trustee, or removed or suspended from the control or management of a charity, on the grounds of misconduct or mismanagement.

2.3.2 In addition, the key roles are subject to the following appointment process and further eligibility requirements:

2.3.3 The **Member Practice Representative**, as listed in Section 3 of the CCG’s Constitution, is subject to the following appointment process by each Member practice:

Nominations – Nomination by individual Member practice;

a) **Eligibility –** An individual appointed by a practice (who is a Member of NHS Devon CCG) to act on its behalf in the dealings between it and the Group, under regulations made under section 89 or 94 of the 2006

Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the

2006 Act (as inserted by section 49 of the 2012 Act);

b) **Appointment process –** Internal process for each Member Practice;

c) **Term of office –** As defined by the practice;

d) **Eligibility for reappointment –** As defined by the practice;

e) **Grounds for removal from office –** In the event that any of the provisions within section 2.3.1 arise.

f) **Notice period –** As defined by the practice.

2.3.4 **Locality Clinical Representatives**, as listed in Section 5.5.3 of the CCG's Constitution, these individual's representation is to influence strategy and policy of the CCG and is subject to the following appointment process:

a) **Nominations –** As per LMC nomination or independently run process;

b) **Eligibility –**

i. all GPs on the Performers' list, declaring themselves to be working in the geography of the CCG; or

ii. Members of a profession regulated by a body mentioned in section25(3) of the National Health Service Reform and Health Care Professions Act 2002, working within a Member practice, who are signatories to a primary medical services contract (GMS, PMS or APMS) under which services are provided in the geographic area of the CCG.

c) **Appointment/Election process –** As per LMC or independent appointment/election process and CCG recruitment Standard Operating Procedure for Governing Body Members;

d) **Term of office –** As defined in the Standard Operating Procedure held outside of this Constitution but available on the CCG website;

e) **Eligibility for reappointment –** As defined in the Standard Operating Procedure;

f) **Grounds for removal from office –** In the event that any of the provisions within section 2.3.1 arise, grounds of removal will be assessed in line with the CCG human resource policies held on the CCGs website; and

g) **Notice period –** As defined in the contract of employment.

2.3.5 The **Chair**, as listed in Section 5 of the CCG's Constitution, is subject to the following appointment process:

a) **Nomination and election –** The CCG, will appoint a Chair. The Chair

will be a Member of the Governing Body and of any committee of the Governing Body as outlined in the CCG Governance Handbook.

b) **Eligibility –** Providers of primary medical services (on the Devon performers list as defined by NHS England, and may be a salaried GP) to a registered list of patients, the majority of whom reside in the CCG's area, under a General Medical Services,

Personal Medical Services or Alternative Provider Medical Services contract in Devon. The Accountable Officer of the CCG is disqualified from being the Chair;

c) **Appointment process –** The CCG will make the appointment in accordance with the standard operating procedure for election/re-election of the chair of the CCG which is held outside of this Constitution but is available on the CCG website.

d) **Term of office –** Up to three years, with an option to be re-elected for a further three years. As defined in the contract of employment;

e) **Eligibility for reappointment –** The Chair is eligible for reappointment, subject to satisfaction of the eligibility criteria listed at 2.3.1;

f) **Grounds for removal from office –** Gross misconduct; losing clinical registration, where applicable; the Governing Body determines that the Membership has lost the confidence in him/her (where 1/3 of Member practices ask for a vote of Member practices and there is a majority vote of no-confidence); where a pecuniary interest constitutes a conflict of such significance to warrant removal from office, failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs. Failure to deliver a material proportion of the Local Delivery Plan or equivalent, as expressed in organisational and personal performance objectives, and/or a failure to act in a manner consistent with and as outlined in the 'Code of Conduct for NHS Managers' and other key guidance and codes. In the event that any of the provisions within section 2.3.1 arise, or in line with the CCG human resource policies; and

g) **Notice period** – Three months from employee, in writing to the Accountable Officer and to the Governing Body. The CCG will provide notice in line with contract.

2.3.6 The **Vice Chair**, as listed in Section 5 of the CCG's Constitution, is subject to the following appointment process and further details outlined in the standard operating procedure held by HR:

a) **Nominations –** The candidate will be locally appointed and will be a Member of the Governing Body;

b) **Eligibility –** If the Chair of the Governing Body is a health care

professional within the meaning of section 14N of the 2006 Act, all Members of the Governing Body other than Lay persons are disqualified from being Vice Chair.

c) **Appointment process –** Governing Body election process as outlined in the CCGs standard operating procedure held outside of this Constitution but available on the CCG website.

d) **Term of office –** Up to three years;

e) **Eligibility for reappointment –** The Vice Chair is eligible for reappointment, subject to satisfaction of the eligibility criteria listed at 2.3.1 and Governing Body re-election;

f) **Grounds for removal from office –** Gross misconduct; where a pecuniary interest constitutes a conflict of such significance to warrant removal from office; failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs. Failure to deliver a material proportion of the Local Delivery Plan or equivalent, as expressed in organisational and personal performance objectives, and/or a failure to act in a manner consistent with and as outlined in the 'Code of Conduct for NHS Managers' and other key guidance and codes. In the event that any of the provisions within section 2.3.1 arise, or in line with the CCG human resource policies; and

g) **Notice period** - Three months from employee, in writing to the Chair of the Governing Body. The CCG will provide notice in line with contract.

2.3.7 The Accountable Officer, as listed in Section 5 the CCG's Constitution, is subject to the following appointment process:

a) **Nominations** – The appointment will be subject to local and national NHS recruitment and selection policy. The candidate must be approved by NHS England. The Accountable Officer will be a Member of the Governing Body and of any Committee of the Governing Body outlined in the Governance Handbook, which is held outside of this Constitution;

b) **Eligibility** –

i. The appointment is subject to national NHS recruitment and selection policy. The candidate must be nationally approved by the CCGs Regulator NHS England.

ii. Will be a Member of the Governing Body and they will therefore need to meet the core requirements as described for Governing Body Members;

iii. The Accountable Officer may not be the Chair of the Governing Body.

c) **Appointment process** – The appointment is subject to national NHS recruitment and selection policy. The candidate must be approved by the CCGs Regulator NHS England;

d) **Term of office** – As determined by the contract of employment;

e) **Eligibility for reappointment** - As determined by the contract of employment;

h) **Grounds for removal from office –** Gross misconduct; where a pecuniary interest constitutes a conflict of such significance to warrant removal from office; failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs. Failure to deliver a material proportion of the Local Delivery Plan or equivalent, as expressed in organisational and personal performance objectives, and/or a failure to act in a manner consistent with and as outlined in the 'Code of Conduct for NHS Managers' and other key guidance and codes. In the event that any of the provisions within section 2.3.1 arise, or in line with the CCG human resource policies; and

f) **Notice period** – Three months from employee, in writing to the Chair of the Governing Body. The CCG will provide notice in line with contract.

2.3.8 The Chief Finance Officer/Director of Finance, as listed in Section 5 of the CCG's Constitution, is subject to the following appointment process:

a) **Nominations** – The candidate will be locally appointed using national NHS recruitment and selection process. The Chief Finance Officer will be a Member of the Governing Body and of the CCG Executive Team;

b) **Eligibility** – The candidate must have a professional qualification in accountancy and the expertise or experience to lead the financial management of the organisation. If the Governing Body's Membership includes two or more individuals of that description, they must designate one of them as the Chief Finance Officer and the individual must be approved by NHS England;

c) **Appointment process** – The appointment will be subject to national NHS recruitment and selection process and CCG Standard Operating Procedure for Governing Body Members held outside of this Constitution;

d) **Term of office** – As determined by contract;

e) **Eligibility for reappointment** - Not applicable

f) **Grounds for removal from office** - Gross misconduct; where a pecuniary interest constitutes a conflict of such significance to warrant removal from office, failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs. Failure to deliver a material proportion of the Local Delivery Plan or equivalent, as expressed in organisational and personal performance objectives, and/or a failure to act in a manner consistent with and as outlined in the 'Code of Conduct for NHS Managers' and other key guidance and codes. In the event that any of the provisions within section 2.3.1 arise, or in line with the CCG human resource policies; and

g) **Notice period** – Three months from employee, in writing to the Chair of the Governing Body. The CCG will provide notice in line with contract.

2.3.9 The Registered Nurse /Chief Nursing Officer, as listed in Section 5 of the CCG's Constitution, is subject to the following appointment process:

a) **Nominations** –The candidate will be locally recruited using the CCG recruitment process. The Chief Nursing Officer will be a Member of the Governing Body and any committee of the Governing Body outlined in the governance handbook held outside of this Constitution;

b) **Eligibility** – Must be a registered Nurse. The nurse cannot be an employee or Member (including shareholder) of, or a partner in, a provider of primary medical services, or a provider with whom the CCG has made commissioning arrangements;

c) **Appointment process** – In line with CCG recruitment policy and CCG Standard Operating Procedure for Governing Body Members, held outside of this Constitution and available on the CCG website.

d) **Term of office** – As determined by the contract of employment;

e) **Eligibility for reappointment** – Not applicable;

i) **Grounds for removal from office –** Gross misconduct; where a pecuniary interest constitutes a conflict of such significance to warrant removal from office, failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs. Failure to deliver a material proportion of the Local Delivery Plan or equivalent, as expressed in organisational and personal performance objectives, and/or a failure to act in a manner consistent with and as outlined in the 'Code of Conduct for NHS Managers' and other key guidance and codes. In the event that any of the provisions within section 2.3.1 arise, or in line with the appropriate CCG policies; and

f) **Notice period** – Three months in writing to the Accountable Officer of the Governing Body. The CCG will provide notice in line with contract.

2.3.10 The Secondary Care Specialist, as listed in Section 5 of the CCG's Constitution, is subject to the following appointment process:

a) **Nominations** – The candidate will be locally recruited using the CCG recruitment process. The Secondary Care Specialist will be a Member of the Governing Body;

b) **Eligibility** – It is essential that the hospital doctor is an experienced specialist. The Regulations set out that the individual must be a medical practitioner who (or within the last 10 years) fulfils (or fulfilled) all the following

i) the individuals name is included in the Specialist Register kept by the General Medical Council under section 34D of the Medical Act

1983(c), or the individual is eligible to be included in that Register by virtue of the scheme referred to in subsection (2)(b) of that section;

ii) the individual holds a post as an NHS Consultant or in a medical specialty in the armed forces;

iii) the individuals name is not included in the General Practitioner Register kept by the General Medical Council under section 34C of the Medical Act 1983(d).

d) **Appointment process** – In line with CCG recruitment policy and CCG Standard Operating Procedure for Governing Body Members;

e) **Term of office** – 3 years

f) **Eligibility for reappointment** the office holder may be re-elected for one further term of three-years, with a maximum period of office of six years over two terms of 3 years;

g) **Grounds for removal from office –** Gross misconduct, where a pecuniary interest constitutes a conflict of such significance to warrant removal from office, failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs. In the event that any of the provisions within section 2.3.1 arise, or in line with the appropriate CCG policies; and

h) **Notice period** – Three months in writing to the Chair. The CCG will provide notice in line with contract.

2.3.11 The CCG has appointed six Non Executive Lay Members and two Associate Non Executive Lay members, but recognises the NHS England requirement that a minimum of three Lay Members must be appointed to the CCG Governing Body, as described in NHS Englannd's Managing Conflicts of Interest: revised statutory guidance for CCGs 2017, is subject to the following appointment process:

a) **Nominations** – These lay persons will be appointed by the Group to the Governing Body and will be subject to national NHS recruitment and selection policy. The candidate will be locally appointed as Office Holders. One lay person appointed to the Governing Body must have qualifications, expertise or experience to enable them to lead on finance and audit matters; and another who has knowledge about the CCG area enabling them to express an informed view about discharge of the CCG functions;

b) **Eligibility** – criteria as defined in person specification agreed by Governing Body;

c) **Appointment process** – In line with NHS recruitment and selection policy and appointment to the Governing Body in line with CCG Standard Operating Procedure for Governing Body Members;

d) **Term of office** – Up to three years;

e) **Eligibility for reappointment** - The Independent Lay Members are eligible for reappointment for one further term of office, subject to satisfaction of the eligibility criteria listed at 2.3.1;

f) **Grounds for removal from office –** Gross misconduct, where a pecuniary interest constitutes a conflict of such significance to warrant removal from office, failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs. In the event that any of the provisions within section 2.3.1 arise,

g) **Notice period** – Three months, in writing to the Chair of the Governing Body. The CCG will provide notice in line with contract.

2.3.12 Each Executive of the Governing Body, as listed in Section 5 of the CCG's Constitution, is subject to the following appointment process:

a) **Nominations** – The candidate will be locally appointed using national NHS recruitment and selection process. Each Executive will be a Member of the Governing Body and of the CCG Executive Team;

b) **Eligibility** – The candidate must have a professional management qualification or equivalent experience and the expertise or experience to lead and support the transformation, strategic direction and commissioning functions of the organisation. Each Executive must be approved by NHS England;

c) **Appointment process** – The appointment will be subject to national NHS recruitment and selection process and CCG Standard Operating Procedure for Governing Body Members held outside of this Constitution;

d) **Term of office** – As determined by contract;

e) **Eligibility for reappointment** - Not applicable

f) **Grounds for removal from office** - Gross misconduct; where a pecuniary interest constitutes a conflict of such significance to warrant removal from office, failure to comply with the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs. Failure to deliver a material proportion of the Local Delivery Plan or equivalent, as expressed in organisational and personal performance objectives, and/or a failure to act in a manner consistent with and as outlined in the 'Code of Conduct for NHS Managers' and other key guidance and codes. In the event that any of the provisions within section 2.3.1 arise, or in line with the CCG human resource policies; and

g) **Notice period** – Three months from employee, in writing to the Accountable Officer and Chair of the Governing Body. The CCG will provide notice in line with contract.

2.3.13 The roles and responsibilities of each of these key roles are set out in the CCG Governance Handbook.

3. MEETINGS OF THE GOVERNING BODY

3.1 Calling meetings

3.1.1 Ordinary meetings of the Governing Body shall be held at regular intervals, no less than six times a year, at such times and places as the CCG may determine. The Chair of the CCG may call a meeting at any time.

3.1.2 One-third or more Members of the Governing Body may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven working days of a requisition being presented, the Members signing the requisition may forthwith call a meeting.

3.1.3 Before each meeting of the Governing Body a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Governing Body's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)). This notice shall be approved by the Chair or by a CCG officer with authorisation from the Chair and the meeting shall be convened in line with the CCG corporate calendar.

3.2 Agenda, supporting papers and business to be transacted

3.2.1 Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Chair of the Governing Body at least 15 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least 8 working days before the meeting takes place. The agenda and supporting papers will be circulated to all Governing Body Members at least 5 working days before the date of the meeting, 4 working days in the case of agenda items for a non-public agenda. The only exceptions to this is where the Chair has specifically highlighted in writing, with clear rationale, to Governing Body Members that a paper may be late due to extraordinary circumstances.

3.2.2 A Governing Body Member or Member representative desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 15 working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 working days before a meeting may be included on the agenda at the discretion of the Chair.

3.2.3 Agendas and certain papers for the CCG's Governing Body– including details about meeting dates, times and venues - will be published on the CCG's website at www.DevonCCG.nhs.uk five working days before the meeting. Where there may be unexpected circumstances this will be no less than three working days as per the statutory guidance.

3.3 Petitions

3.3.1 Where a petition has been received by the CCG, the Chair of the Governing

Body shall include the petition as an item for the agenda of the next meeting of the Governing Body.

3.4 Chair of a meeting

3.4.1 At any meeting of the CCG or its Governing Body or of a Committee or sub-committee, the Chair of the CCG, Governing Body, Committee or sub-committee, if any and if present, shall preside. If the Chair is absent from the meeting, the Vice Chair, if any and if present, shall preside.

3.4.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If both the Chair and Vice Chair are absent, or are disqualified from participating, or there is neither a Chair or deputy, a Member of the CCG, Governing Body, committee or sub-committee respectively shall be chosen by the Members present, or by a majority of them, and shall preside.

3.5 Chair's ruling

3.5.1 The decision of the Chair of the Governing Body on questions of order, relevancy and regularity and their interpretation of the Constitution, Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies/SFIs at the meeting, shall be final.

3.6 Quorum

3.6.1 A meeting of the CCG Governing Body will be quorate when a minimum of nine Members are present. Of these nine Members there must be at least four clinical Members and two Lay Members present.

3.6.2 For all other of the group's Committees and sub-groups, including the Governing Body's Committees and sub-groups, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference (available on the organisations website), which may be revised at the discretion of the Governing Body

3.6.3 In exceptional circumstances and where agreed with the Chair, Members of the CCG Governing Body may participate in meeting by telephone, by the use of video conferencing facilities and / or webcam where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

3.6.4 A senior officer who has been **formally** appointed under authority of the Chair or NHS England, to act up for an appointed Member during a period of incapacity or temporarily to fill a vacancy shall be entitled to exercise the voting rights of the appointed Member and as such will count towards the quorum of the meeting.

3.6.5 If the Chair or other Member has been disqualified from the discussion on any matter, then that individual will no longer count towards the quorum. If the meeting is no longer quorate then the matter may not be further discussed / voted on within that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next item of business where

the meeting is quorate.

3.7 Decision making

3.7.1 Section 5 of the CCG's Constitution, together with the Scheme of Reservation and Delegation, sets out the governing structure for the exercise of the CCG's statutory functions. Generally it is expected that the CCG's / Governing Body's meetings decisions will be reached by consensus. Should this not be possible then a vote of Members will be required, the process for which is set out below:

a) **Eligibility** – each voting Member of the CCG Governing Body will have one vote only;

b) **Majority necessary to confirm a decision** – decisions will be made on the basis of simple majority voting;

c) **Casting vote** – In cases of equal voting, the Chair shall have a second and casting vote; and

d) **Dissenting views** – In the case of a dissenting view, the Member has the right to have that view recorded in the minutes of the Governing Body.

3.7.2 At the discretion of the Chair all questions put to a vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.7.3 If at least one-third of the Members present so request, the voting on any question may be recorded so as to show how each Member present voted or did not vote (except when conducted by paper ballot). If a Member so requests, their vote shall be recorded by name.

3.7.4 In no circumstances, other than those described in section 3.6.4 of these Standing Orders, may an absent Member vote by proxy. Absence is defined as being absent at the time of the vote.

3.7.5 Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

3.7.6 For all other of the CCG's Committees and sub-committees, including the Governing Body's committees and sub-committee, the details of the process for holding a vote are set out in the appropriate terms of reference and in the CCG Governance Handbook www.DevonCCG.nhs.uk

3.8 Emergency powers and urgent decisions

3.8.1 Where it is necessary for an urgent decision to be taken outside of the routine schedule of meetings for the Governing Body, it will be appropriate for the Chair and Accountable Officer to exercise the decision having first consulted with at least two Clinical Members and one Lay Member of the Governing Body. Such decisions are limited to the business that the Governing Body has reserved to itself. Any conflicts of interest must be considered before consultation.

3.8.2 Any such decision taken will be reported to the next formal public meeting of

the Governing Body for formal ratification. This will then be recorded in the minutes of the Governing Body.

3.9 Suspension of Standing Orders

3.9.1 Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these Standing Orders may be suspended at any meeting, provided at least two thirds of the Governing Body are present (including at least one Member who is an officer of the CCG and one who is not), and that of those present, at least two thirds of the Members are in agreement.

3.9.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

3.9.3 A separate record of matters discussed during the suspension of Standing Orders shall be kept. These records shall be made available to the Governing Body's Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

3.10 Record of Attendance

3.10.1 The names of all Members present at the meeting shall be recorded in the minutes of the CCG's meetings. The names of all Members of the Governing Body present shall be recorded in the minutes of the Governing Body meetings. The names of all Members of the Governing Body's committees / sub-committees present shall be recorded in the minutes of the respective Governing Body committee / sub-committee meetings.

3.11 Minutes

3.11.1 The Governing Body must keep minutes of all meetings of the CCG Governing Body and meetings of any committee or sub-committee of the CCG Governing Body carrying out powers or functions of the CCG Governing Body, including;

a) The names of the persons present at the meeting;
b) The decisions made at the meetings;
c) Where appropriate the reasons for the decisions; and
d) The name of the person responsible for taking the Minutes.
e) Recording any declarations of interest and making these visible in line with NHS England's Managing Conflicts of Interest: revised statutory guidance for CCGs 2017

3.11.2 Any such minutes agreed and signed off as a true record at the subsequent meeting of the Governing Body shall be sufficient evidence without further proof of the facts stated in such minutes.

3.11.3 Any public minutes shall be made available or copied on request to any Member or Member practice representative. In addition, public minutes will be made available on request to Members of the public and will also be published on the CCG's website.

3.11.4 The Governing Body must also maintain a Register of Interests of Governing

Body Members, clinical lead representatives and staff.

3.12 Admission of public and the press

3.12.1 Subject to Standing Order 3.12.2 below, meetings of the Governing Body shall be open to the public, this includes the Annual General Meeting. The meetings of the CCG held in public are to ensure transparency of decision making and the manner in which decisions have been made.

3.12.2 The Governing Body may, by resolution, exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) where publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

3.12.3 In the event the public could be excluded from a meeting of the Governing Body pursuant to Standing Order 3.12.2 above, the group shall consider whether the subject matter of the meeting would in any event be subject to disclosure under the Freedom of Information Act or any such similar Act(s) or directive(s), and if so, whether the public should be excluded in such circumstances.

3.12.4 The Chair (or Vice Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Governing Body's business shall be conducted without interruption and disruption.

3.12.5 Without prejudice to the power to exclude the public pursuant to Standing Order 3.12.2 above the Governing Body may resolve (as permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) to exclude the public from a meeting (whether during whole or part of the proceedings) to suppress or prevent disorderly conduct or behaviour.

3.12.6 Matters to be dealt with by the Governing Body following the exclusion of representatives of the press, and other Members of the public shall be confidential to the Members of the Governing Body.

3.12.7 Members and officers or any employee of the Governing Body in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Governing Body, without the express permission of the Governing Body. This prohibition shall apply equally to the content of any discussion during the Governing Body meeting which may take place on such reports or papers.

3.12.8 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the CCG or Committee thereof. Such permission shall be granted only upon resolution of the CCG.

4. COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees and Sub-Committees

4.1.1 The CCG may appoint Committees and sub-committees of the CCG, subject to any regulations made by the Secretary of State, and make provision for the appointment of Committees and sub-committees of its Governing Body. Where such Committees of the Governing Body, are appointed they are included in Section 5 of the CCG's Constitution.

4.1.2 Other than where there are statutory requirements, such as in relation to the Audit Committee, Remuneration and Workforce Committee or Primary Care Commissioning Committee, the Governing Body shall determine the Membership and terms of reference of Committees, and shall, if it requires, receive and consider reports of such Committees at the next appropriate meeting of the Governing Body.

4.2 Terms of Reference

4.2.1 The provisions of these Standing Orders shall apply where relevant to the operation of the Governing Body, the Governing Body's Committees and sub-committee and all Committees and sub-committees unless stated otherwise in the Committee or sub-committee's terms of reference. The statutory terms of reference of a Committee of the Governing Body are held within this Constitution and all other Committees and sub groups are held outside of the Constitution and shall have effect as if incorporated into the Constitution, and are available on the organisation's website.

4.3 Delegation of Powers by Committees to Sub-committees

4.3.1 Where Committees are authorised to establish sub-committees/groups they may not delegate executive powers to the sub-committee/group unless expressly authorised by the CCG through approval from the Governing Body.

4.4 Approval of Committees and Sub-Committees

4.4.1 The Governing Body is able to establish its own Committees and terms of reference for each of these committees. Where a committee is established it must be formally approved and minuted at meetings held in public of the Governing Body. Details of these committees are held outside of the Constitution within the CCG Governance Handbook.

4.4.2 The Committees of the Governing Body are authorised to establish working groups with the approval of the Governing Body to assist them in discharging their respective duties. These working groups will be detailed in the CCG Governance Handbook. The Committees of the Governing Body will provide any detail and relevant reports to the Governing Body of the business of the working groups.

4.4.3 The CCG shall agree such travelling or other allowances as it considers

appropriate though relevant HR policy which are held outside of the Constitution.

4.5 Applicability of Standing Orders

4.5.1 The provisions of these Standing Orders shall apply where relevant to the operation of the Governing Body, the Governing Body's committees and sub-Committee and all Committees and sub-committees unless stated otherwise in the Committee or sub-committee's terms of reference.

5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

5.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Audit Committee for action or ratification. All Members of the CCG and staff have a duty to disclose any non-compliance with these Standing Orders to the Accountable Officer as soon as possible.

6. USE OF SEAL AND AUTHORISATION OF DOCUMENT

6.1 Clinical Commissioning Group's seal

6.1.1 The common seal of the CCG shall be kept by the Accountable Officer or by a nominated Manager in a secure place (with Governance).

6.1.2 Where it is necessary that a document shall be sealed, the seal shall be affixed in

6.1.3 The CCG may have a seal for executing documents where necessary. Subject to the approval limits set out in the Use of the seal standard operating procedure and Scheme of Delegation and financial limits, which is held in the CCG Governance Handbook and reviewed by the Chief Finance Officer no less than once a year. The following individuals or officers are authorised to authenticate its use by their signature:

a) the Accountable Officer;
b) the Chair of the Governing Body;
c) the Chief Finance Officer; and
d) any senior officer authorised by the Accountable Officer.

6.1.4 The use of the Common Seals include:

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

6.2 Execution of a document by signature, not requiring the seal

6.2.1 CCG employees are only authorised through their held officer role, by authority of the Accountable Officer or Governing Body to execute a document on behalf of the CCG in line with their delegated financial limits, as detailed in the Scheme of Reservation and Delegation and Financial Limits.

7. OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS / PROCEDURES AND REGULATIONS

7.1 Policy statements: general principles

7.1.1 The Governing Body (or committee of Governing Body, or senior officer, if delegated to do so) will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS Devon CCG. The decisions to approve such policies and procedures will be recorded in an appropriate CCG minutes and will be deemed where appropriate to be an integral part of the CCG's Standing Orders

Appendix 4: Standing Financial Instructions

1. INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (Prime Financial Policies) and supporting detailed financial policies shall have effect as if incorporated into the CCG's Constitution.

1.1.2 The Standing Financial Instructions are part of the CCG's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration; lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the Scheme of Reservation and Delegation which is held outside of the Constitution in the CCG Governance Handbook.

1.1.3 In support of these Standing Financial Instructions, the CCG has prepared more detailed policies, approved by the Chief Finance Officer which are available on the CCGs website www.DevonCCG.nhs.uk

1.1.4 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the CCG and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Audit Committee is responsible for approving all detailed financial policies.

1.1.5 A list of financial authority limits are available at the end of this Constitutional document under Section 21, and are also published and maintained on the CCG's website www.DevonCCG.nhs.uk

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance Officer must be sought before acting. The user of these instructions and associated policies should also be familiar with and comply with the provisions of the CCG's Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.1.7 Failure to comply with these instructions, Prime Financial Policies and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2 Overriding Standing Financial Instructions

1.2.1 If for any reason these Standing Financial Instructions or associated financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-

compliance shall be reported to the next formal meeting of the Governing Body's Audit Committee for referring action or ratification. All of the CCG's Members and employees have a duty to disclose any non-compliance with these instructions to the Chief Finance Officer as soon as possible.

1.3 Responsibilities and delegation

1.3.1 The roles and responsibilities of CCG's Members, employees, Members of the Governing Body, Members of the Governing Body's committees and sub-committees/groups, Members of the CCG's Committee and sub-committee/groups (if any) and persons working on behalf of the CCG are set out in Section 5 of this Constitution.

1.3.2 The financial decisions delegated by Members of the CCG are set out in the CCG's Scheme of Reservation and Delegation (which is held outside of this Constitution in the CCG Governance Handbook).

1.4 Contractors and their employees

1.4.1 Any contractor or employee of a contractor who is empowered by the CCG to commit the CCG to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that such persons are made aware of this.

1.5 Amendment of Standing Financial Instructions

1.5.1 To ensure that these Standing Financial Instructions remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the Governing Body's Audit Committee, the Chief Finance Officer will recommend amendments, as fitting, to the Governing Body for approval.

2. INTERNAL CONTROL

POLICY – the CCG will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies

2.1 The Governing Body is required to establish an Audit Committee with terms of reference agreed by the Governing Body.

2.2 The Accountable Officer has overall responsibility for the CCG's systems of internal control.

2.3 The Chief Finance Officer will ensure that:

a) financial policies are considered for review and update annually;
b) a system is in place for proper checking and reporting of all breaches of financial policies; and
c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

POLICY – the CCG will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews

3.1 In line with the terms of reference for the Governing Body's Audit Committee, the person appointed by the CCG to be responsible for internal audit and appointed external auditor will have direct and unrestricted access to Audit Committee Members and the Chair of the Governing Body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2 The person appointed by the CCG to be responsible for internal audit and the external auditor will have access to the Audit Committee and the Accountable Officer to review audit issues as appropriate. All Audit Committee Members, the Chair of the Governing Body and the Accountable Officer will have direct and unrestricted access to the head of Internal Audit and external auditors.

3.3 The Chief Finance Officer will ensure that:

a) the CCG has a professional and technically competent internal audit function;
b) the Governing Body's Audit Committee approves any changes to the provision or delivery of assurance services to the CCG.

4. FRAUD AND CORRUPTION

POLICY – the CCG requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The CCG will not tolerate any fraud perpetrated against it and will actively chase any loss suffered

4.1 The Audit Committee will satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.2 The Audit Committee will ensure that the CCG has arrangements in place to work effectively with NHS Protect.

5. EXPENDITURE CONTROL

5.1 The CCG is required by statutory provisions[56] to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

5.2 The Accountable Officer has overall executive responsibility for ensuring that the CCG complies with certain of its statutory obligations, including its financial and accounting obligations and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.3 The Chief Finance Officer will:

a) provide reports in the form required by NHS England;
b) ensure money drawn from NHS England is required for approved expenditure only and is drawn down only at the time of need and follows best practice; and
c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the CCG to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. ALLOTMENTS[57]

6.1 The CCG's Chief Finance Officer will:

a) periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the CCG's entitlement to funds;
b) prior to the start of each financial year submit to the CCG Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and
c) regularly update the CCG Governing Body on significant changes to the initial allocation and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the CCG will produce and publish annual plan(s) for commissioning[58] that explains how it proposes to discharge its financial duties. The CCG will support this with comprehensive medium term financial plans and annual budgets

7.1.1 The Accountable Officer will compile and submit to the CCG Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.1.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the Governing Body.

7.1.3 The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body. This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

7.1.4 The Accountable Officer is responsible for ensuring that information relating to the CCG's accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.

7.1.5 The Governing Body will approve consultation arrangements for the CCG's commissioning plan[59].

[56] See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act
[57] See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
[58] See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.
[59] See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the CCG will produce and submit to NHS England accounts and reports in accordance with all statutory obligations[60], relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England

8.1.1 The Chief Finance Officer will ensure the CCG:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Audit Committee;
b) prepares the accounts according to the timetable approved by the Audit Committee;
c) complies with statutory requirements and relevant directions for the publication of Annual Report;
d) considers the external auditor's management letter and fully address all issues within agreed timescales; and
e) publishes the external auditor's management letter on the CCG's website www.DevonCCG.nhs.uk

9. INFORMATION TECHNOLOGY

POLICY – the CCG will ensure the accuracy and security of the CCG's computerised financial data

9.1 The Chief Finance Officer is responsible for the accuracy and security of the CCG's computerised financial data and shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the CCG's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for both the Data Protection Act 1998 and GDPR;
b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and
d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.

9.2 In addition the Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

60 See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act

10. ACCOUNTING SYSTEMS

POLICY – the CCG will run an accounting system that creates management and financial accounts

10.1 The Chief Finance Officer will ensure that:

a) the CCG has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England; and
b) contracts for computer services for financial applications with another health organisation or any other agency, shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

10.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

POLICY – the CCG will keep enough liquidity to meet its current commitments

11.1 The Chief Finance Officer will:

a) review the banking arrangements of the CCG at regular intervals to ensure they are in accordance with Secretary of State directions[61], best practice and represent best value for money;
b) manage the CCG's banking arrangements and advise the CCG on the provision of banking services and operation of accounts;
c) prepare detailed instructions on the operation of bank accounts.

11.2 The Audit Committee shall approve the banking arrangements.

12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

POLICY – the CCG will

- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the CCG or its functions[62]
- ensure its power to make grants and loans is used to discharge its functions effectively[63]

61 See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
62 See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.
63 See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.

12.1 The Chief Finance Officer is responsible for:

a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;
b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;
c) approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by statute. Independent professional advice on matters of valuation shall be taken as necessary; and
d) for developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

POLICY – the CCG:

- will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending
- will seek value for money for all goods and services
- shall ensure that competitive tenders are invited for
    - the supply of goods, materials and manufactured articles;
    - the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
    - for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals

13.1 The CCG shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the CCG's Audit Committee.

13.2 The Governing Body may only negotiate contracts on behalf of the CCG, and the CCG may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the CCG's Standing Orders;
b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and
c) take into account as appropriate any applicable NHS England or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

13.3 In all contracts entered into, the CCG shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the CCG.

14. COMMISSIONING

POLICY – working in partnership with relevant national and local stakeholders the CCG will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility

14.1 The CCG will coordinate its work with NHS England, other Clinical Commissioning Groups, local providers of services, local authorities, including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2 The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.

14.3 The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT AND INSURANCE

POLICY – the CCG will put arrangements in place for evaluation and management of its risks

15.1 The process of risk management within the CCG will be determined by the Risk Management framework Policy. Risks will be identified in line with CCG objectives. Mitigating controls, actions and associated assurances will be set out within an assurance framework. Directorate identified leads will be responsible for ensuring that risks are reviewed on a regular basis and that action plans are implemented and monitored

15.2 Each directorate will provide updates to the CCG Assurance Framework detailing their risks and mitigations. Risks will be scored using a 5 x 5 matrix with impact and likelihood scores being based on risk tolerances as described in the Risk Management Framework Policy

15.3 The Governing Body will review, no less than quarterly, high scoring risks using its 5x5 matrix and in addition, the Assurance Framework will be presented to the Audit Committee and relevant sub-committees of the Governing Body for the purpose of assurance and scrutiny throughout the year.

15.4 Management processes will ensure all significant risk and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk.

16. PAYROLL

POLICY – the CCG will put arrangements in place for an effective payroll service

16.1 The Chief Finance Officer will ensure that the payroll service selected:

a) is supported by appropriate (i.e. contracted) terms and conditions;
b) has adequate internal controls and audit review processes; and
c)has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2 In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll.

17. NON-PAY EXPENDITURE

POLICY – the CCG will seek to obtain the best value for money goods and services received

17.1 The Audit Committee will recommend the level of non-pay expenditure on an annual basis to the Governing Body for approval, and the Accountable Officer will determine the level of delegation to budget managers.

17.2 The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3 The Chief Finance Officer will:

a) advise the Audit committee on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained;
b) and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation;
c) be responsible for the prompt payment of all properly authorised accounts and claims;
d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

POLICY – the CCG will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the CCG's fixed assets

18.1 The Accountable Officer will:

a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;
b) be responsible for the management of all stages of capital

schemes and for ensuring that schemes are delivered on time and to cost;
c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges; and
d) be responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2 The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

19. RETENTION OF RECORDS

POLICY – the CCG will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance

19.1 The Accountable Officer shall:

a) be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance;
b) ensure that arrangements are in place for effective responses to Freedom of Information requests; and
c) publish and maintain a Freedom of Information Publication Scheme.

20. TRUST FUNDS AND TRUSTEES

POLICY – the CCG will put arrangements in place to provide for the appointment of trustees if the CCG holds property on trust

20.1 The Chief Finance Officer shall ensure that each trust fund which the CCG is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

21. Financial limits

Ref	Matters delegated	Delegated to
1	**Bank accounts** (a) Opening bank accounts or procuring banking services in accordance with mandates approved by the Governing Body (b) Addition or removal of signatories to bank accounts	(a) DOF (b) DOF or authorised signatory to the bank accounts (in accordance with the bank account mandated authorities)
2	**Business cases – new commitments outside of delegated budgets** (a) up to £250.000 (b) up to £500,000 (c) £500,001 and above	(a) Executive team Member and Associate Director of Finance (b) Executive team (c) Full business case for Governing Body approval
3	**Commissioning expenditure in line with delegated budgets for the commissioning of services** (a) up to £250,000 (b) up to £500,000 (c) £500,001 and above	(a) Delegated budget holder (b) Executive team Member or Associate Director of Finance (c) DOF or AO or DOC
4	**Administrative Spend on Goods and Services (Non Commissioning Spend) – Limits for Requisition and/or Invoice approval of delegated budget** (a) up to £500 (b) up to £15,000 (c) up to £50,000 (d) up to £250,000 (e) from £250,001	(a) Designated personal assistants (b) Designated business manager (c) Delegated budget holder (d) Executive team Member (e) Executive team
5	**Capital schemes including finance leases** (a) up to £250,000 (b) from £250,001	(a) DOF (b) Governing Body

6	**All Legal Costs**	Approval through legal advice request form administered by the governance team
7	**Condemning and disposal** (a) Condemning or disposal of unserviceable items (other than IT equipment) with an estimated replacement cost: (i) up to £100 (ii) £101 to £5,000 (iii) £5,001 and above (b) Condemning or disposal of all unserviceable IT equipment	 (a)(i) Designated budget holder (a)(ii) ADOF (a)(iii) DOF (b) Executive team Member responsible for IT
8	**Petty Cash** Petty cash float replenishment up to £500 per week	 ADOF
9	**Losses, write-offs and compensation** (a) Losses of cash due to theft, fraud, overpayment etc. – up to £50,000 (b) Fruitless payments (including abandoned capital schemes) – up to £250,000 (c) Write-off or bad debts up to £10,000 (d) Claims abandoned and other – up to £50,000 (e) Damage to buildings, fittings, furniture and equipment, loss of property and equipment in stores or in use due to culpable causes (fraud, theft, arson etc.) – up to £50,000	(a) to (e) DOF or AO
9	(f) Compensation payments made under legal obligation (excluding clinical negligence) – up to £50,000 (g) Extra contractual payments to contractors – up to £50,000 (h) Ex-gratia payments to staff for loss of personal effects: (i) up to £100 (ii) £101-£500 (iii) above £501 (i) Ex gratia payments for personal injury claims involving negligence where legal advice obtained and followed	(f) to (g) DOF or AO (h)(i) Designated budget holder (h)(ii) Executive team Member (h)(iii) DOF or AO (i) DOF or AO

	(j) Other ex gratia payments except cases of maladministration where there was no financial loss to the claimant (k) Any of the above (a) – (j) limits exceeded	(j) DOF or AO (k) Governing Body
10	**Verification and High Cost Panel Decisions regarding individual packages of care** (a) Up to £1,000 per week (b) Up to £1,300 per week (c) From £1,301 to £1600 per week (d) From £1,601 to £5,000 per week (e) Above £5,001 per week **Urgent placements:** Crisis Response Requests (48hr period) until information gathered – (b) above with update and review by (c) and full panel application if required.	(a) Quality Assurance Practitioner/ CHC lead Nurse (b) Quality Assurance Lead Nurse or Senior Commissioning Manager (c) Associate Director of Quality Assurance and Nursing (CHC)/ Deputy Head of CHC and Nursing or in their absence 2 QA leads with IPOC Panel ratification at next panel (d) Individual Package of Care (IPOC) Panel (e) CNO and DFO or CO or COO or Director of Commissioning

Glossary
DOF – Director of Finance
ADOF – Associate Director of Finance
AO – Accountable Officer
DOC – Director of Commissioning
CNO – Chief Nursing Officer
QA – Quality assurance

END

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Remuneration and Strategic Workforce Committee

Date of Governing Body: 30 July 2020

Dates of Committees covered in this report: 8 July 2020

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

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- HR Update including coronavirus response, Gender Pay Gap and Equality, Diversity and Inclusion
- Re-charging of STP posts hosted by the CCG
- Independent Chair, Devon STP
- ICS Chief Executive and AO of the CCG
- Remuneration and Strategic Workforce Effectiveness Report

Reports received and noted

- The Remuneration and Strategic Workforce Committee **noted** the contents of the "Staff Response during COVID19" section of the report and **thanked all staff** for their flexibility and especially the AO and executive directors for their contribution and leadership during the pandemic.
- The Remuneration and Strategic Workforce Committee **noted** the process for the recharging of STP costs.
- Strategic and Remuneration Workforce Committee Effectiveness Report
    - **Acknowledged** the encouragement to participate fully in future Effectiveness Surveys to build a better picture of the Committee members' views and concerns
    - **Noted** that a review of the forward planner will be undertaken to ensure timeliness of papers and Executives encourage staff to prepare papers in a timely manner
    - **Noted** that a review of draft papers should be undertaken to ensure that they are appropriate and of a good standard and quality to inform the Remuneration and Strategic Workforce Committee
- **Independent Chair of Devon STP**
    - **Noted** the extension of Dame Suzi Leather in the role of Independent Chair of the Devon STP running to 31st July 2021, approved by Governing Body on 27th February 2020.
    - Supported the continuation of 15 hours per week until the current contract end date of 31st July 2021.

Risk Register Review Updates

- **N/A**

Committee Decisions

- Minutes of the meeting held 17 March were **reviewed** and **approved** as a true and accurate record of the meeting
- The action log was **reviewed**, and it was
  - **agreed** for formal closure of action 1
  - It was **agreed** for formal closure action 2
  - It was **agreed** for formal closure of action 3

Items of concern to be escalated to the Governing Body

- **None**

Recommendations for Governing Body

At the meeting held on 08 July the Remuneration and Strategic Workforce Committee received a paper that set out the recommendations in regards to the nature of the **Devon ICS Lead Role** and next steps required for the permanent appointment of this role including the design of the role and the appointment process and is detailed in appendix1.

Following discussion, the Remuneration and Strategic Workforce Committee recommended that the Governing Body:

- **support and approve** the combination roles of ICS Lead with the Accountable Officer of the CCG
- **support and approve** the establishment of a system coordination group to oversee the development of the ICS Chief Executive role (incorporating the CCG AO) job description, person specification and appointment process
- **support and approve** on completion of the development of a robust appointment process, approval will be sought from the Remuneration and Strategic Workforce Committee and, thence, Governing Body ahead of advertisement launch.

Recommendations for other Committees

- **None**

Terms of Reference or other committee effectiveness issues

- **None**

Management of Conflict of interests:

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register.

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

NHS
Devon
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REMUNERATION AND STRATEGIC WORKFORCE COMMITEE

Report title: ICS Chief Executive and AO of the CCG role				
Date of committee: 8th July 2020 **Date report produced: 2nd July 2020**				
Author (s) Name and Title: • Samantha Tribble, HR Manager **Contact Details:** samanthatribble@nhs.net		**Supporting Executive Name and Title:** Paul Johnson, Clinical Chair NHS Devon CCG **Contact Details:** paul.johnson4@nhs.net **Report Approved by:** **Name and Title:** Paul Johnson, Clinical Chair NHS Devon CCG **Date: 02.07.2020**		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

ICS leaders will be at the heart of the NHS' transition towards system collaboration, with commissioner, providers, local government and wider sector partners working together to improve services. ICS leaders will be responsible for convening these systems, developing the governance required and make effective decisions, directing resource and – most importantly – driving rapid implementation of key service improvements.

The Devon ICS leader will be crucial to the development of the system and it is therefore important that the role is clearly defined, and the right person is appointed to the role on a substantive basis. A number of interim arrangements have enabled us to progress some areas but the Devon System is now looking for a permanent appointment to provide stability and long term leadership.

This paper sets out the recommendations in regards to the nature of the Devon ICS Lead role and next steps in the permanent appointment of this role including the design of the role and the appointment process for it.

Management of Conflict of interests:

Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided, and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the

Governance team
via **d-ccg.governance@nhs.net** to update the central register.

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

N/A

Key recommendations and actions requested:

- **Recommendation 1:** Combine the roles of ICS Lead with the Accountable Officer of the CCG
- **Recommendation 2:** Establish a system coordination group to oversee the development of the ICS Chief Executive role (incorporating the CCG Accountable officer) job description, person specification and appointment process.
- **Recommendation 3:** On completion of the development of a robust appointment process, approval will be sought from the Remuneration and Strategic Workforce Committee ahead of advertisement launch.

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

None

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

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

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

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ICS Chief Executive and Accountable Officer (AO) of the CCG role

1. Introduction

1.1. ICS leaders will be at the heart of the NHS' transition towards system collaboration, with commissioner, providers, local government and wider sector partners working together to improve services. ICS leaders will be responsible for convening these systems, developing the governance required and make effective decisions, directing resource and – most importantly – driving rapid implementation of key service improvements.

1.2. The Devon ICS leader will be crucial to the development of the system and it is therefore important that the role is clearly defined, and the right person is appointment to the role on a substantive basis. A number of interim arrangements have enabled us to progress some areas but the Devon System is now looking for a permanent appointment to provide stability and long term leadership.

1.3. This paper sets out the recommendations in regards to the nature of the Devon ICS Chief Executive (CE) role (incorporating the CCG AO role) and next steps in the permanent appointment of this role including the design of the role and the appointment process for it.

2. System Leadership – nature of the role

2.1. The regional NHSEI team have very clearly set out their intention around system leadership in Devon.

2.2. Given the level of challenge that we face, NHS England Improvement (NHSEI) consider that we need system leadership that brings long term stability, sufficient capacity and the necessary legislative authority to meet that challenge.

2.3. In order to do this, NHSEI state that the system lead must be:

- a substantive appointment;
- a full-time appointment;
- combined with the role of Accountable Officer (AO) of the CCG.

2.4. Four of the seven South West STPs have combined the role of STP Chief Executive (CE) and AO and 12 of the remaining 37 systems in England have combined roles. Only 8 systems in England have STP CE who is not also a leader of an organisation within the system.

2.5. The nature of substantive STP Leaders in England is as follows:

STP Leaders	Number
Independent Leader	8
CCG AO	16
Acute Provider CE	10
Community Provider	4
Local Authority CE	1

3. Benefits

Benefits to the system

3.1. NHSEI has published guidance on the appointment of Integrated Care System Leaders *(Appointments*

Guidance – Integrated Care System Leaders and Non-Executive Chairs, Version 1 February 2020). Within this document it states:

"The view from the national NHSE&I team is that an ICS Leader who also holds a joint role as the CCG AO has the most levers to deliver transformation across an ICS."

3.2. Some of the benefits described include:

- System leadership is already an agreed CCG AO function, therefore holding a joint role provides statutory powers to the ICS Leader to deliver the vision for the system;
- Allows alignment of all commissioning towards the system vision;
- Creates a clear and tangible ICS level within the system by keeping the ICS Leader focused on system level transformation built around the CCG.

3.3. Appendix A provides further information comparing different leadership options.

Benefit to the CCG

3.4. The need for well-developed strategic commissioning in a high functioning ICS is well described. Devon CCG is well placed to be the NHS arm of that strategic commissioner, working in partnership with our local authorities.

3.5. Many of the key functions of an ICS would be fulfilled by a strategic commissioner including:

- Population Health Needs Analysis;
- Setting outcomes;
- Standardisation and Reducing Variation;
- Reducing health inequalities;
- Holding to account on delivery.

3.6. In the absence of any statutory change, the CCG is the only organisation able to, and responsible for, fulfilling these functions.

3.7. Therefore, combining the ICS Lead role with the AO of the CCG should give the greatest opportunity for the CCG to provide the necessary system leadership to ensure that these strategic commissioning functions underpin our service design, transformation and delivery.

Recommendation 1: Agreement, in principle, to combine the roles of ICS Lead with the Accountable Officer of the CCG.

4. Recruitment process

4.1. In order to fill the ICS CE role, it will be vital to establish a robust appointment process and it is recommended that a system coordination group is established to lead this work. It is proposed that this group will comprise of the following members:

- Paul Johnson (Clinical Chair, NHS Devon CCG) – convener and chair of this recommended group;
- Graham Turner (Non-Executive Lay Member and Chair of the Remuneration and Strategic Workforce Committee);
- Suzi Leather (STP Chair);
- Elizabeth O'Mahony (South West Regional Director, NHSEI) and;
- a further STP partner organisation Chair.

4.2. Seek independent individual/ executive to act an as advisor to this group.

4.3. This group will inform the development of a job description, person specification and appointment process which will ensure open and transparent competition. The group will consider open advertisement, robust shortlisting, psychometric assessment, stakeholder engagement events and formal interviews.

4.4. In considering the correct approach, the group will be informed by best practice, NHSEI guidance *(Appointments Guidance – Integrated Care System Leaders and Non-Executive Chairs, Version 1 February 2020);* adapting as required and as per the local context in order to attract suitable candidates.

4.5. It is useful to note that in 2017/18 through the appointment of the STP and CCG Chief Executive (Sophia Christie), a joint job description was created and therefore we already have this available to inform thinking, alongside NHSEI guidance.

Recommendation 2: Establish a system coordination group to oversee the development of the ICS Chief Executive role (incorporating the CCG Accountable officer) job description, person specification and appointment process.

4.6. On completion of the development of a robust appointment process, approval will be sought from the Remuneration and Strategic Workforce Committee ahead of advertisement launch.

4.7. It is anticipated that the role will be advertised in September 2020.

Recommendation 3: On completion of the development of a robust appointment process, approval will be sought from the Remuneration and Strategic Workforce Committee ahead of advertisement launch.

5. Recommendations

- **Recommendation 1:** Combine the roles of ICS Lead with the Accountable Officer of the CCG.
- **Recommendation 2:** Establish a system coordination group to oversee the development of the ICS Chief Executive role (incorporating the CCG Accountable officer) job description, person specification and appointment process.
- **Recommendation 3:** On completion of the development of a robust appointment process, approval will be sought from the Remuneration and Strategic Workforce Committee ahead of advertisement launch.

Appendix A: ICS Leader options – a table comparing benefits and levers

The table below compares the levers available to an ICS Leader who is also a CCG AO with:

- **An ICS Leader who is also Provider CEO**
- **An ICS Leader who is also Local Government Executive**
- **An independent ICS Leader**

CCG AO	Provider CEO	Local Government Executive	Independent
This provides a clear leader aligned to the single CCG or across multiple CCGs with a single AO, enabling clear reporting to the regional team and clear division of roles between the ICS and 'place' levels	The Provider CEO and the CCG AO will both have to report to the regional team, creating two reporting lines. Division between the ICS and 'place' levels will not be as clear as the In most cases the Provider CEO will also be involved in their local 'place'	A Local Authority (LA) does not have reporting lines into the regional team, therefore new procedures will need to be developed to align with the CCG AO and wider system	Creates a clear division between ICS and 'place' levels within the system and creates clear reporting lines to the regional team. CCG AO would still need to be in place to conduct legal duties
Can align all commissioning towards the system vision	Does not have the legal powers to influence commissioning decisions as this would create a conflict of interest	They can only influence social care commissioning, however, they can create alignment between health and social care commissioning	Does not have the legal powers to influence commissioning decisions
System leadership is already an agreed CCG AO function, therefore, holding a joint role provides statutory powers to the ICS Leader to deliver the vision for the system	There are no specific functions or levers held by Provider CEOs that enable a system-wide role	LA leaders do not have any statutory powers over NHS organisations	The role would not have any statutory powers over any organisations within the system, meaning all decisions could only be followed through agreement

CCG AO	Provider CEO	Local Government Executive	Independent
Creates a clear framework for future leaders of the system to adopt and follow, ensuring the system is not reliant on a single individual	A clear framework can be established; however, it would not be based around any existing system leadership duties.	A clear framework can be established; however, it would not be based around any system leadership duties.	Creates a clear framework, however, all future leaders will have to re-establish relationships
Enables provider CEOs or LA leaders to act as 'place' leads, these will be responsible for delivering transformation within each ICP, closer to ground and leading all provision across all partners	Provider CEO would be unable to act as the 'place' lead for their local 'place' and lead on local delivery and transformation	LA leaders can also act as 'place' leads, enabling them to align health and social care for their local area	Enables provider CEOs or LA leaders to act as 'place' leads, these will be responsible for delivering transformation within each 'place, closer to ground and leading all provision across all partners
Creates a clear and tangible ICS level within the system	Not as clear as where there is an overlap with the 'place' level	Not as clear as where there is an overlap with the 'place' level	Level is clear but no direct link with the CCG(s) that sit at the ICS level
Having the capacity to conduct both roles will prove difficult. However, the day to day activities for the CCG AO can be delegated to a Chief Executive role or leadership team within the CCG. The legal duties for these activities will still sit with the AO, but it will free up their capacity	Capacity will also be an issue and duties will have to be delegated	Capacity will also be an issue and duties will have to be delegated	Capacity will not be an issue as the independent lead will hold the role full time

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GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 30 July 2020

Dates of Committees covered in this report 16 July 2020

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

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

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- **Risk Register Reports – see Risk Register review below.**
- **Quality & Performance Report – the Committee received information on key quality and performance indicators for the period 1 April to 30 May 2020, including those contained in the NHS Constitution. The following areas were highlighted: -**
    - **Referral to treatment times - a further fall in RTT 18 week performance from 67.0% to 59.3% at STP level compared to the target of 92% and national performance of 62.2%. Long wait patients continued to increase, with over 52 week waits rising quickly at all providers in May. The Committee was informed that a single system Patient Targeted List was in the early stages of preparation.**
    - **Diagnostic waiting times have been significantly affected by the Covid-19 pandemic. The STP position of 43.9% remains well below the 99% target but is slightly better than the England position of 41.5%.**
    - **A&E waiting times - performance against the A&E 4- hour wait target improved as overall attendance volumes fell by 40% in April and, although they have been increasing during May and June, remain below expected levels. June performance was 93.0% for all types and 91.3% for type 1 attendances, slightly down on the May position and below the 95% national target. The England position was 93.6%.**
    - **Performance against the Cancer Waiting Times standards remained relatively stable through the initial Covid-19 period and has improved in May. The STP position against the 62-day standard rose from 71.1% to 74.9%. Whilst the STP underperformed against the 85% target it remains above the national position of 69.9%.**
    - **Urgent & Emergency Care – Significant pressure on the 111 service with increased call volumes during April. Despite reduced call volumes reported during May at 88.79% of their**

forecasted call volume, there remained significant levels of call abandonment.

- **Mental Health (MH) – Delays in serious incident reporting continue within Devon Partnership Trust (DPT).**
- **Care Home Support Model - The Care Home & Home Care Cell led by the CCG with membership from three Devon Local Authorities and CQC, continues to provide significant resource and support to community and social care settings and partners.**
- **CCG Performance Reporting from 1 August to 30 March 2021 - guidance relating to this period is yet to be published, but the Executive is working with provider colleagues to look at the range of performance compliance that can be achieved using innovation and new ways of working and, in particular, at how a partnership approach might focus performance improvement on reducing inequalities.**

Reports received and noted

- **April – June 2020 Contract Award Update – the Committee noted a number of direct contract awards in the first quarter, including those for Providers with whom the CCG held contracts in 2019 / 2021 where this was in line with CCG policy, those made in order for the Nightingale Hospital to be developed, and a small number of direct awards, primarily as a result of urgent need in response to COVID. In all cases the risk was assessed as low.**

Risk Register Review (changes and areas of concern)

- **There have been no changes to risk scores.**
- **Following discussion, it was NOT agreed to close Risk 03 as had been recommended - a risk that crews may be delayed responding to 999 calls on days when there are delays in handing over patients to Emergency Department. The Committee felt that although this risk is being actively managed with daily reporting, it remained a risk.**
- **Following discussion, it was NOT agreed to close Risk 20 - a risk that tier 2 patients who have shown no significance of healing following 4 weeks of treatment with compression therapy, will not receive a consistent standard of care across the South Devon and Torbay footprint. Although it was reported that this service had been re-commissioned to align with the rest of the County, it appeared that there were some issues still to be resolved.**
- **It was agreed to close Risk 111, which related to the CCG's inability to deliver its agreed control total in the 2019/2020 financial year, but to replace it with a similarly worded risk in relation to the 2020/2021 financial year.**
- **It was agreed to add a new risk – regarding the possibility that some of the excess costs over and above the budget set are not funded by NHSE through the top up process leading to an inability to deliver against the temporary financial regime for the period to 31st July 2020. Whilst we have had funding to cover the CCG's first two months of COVID19 costs, it is not guaranteed that this arrangement will continue.**

Committee Decisions

- **Devon CCG Monthly Finance Report - the report reminded the Committee of the draft budget previously agreed (a deficit position of £47.8m with a savings requirement of £22.6m). This draft budget had not received approval by NHSE, who had instead put in place a temporary financial regime for the period 1 April to 31 July 2020, with an expectation that CCGs will break even**

during this time. Variance against plan will be reviewed, with a retrospective allocation being made if considered reasonable. The Committee agreed that: -

  - The potential risk that not all excess cost will be funded by NHSE should be added to the risk register.

  - Early actions to scope the deliverability of savings for the remainder of the year are needed.

- A report on the CCG Interim Financial Framework & Planning Update 2020-21 indicated that the interim budget for the 4-month period is higher than it otherwise would have been, but that the current monthly rate of expenditure is also higher than planned. The Committee noted that the current temporary finance regime would be rolled over until the end of August, with the potential of it being extended to the end of September. Issues with the methodology used by NHSE/I raise issues with predicting future financial impacts as COVID restrictions ease. The Committee agreed: -

  - That the Executive should model potential year end projections, given the effect of the temporary finance regime, the work to be undertaken on the assumptions regarding the savings requirement and the current monthly expenditure levels.

  - To support the Executive in its representations to NHSE/I regarding the risks arising from the current framework.

- Financial Implications of Services Stood Down During COVID19 – the Committee approved the approach taken to those services, which could not be provided in a COVID 19 safe manner and were not vital to the pandemic response, and which had been stood down and provided with financial support in line with NHSE/I guidance.

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

Recommendations for Governing Body

- None

Recommendations for other Committees

- None

Terms of Reference or other committee effectiveness issues

- Committee Effectiveness Report and Revised Terms of Reference – the Committee noted that the Effectiveness report was based on only two responses and was of the view that the lack of participation indicated that improvement was required in the 2020/21 reporting cycle. As noted above, updated and amended Terms of Reference were agreed.

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GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: 30th July 2020

Dates of Committees covered in this report: 8th July 2020

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

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

Contact Details: nick.ball1@nhs.net

Reports received and noted

- Freedom to Speak Up Guidance - discussed and provided some assurances. Further clarification will be sought from HR on some areas.

- Risk Assurance & Policy Framework Report – discussed and provided assurance that the Corporate risk register, the COVID risk register and the Assurance Framework has continued to be managed throughout the COVID incident and agree that additional pandemic risks were managed appropriately. The risk management framework policy was received and approved by the Audit Committee

- Audit Committee Terms of Reference – the audit committee received and approved minor changes to the terms of reference in line with the feedback received from NHSE when reviewing the constitution.

- Information Governance Report – presented to the audit committee for noting.

- Financial instructions and accounting policies report – presented to the audit committee which noted that changes of work going to be completed by September.

- Internal Audit Update Report – presented to the Audit Committee for completeness and describe final reports from 2019/20.

- Internal Audit Annual Report – The internal audit service provides a service in accordance with the requirements set out in the mandatory Public Sector Internal Audit Standards, comprising the Definition of Internal Auditing, the Code of Ethics and the International Standards for the Professional Practice of Internal Auditing. Adopts a risk-based auditing approach and maintains an Internal Audit Manual to support compliance with Internal Audit Standards. The Audit Committee received and noted the report with the highest level of significant assurance opinion being provided.

- Internal Audit Plan Report - The Audit Committee first reviewed the Draft Audit Strategy and Audit and Assurance Plan at the March 2020 meeting. In light of COVID-19, and the need for the CCG to redirect resources away from business as usual and to the COVID-19 response, it was agreed at the May Audit Committee that the Audit Plan should be reviewed and updated. The revised draft has been

reviewed by the Executive Team and feedback received has been addressed in the version of the draft plan set out in this document. The Audit Committee is asked to consider and approve the revised plan

- External Audit Progress report – the paper provides the Audit Committee with a report on progress in delivering Grant Thornton's responsibilities as the CCG's external auditors. Grant Thornton had been unable to issue their opinion on the NHS NEW Devon CCG work on the instructions of NHSE. This has now been approval from NHSE to finalise this work, with the requirement that outstanding MHIS statements are published by 9 July 2020. Grant Thornton are liaising with the CCG's officers to ensure that this deadline is met. Financial Statements Audit - Our audit of the 2019/20 financial statements is now complete. Our Audit Findings Report was discussed with the Audit Committee on 18 June 2020 and the audit opinion was issued on 24 June 2020. Overall Grant Thornton concluded: unqualified opinion on the financial statements, qualified regularity opinion, qualified, except for, value for money conclusion.

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

- Counter Fraud Annual Report – The report summarises the work undertaken by the Local Counter Fraud Specialist (LCFS) during 2019-20 in line with NHSCFA requirements and in accordance with the NHSCFA Annual Report template 2020 which requires certain arrangements to be in place in order to meet the NHSCFA standards

Risk Register Review Updates

- Summary review of updates to corporate risk register, COVID risk registers and Assurance Framework as at 8 July 2020 were reviewed at this meeting.

4. Appendix 4 COVID Risk Register v1.11 1€

4. Appendix 2 Corporate Risk Regist

Committee Decisions

The Audit Committee

- Noted the Freedom to Speak Up Guidance
- Noted and approved the Risk Assurance & Policy Framework Report
- Noted and approved the Draft Audit Committee Terms of Reference
- Noted the Information Governance Report
- Noted the Financial Instructions and Accounting Policies Report
- Noted the Internal Audit update report
- Noted the Internal Audit Annual Report
- Noted and approved Internal Audit Plan Report
- Noted the External Audit progress report
- Noted the Counter Fraud Progress Report
- Noted the Counter Fraud Annual Report

Items of concern to be escalated to the Governing Body
• N/A
Recommendations for Governing Body
• Approval of Audit Committee Terms of Reference • Approval of Risk Management Framework Policy   Audit committee ToR July 2020 approved.d 4. Appendix 5 Assurance Framework
Recommendations for other Committees
• **N/A**
Terms of Reference or other committee effectiveness issues
• Terms of Reference amendments reviewed and approved**.**

Management of Conflict of interests:

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V1.11 updated 16 June to 25 June 2020

Area of Risk	There is a risk that….....	Impact	Initial Likelihood	Initial Impact	Initial Risk Score	Current Likelihood	Current Impact	Current Risk score at last review	Risk Score Movement at last review	Mitigating Actions in Place	Exec Lead	Risk Owner	Further Action Required
CCG Business	The CCG does not have effective and efficient mechanisms for incident management	CCG is unable to co-ordinate the range of activities required for incident management. CCG play its part as a system leader during the COVID incident	2	4	8	2	4	8	⟺	Incident Control Room established with underpinning SOPs. Daily huddles and battle rhythm in place. Links to Regional ICC. System Gold Call three times a week LRF links in place and with local provider EPRR Leads. Business Continuity plans reviewed and refreshed;	Sonja Manton	Ginny Snaith/ Clare Doble	Weekly review with Incident Managers. Incident response review underway
CCG Business	The activity and performance requirements nationally mandated are not fulfilled due to local system capacity response to COVID 19, reducing critical care and elective capacity.	a)CCG and system do not meet agreed performance and activity targets b)CCG in contravention of its constitution c)patients are not seen within the mandated target times	2	4	8	2	4	8	⟺	Nationally mandated requirements have been revised. CCG is complying with these requirements Risk is recorded on the Regional Critical Care Cell Risk Register (SFT 23/04/2020) 10/06/2020 reviewed DB/JD no change	John Dowell	Derek Blackford	
CCG Business	The CCG is unable to discharge its mandated and constitutional role due to the need to respond to the COVID outbreak and diverting its resource and expertise to lead this response at local level	a)CCG contravenes its constitution and role as system leader	2	4	8	2	4	8	⟺	CCG has reviewed and redeployed staff. Exec Team meets 3 times a week to review hot topics, and reviews list of deployed staff on a regular basis to ensure needs of the organisation are met. Exec Team also reviews incident management mechanism and cell structure to ensure fit for purpose to meet the needs of the organisation. NHSE/I aware of organisational need to redeploy staff as a result of Covid19. Daily CEO meeting with Devon providers in place.	Simon Tapley	Sarah Thompson/ Ginny Snaith	
CCG Business	Mandated quality and safety standards are compromised as resource is diverted to support COVID response, with less focus on normal quality reporting and intervention	The impact would be that: a)CCG quality team less sighted on quality or safety issues within provider settings b)CCG in contravention of its constitution and role as a system leader. C) Ability to understand themes related to quality across system diminished	4	4	16	4	4	16	⟺	CCG Safety Systems and Patient Experience Teams in place and monitoring serious incidents and complaints, thematically analysing available information, and cross referencing with other information sources where available. Nursing & Quality attendance at provider Governance Committees to continue.	Phillip King/Darryn Allcorn	Lorraine Webber	Some clinical cell staff returning to support review and restoratio/transformation of quality surveillance function LW 29/05/2020
CCG Business	Governance and accountability channels are compromised or not followed as required due to the constantly changing environment, speed at which tasks or guidance require enactment or lack of knowledge and understanding of governance requirements	The impact of this: a)compromising of the CCGs constitutional requirements b)unlawful and/or unsafe decisions being made c)no or limited audit trail of decision making processes	2	4	8	2	4	8	⟺	CCG has reviewed governance and accountability arrangements and proposed interim arrangements. Agreed at March GB. Paper on new arrangements approved at April GB Internal Audit undertaking COVID review of Core Governance	Ginny Snaith	Clare Doble	
Service Provision	There will be insufficient critical care capacity and capability to respond to the modelled surge/increase of COVID positive patients in Devon	This impact of this: a) COVID 19 patients may not have access to the level of critical care and equipment they need b) lack of required intervention will increase level of deaths	3	5	15	3	5	15	⟺	Modelling work underway Nightingale Hospital under construction Daily monitoring of critical capacity Staff re-training underway to support if required Programme to access increased number of ventilators Risk is recorded on the Regional Critical Care Cell Risk Register (SFT 23/04/2020)	Penny Harris	Penny Harris	Ongoing link to Regional cell as much work co-ordinated through this route
Service Provision	Decisions to make changes to services commissioned by the CCG through providers are done so without full cognoscente, clinical oversight and agreement whilst responding to the COVID 19 outbreak and management of capacity and resource	The impact: a)decisions made in isolation and impact on other services or capacity in system b)inequitable access for patients to services	3	5	15	3	5	15	⟺	Process in place for CCG AO sign-off of all proposed service changes - This includes risk assessment and clinical input. QEIA requested by CCG is assessed as required. QEIA has been streamlined/ adapted for COVID pandemic period service changes. Clinical Reference Group reviews Service Change log on a weekly basis. Service changes also reported to the CCG Governing Body on a monthly basis. 5.6.2020 update: Process remains in place and reported as above. Assessment of providers consideration to EDI included.	Simon Tapley	Sarah Wright	Review of QEIA to ensure robust process This risk has been escalated via the CCG SCG sitrep report. CCG working closely with Local Authorities to support provision of care in Care Homes - this risk has been escalated via SCG+G11 sitrep
Service Provision	That patients across the age spectrum, who require urgent or ongoing care will not access care in a timely way due to fears or uncertainty about attending or contacting hospital services	a)escalation requiring emergency admission and / or treatment b)early death or harm, including reduction of treatment options c)Future capacity unable to cope with backlog or sudden increase in referrals as lockdown is lifted.	5	5	25	2	5	10	↓	This risk has been escalated via SCG sitrep reporting to National partners. CCG Comms in line with national Comms to encourage the population to access services. Clear guidance has been received, communicated and implemented in both primary and secondary care in the management of cancer services. The CCG has joined with the Cancer Alliance, CRUK and Macmillan to agree a local communications message and campaign to encourage patients to present to their GP if they have concerning symptoms and to attend their appointments stressing the safetymeasures that have been put in place to enable these interactions to happen safely. LW 06/06/2020 I would update that 'adverse impacts' as a result of access to service or treatment delays are routinely monitored through our quality assurance routes which includes SI's, complaints, PALs enquiries and all core quality and safety intelligence that we review regularly. Themes from provider specific access or delay incidents are reviewed within their governance meetings attended by senior CCG nursing team and this adds to our overall surveillance programme. 08/06/2020 The Executive Team discussed and agreed to reduce the likelihood score to 2.	Simon Tapley	Lorraine Webber	

Service Provision	Care home and care at home could become compromised, due to outbreak risk, PPE, staffing and pathway issues. LW 05/06/2020	Unable to discharge patients from hospital in a timely manner to create required acute capacity Individuals safety & quality of care at risk due to: inadequate packages of care, staff capacity, equipment and training. LW 05/06/2020	5	4	20	3	4	12	↓	CCG working closely with Local Authorities to support provision of care in Care Homes. 30.5.2020: SW: CCG led, multi partner Care Home & Care at Home Cell commenced 25.5.2020. CCG continue to support the LAs, care homes and home care through Care Home, PPE and Discharge Cells. Includes training and supply of PPE. 5.6.20 Support plan with programme of inputs in place and progressing - includes medicines, primary care, clinical nominated leads, training, digital and market support 1/06/2020 It was noted that training and support packages are in place for care homes, and there will be a further change recommended in due course to reduce the impact score again once we get the local outbreak plans. SM described an offer from the AHSN to support digitalisation and rapid evaluation and learning from the care homes cell. PK will pick this up outside of the meeting.	Simon Tapley	Jo Shill	
Service Provision	The CCG will have insufficient plans in place to move the Devon system back into business as usual following COVID due to the capacity of staff to focus on recovery and re-establishment of elective and planned care.	a)Lose opportunity to implement system transformation b)delay in reestablishment of normal business and access to services c)deterioration in health of previously non-urgent diagnosed patients d)lack of clarity around service provision and return to BAU	4	4	16	4	4	16	↔	Recovery cell developing the arrangements required to ensure transformational recovery of services post-incident. Restoration and Transformation cell and programme is well underway. The Restoration and Transformation Cell has weekly drop-in sessions with the CCG Executive Team on a Friday. This covers services standing back up, each workstream to respond to the Phase 2 NHSE/I requirements and updates from their programme.	Simon Tapley	John Finn	
Primary Care	COVID-19 outbreak could adversely affect the primary care teams ability to deliver current workplan and business as usual tasks.	The impact of this is that the delivery of general practice is compromised and could affect all areas of the healthcare system.	3	3	9	2	3	6	↓	**Apr 20 - COVID report due to monthly Primary Care Committee.** CCG Primary Care COVID lead identified Primary Care participation in CCG Daily COVID calls Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Regional NHS England and Public Health England updates Team reviewing daily COVID updates from comms team COVID report due to monthly Primary Care Committee Team business continuity plan Team what's app group enabled Working from home processes enabled 10/06/2020 - the Primary Care team has been divided into a COVID Team and a Business as Usual/operational team to ensure capacity to fulfil all requirements	Jo Turl	Mandy Seymour	Apr 20 - Team business continuity plan. Team what's app group enabled. Working from home processes enabled. COVID report due to monthly Primary Care Committee.
Primary Care	COVID-19 may result in GP practices being unable to return to business as usual in line with guidance if GPs are still actively dealing with COVID issues.	The impact of this is that the delivery of general practice is compromised and could affect all areas of the healthcare system.	5	5	25	2	4	8	↓	CCG team are keeping a log of any activity stood down PC team will work with recovery cell to reinstate Business as usual 10/06/2020 IT solutions have helped to support delivery of primary care by remote working	Jo Turl	Mandy Seymour	
Primary Care	Other primary care providers (other than GP or pharmacy) are not fully briefed or supported at a local level because NHSE commissioners and resource is redeployed to support COVID adding additional pressure on the Devon Primary Care commissioning team.	a) Increased workload for primary care team b) Potential reduction in services due to mixed or insufficient advice and guidance	3	3	9	3	2	6	↓	CCG Primary Care Team working with NHSE to coordinate messages 10/06/2020 Primary Care Team is supported by additional staff seconded to the team. Weekly calls with NHSE/I to mitigate and discuss any risks and escalate issues.	Jo Turl	Mandy Seymour	
Primary Care	There is insufficient access to digital solutions to support new ways of working in primary care	Patients may attend care facilities when care could more effectively and safely be delivered at home	4	4	16	2	3	6	↓	The CCG had deployed around 500 laptops to Devon GP practices as well as providing or funding several other remote working methods to allow GPs and other practice staff to work from home when required. A further batch of laptops (200) are about to be deployed at PCN level. Risk of resources (laptops etc) not being in right place if Track and Trace ends up in focussed isolation in small number of practices remains but will be localised JG	Andrew Millward	Jim Goodwin	Rollout of additional 200 laptops to PCNs. Hold stock of laptops in case of localised issues in practices (e.g. if track and trace ends up in high number of individuals having to isolate from one practice) JG
Ethical Framework	Decisions will not be made based on an ethical framework	Poor decision making will result in harm to patients. Significant risk of legal challenge	5	5	25	2	5	10	↓	Ethical Framework developed by NHSE/I. Ethical Reference Group established for Devon system 27/05/2020 Exec Team - Recommended the likelihood score can be reduced for this risk, as likelihood of not following the framework is reduced if it is approved by each organisation Board	Penny Harris /Paul Johnson	Penny Harris	Local implementation of framework. Ongoing review of decision making and support for frontline clinicians
CCG Staff	There are insufficient numbers and capable workforce to support the required response to the COVID outbreak	CCG unable to support local system as required or needed	2	3	6	2	3	6	↔	All BAU functions reviewed and staff redeployed where appropriate. Regular reviews by Managers and Executives to ensure appropriate staffing in place.	Andrew Millward	Piers Tetley	
CCG Staff	Staff will suffer an increase in mental health issues due to social isolation, lone working and reduced direction driven by home working	a)reduction in staff available to work due to health b)reduction in staff available to work due to personal relationship breakdown c) increase in self harm/suicidal tendencies	4	3	12	3	3	9	↓	Managers contacting staff on regular basis Video briefings from Simon Tapley Regular written communications Staff made aware of access to support services Use of Teams to provide video contact 05/06/2020 likelihood score reduced AM	Andrew Millward	Piers Tetley	Weekly programme of activities to be co-ordinated by Staff Forum e.g. Virtual Coffee Roulette
CCG Staff	CCG staff are not fully utilised during COVID response if BAU not required in their area and redeployment not forthcoming	continued to be paid but no outputs recorded Reduced motivation Loss of skills	5	3	15	4	3	12	↓	Redeployment list held by HR. Managers and Execs reviewing with staff on regular basis. Liaison with providers (and other potential organisations for redeployment) 05/06/2020 likelihood score reduced AM	Andrew Millward	Piers Tetley	

PPE	There is an insufficient supply and access to appropriate PPE equipment to support the clinically safe management of COVID spread both to protect staff from already infected individuals and to contain further spread	The impact is: i) Potential scarcity of PPE as a result of volatility and uncertainty of supply due to changing policy landscape; ii) PPE may be a rate limiter in the recovery and restitution of non-elective and elective work in secondary care and primary care services; iii) Unable to meet the needs of care homes and increased infection rates if unable to complete fit testing given the size of the task and the differing designs available; iv) That there is inadequate supply of PPE to care homes as other COVID work steps down, such as LRF supply.	5	5	25	4	4	16	↓	This risk has been escalated via the CCG SCG sitrep report. PPE cell established and co-ordinating provision of PPE from local and national sources Processes developed by PPE Cell to compliment existing processes which include daily monitoring of all stock levels 15/06/2020 Exec - This will be kept under review as may be some issues around drops for push deliveries, although currently all providers have over 72 hours' worth of stock.	Phillip King/Darryn Allcorn	Vanessa Crossey	Improved liaison with LRF. Improved reporting from providers on current stocks
Staff testing	Front line staff including community staff do not have ready and easy access to testing	The impact of this: a)unintentional increase in spread of COVID to individuals and patients as people continue to provide care or go about essential tasks b)Staff may self-isolate believing they have COVID due to symptoms and reducing clinical and care workforce	3	5	15	1	5	5	↓	Processes established for identifying staff for testing. Significant capacity available but uptake currently low (only using about a third of the capacity). All symptomatic staff have access to testing and currently working through process for testing asymptomatic staff. This includes support to the care sector as well as NHS staff through local coordination centres. National testing has increased in capacity and there is capacity for all Care Home staff to access testing through the National Portal. System are looking at all sectors to ensure those of greatest priority have additional support for testing.	Sonja Manton	Fiona Peck	Ensure that there is sufficient capacity for testing as elective services resume
Patient testing	Residents and staff in the Devon system will have inequitable access to testing and interpretation of guidance because there is no overarching single point of contact in Devon to co-ordinate this because responsibility lies with multiple stakeholders (three different local authorities serving the wider Devon population and regulatory bodies)	a)safety of staff and residents of care homes compromised b)inconsistent messaging to care homes across CCG footprint c)increased spread of Coronavirus in care home setting d)reduction in care home capacity if homes close to new admissions e)increased DTOCs in acute setting because of reduced capacity	3	5	15	2	5	10	↓	CCG resource identified to support wider work on testing, linking with pathology network and LRF leadership on testing. Joint working arrangements with LAs through incident management arrangements. Maximising use of local acute testing capacity via locality coordination centres. Senior leadership also now working to join up work across all the testing pillars, including dedicated time with the LRF. Process in place to work as a network and arrange for testing across providers/ sites to ensure ease of access.	Sonja Manton	Fiona Peck	Testing becomes embedded in Local Incident Plans
Vulnerable groups	Patients who are on or will need to access an End of Life pathway are unable to access the support and care they need due to the focus on the COVID-19 outbreak	a)Inequitable access to care and treatment b)patients receive poor experience in EOL pathway c)clinicians and patients/families unclear on pathway d)uncertainty on where to get information	4	4	16	4	4	16	↔	Multiagency end of life group established to develop pathway and communicate with relevant groups. Programme of work in place with key CCG staff to support arrangements for EoL CCG system leadership role, including support from Clinical and Meds Op Cells.	Phillip King/Darryn Allcorn	Lorraine Webber	EOL Task & Finish group undertaking surge capacity planning and a small expert group now reviewing treatment escalation plans (TEP) including DNAR process issues for out of hours clinical staff where printed or email version of TEP is used. Revised VOED guidance approved and in place. LW 01/06/2020
Vulnerable groups	Individuals across Devon system are falling through gaps in the nationally described process for identifying patients who should be shielding	a)patients who think they should be shielding isolate and are not eligible for support b)patients identified by secondary care may be taken off by primary care and not informed	4	4	16	2	4	8	↓	CCG giving regular updates to primary care via daily bulletins and weekly webinar with guidance and advice Commissioning ADs co-ordinating response to shielded patients across localities and partners BI working to share data across all partners 10/06/2020 Project manager in place to coordinate system response	Jo Turl	Mandy Seymour	
Vulnerable groups	Safeguarding arrangements during the COVID-19 incident are continuing, but may not be as effective during this period due to the limitations all organisations are required to work to during the incident.	The impact to the CCG is that we may not be receiving assurance from providers that vulnerable people are being identified and responded to and could be experiencing abuse and neglect.	4	4	16	3	4	12	↓	Guidance sent to providers to disseminate to front line staff regarding remote working practices that encourage disclosure. Practitioners still having face to face contact with vulnerable patients. Rise in education provision and attendance by vulnerable children, and rise in individuals re-engaging with health services gives greater opportunity for abuse to be identified and addressed. Calls continue with provider safeguarding leads, now moved to fortnightly and meeting scheduled to focus on non-covid issues. Ability to gain assurance from providers has increased as provider safeguarding committees are reinstated. Limited redeployment within safeguarding services currently. 05/06/2020 MT reduced likelihood score , the reason for this is the increase in education provision and attendance at school by vulnerable children, and rise in individuals re-engaging with health services giving greater opportunity for abuse to be identified and addressed. Ability to gain assurance from providers has increased as provider safeguarding committees are reinstated.	Phillip King/Darryn Allcorn	Michele Thornberry	

COVID Risk Register Risk Movement

Risk Ref.	Exec Lead	Initial Likelihood (L)	Initial Impact (I)	Initial Risk Score	L	I	Risk score @ 05/05/2020	L	I	Risk score 11/05/2020	L	I	Risk score @ 14/05/2020	L	I	Risk score 19/05/2020	L	I	Risk score @ 26/05/2020	L	I	Risk score @ 28/05/2020	L	I	Risk score @ 02/06/2020	L	I	Current Risk score @ 10/06/2020	L	I	Current Risk score @ 16/06/2020	Risk Score Movement	Status
COVID 01	Sonja Manton	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	no change	open
COVID 02	John Dowell	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	no change	open
COVID 03	Simon Tapley	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	no change	open
COVID 04	Phillip King/Darryn Allcorn	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	no change	open
COVID 05	Ginny Snaith	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	2	4	8	no change	open
COVID 06	Penny Harris/ Sarah Thompson	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	no change	open
COVID 07	Simon Tapley	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	no change	open
COVID 08	Simon Tapley	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	2	5	10	2	5	10	down	open
COVID 09	Simon Tapley	5	4	20	5	4	20	5	4	20	5	4	20	5	4	20	5	4	20	5	4	20	5	4	20	3	4	12	3	4	12	down	open
COVID 10	Simon Tapley	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	no change	open
COVID 11	Jo Turl	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	2	3	6	2	3	6	down	open
COVID 12	Jo Turl	5	5	25	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	2	4	8	2	4	8	down	open
COVID 13	Jo Turl	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	2	6	3	2	6	down	open
COVID 14	Andrew Millward	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	2	3	6	2	3	6	down	open
COVID 15	Penny Harris /Paul Johnson	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	2	5	10	2	5	10	2	5	10	2	5	10	down	open
COVID 16	Andrew Millward	2	3	6	2	3	6	2	3	6	2	3	6	2	3	6	2	3	6	2	3	6	2	3	6	2	3	6	2	3	6	no change	open
COVID 17	Andrew Millward	4	3	12	4	3	12	4	3	12	4	3	12	4	3	12	4	3	12	4	3	12	4	3	12	3	3	9	3	3	9	down	open
COVID 18	Andrew Millward	5	3	15	5	3	15	5	3	15	5	3	15	5	3	15	5	3	15	5	3	15	5	3	15	4	3	12	4	3	12	down	open
COVID 19	Phillip King/Darryn Allcorn	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	5	5	25	4	5	20	4	4	16	down	open
COVID 20	Sonja Manton	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	1	5	5	1	5	5	1	5	5	down	open
COVID 21	Sonja Manton	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	2	5	10	2	5	10	2	5	10	down	open
COVID 22	Phillip King/Darryn Allcorn	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	no change	open
COVID 23	Jo Turl	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	2	4	8	2	4	8	down	open
COVID 24	Phillip King/Darryn Allcorn	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	3	4	12	3	4	12	down	open
COVID 25	Simon Tapley	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	3	4	12	down	open
COVID 26	Sonja Manton	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	2	5	10	down	open
COVID 27	Phillip King/Darryn Allcorn	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	no change	open
COVID 28	Penny Harris	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	4	5	20	3	5	15	3	5	15	3	5	15	no change	open
COVID 29	Phillip King/Darryn Allcorn	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	3	5	15	no change	open
COVID 30	Jo Turl	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	2	3	6	2	3	6	down	open
COVID 31	Jo Turl	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	3	4	12	3	4	12	no change	open
COVID 32	Sarah Thompson										3	4	12	3	4	12	3	4	12	3	4	12	3	4	12	3	4	12	3	4	12	no change	open
COVID 33	Sarah Thompson																3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	no change	open
COVID 34	Sarah Thompson																4	4	16	4	4	16	4	4	16	4	4	16	4	4	16	no change	open
COVID 35	Sarah Thompson																4	3	12	4	3	12	4	3	12	4	3	12	4	3	12	no change	open
COVID 36	Sarah Thompson																3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	no change	open
COVID 37	Sarah Thompson																3	3	9	3	3	9	3	3	9	3	3	9	3	3	9	no change	open
COVID 38	Simon Tapley																												3	3	9	New 16/06.2020	open

Risk Assessment Scoring Guidelines

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

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

Assessing the likelihood/probability of risk

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

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

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

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

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

NHS Devon Clinical Commissioning Group

NHS DEVON CCG
Risk Report (High Risks Only)

Date produced: 24-06-2020 - 09:46

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners
111	We will make best use of resources [Reporting Committee] Finance and Performance	There is a risk that the CCG will not be able to deliver its agreed control total for 2019-2020 as a result of the £80m savings target held by the CCG which includes £45m of system savings primarily directed at mitigating acute activity growth and cost savings as a result of transformation of existing services/practices. (HISTORIC ID: Na)	Contractual review mechanisms have been established to identify and agree activity variations as a result of reduced growth and or service change. A Risk Sharing agreement has been agreed with all local acute providers on how the £45m risk is managed in year. [Control Gaps] A formal PMO led Reporting/challenge mechanism is in the process of being established to capture the risk of the delivery of all savings programmes.	20 [10/10/2019] ▲ 20 (L=5 x I=4) [01/08/2019] ▲ 16 (L=4 x I=4) [31/07/2019] 14 (L=4 x I=4)	Risk Opened: 31/07/2019 Reviewed: 14/01/2020		Regular monthly reporting to the Finance Committee/Governing body on the inherent risk in the savings plan. Monthly finance working group meetings with system partners to discuss progress on delivery of the system savings target. [Assurance Gaps] None identified	Executive Lead: John Dowell Owner: Kevin Wheller

108	We will make best use of resources [Reporting Committee] Primary Care Commissioning	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand and capacity) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system could be affected. This risk replaces risk 09 (SDT) and 68 (NEW Devon) (HISTORIC ID: Na)	GP Strategy STP Workforce Group & Strategy Locality Workforce Groups GP Provider Collaborative Groups Regional Workforce Board 100 day plan in design for Plymouth system Regular review at Primary Care Operational Group Regular review at Primary Care commissioning committee Feb 19 - The GP framework associated with the long term plan, having been released, is being reviewed for opportunities to further mitigate this risk Apr 19 - Work continues to support practices in working closer together and with wider parts of the system and also building on the skill mix development as outlined in the contract reform GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments 20 Jun 19 - risk reviewed at Primary care operational group. No further update Jul 19 - 100 day plan in design for Plymouth system 7 Aug 19 - Reworked as Plymouth Prospectus; financial implications being reviewed; on track for 1 Sept 19 launch. 2 Sept 19 - Plymouth Prospectus circulated to Plymouth practices. Others were sent to practices in South Hams, West Devon and the rest of Devon to inform them of the prospectus and encourage them to send expressions of interest for when CCG launch our longer term transformation plans 10 Oct 19 - BMJ Job Fayre in London on 4th & 5th October 19; stand promoting SW region - supported by CCG staff and Plymouth GP. 14 Nov 19 - Risk score has been reviewed in light of CQC contract suspension of one practice within Western system, given (material) impact on 3 practices covering circa 25,000 patients. Score has not been adjusted as this was felt to be a manifestation of the risk rather than an escalation of it. 16.12.19 risk score not adjusted due to current list dispersals (from 2 practice closures) [Control Gaps] Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support In part a lack of evidenced change to new models	20 [29/05/2019] 20 (L=5 x I=4)	Risk Opened: 29/05/2019 Reviewed: 10/06/2020	[10/06/2020] Feb 20 - Implementation of GP Strategy being drawn up. New PCN DES specification confirmed. Development teams to work with networks to support maximum use of funds available. BMJ subscription confirmed – all GP vacancies to be advertised nationally. Scheme beginning 1 April and in collaboration with LMC. Apr 20 - risk currently being managed as part of the COVID risk management process May 20 - work to support practices including implementation of digital applications, reduce admin burden by clarifying the expectations re reporting, claiming and payment methods for LES / DES and other activities during the period of COVID Jun 20 - there has been some early successful interest through BMJ subscription. work continues to support including the implementation of digital applications, reduce admin burden by clarifying the expectations re reporting, claiming and payment methods for LES / DES and other activities during the period of COVID,	Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. practice resilience toolkit Heat map devised to identify vulnerable GP practices Regular resilience meetings with Devon LMC Work continues to develop Primary Care Networks and fill roles [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Paul Baker

109	We will continue to commission safe, effective and accessible services [Reporting Committee] Audit	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •Reduced quality of care with impact on patient safety leading to increased public and media attention and reputational damage •Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (HISTORIC ID: Na)	For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group on a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. 21/04/2020 - We are currently not monitoring performance on this standard in line with national guidance 27/02/2020 - The 2 weekly oversight by NHSIE has shown that we are on plan to meet the agreed trajectories for 52 week waits and diagnostics. There was a risk of losing 50% of the 52 week funding for RDE due to a gap in assurance however we have provided further info and the funds are now available 13/01/2020 - The system has maximised the opportunity to minimise the risk of delivery for 52w by obtaining and committing to revised trajectory as a result of 1.7 million of elective winter monies. This investment for UHP reduces the overall size of the waiting list as it does in South Devon and RD&E the investment in orthopaedics reduces the forecast to 38 these investments are monitored by detailed reporting template supplied by NHSE. The RD&E position improves to 38 while the other providers are still on trajectory to have zero 52ww breaches. The investment of winter elective monies will improve the overall STP position for diagnostics to 6.5% 19/11/2019- 52ww performance remains influx. The system wide PTL is fully operational and learning in Sept/Oct with regard to barriers patients accessing outsource activity is being used to refocus actions on gaining maximum benefit from outsourcing. Recent improvements in diagnostic have shown marginally improvement in 62 day standard. the system commitment to deliver diagnostic performance at 7% is dependant on a system wide plan to clear all endoscopy breaches by 31st March. A recent decision to9 stand down the mobile unit for East Devon and South patients and replace with trust wide insourcing and outsourcing plans will need careful monitoring during November /December to ensure no negative impact on this performance. 16/10/2019 - We have gained assurance that trusts are now compliant with the prostrate pathway which had been an significant barrier of the achievement of the 62 standard. Following agreement from NHSE medical director on the 24th October we were moved to procurement of the stand alone endoscopy unit to support RD&E and Torbay hospitals. Revised forecast for all 4 trusts at system level have now been quantified and delivered to NHSE these forecasts will be upgraded monthly in relation to all actions agreed at place or system. The 52 ww patient treatment list is now fully operational and sufficient independent sector capacity availability to impact significantly on 52ww performance early review of the process has identified the need for a more proactive approach to support patients choosing independent sector activity to support 52WW clearance. This approach has been agreed by the planned care programme board and will be operational from November 04th 13/09/2019 - In response to a request at the August System Performance Group a number of system wide plans to improve performance in diagnostics and 52ww were presented and agreed at September System Performance Group. It was recognised that the actions would contribute further to the improvement in 62 week pathways as well. The detail of these are as follows: a plan for North and East to clear endoscopy backlogs by outsourcing and insourcing at both RD&E and South Devon health Care Trust. This work is mirrored in similar plan at UHP to outsource to Care UK . An agreed protocol to enable and support increased capacity in contrast MRI and CT has been agreed at RD&E . 26/07/2019 - The CCG has a single point of focus and assurance for the each of these actions in each locality these heads of performance are responsible fde collating information around referrals, contract performance against	16 [22/10/2019] = 16 (L=4 x I=4) [31/07/2019] ▲ 16 (L=4 x I=4) [06/06/2019] 9 (L=3 x I=3)	Risk Opened: 06/06/2019 Reviewed: 22/04/2020	[27/08/2019] System performance meeting monthly with providers,	Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. 13/01/2020 scrutiny at Dec SPG has provided assurance on these plans and elective board 19/11/2019 scrutiny at Nov SPG has provided assurance on these plans 16/10/2019 The quality of financial forecasting has been significantly improved with high degree of accuracy looking forward 3 months now achievable 13/09/2019 RAPS recovery action plans over the pervious 2 weeks have been quantified and outputs reflected in revised forecasts [Assurance Gaps] none identified	Executive Lead: Sonja Manton Owner: John Finn

			the plan and remedial actions to deal with referral growth deviation from contract activity levels and actions to improve performance at trust and system. Monthly reporting at place will now feed into System Performance Group. [Control Gaps] 13/01/2020 - Opel 4 esculation at the start of January puts some risk into this delivery 19/11/2019 RD&E ability to deliver the 5 endoscopy lists per week for 6 months within their organisation needs to be carefully understood and assurance gained. 16/10/2019 uncertainty around funding for endoscopy still an issue. Sufficient commissioning support to support recovery action plans at place. 13/09/2019 staffing at RD&E to provide increased endoscopy					
113	We will make best use of resources [Reporting Committee] Audit	There is a risk that there is a failure to deliver the CCGs key critical functions in an emergency which will impact on the CCGs statutory obligations This includes; fire, flood, loss of premise (partial or total) loss of electricity, loss of telecoms partial or total, loss of staff (pan flu/industrial/political action etc) (HISTORIC ID: Na)	An overarching Business Continuity Plan is in place and was reviewed and approved by the Executives in September 2019. Individual Business Continuity Plans are also in place for directorates and workstreams. [Control Gaps] Not all staff are aware of their directorate Business Continuity Plan, this is being addressed through communications briefings and intranet links following approval of the CCG Business Continuity Plan during October 2019. Currently the Head of Governance is covering for the vacant position of Emergency Preparedness Resilience Response Lead and European Union Exit Lead – new appointment anticipated to commence in Q4.	16 [24/04/2020] ▲ 16 (L=4 x I=4) [29/08/2019] 6 (L=2 x I=3)	Risk Opened: 03/09/2019 Reviewed: 21/04/2020	[11/09/2019] Executives have been signed up Strategic leadership in crisis training with NHSE 14 October 2019., [11/09/2019] Internal audit is being undertaken by ASW during the second week in October to review the CCGs business continuity plans. , [11/09/2019] Severe weather plans and communications plans are being reviewed by relevant service area (Urgent control leads and communications team) and feedback awaited in anticipation of NHSE assurance visit October 2019. , [11/09/2019] Cascade lists of staff have been developed and HR have recently published a staff structure by directorate/service provision, [11/09/2019] Overarching BCP has been drafted and is to be presented to Executive for consideration of approval 24 September 2019, [11/09/2019] The Head of Governance is meeting with BCP Leads across the CCG to test their BCPs,	Our Business continuity plan was graded as green, and our overall Emergency Preparedness Resilience Response rating was satisfactory for 18/19. Each directorate has a Business Continuity Plan in place and these have been reviewed during July/Aug 2019 The CCG was reviewed against the EPRR Core assurance standards by NHS England on 02 October 2019 - the outcome was fully compliant and will be presented to Governing Body end of October 2019. [Assurance Gaps] Capacity in the governance team to accommodate all requirements for Emergency Preparedness Resilience Response core assurance standards	Executive Lead: Sonja Manton Owner: Clare Doble
115	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that Transforming Care will not meet its "building the right support" trajectory and NHS LTP metric to reduce the number of children with LD and or Autism in a hospital place by 2023/24. The impact of this is Children will be place in out of area hospital placements a long way from home and their families, which will have a reputational risk for the CCG. (HISTORIC ID: Na)	Controls are the arrangements made or precautions taken, to reduce risk. (e.g. Governance processes / statutory frameworks, management structure & accountabilities, communications & patient / public feedback, policies & procedures / reviewed at team meetings etc). Please provide details of controls in place, below: Developing proposals to submit to Executive team Seeking additional resources from NHSE to implement proposals Considering existing resources which could be redirected Re-structure adults TCP team to support Children's TCP Recruitment process underway for Clinical lead post to March 2020 Additional co-ordination of CETR process UPDATE 27.04.20: •In line with national guidance, the Learning Disability and Autism Programme is continuing and performance monitoring is ongoing during COVID-19. •Good progress has been made with dedicated resource focused on reducing the number of Children and Young People in placement from 16 to 8 (21.04.2020). This is regularly reviewed and overseen by a fortnightly tracker meeting and reporting to the monthly Learning Disability and Autism Programme (LDAP) Group •Risk remains, as there is increasing activity in admission avoidance,(new admissions or re admissions) acerbated by COVID and risk to children with LD & Autism being restricted within their homes. [Control Gaps] Additional capacity needed to deliver Greater work needed to join up system approach to service Lack of project management to deliver CAMHS Capital Tier 4 admission avoidance project	16 [02/12/2019] 16 (L=4 x I=4)	Risk Opened: 23/01/2020 Reviewed: 05/05/2020	[23/01/2020] Draft proposal to be delivered at hot topics which details plans and resources required to address risk. This has now been approved. Ongoing conversations with NHSE re assurance. Reviewing existing resources to support Children's TCP plan. Meeting to be set up for Feb between CCG Director of Commissioning, and Directors of Children's in the Local Authorities. ,	For each of the risks and controls a source of assurance is set out ie. What provides evidence that the organisation has identified the risks and has controls in place. (e.g. Internal audit report, report to Board or Board Committees) Please provide details of assurances below: TCP Tracker meeting Care and Education Treatment reviews Performance data Escalation calls from NHSE TCP Steering Group LD and Autism Leadership group [Assurance Gaps] Joined up with NHSE Specialised Commissioning Linking in with Children's services, social, EHCP's	Executive Lead: Jo Turl Owner: Shona Charlton

116	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that there will be a system impact from the COVID-19 outbreak (caused by a strain of coronavirus), affecting routine business among provider organisations and the CCG. The impact of this is; a) that both the CCG and provider organisations have a reduced capacity for routine business. b) that the CCG loses lines of assurance and accountability from provider organisations, reducing overall sight of, and assurance levels around, provider organisations. Potential mortality and morbidity impacts are included in this risk. Staff morbidity would exacerbate individual provider and system impact. (HISTORIC ID: Na)	June 2020 - Since the risk was developed in March, there has certainly been a system impact & the system as a whole has worked to mitigate this. All regional and local system command and control structures remain in place including a range of incident cells and the CCG Incident Management teams to ensure continuation of business and service provision in line with national guidance (JP/LW) May 2020 - The request to close this risk following discussion at QAC was declined due to the likelihood of command structures being stepped down and aspects of the risk that QAC need to be sighted on (SD) May 2020 - Covid response to global pandemic is well embedded within the formal incident management structure & actions across the CCG & wider Devon system. Liaising through regional LRF - command structure in place. All Covid-19 related risks are now captured in the Covid-19 risk register which is reviewed weekly and has Executive oversight. Recommendation to close this risk will be verbally communicated at the QAC on 28 May (LW) April 2020 - COVID risks are being sorted separately (SZ) CCG Incident Control room functions Care Cell: attached to Incident Control room Regional NHS England and Public Health England updates Provider & CCG business continuity plan implementation [Control Gaps] Resource required within the CCG in collaboration with provider organisations to support the COVID-19 response, coupled with anticipated staff sickness related to same, is resulting in cancellation of assurance meetings/work and de-prioritisation of other facets of organisational assurance.	15 [11/03/2020] 15 (L=5 x I=3)	Risk Opened: 11/03/2020 Reviewed: 18/06/2020	[10/04/2020] Incident control room functions as evidenced in action log,	June 2020 - All regional and local system command and control structures remain in place including a range of incident cells and the CCG Incident Management teams to ensure continuation of business and service provision in line with national guidance (LW) The CCG Incident Control room functions on a continual basis and includes senior leadership. [Assurance Gaps] None identified	Executive Lead: Darryn Allcorn Owner: Jonathan Plumb

44	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that children and young people will experience significantly delayed waiting times for Autism (ASD) assessment. This risk is applicable to all under 18s across the STP footprint, although the numbers and wait times would be higher in NEW Devon so this could be seen as the higher area of risk. Historically demand has far outweighed capacity for ASD assessment and currently there are a number of services that Children and Young People and families cannot access without a formal diagnosis across the local area. Referral rates continue to rise despite significant work within health services and the wider system to make processes leaner, increase capacity for assessments and offer better needs led increase capacity for assessments and offer better needs led support for CYP and their families. UPDATE SEP 19: A new STP wide risk is with the Director of Commissioning for final sign off, while this risk has been updated it should not be considered in isolation to other ASD risks which were in place before the CCG merger. UPDATE OCT 19: Risk still awaiting sign off 31.10.19. (HISTORIC ID: 111)	Senior Managers have discussed a business case for allocating additional resource to ASD assessment, services, (although none were able to be allocated at this time) and waiting lists have been presented to senior managers as a cost pressure for 2019/20. Regular reporting between Torbay & South Devon Foundation Trust and children's commissioner. Waiting times and improvement work monitored through Contract Review Meetings with Virgin Care Limited. Action plans and trajectory work with both Virgin Care Limited and Torbay & South Devon Foundation Trust have been supported by commissioners and monitored through contractual routes, Contract Review Meetings and Joint Technical Working Group respectively. Multi provider, system wide ASD forum led by Virgin Care Limited to support continuous development. The re-procurement of children's community and wellbeing services have set out expectations for improved services as part of the NDITS specification and action plans will be required as part of mobilisation of the new provider. Sitrep reporting instigated for all providers following Devon SEND inspection highlighting long waits for ASD assessment. ASD strategic group is now meeting monthly and the neuro developmental Strategy Project Group has agreed to develop some of the operational aspects linked to the Written Statement of Action for Devon County Council. Update Oct 2019; Childrens Commissioners and providers are attending adults AIG for ASD funding to ensure there is focus on the14-18 cohort. UPDATE APRIL 2020: Monthly reporting by CFHD continues and shows continue monthly growth in referrals (March 200) impacting on waiting times (avg 291 weeks). The issues is being overseen through regular contact with the provider CFHD. Desk top assessments have been carried out where possible and capacity has shifted to offering telephone support and advice rather than assessments. Numbers of children waiting for assessment in March 2474 (Devon and Torbay). [Control Gaps] The re-procurement of children's community health and wellbeing services across the STP has not supported conditions conducive to enabling system wide performance improvement work and current providers are unlikely to make major changes/investments into the system when they are unclear what the new provider of Children's Community Health Wellbeing Services will want. Additional finances cannot be allocated due to the re-procurement of Children's Community Health Wellbeing Services. There is a pause on improvement planning work by Virgin Care Limited because of their contract ending. The multi agency ASD forum will postpone working until there is clarity on what the new provider for Children's Community Health Wellbeing Services wants to put in place from April 2019. The focus of the ASD Strategic Group is Devon and does not incorporate Plymouth or Torbay, although it is anticipated that service development will be shared through the wider system.	15 [31/10/2019] ▲ 15 (L=5 x I=3) [25/09/2019] ▼ 10 (L=2 x I=5) [25/09/2019] = 10 (L=5 x I=2) [19/09/2019] ▲ 15 (L=5 x I=3) [24/04/2018] 10 (L=5 x I=2)	Risk Opened: 01/04/2013 Reviewed: 22/04/2020	[22/01/2020] UPDATE JAN 2020: A new STP wide risk is with the Director of Commissioning for sign off, to combine risks 15, 44 and 75., [19/09/2019] Reason: Risk 44 (NEWD CCG)/ 15 (SDT CCG) is proposed for step down from the Corporate Risk Register to the Women's and Children's Team Risk Register as the scoring sits below 16. This risk will be reviewed and updated at monthly team meetings. Performance against waiting times will benefit from more structured monitoring as part of the new contract for Children's Community Health and Wellbeing Services from April 2019 and through situational reporting to commissioners following the Devon SEND inspection and Written Statement of Action. https://nww.newdevonccg.nhs.uk/riskregister/ UPDATE SEP 19: A new STP wide risk is with the Director of Commissioning for final sign off, while this risk has been updated it should not be considered in isolation to other ASD risks which were in place before the CCG merger. ,	Business cases have identified what additional resources could achieve across the STP. Priorities for ASD have not been challenged in the Children's Community Health Wellbeing Services reprocurement process. A significant amount of patient/ family engagement was undertaken as part of the reprocurement of children community health and wellbeing services, so commissioners understand what is important and length of wait for assessment was less so where families are communicated with effectively and feel supported. Virgin Care Limited also undertook an engagement exercise in 2017/18. Devon SEND inspection highlighted significantly high waiting times for ASD assessment and providers have responded to regular meetings to discuss ways to move forward jointly with commissioners. A bid to NHSE for funding to reduce ASD waiting times was partially successful. Providers are expected to use any additional resource in 2018/19. A business case has been developed alongside the Adults business case, requesting funding to the waiting list crisis and to support post and pre diagnosis. National picture is similar to ours. UPDATE SEPTEMBER 2019 £750K funding has been secured for a waiting list initiative across 2019/20 - 2020/21. This will enable over 1/3 of those waiting to be assessed. In addition a business case will be presented at Integrated Community Executive for post and pre diagnostic funding in January 2020. The adults business case to the Integrated Community Executive secured funding for pre diagnosis services from the age of 14 upwards. There are plans to pilot and roll out a schools focused set of behavioural workshops. Adult will mirror this with similar provision. [Assurance Gaps] Virgin Care Limited , who hold a significant majority of the waiting times have paused development work while the new provider of CCHWS confirms their long term plans and mobilisation starts. Due to the service's inclusion in the reprocurement of children's community health services no additional resource can be given from the CCG to address the waiting lists or develop new ways of working, at this time. There is a lack of understanding as to why parents are asking for an ASD assessment, to inform the wider system barriers to not having a diagnosis. There is a lack of clarity as to why referral rates are increasing generally. There is a lack of clarity as to which services are referring in for an ASD assessment. Funding from NHSE for waiting times is not enough to have a significant or sustained impact. Aspirations within the WSOA, including the reduction in waiting times will not be achieved if additional funding is not received for services. UPDATE SEP 2019 Waiting list initiative	Executive Lead: Sonja Manton Owner: Siobhan Grady

							funding will ensure a meaningful number of assessments are carried out but this will still leave a significant number of CYP waiting.	
102	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that the number of Devon Partnership Trusts overdue Root Cause Analysis Serious Incident (SI) reports might affect the embedding of learning and improvement. The impact of this to the CCG is a lack of assurance that patient safety improvements from incident learning are identified and actioned in a timely way (Previously linked to mirrored risk 103 which is now closed) (HISTORIC ID: Na)	June 2020 - QAC paper planned for July 2020 (joint CCG DPT CNO's) (SW) May 2020 - Meeting arranged w/c 01/06/20 with Chris Burford, DPT & Phillip King, Devon CCG to include discussions around the increase in outstanding SI's & for an agenda item at the June QAC to be added on outstanding DPT RCA's. It was agreed this risk needs to be reviewed following the meeting with DPT (SD) May 2020 - Executive level decision has taken place during May 2020 between the organisations' Director of Nursing to address on-going late serious incidents (SW) April 2020 - The number of overdue SIs has increased. DPT remain committed to resolving but have lost staff to the COVID-19 frontline reducing their capacity to undertake RCAs. Safety systems team in regular contact with DPT (SZ) March 2020 - All overdue RCA's have been allocated to reviewers as of 5th March 2020. It was felt at Quality Assurance Committee on 12/03/20 whilst the number has not improved the quality and engagement is improved. The risk score will be reviewed as planned in April (IL) [Control Gaps] April 2020 - The number of overdue SIs has increased. DPT remain committed to resolving but have lost staff to the COVID-19 frontline reducing their capacity to undertake RCAs (SZ) March 2020 - DPT are not meeting trajectory, 31 remain overdue, this continues to be escalated to DPT Director of Nursing via DPT Head of Safety and Risk (IL) Assurance still lacking at Quality Committee in Common due to the written report on the management of Serious Incident's not being submitted – CCG chasing	15 [21/02/2019] ▼ 15 (L=5 x I=3) [25/01/2019] 20 (L=5 x I=4)	Risk Opened: 25/01/2019 Reviewed: 15/06/2020		March 2020 - The quality of investigations has greatly improved with less being returned for further information. The number of reported investigations has reduced to average 7 a month opposed to 12-13 a month, this is due to work with CCG / DPT/safeguarding and NHSE, reduced duplication and ensured only appropriate incidents reported. The number of overdue investigations has plateaued. There are now more clinical reviewers so more capacity in the team following training undertaken (IL) [Assurance Gaps] Action planning for overdue incidents is not visible whilst overdue. The quality of 'immediate' 72hr reporting is important in assuring that identified safety issues have been implemented.	Executive Lead: Darryn Allcorn Owner: Sara Wright

NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group
Audit Committee
Terms of Reference

1. Constitutional Obligations

1.1 The Clinical Commissioning Group's Governing Body hereby resolve to establish a Committee of the Governing Body known as the Audit Committee. The Committee is established in accordance with Devon Clinical Commissioning Group's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

1.2 These terms of reference set out the Membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's Constitution and standing orders.

1.3 The Audit Committee is an assurance Committee of the Governing Body and has the ability to execute any powers assigned to it by the Governing Body and those specifically delegated in these terms of reference and/or through the CCGs Constitutional Scheme of Reservation and Delegation.

1.4 The Local Audit and Accountability Act 2014 (the Act) requires every 'relevant authority' to appoint an 'Auditor Panel' to exercise functions set out in the Act (part 3, section 9). The Governing Body has resolved to nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, Paragraph 1 of the 2014 Act and details of the Auditor Panel responsibilities and purpose are encompassed within the Audit Committee's terms of reference in line with the Act.

2. Purpose

2.1 The purpose of the Audit Committee is to assist the CCG in delivering its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide evidence-based assurance to the Governing Body that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Financial statements are prepared in a timely fashion, and give a true and fair view of the financial position of the CCG for the period in question
- Affairs are managed to secure economic, efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities Governing bodies can – if they choose – nominate a 'subset' of the Audit Committee to act as the Auditor Panel. If a subset is used, there must be at least three Members with a majority who are independent and non-executive Members of the Governing Body. (HFMA briefing December 2015)

2.2 It is the responsibility of the Committee to make recommendations to the Governing Body on determinations about the assurances received surrounding any internal or external audit findings and probity issues on behalf of the CCG.

2.3 It shall support the objectives of the CCGs Governing Body as outlined in the Operational Plan and provide assurances to the Governing Body that these are being met and considered.

2.4 It will promote a whole system culture of continuous improvement, ensuring that assurance and probity sits at the heart of health and social care locally, whether provided by NHS or non-NHS providers.

2.5 It will seek assurance that the CCG is fulfilling its statutory duties through continuous monitoring and this will be detailed in the organisation's annual governance statement and annual report, under the relevant Acts, and current national guidance.

2.6 The Committee is authorised by the CCG Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the Committee.

2.7 The Committee is authorised by the CCG Governing Body to obtain external legal or other independent professional advice and to secure the attendance of advisers with relevant experience and expertise if it considers this necessary.

2.8 The Committee is responsible for the approval of the Annual Financial Statements and Annual Governance Statement prior to submission to the CCG Governing Body.

3. Responsibilities

The responsibilities of the Committee can be categorised as follows:

3.1 Governance, Internal Control and Risk Management
The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisation's core objectives.

3.1.1 In particular the Committee will review the adequacy and effectiveness of:

a) All risk and control related disclosure statements (in particular the Annual Governance Statement and any declarations of external compliance), together with any accompanying Head of Internal Audit Opinion, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the CCG Governing Body
b) The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
c) The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
d) The policies and procedures for all work related to counter fraud and security as required by

NHS Counter Fraud Authority (NHSCFA).

3.1.2 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective risk assurance framework to guide its work and that of the audit and assurance functions that report to it. To enable this, the Audit Committee will have sight of the full risk assurance framework no less than four times a year to enable it to report on its assurances of internal control and the process of risk management throughout the organisation to the Governing Body.

3.1.3 The Audit Committee shall review the findings of other significant assurance functions through effective relationships with other key Committees so that it understands processes and linkages and will receive assurance that these Committees are working effectively through the annual Committee effectiveness reviews. However, these other Committees must not usurp the Committee's role.

3.1.4 The Committee will review the Finance and Performance reporting and Quality reporting to the Governing Body at each meeting. The Committee will challenge the content of the report and seek assurance that it is based on sound systems of control and that there are appropriate action plans in place to mitigate the risk areas. This will provide the opportunity for detailed scrutiny of the performance of the CCG prior to this being presented to the Governing Body.

3.1.5 Where timeliness is of the essence in managing a significant risk or issue, the Chair of the Committee will be informed of an issue by the quickest possible means (e.g. verbally) and this will be acted upon in accordance with the risk management strategy and risk escalation processes of the CCG.

3.2 Auditor Panel

3.2.1 The Auditor Panel for NHS Devon CCG forms a subset of the Audit Committee and shall comprise of the core Membership of the Audit Committee. This Membership consists of at least 3 Members with a majority who are independent and recognised as non-executive lay Members of the Governing Body.

3.2.2 The Auditor Panel is a non-executive lay Member Committee and has no executive powers other than those specifically delegated in these terms of reference. In line with the requirements of the Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 (regulation 6) each Members independence must be reviewed against the criteria laid down in the regulations[2].

3.2.3 The Auditor Panel chairperson and/or Members of the panel can be removed in line with rules agreed by the Governing Body.

2 If a specially established panel is nominated with new Members (i.e. not from the existing Audit Committee, a full recruitment process must be followed in line with Regulation 3. This means that any prospective Members who are not on the Governing Body must be appointed in response to an advertised vacancy and after submitting an application.

3.2.4 The Auditor Panel's chairperson shall formally state at the start of each meeting that the Auditor Panel is meeting in that capacity and NOT as the Audit Committee.

3.2.5 Auditor Panel business shall be identified clearly and separately on the agenda and Audit Committee Members shall deal with these matters as Auditor Panel Members NOT as Audit Committee Members.

3.2.6 The Auditor Panel's functions are to:

a) Advise the CCG's Governing Body on the selection and appointment of the external auditor. This includes:
b) Agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules;
c) Making a recommendation to the Governing Body as to whom should be appointed;
d) Ensuring that any conflicts of interest are dealt with effectively;
e) Advise the CCG's Governing Body on the maintenance of an independent relationship with the appointed external auditor
f) Advise (if asked) the CCG's Governing Body on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable;
g) Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor;
h) Advise the CCG's Governing Body on any decision about the removal or resignation of the external auditor.

3.3 External Audit

3.3.1 The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management responses to their work. This will be achieved by:

a) Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Governing Body when appropriate)
b) Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
c) Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
d) Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Governing Body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
e) Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

3.4 Internal Audit

3.4.1 The Committee shall ensure that there is an effective internal audit function established by management that meets the Public sector internal audit standards, 2017 and

provides appropriate independent assurance to the Committee, Accountable Officer and CCG Governing Body.

This will be achieved by:

a) Consideration of the provision of the Internal Audit service and costs involved,
b) Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
c) Considering the major findings of internal audit work (and managements response) and ensuring coordination between the internal and external auditors to optimise the use of audit resources;
d) Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
e) Monitoring the effectiveness of internal audit and carrying out an annual review

3.5 Counter Fraud and Bribery

3.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority (NHSCFA) standards and shall review the outcomes of work in these areas.

3.5.2 The Committee shall also ensure that there is a counter fraud specialist within the CCG and that policies and procedures for all work related to fraud are in place while also ensuring that procedures are in place which ensure that it cannot be guilty of any bribery or corruption. The Committee will receive reports from the Local Counter Fraud Specialist on current investigations.

3.6 Financial Reporting

3.6.1 The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

3.6.2 The Committee should ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

3.6.3 The Committee shall review the annual report and financial statements before submission to the Governing Body, focusing particularly on:

a) The wording in the annual governance statement and other disclosures relevant
b) to the Terms of reference of the Committee;
c) Changes in, and compliance with, accounting policies, practices and estimation
d) techniques;
e) Unadjusted mis-statements in the financial statements;
f) Significant judgements in preparation of the financial statements
g) Significant adjustments resulting from the audit
h) Letters of representation
i) Explanations for significant variances

3.7 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

3.8 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

4. Membership

The core Membership of the Audit Committee shall be:

The following Members have voting rights:

- (Chair) Non-Executive Lay Member – who has qualifications expertise or experience to enable them to lead on finance, probity, governance and audit matters enabling them to express an informed view about discharge of the CCG functions
- Additional Non-Executive Lay Member representatives
- Registered Nurse
- Secondary Care Consultant

The following attendees do not have voting rights:

GB locality clinical representative

Under the NHS (CCG Groups) Regulations 2012, (14) Audit Committee (3) The following are disqualified from Membership of a CCG's Audit Committee:

(a) the Chair of the CCG's Governing Body

(b) the CCG's Chief Finance Officer

Attendees do not have voting rights and include:

The Chief Finance Officer/Director of Finance, Governance representative, Head of Internal Audit, the local counter fraud specialist (LCFS) and representatives from external audit shall normally attend meetings. At least once a year the Committee Members should meet privately with the external and Internal Auditors without any senior officer present.

The Accountable Officer and CCG Chair can attend any Committee meeting but cannot be the Chair of the Audit Committee.

The Accountable Officer/Chief Officer does not have voting rights, and, should be invited to attend and discuss at least annually with the Audit Committee the process for assurance that supports the CCGs input into the annual governance statement. He or she should also attend when the Committee considers the CCG input into the draft Internal Audit plan and Annual Accounts.
The Chair of the Committee may co-opt any non-voting Clinicians, Executive or Managing Directors, nominated deputies and lead managers as appropriate and particularly, when the Committee is discussing areas of risk or operation that are the responsibility of that attendee.
Note: When a Committee Member is unable to attend, a nominated formal deputy with sufficient authority must attend in their place. Deputies will have the decision making and voting rights of the person he/she is representing.

5. Quorum

5.1 A quorum of the Audit Committee and the Auditor Panel shall be two of the Non-Executive Lay Members and one clinical Member.

5.2 A decision put to a vote at the meeting shall be determined by a majority of the votes of independent Members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

5.3 People invited to attend, or those in attendance to the Committee do not have the right to vote.

5.4 If the Committee Chair is absent then the Members of the Committee will select a chair for that meeting from the voting Members present – this will be overseen by the most senior officer responsible for governance as the Chair needs to be an independent representative of the CCG.

6. Register of Interests

6.1 The Register of Interest will be reviewed at each Audit Committee meeting in line with the NHS Audit Committee Handbook.

6.2 Members will be asked by the Chair of the Audit Committee to declare any interests at the beginning of each meeting. If a Member feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

6.3 **Auditor Panel**. Conflicts of interest must be declared and recorded at the start of each meeting of the Auditor Panel. Auditor Panel register of interest must be maintained by the panels chairperson and submitted to the Governing Body in accordance with the CCGs standards of business conduct policy. If a conflict of interest arises, the chairperson may require the affected Auditor Panel Member to withdraw at the relevant discussion or voting point.

7. Frequency of Meetings

7.1 The Audit Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per annum at appropriate times in the reporting and audit cycle which must be documented in the corporate calendar and aligned to provide assurance in a timely manner to Governing Body. The Governing Body, Accountable Officer, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

7.2 The Head of Internal Audit, representative or external audit and counter fraud specialist have a right of direct access to the Chair of the committee.

7.3 The Auditor Panel will usually meet on the same day as the Audit Committee, either before or after dependent upon availability of Members and governance arrangements. The Auditor Panel's chairperson may invite executive directors and others to attend depending on the requirements of each meeting's agenda. These invitees are not Members of the Auditor Panel.

7.4 The Committee has agreed that in the interest of expediency or when there are few items to be discussed that business of the committee can be conducted by e-mail and the actions/decision will be recorded by the Administrator for purposes of transparency and recording. Where a discussion is required, all Members must respond, and the administrator will oversee this to ensure that all Members are accounted for.

8. Reporting arrangements

8.1 The Committee Chair shall report formally to the CCGs Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the public meeting of the CCGs Governing Body. The Committee shall make recommendations to the CCGs Governing Body on any area within its remit where action or improvement is needed.

8.2 The Committee is authorised by the CCG Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

8.3 The Committee may require the attendance at its meetings of any officer of the CCG and the production of any document.

8.4 The Committee is authorised by the CCG Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8.5 The Auditor Panel is a sub group of the Audit Committee and is authorised by the Governing Body to carry out the functions specified at 3.2.6 and can seek any

information it requires from any employees or relevant third parties. All employees are directed to co-operate with any request made by the Auditor Panel.

8.6 The Auditor Panel is authorised by the Governing Body to obtain outside legal or other independent professional advice (for example, procurement specialists) and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such 'outside advice' must be obtained in line with the organisations existing rules (e.g. legal framework policy).

8.7 Minutes and reports of the meetings will be produced and held by the Administrator of the Committee, accessible to the Chair, core Membership and the Director responsible for the corporate function. Extracts from Minutes will be made public as appropriate under the freedom of information act.

9. Statutory Functions, Committee Oversight and KPIs (Internal Monitoring)

9.1 The Governing Body has delegated the following authorities to the Audit Committee:

• Authority to establish sub-groups
• Provision of an independent and objective view of the CCG's systems of internal control, information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance, risk, quality and performance management systems underpinned by the assurance framework
• Appoint Internal Auditors
• Approve the internal audit plan
• Review financial policies
• Approval of the CCGs risk management framework and risk assurance framework

9.2 The Committee will undertake an annual review of the performance and effectiveness of the CCG Governing Body associated sub-committees to ensure that the Committee structure and work plans reflect the current and future needs of the CCG Governing Body.

9.3 In addition, the Committee will review the work of other sub-groups within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. These may include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Public Sector Audit Appointments Ltd, National Audit Office, Financial Reporting Council) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal College, accreditation bodies).

9.4 The reviews will be spread throughout the year with an Annual Report produced by the Committee for the Governing Body.

10. Administration

10.1 The Committee and its sub-group shall be supported administratively by its Administrator his or her duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the Chair to prepare reports to the Governing Body
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example, with the internal/external auditors, Auditor Panel or local counter fraud specialists
- Maintaining records of Members appointments and renewal dates
- Advising the Committee on pertinent issues/areas of interest/policy developments
- Advising the Auditor Panel on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Ensuring that Committee Members receive the development and training they need.
- Ensuring that panel Members receive the development and training they need
- Providing appropriate support to the Chairperson and Panel Members

10.2 Following each meeting, the Administrator will:

- Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by Members.
- Maintain a record of decisions taken for transparency through each Audit Chairs report.
- Maintain a log of summary written reports provided to Governing Body from formal meetings.

11. Review

An annual effectiveness review will be undertaken by the Head of Governance as good governance practice and to ensure compliance with the Annual Governance Statement.

These Terms of Reference will be reviewed on an annual basis or sooner if required through the Head of Governance with recommendations made to the CCGs Governing Body for approval via the Audit Chair.

END

Updated 18/06/2020 Corporate Objective	Assurance Framework Ref	Corporate Risk Register mapping	Initial Risk Score	last score change	Date risk score changed	Risk Movement from initial risk score (Trend)	Risk Appetite /Target Score	Assurance Score	Lead Director	Date AF Risk Reviewed	Principle Risks *There is a risk that…….*
We will continue to commission safe, effective and accessible services by:											
• Being in the top 10% of CCGs by improving performance against core NHS standards	1	3, 11, 106, 109	20			⇔	10	8	Sarah Thompson	18/06/2020	We do not have sufficient, credible plans to deliver improved performance within agreed timescales
• Meeting all statutory requirements	2	38, 102, 104, 110	20			⇔	15	8	Simon Tapley	02/03/2020	The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress.
• Improving our populations health, their experience of care and the cost-effectiveness	3		20			⇔	15	10	Sonja Manton	17/06/2020	The pace of change for roll out of ICM is too slow and therefore does not achieve planned outcomes
• Increasing the use of technology	4	42, 44,	20	16	16/06/2020	⇩	15	10	Jo Turl	16/06/2020	We do not commission mental health services which meet local need or national expectation
	5		16	9	20/08/2019	⇩	12	11	Andrew Millward	17/06/2020	We do not develop commissioning plans which incorporate best practice in the use of technology
We will work as a strategic partner in Devon by:											
• Working as one system to support the delivery of all objectives	6	90, 95	20			⇔	15	11	Simon Tapley	02/03/2020	We do not have full commitment from all system partners to deliver operational system plan so change is not delivered.
• Working more closely with local communities to plan local services	7	100	20	15	20/08/2019	⇩	15	11	Simon Tapley	02/03/2020	The system does not have robust mechanisms for identifying and responding to emerging risks
• Developing evidence-based services	8	107	8	6	20/08/2019	⇩	8	12	Andrew Millward	16/06/2020	Our plans do not reflect the views of patients and the public as there has not been sufficient engagement.
• Empowering, motivating and developing our staff	9	15, 20, 24	16	12	16/06/2020	⇩	8	11	Andrew Millward	16/06/2020	We do not develop evidence-based commissioning plans due to lack of capacity and capability within the CCG
	10		12	3	16/06/2020	⇩	4	12	Andrew Millward	16/06/2020	We have not addressed the issues raised in the 2018 staff survey so staff leave or do not perform to their full potential
We will improve the physical and mental health of our population by:											
• Integrating and personalising care • Addressing issues that cause ill health	11		16			⇔	8	11	Ginny Snaith	16/06/2020	We have not evolved our integrated strategic commissioning arrangements sufficiently to develop plans to deliver improvements in population outcomes
• Reducing health inequalities	12	77, 92	20			⇔	10	8	Sonja Manton	17/06/2020	We have not invested sufficiently in prevention so we do not achieve improvements in population health
	13	75	16	12	12/02/2020	⇩	8	8	Jo Turl	16/06/2020	We are not targetting our resources at the areas that most need them so health inequalities are exacerbated.
We will make best use of resources by:											
• Using population health management approaches to target resources where they are needed most	13	See AF13	16	12	12/02/2020	⇩	8	8	Jo Turl	16/06/2020	We are not targetting our resources at the areas that most need them so health inequalities are exacerbated.
• Improving efficiency, productivity and sustainability	2	See AF 2	20			⇔	15	8	Simon Tapley	02/03/2020	The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress
• Achieving financial balance across the whole health and care system in Devon	6	See AF6	20			⇔	15	11	Simon Tapley	02/03/2020	We do not have full commitment from all system partners to deliver operational system plan so change is not delivered.
• Increasing investment in services to meet identified need	14	105, 108	20	12	16/06/2020	⇩	15	8	Jo Turl	16/06/2020	There is insufficient workforce capacity and capability in Primary Care (GPs, nurses and pharmacists) to meet demand

Objective: We will commission safe, effective and accessible services.		Director Lead: Sarah Thompson
Risk: AF 1 – We do not have sufficient, credible plans to deliver improved performance within agreed timescales		**Date Last Reviewed: 18/06/2020** **Reviewer: Sarah Thompson**
Corporate risks	3, 11, 106, 109	
Risk Rating	Impact x likelihood	Reason for current score:
Initial:	**5x4 = 20**	Plans based on potential opportunities but impact is only hypothetical and cannot be tested without delivery
Current:	**5x4 = 20**	
Appetite:	**5x2 = 10**	Rationale for risk appetite:
		Robust plans can be produced to ensure delivery
Controls: (What are we currently doing about this?)		Assurances:
System Operating Plan has been produced and signed off by all partner organisations. Detailed workplans have been agreed and leads have been identified/appointed SPG has identified and is progressing system solutions for 52 weeks and diagnostics. Planned Care Programme Board now established with CEO leadership. The Devon A & E delivery board is now managing system priorities for urgent care and led by STP CEO PMO is using a standardised approach to action planning by using PMO support offer and templates		PDEG and committees have governance arrangements in place for system working and monitoring performance A&E Delivery Boards, Planned Care Forums and ICM Groups in place in each locality
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**8**
Further Development of LCPs to deliver at locality level Specific pieces of work will be implemented and will demonstrate future deliverability Ongoing review of delivery will result in changes to plans		Gaps in Assurance: (What additional assurances should we seek?) Line of reporting to CCG needs to be strengthened to focus on CCG deliverables which contribute to system plan

Date	Update on actions taken
05/12/2019	Additional independent capacity to support diagnostics and 52 week wait in place to March 2020
18/06/2020	Performance outturn for 2019 to 2020 was presented to the GB 18/06/2020 and GB have signed of agreement to the position (SFT)

Objective: We will commission safe, effective and accessible services. We will make the best use of resources		**Director Lead: Simon Tapley**
Risk: AF2 – The CCG does not meet its statutory requirements and corporate objectives because it does not have effective mechanisms for monitoring progress		**Date Last Reviewed: 02/03/2020 Reveiwer: Simon Tapley**
Corporate risks	38, 102, 104, 110	
Risk Rating	Impact x likelihood	Reason for current score:
Initial:	**5x4 = 20**	Insufficient capacity for programme management in CCG due to demands of system working
Current:	**5x4 = 20**	
Appetite:	**5x3 = 15**	Rationale for risk appetite:
		CCG needs to ensure robust programme management.
Controls: (What are we currently doing about this?)		Assurances:
Agreed recruitment to increase PMO capacity – Business Case agreed by Exec Team 18/6/19. Monitoring performance of recovery action plans		Quality and Performance reports to GB and Committees largely focus on provider performance
Control Gaps		
Mitigating Actions: (What should we do?)		
Need to establish reporting mechanisms/ formats/content and clear expectations of role of PMO and others in supporting new arrangements SA dashboard will be developed to clearly set out progress against agreed metrics.		Assurance Score: **8** Gaps in Assurance: (What additional assurances should we seek?) Robust reporting to GB and Committees on: Delivery of Operational Plan Progress with delivery of Corporate Objectives

Date	**Update on actions taken**
11.02.2020	Appointment of Interim Chief Operating Officer with a focused portfolio on performance
	Regular reporting on QIPP plans by programme leads and PMO to executive team and senior leadership team
	Development of a target operating model and alignment of planning cycles

Objective: We will commission safe, effective and accessible services.		Director Lead: Sonja Manton
Risk: AF3 – The pace of change for roll out of ICM is too slow and therefore does not achieve planned objectives		**Date Last Reviewed: 17/06/2020** **Reviewer: Sonja Manton**
Corporate risks		
Risk Rating	Impact x likelihood	Reason for current score:
Initial:	**5x4 = 20**	Progress with implementation of ICM blueprint has stalled
Current:	**5x4 = 20**	
Appetite:	**5x3 = 15**	Rationale for risk appetite:
		Blueprint has been developed and mechanisms in place for implementation. Systemwide commitment to delivery
Controls: (What are we currently doing about this?)		Assurances:
Blueprint developed and agreed by the system Revised arrangements for ownership, accountability and governance Systemwide approach led by joint SROs in NHS and LA Systemwide resource agreed for implementation Priorities and programmes of work agreed led by the system During the COVID response the localities have set up meetings to integrate services to support people out of hospitals, which has progress the delivery of the programme at pace.		Reporting to system and CCG AO by programme workstream (temporally changed during COVID) The locality meetings report to the CCG via the Directors of Commissioning and the COO
Control Gaps		
The programme as designed has been temporarily been de-prioritised however the locality meetings have progressed integration during the COVID incident		Assurance Score: **10**
		Gaps in Assurance: (What additional assurances should we seek?)
Mitigating Actions: (What should we do?)		Formalise the feedback of the locality meetings
Further development of Locality groups to support implementation to take on the learning from COVID Further data analysis required to understand actual vs hypothesised impact and whether this can be better than flat levels of growth. This will be supported by the further development of the One Devon dataset. Development work required to increase local system maturity and reduce variation between systems Roll out of the PHM programme from September		

Date	Update on actions taken
31/10/2019	Strengthened programme resource and reporting in place; further shaping of LCP proposals as part of ICS; proposal for independent review of ICM impact being considered
Jan-20	Framework gap analysis completed in each locality, informing local priorities for delivery. Locality commissioner and provider leadership working together with clear line of sight to monthly programme board.
17/06/2020	Locality groups progressing integrated out of hospital care at pace
17/06/2020	Agreement to the PHM programme roll out form September 2020

Objective: We will commission safe, effective and accessible services.		**Director Lead:** **Jo Turl**
Risk: AF4 – We do not commission mental health and learning disability services which meet local need or national expectation		**Date Last Reviewed: 16/06/2020** **Reveiwer: Jo Turl**
Corporate risks	42, 44,	
Risk Rating	Impact x likelihood	Reason for current score:
Initial:	**5x4 = 20**	The CCG in January the CCG committed to supporting the use of additonal ward in Devon to provie DPT with additional 16 beds
Current:	**4x4 = 16**	
Appetite:	**5x3 = 15**	Rationale for risk appetite:
		Delivery programme agreed to support system working
Controls: (What are we currently doing about this?)		Assurances:
Mental Health Care Partnership will oversee work programme (including Out of Area Placements and First response) 2 day mental health conference held Transforming Community Services Group for LD will now oversee childrens TCP cohort CCG have commissioned additional input into CMHTs which should help reduce waiting times. Currently agreeing The CCG in January the CCG committed to supporting the use of additonal ward in Devon to provie DPT with additional 16 beds Mental Health/Learning Disability/Autism (MHLDA) cell as part of the COVID work are reviewing the demand profile for the population, peri/post covid the CCG will commission future services based on the needs analysis.		Exec to Exec meetings with providers Report to NHSE Regular contract meetings with Providers
Control Gaps		
		Assurance Score: **10**
Mitigating Actions: (What should we do?)		Gaps in Assurance: (What additional assurances should we seek?)
Potential for additional in patient beds to be commissioned through ELYSIUM subject to captial Review of Learning Disability Beds Work being undertaken to understand and develop the market		Support required from PMO in CCG to improve regular and adhoc reporting arrangements

Date	Update on actions taken	

Objective: We will commission safe, effective and accessible services.		Director Lead: Andrew Millward
Risk: AF5 – We do not develop commissioning plans which incorporate best practice in the use of technology		**Date Last Reviewed: 17/06/2020** **Reveiwer: Andrew Millward**
Corporate risks		
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x4 = 16**	This risk is applicable across the STP and closer links with commissioning will be explored to support this area of concern'
Current:	**3 x 3 = 9**	**Rationale for risk appetite:**
Appetite:	**4 x 3 = 12**	Arrangements can be developed that will ensure closer working
Controls: (What are we currently doing about this?)		**Assurances:**
Digital workstream in place and workplan agreed – Reporting into PDEG. System Director – Nick Hopkinson and SRO Suzanne Tracey John McCormick – Clinical Digital Lead – Linked to national programme CCG represented by Jim Goodwin		PDEG AEDB, Planned Care Boards, ICM
Control Gaps		
Develop a new operating plan through the CCG commissioning processes to ensure that we take every opportunity to make the best use of technology, specifically in service reviews and service specification documentation		**Assurance Score:**
Mitigating Actions: (What should we do?)		**11**
Increased representation from CCG staff on workstream programme steering group Improve links between digital workstream group and delivery groups such as AEDB, Planned Care Boards and ICM Groups Ensure Digital rep on each LCP to champion use of technology Each commissioning group to identify good practice from outside Devon		**Gaps in Assurance: (What additional assurances should we seek?)** Commissioning plans need to incorporate delivery of required technological changes

Date	Update on actions taken
25/10/2019	There are no updates to make at this time NH

Objective: We will work as a strategic partner in Devon We will improve the mental and physical health of the population		Director Lead: Simon Tapley
Risk: AF6 – We do not have full commitment from all system partners to deliver operational system plan so change is not delivered		**Date Last Reviewed: 02/03/2020** **Reveiwer: Simon Tapley**
Corporate risks	90, 95	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**5x4 = 20**	Development work required to support system working arrangements
Current:	**5x4 = 20**	
Appetite:	**5x3 = 15**	**Rationale for risk appetite:**
		System is required to reach ICS status by April 2021.
Controls: (What are we currently doing about this?)		**Assurances:**
System workplan agreed and being managed through system PMO Regular reports from all workstreams and projects to PDEG. STP SRO and Chair appointed		Progress monitored through Programme Delivery Executive Group(PDEG) and feedback to CCG through AO and other Execs Updates on operational plan to GB Non-Exec Directors aligned to Locality Care Partnerships
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**11**
		Gaps in Assurance: (What additional assurances should we seek?)
Operational Plan working group co-ordinating production of plan to ensure all organisations are involved and fully committed PMO establishing programme management arrangements ICS Board to start meeting in April 20		Need to have PDEG performance reports to CCG Finance and Performance Committee Need to develop Non-Executive oversight of system working

Date	Update on actions taken

Objective: We will work as a strategic partner in Devon		Director Lead: Simon Tapley
Risk: AF7 – The system does not have robust mechanisms for identifying and responding to emerging risks		**Date Last Reviewed: 02/03/202012/08/2019** **Reveiwer: Simon Tapley**
Corporate risks	100	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**5x4 = 20**	System Risk Register now in place through the STP Directors.
Current:	**5x3 = 15**	
Appetite:	**5x3 = 15**	**Rationale for risk appetite:**
		All statutory organisations have risk management processes in place
Controls: (What are we currently doing about this?)		**Assurances:**
Most workstreams and programmes of work have risks identified and are managing risk log Programme managers meeting reviews risks to individual programmes STP Risk Register partially populated		Finance working group monitors financial risks SPDG monitors performance and delivery risks Clinical cabinet monitors clinical risks AEDB, Planned Care and ICM Groups also maintain overview of relevant risks
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**11**
STP Directors to update and fully populate risk register Electronic/ online system to be developed to facilitate updating		**Gaps in Assurance: (What additional assurances should we seek?)** ? Prevention Board Need PDEG report to Finance and Performance Committee Need to clarify reporting and management mechanisms for risks identified at local QSGs.

Date	Update on actions taken
12/08/2019	System Risk Register now in place through the STP Directors.
02/03/2020	System Risk Register not fully populated - STP Directors are working on this

Objective: We will work as a strategic partner in Devon		Director Lead: Andrew Millward
Risk: AF8 – Our plans do not reflect the views of patients and the public as there has not been sufficient engagements		**Date Last Reviewed: 16/06/2020** **Reviewer: Andrew Millward**
Corporate risks		
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x2 = 8**	The rationale is that we have just been given a GREEN STAR rating (rated Outstanding) for our engagement by NHS England (one of only 25 CCGs in the country).
Current:	**3x2 = 6**	
Appetite:	**4x2 = 8**	**Rationale for risk appetite:**
		Risk level will fluctuate with time (e.g. when large or contentious consultation underway) so plan is to maintain risk at current level by actions outlined.
Controls: (What are we currently doing about this?)		**Assurances:**
We have a new citizens panel - 1700 people from across Devon. This panel is totally representative of the Devon population and enables us to engage with them on a regular basis. 16/06/2020 Engagement strategy/Plan agreed Engagement Panel meeting on monthly basis. CCG-wide communications strategy written and published. 16/06/2020		NHSE Annual Assurance on engagement NED for Patient and Public Engagement Engagement Panel with patient representatives
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**12**
Implement engagement process for LTP Continue to develop all staff within the CCG to increase capacity supporting engagement Continue to support and develop PPGs to deliver their practice role and to increase their involvement in wider engagement initiatives		**Gaps in Assurance: (What additional assurances should we seek?)** We have agreed new arrangements for Engagement Panel reporting/accountability, which will have formal governance links to the Quality Committee.

Date	Update on actions taken

Objective: We will work as a strategic partner in Devon		Director Lead: Andrew Millward (Piers Tetley & Katy Kerley)
Risk: AF9 – We do not develop evidence-based proposals due to lack of capacity and capability within the CCG		**Date Last Reviewed: 16/06/2020** **Reveiwer: Andrew Millward**
Corporate risks	15, 20, 24	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x4 = 16**	We have started to review our staff across the CCG as part of the OD ad talent management programme. 16/06/2020
Current:	**4x3 = 12**	
Appetite:	**4x2 = 8**	**Rationale for risk appetite:**
		CCG has identified the need to develop this expertise or identify support from elsewhere
Controls: (What are we currently doing about this?)		**Assurances:**
Some individuals with high levels of knowledge and skills including those linking to national roles OD and talent management programme Vacancy control panel to review staffing and vacancies A new appraisal process in place to identify training and development needs		Staffing (including capability and capacity) regularly reviewed by Executive team 16/06/2020 QEIA process
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**11**
Need to review current levels of skills and experience in commissioning team Develop stronger links with AHSN and establish potential level of support Need horizon scanning mechanisms to translate national examples for applicability in Devon		**Gaps in Assurance: (What additional assurances should we seek?)**

Date	Update on actions taken
31/10/2019	Talent Management proposals discussed with executive and SLT in Oct and Nov respectively - anticipate commencement of implementation in Q4
07/02/2020	A Talent Management (TM) approach has been developed and shared with Execs and SLT. TM conversations are in progress with deadlines for conversations from Exec - band 8a to be complete by 31st Jan 2020 (this is in order to meet the deadline for national development programmes) and for all individuals within the organisation to have had a conversation by 31st March 2020.
07/02/2020	Talent focus group for check and challenge of processes has met and will continue to meet monthly with reps from Staff Partnership Forum, Working Together Group, Clinicians, DRSS and HR.
07/02/2020	Devon CCG Talent Board to meet mid/late Feb. OD Strategy will be presented at GB March 2020
02/06/2020	This is being reviewed as part of the strategic commissioning programme of work.

Objective: We will work as a strategic partner in Devon		Director Lead: Simon Tapley
Risk: AF10 – We have not addressed the issues raised in the 2018 staff survey so staff leave or do not perform to their full potential		**Date Last Reviewed: 16/06/2020** **Reviewer: Simon Tapley/ Andrew Millward**
Corporate risks		
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4 x 3 = 12**	We have had the 2019 staff survey results and these show improvement. Devon CCG was classed in the top quartile of improving CCG. There are still some areas requiring improvement and will be addressed during the year.
Current:	**3 x 1 = 3**	
Appetite:	**4 x 1 = 4**	**Rationale for risk appetite:**
		It is within the CCGs powers to address many of the issues raised in the staff survey and it is important to maintain key staff
Controls: (What are we currently doing about this?)		**Assurances:**
Each Directorate has reviewed staff survey and agreed actions Redesigned appraisal process Increased staff engagement and listening events Development and implementation of organisational Vision and Values Celebrate You initiative and successful first event		Remuneration and Strategic Workforce Committee HR Dashboard to SLT, Execs and Governing Body Monthly meeting of Staff Partnership Forum
Control Gaps		
		Assurance Score:
		12
Mitigating Actions: (What should we do?)		**Gaps in Assurance: (What additional assurances should we seek?)**
Staff Partnership Forum is continually focused on addressing the issues from the survey. Implementing quarterly survey to obtain ongoing feedback Develop and implement Talent Management Programme		

Date	Update on actions taken
Dec-19	Implementation of talent management approach including talent conversations
Feb-20	NHS Devon CCG Talent Board took place on 28 February 2020
Jan-20	Implementation of Health and Wellbeing Strategy - launch of strategy and health and wellbeing champions
Aug-19	Meetings of the Working Together Group are in place to consider how we can further embed the CCG values
Jun-20	Directorates have been asked to review the 2019 staff survey and come up with an action plan for their teams by December 2020

Objective: We will improve the mental and physical health of the population		Director Lead: Ginny Snaith
Risk: AF11 – We have not evolved our integrated strategic commissioning arrangements sufficiently to develop plans to deliver improvements in population outcomes		**Date Last Reviewed: 16/06/2020** **Reveiwer: G Snaith**
Corporate risks		
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x4 = 16**	Integrated strategic commissioning is developing and there are examples of good practice but comprehensive framework is not in place
Current:	**4x4 = 16**	
Appetite:	**4x2 = 8**	**Rationale for risk appetite:**
		Arrangements are developing and good relationships in place
Controls: (What are we currently doing about this?)		**Assurances:**
Integrated Commissioning Executive (ICE) meeting monthly Strategic Commissioning Programme Board established and workplan agreed Some limited commissioning for outcomes (e.g. ICP procurement) BCF plans in place Some Section 75s in place Several Joint roles appointed and working well Good working relationships between individuals		ICE monitors progress and reports into CCG through AO and other Execs. Papers from ICE shared with Governing Body.
Control Gaps		**Assurance Score:**
ICE not currently meeting - Review of ToR required SCPB not currently meeting - Review of ToR required		**11** **Gaps in Assurance: (What additional assurances should we seek?)** Arrangements for strategic commissioning currently under review to incorporate lessons learnt during COVID incident
Mitigating Actions: (What should we do?)		
Delivery of Strategic Commissioning programme workplan Workplan to be revised to reflect Local Authority input		

Date	Update on actions taken
18.1.2019	Proposal for Strategic Commissioning Programme Board to be reviewed by ICE 22.10.19
18.1.2019	Strategic Commissioning Development action plan to be reviewed by CCG Exec 24.10.19
03.02.2020	Workplan agreed and delivery commenced

Objective: We will improve the mental and physical health of the population		Director Lead: Sonja Manton
Risk: AF12 – We have not invested sufficiently in prevention so we do not achieve improvements in our population health		**Date Last Reviewed:17/06/2020** **Reveiwer: Sonja Manton**
Corporate risks	77, 92	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**5x4 = 20**	Low levels of investment in prevention mean that limited progress is being made. Low level of system commitment is making it difficult to address this.
Current:	**5x4 = 20**	
Appetite:	**5x2 = 10**	**Rationale for risk appetite:**
		Prevention is key to ensuring long term and sustainable change in population health
Controls: (What are we currently doing about this?)		**Assurances:**
£2m investment in prevention 40 bids received for this money Prevention workstream co-ordinating wider prevention agenda with projects embedded in other workstreams System SRO appointed Dedicated PMO resource for programme management Significant progress with some projects e.g. Active Devon		programme reporting through the STP to the CCG through the Accountable Officer and other Executives 17/06/2020
Control Gaps		
Criteria / prioritisation framework for investment not in place - resulting in investment spread across primary, secondary and tertiary prevention opportunities. In light of the COVID incident the needs of the population will have changed and these need to be further understood.		**Assurance Score:** **8**
Mitigating Actions: (What should we do?)		**Gaps in Assurance: (What additional assurances should we seek?)**
Programme developing business cases to expand to cover all areas of the LTP. Need to increase system commitment to prevention to ensure input from all organisations Need to clarify investment for future years to support projects requiring recurrent funding. Ensure that Prevention is regularly on system agendas and sufficient time available for discussion Investment via prevention fund to be temporary (albeit in some cases longer-term temporary) with plans to transition to BAU funding for all schemes.		GB needs improved oversight of prevention programme Temporary change of STP governance and reporting during the COVID incident 17/06/2020

Date	Update on actions taken
31/10/2019	Deep dive into Prevention programme presented to October PDEG - included LTP requirements and how these have been incorporated, how current prevention investment is being spent and the anticipated ROI and benefits.
17/06/2020	Agreed to be part of national population health management from September 2020
17/06/2020	Temporary financial framework in place to end of July, discussions on month 5 to 12 still underway at national level

Objective: We will improve the mental and physical health of the population We will make the best use of resources		**Director Lead: Jo Turl**
Risk: AF13 – We are not targeting our resources at the areas that most need them so health inequalities are exacerbated		**Date Last Reviewed: 16/06/2020 Reveiwer: Jo Turl**
Corporate risks	75	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**4x4 = 16**	GB decision has agreed a change in funding by locality and money will be used to address health inequalities
Current:	**4x3 = 12**	
Appetite:	**4x2 = 8**	**Rationale for risk appetite:**
		Evidence available to support decision making
Controls: (What are we currently doing about this?)		**Assurances:**
Framework in place for development of Locality Care Partnerships LCPs have developed workplans based on local population health need CCG have agreed a fair shares funding model, Currently identify locality profiles where we will identify investment and disinvestment opportunities		Finance and Performance Committee review financial spend and delivery
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		**8**
Need to agree process for moving to resource allocation based on health need Need Governing Body decision to accelerate shift of resource to primary and community care. Need to develop CCG and System approach to Population Health Management including access to shared information datasets and developing skills of commissioning staff.		**Gaps in Assurance: (What additional assurances should we seek?)** Mechanisms and information required to monitor spend at locality level not yet developed.

Date	Update on actions taken
31-Oct-19	Governing Body have signed off the equity movement which will start to address inequalities between localities
16/06/2020	Due to COVID incident this work will now be picked up in restoration plans

Objective: We will make the best use of resources		Director Lead: Jo Turl
Risk: AF14 – There is insufficient workforce capacity and capability in Primary Care (GPs, nurses and pharmacists) to meet demand		**Date Last Reviewed: 16/06/2020** **Reveiwer: Jo Turl**
Corporate risks	105, 108	
Risk Rating	Impact x likelihood	**Reason for current score:**
Initial:	**5x4 = 20**	During COVID primary care has made significant advances in digital usage
Current:	**3 x 4 = 12**	
Appetite:	**5x3 = 15**	**Rationale for risk appetite:**
		Primary Care Networks offer opportunity to develop new ways of working.
Controls: (What are we currently doing about this?)		**Assurances:**
GP Strategy agreed The CCG have agreed and are funding the gold package for GP job adverts in the HSJ During COVID primary care has made significant advances in digital which may impact on the need for additional workforce. This requires further investigation GP International Recruitment Scheme. Heat map devised to identify vulnerable GP practices Regular resilience meetings with Devon LMC CCG and STP attending recruitment events The CEO chair of STP workforce programme, this includes primary care representation on all work programmes. Also GP representation on STP programme board and dedicated PC workforce support.		Primary Care Commissioning Committee Primary Care Operational Group STP and Workforce Groups Regional Workforce Board **Assurance Score:** **8** **Gaps in Assurance: (What additional assurances should we seek?)**
Control Gaps		
Mitigating Actions: (What should we do?)		
Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. Developing role of Primary Care Networks		

Date	Update on actions taken	

scoring

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

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

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

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

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

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

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

Risk Assessment Scoring Guidelines

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

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

Assessing the likelihood/probability of risk

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

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

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

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

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

of Risk Appetite and Acceptable Risk Score

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

NHS
Devon
Clinical Commissioning Group

Risk Management Framework

NHS Devon Clinical Commissioning Group

Author (s): Theresa Farris, Risk and Governance Manager NHS Devon CCG Clare Doble Head of Governance Ginny Snaith; Board Secretary	Contact Details: theresa.farris@nhs.net clare.doble@nhs.net	
Approved by: Governing Body	Date of formal approval	Review Date:
Date Issued:		V6
All policies are held centrally by Governance: d-ccg.governance@nhs.net		

Document Change History: Risk Management Framework Policy		
Version	**Date**	**Comments (i.e. reviewed/amended/approved)**
V1	August 2017	Review and produce a joint policy for Northern, Eastern and Western Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group. To reflect the risk appetite of both organisations as they align systems.
V 1.4	November 2017	Staff Forum & Staff Council – NEW Devon 7 November 2017 and SDT CCG 20 November 2017
V1.5	July 2018	Risk Appetite approved by Chief Officers Team Meeting
V1.5	July 2018	Risk Appetite discussed at Audit Committee – committees in common
V1.6	12 September 2018	Audit Committee – committees in common - **APPROVED**
V1.6	27 September 2018	Governing Body – meeting in common APPROVED
V2	April 2019	Review to reflect merger of the organisations and recommendations of Internal Audit March 2019
V3	April 2019	Reviewed by Board Secretary
V4	April 2019	Following feedback from Exec Team 30th April 2019
V5	June 2019	Reviewed at Audit Committee and Senior Leadership Team
V5	June 2019	Governing Body July 2019
V5.1	July 2019	Minor corrections to format
V5.2	August 2019	Amendment to corporate objectives page 26 appendix 4 Minor corrections to forms appendix 1 Addition of closure box appendix 4 Replace Assurance Framework documentation
V6	March 2020	Amendments following outcome of internal audit of risk management • Index updated • Added section 4.4 Directorate risks • Use of action field in corporate risk register added section 5.4 all staff • Section 7.1 capture of risks and use of action field explained • Section 8 added risk management and risk escalation flow chart. Clarity of wording now reds directorate risk

		• Section 9 added directorate risks • Section 10 level at which risk managed updated, included update to section 10.4 to include Programme Management Office process • Section 11 timescales for review updated • Section 14 Risk Training updated as recommended by Internal Audit outcome • Addition appendix 7 Risk Management Training programme
	June 2020	Reviewed by Board Secretary
	June 2020	Present to Executive Team for approval
	July 2020	Present to Audit Committee for approval – approved 08 July 2020
	July 2020	Include in Audit Committees Chairs report for Governing Body information and agreement
	August 2020	Publish on website and intranet Article in staff bulletin Uploaded to Risk teams page Risk Co-Ordinator's advised of review, use of corporate risk register and directorate risk registers

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

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

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

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

Risk Management Framework Contents		
Section	**Title**	**Page**
1	Statement of Intent	4
2	Introduction	5
3	Purpose and Scope	5
4	Definitions	7
5	Accountabilities and Responsibilities	8
6	Risk Appetite	11
7	Risk Capture	12
8	Risk Monitoring and Review	13
9	Risk Reporting	15
10	Risk Registers Corporate Risk Register Team Risk Registers	15
11	Assurance Framework	19
12	Mitigating Action	19
13	Incident Reporting	20
14	Monitoring Effectiveness and Compliance	20
15	Document review and Version Control	21
16	Document review and Version Control	22
Appendices		
1	Risk Appetite and Risk Scoring Matrix	23
2	Assessing the Impact of Risk	25
3	Glossary	27
4	Risk Capture Template	29
5	Governing Body Assurance Framework	31
6	Adequacy of Assurance scoring	33
7	Risk Management Training Matrix	34

Risk Management Framework

1. Statement of Intent

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

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

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

To this end:

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

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

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

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

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

2. Introduction

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

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

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

2.3 Key success factors for embedding risk:

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

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

3. Purpose and Scope

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

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

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

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

3.5 The framework provides a method by which organisational understanding of risks in all its

constituent parts, control measures, importance of actions, review and ownership is robustly assured through the CCG governance structure.

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

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

4. Definitions

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

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

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

4.4 **Team Risk Registers**
Team risk registers have been established, using a standard risk template to record risks that have been removed from the corporate risk register and are being managed operationally. This will provide assurance that any residual risk is managed and where necessary escalated to the corporate risk register. See section 8

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

Change	These concern risks that programmes and projects do not deliver agreed benefits within an agreed budget, and/or introduce new or changed risks that are not effectively identified and managed.
Legal and Compliance	These include Health & Safety; Data Protection, Employment practices; employment legislation; the NHS constitution; freedom of information; civil contingencies; deprivation of liberty and regulatory issues.
Operations	These concern the day to day concerns that the CCG is confronted with as it strives to deliver its strategic objectives. They can be anything from loss of key staff to process failure. It covers risk events such as failure by a third party to deliver a service for the operational, breakdown in partnership with third party, failure to manage internal change etc. Operational risks are largely short or medium term where impact is high/medium, and likelihood/probability is low to high
Information & Technology	These concern the day to day issues the CCG is confronted with as it drives to deliver its strategic objectives. They can be anything from loss of data to failure of a key IT system. It covers risk events such as cyber security a technological breakdown, loss of hard or soft copy data, failure by a third party to deliver a service breakdown in partnership with third party, failure to manage internal change etc
People	These concern insufficient staff resources (capacity and capability). These risks can have a significant impact on the performance and reputation of the CCG.
Strategic	These concern the long-term strategic objectives of the CCG. They can be affected by external factors such as the economy, changes in the political environment, technological changes, and in legal and regulatory changes. The strategic risks are mainly significant risks that can potentially impact the whole of the CCG.
Clinical	These concern risks that arise directly from the commissioning of healthcare to patients. This includes safeguarding, clinical errors and negligence, healthcare associated infection and failure to obtain consent.
Reputational	It is important that the reputation of the CCG is protected through robust systems of communication with stakeholders. Systems of communication with external stakeholders that contribute to minimise risk need to be in place, including regular meetings, patient surveys, publications and public meetings. The CCG has a large and diverse range of stakeholders with whom it needs to develop and maintain engagement

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

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

The risk management process is a continual cycle and is the responsibility of everyone in the organisation.

5. Accountabilities and Responsibilities

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

5.2 For risk management to be part of operational activity throughout the CCG, it is important that individual accountability is clearly defined. All staff must accept the management of risks as one of their fundamental duties and must have a sense of ownership and commitment to identifying and minimising risks. Risk issues are present in the CCG at all times and the day to day management of those risks is the responsibility of all staff employed by the CCG.

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

5.4. Key responsibilities for risk management are:

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

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

	regard to the identification of risk within their sphere of work. Individual accountability must be clearly defined and reflected in objective setting and performance reviews through line management accountabilities. • Be alert to risks and recognise their duty to report them through their line management arrangements so that appropriate action can be taken. • Be aware of existing risk assessments related to their area of work and relevant procedures or control measures to be adopted to reduce identified risks • Contribute to minimising risks wherever possible • Be familiar with the CCGs risk management framework (this document) and associated standard operating procedures • Recognise their duty under legislation to take reasonable care for their own safety and of others that may be affected by the CCGs business • Report incidents and serious incidents requiring investigation (SIRI) as per the respective policies, which should be read in conjunction with this policy • Attend all relevant risk management training as required by this framework and job description. • Ensure the action field on the CRR should be appropriately completed, ie it should detail the actions needed to strengthen control and/or assurances further.
Information Asset Owners (IAOs)	The CCG's Information Asset Owners (IAOs) shall ensure that information risk assessments are performed at least annually. IAOs will submit the risk assessment results to the SIRO via the IG Forum for review. IAOs are senior individuals involved in running the relevant business areas. Their role is to understand and address risks to the information assets they 'own'. IAOs are likely to be supported by Information Asset Administrators (IAAs) e.g. User Administrators who are operational staff with day to day responsibility for managing risks to their information Assets. The CCG's Information Asset Register holds a list of all the current IAOs and IAAs.
Partnership working groups	The CCG is committed to the continuing development of partnership working with other health and social care and other organisations in line with our Working with Industry Policy In commissioning quality services, the CCG needs to be acutely aware of accountability arrangements and the management of risks in partnership working arrangements. There is an understanding that in addition to internal risks, there are also external risks that the CCG shares with partner organisations such as NHS England, Local Acute Trusts), Local Authority, social care and other partner stakeholders. These risks need to be assessed and where necessary appropriate 'risk sharing' management arrangements set in place. When partnership agreements are being developed risk management will be specifically addressed. This will need to incorporate clear lines of accountability and responsibility for staff working across partner organisations. Within the agreement there will be an explicit statement that sets out how the risk management structures and systems of the organisations will link and how decisions will be made, and which organisations will lead on the management of a specific identified risk. The CCG will work closely with partner organisations to achieve a shared ownership of risks facing the health economy and the solutions that are implemented. The CCG expects risk management to be a priority for those from whom it commissions services.

Contractors	Contractors and temporary staff are required to follow CCG policies and procedures as well as being aware of risk assessments within their area of work.
Commissioning services	The CCG commissions health services on behalf of the registered population of Devon. The CCG Governing Body must be informed of, and where necessary, consulted on all significant risks that arise from the service level agreements with other healthcare providers. The failure of a commissioned service to deliver services as agreed would be a significant threat to the achievement of one or more objectives of the CCG. Therefore, risks must be systematically identified, assessed and analysed in the same way as other risks to the CCG with clear accountabilities defined. Risk associated with commissioned services will feature in the CCGs corporate risk register to enable the Governing Body to be fully informed on the risk profile of the CCG.

6. Risk Appetite

6.1 The Good Governance Institute states:

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

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

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

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

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

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

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

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

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

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

7. Risk Capture

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

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

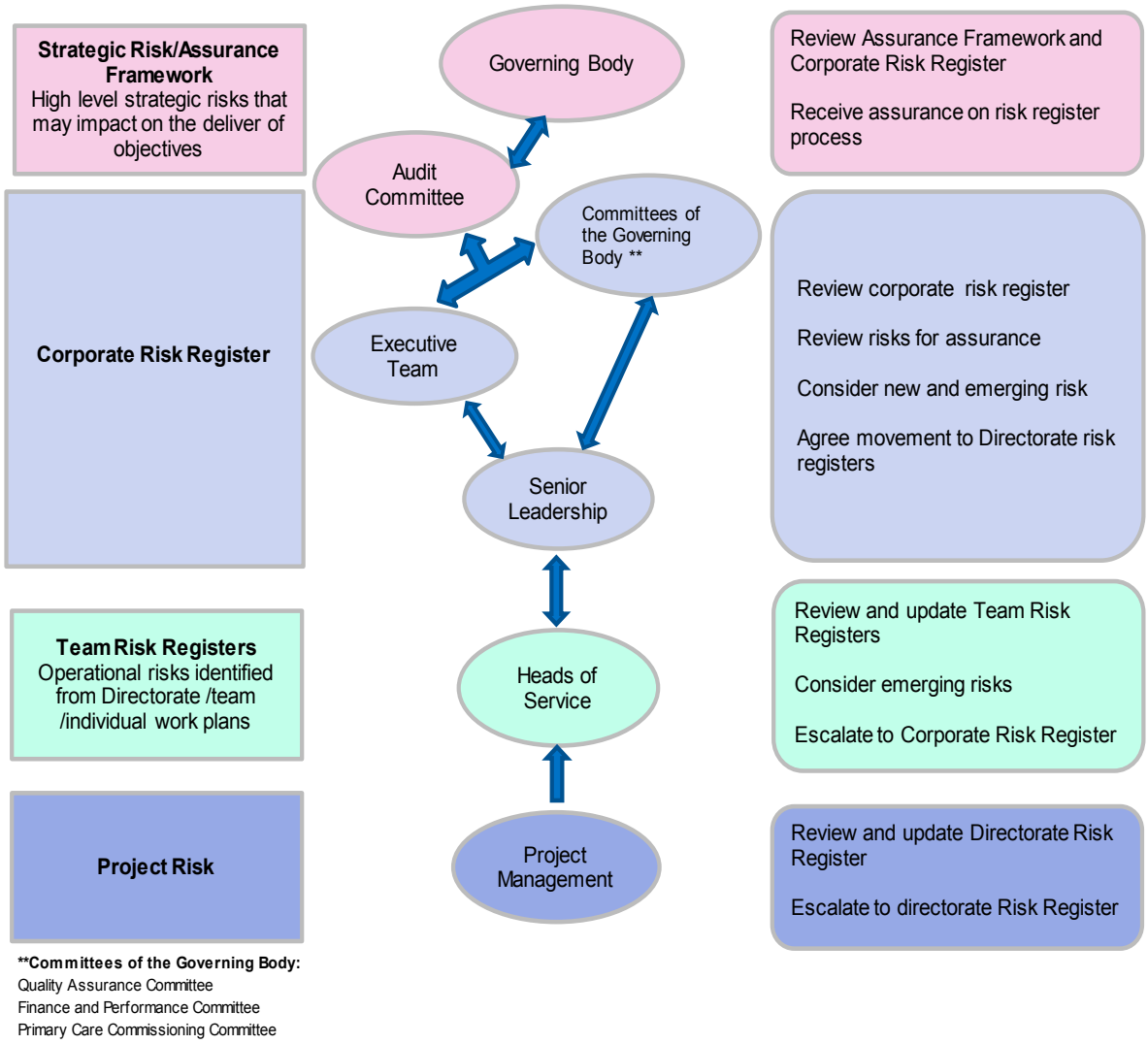
Risk information should be captured for the following fields using the template in Appendix 4.

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

8. Risk Monitoring and Review

8.1 Risk will be scrutinised in the following way:

Risk Management and Risk Escalation V1 2300620



Team Level – Team risks shall be reviewed at team meetings to ensure that risks are continually monitored, accurately reflecting current position and that the Executive Director is satisfied that the current position of risks within their department is a true and accurate reflection of the department risk profile.

Executive Directors will have responsibility for agreeing the addition of risks to the team risk register, escalation to the CRR or removal of risks from the corporate risk register to be recorded on team risk registers which will be monitored at team level.

Risks must not appear on the CRR and Team Risk Register (TRR) at the same time – They must be stepped down (transferred) or escalated as appropriate with Executive approval

Risks removed from the CRR, with Executive approval and agreement from the responsible committee must be added (transferred) to the TRR for regular review to ensure that the risks remain in view and can be escalated to the CRR with Executive approval should the risk score change in line with the risk appetite.

Executive Team

The executive team will review the assurance framework twice a year as a specific agenda item

Senior Leadership Team– will act as the CCG's senior risk committee. All risks will be brought before the group monthly as a specific agenda item for review and recommendation of any additions and changes. Additionally, the group will ensure that the Risk Register is used to develop the agendas for meetings to ensure that all high-risk areas are reviewed on a regular basis.

Governing Body Committees – As appropriate, committees will provide assurance of the risk process following formal accountability of the risk process from heads of department at department level and locality clinical leads at locality level. The Committees will provide assurance that collectively the Assurance Framework and the corporate risk register form a true reflection of the risk profile of the organisation, that evidence of robust risk management is in place on captured risks and that those risks are accurately assessed prior to Governing Body reporting.

Governing Body – The Governing Body is ultimately accountable for risk management in the CCG and assure themselves through the risk register and the Assurance Framework that assurance over risks identified to achieving the vision, priorities and aims/objectives in the CCG are being managed effectively.

The Governing Body is ultimately responsible for:

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

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

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

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

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

Risk Level;	Frequency of review by risk owners	Management of risks
Low Risk	No less than Quarterly	Managed by teams
Medium Risk	Monthly	Managed by directors
High Risk		Report to Senior Leadership Team
Significant Risk		Report to Audit Committee / Governing Body

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

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

Risk will be reviewed as detailed in the following table:

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

9. Risk Reporting

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

9.2 Team risk registers will be updated by the named risk owner with assistance from the risk co-ordinator no less than monthly and discussed and reviewed at team meetings no less than quarterly.

10. Risk Registers

10.1 Level at which risk is managed, recorded and monitored

Level of Risk	Risk Register	Risk Score	Risk Impact
Strategic	**Board Assurance Framework** (AF) The AF serves as the key document to assure the Governing Body that risk management is in place to address risks to the organisation's principal objectives **Section 11** **Appendix 5**	**Significant risk 15 to 25**	**Requires Board level and Executive Director scrutiny and oversight** **Supports the annual governance report**
Corporate	**Corporate risk register** High level operational risk monitored by the Senior Leadership Team Risk will have an organisational wide impact These are risks which cannot be managed at Directorate level	**High risks 8 or above or in accordance with risk appetite appendix 1**	**High level operational risk** **Monitored by the Senior Leadership Team** **Organisational wide impact** **Cannot be managed at Directorate level.**
Team	**Team risk registers** Teams will hold a risk register to manage operational risks identified from directorate /team /individual work plans. This will include risk that have been removed (transferred) from the corporate risk register	**Moderate to low or Residual risk score in accordance with the risk appetite appendix 1**	**Operational** **Managed at team or programme level**
Project	**Risk and Issues logs** Relate to specific time limited projects If further escalation is required Head of PMO will discuss with the Board Secretary.	**Issues logs refer to risk specific to providers that CCG should be aware**	**Relate to specific time limited projects**

The Assurance Framework will be overseen by the Board Secretary, who is responsible for reporting and presenting to the Governing Body for approval no less than annually. The corporate risk register is also overseen by the Board Secretary, delegating any actions through the Head of Governance. The Chair of the Governing Body and chairs of relevant Committees will lead the discussion on these risk registers and hold the executives to account when appropriate.

The CCG captures corporate risks on a single database.

The risk assessment process provides a systematic examination of the CCG's work processes and enables the reporting of a CCG wide risk profile to the appropriate level as

described above. Appendix 1 contains the matrix that is to be used when scoring the identified risks.

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

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

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

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

- Teams will hold a risk register to manage operational risks identified from directorate /team /individual work plans. This will include those risks that have been de-escalated or transferred from the corporate risk register.

- Risks exceeding a rating of 15 (significant) will be reported on the Corporate Risk Register and presented to the Senior Leadership Team, Audit Committee and Governing Body.

- The Senior Leadership Team will discuss the potential escalation of other corporate risks to the assurance framework depending on the perceived impact to corporate priorities and objectives

- Programme Management Office (PMO) will work with the CCG teams to understand their programmes of work, discussing and understanding programme risks identified. The PMO team meets weekly to discuss areas of work and any programme risks or issues will be discussed at that meeting. If further escalation is required Head of PMO will discuss with Board Secretary.

- Provider performance issues and risks, that raise serious patient safety concerns, should be separately recorded on the CRR (not subsumed into the over-arching provider performance risk currently recorded on the CRR). The responsible Executive will approve the addition of the risk to the CRR and the Quality Assurance Committee will agree to the recording of such risks on the CRR.

10.6 **Controls**

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

As the Department of Health's guidance recognises "The relationship between a risk and

control is not necessarily straightforward. One specific risk may be mitigated by a number of controls. Some of those controls may only be effective when operating in conjunction with other controls and one control may relate to more than one risk."

Examples of key controls include:

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

10.7 **Assurances**

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

10.8 **Gaps in Controls and Assurances:**

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

11. Assurance Framework

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

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

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

Governing Body Assurance Framework		**Timescale**
Maintenance Coordination	Governance Team	Ongoing and at least bi-monthly
Updating		Ongoing and at least bi-monthly
Review and sign off	Directors	Ongoing and at least bi-monthly
Monitoring	Directors	Twice a year

	Audit Committee Governing Body	Quarterly Quarterly via Audit Chairs Report

12. Mitigating Action

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

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

13. Incident Reporting

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

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

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

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

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

14. Risk Training

14.1 As described in section 5 - Accountabilities and Responsibilities- all staff are responsible for complying with the risk management framework policy. This will ensure that all identified remedial actions are taken for risks identified within their area of responsibility.

14.2 All staff must familiarise themselves with the Risk Management Framework Policy and develop an understanding of what is expected of them in line with risk management within the CCG.

Staff will be offered risk management training commensurate with their duties and responsibilities.

The CCG will implement a structured programme of Risk Management training. As detailed in appendix 7.

Risk Management Presentations, which are kept under review, are available to all staff within the CCG as part of continuous training.

All staff can request additional risk management training through the Governance Team d-ccg.governance@nhs.net

14.2 Annual risk awareness training for Governing Body members, Executives and their senior officers (direct reports), will be facilitated by the Board Secretary.

14.3 In addition:

a. Staff new to the organisation will receive risk management training via the induction programme.
b. Support and training for Directors, Deputy Directors, Associate Directors and key managers is ongoing throughout the year via the risk updating process.
c. All staff must ensure that they have the knowledge, skills, support and access to expert advice necessary to implement the strategies, policies and procedures associated with this Policy
d. Details of the risk management framework will be available to all employees of the CCG and communicated to stakeholders and the public. Via the following:
    - Induction programme
    - Local induction via team risk co-ordinator
    - Risk assessment
    - CCG staff bulletin
    - Risk reports to CCG Governing body and sub committees
    - Risk reports to identified committees/groups to review and support programme risk. Escalating to corporate risk register as necessary

e) Risk management training will be reported annually to the Audit Committee as

part of the annual report to the committee on COI, Gifts Hospitality and sponsorship report.

15. Monitoring Effectiveness and Compliance

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

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

a. The AGS is reviewed and approved annually by the Audit Committee before being submitted to the Governing body as part of the annual report and accounts.
b. The Audit Committee also review risk though papers submitted throughout the year. In addition to risk reports being submitted to:
   - Quality Assurance Committee
   - Finance and Performance Committee
   - Primary Care commissioning Committee
   - Senior Leadership Team

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

16. Document review and Version Control

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

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

Appendix 1

Summary of Risk Appetite and Acceptable Risk Score

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

Risk Assessment Scoring Guidelines

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

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

Assessing the likelihood/probability of risk

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

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

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

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

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

Assessing the impact of risk

Appendix 2

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

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

Appendix 3

Glossary

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

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

Appendix 4

Risk Register Template (July 2020)

Date risk opened:					
Risk Description:	***There is a risk that*** .. ***The impact of this is (the impact statement should clearly state the effect of the risk to the CCG)***				
Is the risk evidenced on a provider risk register *Please comment in the assurance box*					***Yes / No***
Risk Register Indicate which register the risk will be recorded.	***Corporate Risk Register***				***Team Risk Register*** *Name*
Executive Lead:					
Programme lead/senior manager					
Risk Owner:					
Risk Name*:(2-4 word title to describe risk eg: Fracture liaison service)*					
Risk Score *(likelihood score x impact score) – please refer to risk matrix scoring section of risk policy*					
Likelihood:	*Rare (1)*	*Unlikely (2)*	*Possible (3)*	*Likely (4)*	*Almost Certain (5)*
Impact:	*Low (1)*	*Minimal (2)*	*Medium/Moderate (3)*	*High (4)*	*Significant (5)*
Risk Coordinator:					
Committee Reported to:					
Other reporting areas					
CCG Objectives *(please indicate the objective the risk links to)*	**We will continue to commission safe, effective and accessible services** ○ Being in the top 10% of CCGs by improving performance against core NHS standards ○ Meeting all statutory requirements ○ Improving our populations health, their experience of care and the cost-effectiveness ○ Increasing the use of technology **We will work as a strategic partner in Devon** ○ Working as one system to support the delivery of all objectives ○ Working more closely with local communities to plan local services ○ Developing evidence-based services			**We will improve the physical and mental health of our population** ○ Integrating and personalising care ○ Addressing issues that cause ill health ○ Reducing health inequalities **We will make best use of resources** ○ Using population health management approaches to target resources where they are needed most ○ Improving efficiency, productivity and sustainability ○ Achieving financial balance across the whole health and care system in Devon ○ Increasing investment in services to meet identified need	

	○ Empowering, motivating and developing our staff	

Controls:	*Controls are the arrangements made or precautions taken, to reduce risk. (eg. Governance processes / statutory frameworks, management structure & accountabilities, communications & patient / public feedback, policies & procedures / reviewed at team meetings etc). Please provide details of controls in place, below:*
Control Gaps: *(Detail gaps or state 'none identified')*	
Assurances:	*For each of the risks and controls a source of assurance is set out ie. What provides evidence that the organisation has identified the risks and has controls in place. (e.g. Internal audit report, report to Board or Board Committees) Please provide details of assurances below:*
Assurance Gaps: *(Detail gaps or state 'none identified')*	
Actions	
Executive Lead Approval	**Name** **Date:**
Added to Risk Register	**Date**
Closure of risk transfer or Escalation	**Rationale for risk closure, transfer for Escalation** **Risk closure transfer or escalation approved by executive** **Name** **Date**

Governing Body Assurance Framework

Governing Body Assurance Framework Risk Tracker

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

Oct-19 **Corporate Objective**	**Assurance Framework Ref**	**Corporate Risk Register mapping**	**Initial Risk Score**	**Updated score on review August 2019**	**Risk Movement (Trend)**	**Risk Appetite /Target Score**	**Assurance Score**	**Lead Director**	**Date AF Risk Reviewed**	**Principle Risks** ***There is a risk that…….***
We will continue to commission safe, effective and accessible services by:										
• Being in the top 10% of CCGs by improving performance against core NHS standards										
• Meeting all statutory requirements										
• Improving our populations health, their experience of care and the cost-effectiveness										
• Increasing the use of technology										
We will work as a strategic partner in Devon by:										
• Working as one system to support the delivery of all objectives										
• Working more closely with local communities to plan local services										
• Developing evidence-based services										
• Empowering, motivating and developing our staff										
We will improve the physical and mental health of our population by:										
• Integrating and personalising care										
• Addressing issues that cause ill health										
• Reducing health inequalities										
We will make best use of resources by:										
• Using population health management approaches to target resources where they are needed most										
• Improving efficiency, productivity and sustainability										
• Achieving financial balance across the whole health and care system in Devon										
• Increasing investment in services to meet identified need										

Corporate Objective:		**Director Lead:**
Risk: AF 1 –		**Date Last Reviewed:** **Reveiwer:**
Corporate risks		
Risk Rating	Impact x likelihood	Reason for current score:
Initial:		
Current:		
Appetite:		Rationale for risk appetite:
Controls: (What are we currently doing about this?)		Assurances:
Control Gaps		
		Assurance Score:
Mitigating Actions: (What should we do?)		
		Gaps in Assurance: (What additional assurances should we seek?)
Date	**Update on actions taken**	

Adequacy of Assurance scoring

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

1	Does this assurance provide evidence that the controls are achieving the desired outcome?	Yes - proceed to Section 2 No - Do not proceed with this assessment and the score will automatically be 0. If the item highlights areas where controls are not in place or are not achieving the desired outcome, please add this information to the "gaps in Controls" section of the Risk.

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

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

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

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

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

Appendix7

Risk Training Matrix

Course/training summary	Target Audience	Minimum Frequency
Introduction to Risk Management This will be provided by a presentation available via teams and access recorded by the Governance Team.	All employees	Induction Every 2 years
The Risk and Governance Manager will clarify the role of the Risk Coordinator and their responsibilities within the Risk Policy with a face to face meeting.	Risk Co-ordinators	On appointment Subsequently through peer group meetings
Risk Owners responsibility for identifying and managing risk to ensure that risks in their specific area of responsibility are recorded in accordance with the Risk Policy.	Risk Owners	On appointment
To provide an overview and understanding of the Senior Leadership Committees responsibilities as described in the Risk Policy.	Senior Leadership Team	Annually and through monthly discussions of risk report and corporate risk register
To provide Governing Body members with an understanding of risk management within the CCG and their responsibilities, to include: • An understanding of the risk assessment process • An understanding of 'the language' and common acronyms used in risk assessment • How risk links to the operational and business planning processes • The reporting processes within the CCG • How risk management is embedded in the culture of the CCG	Governing Body	On appointment and every 2 years Governing Body members require risk management training every two years in accordance with national guidance.

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Twelve Steps to Risk Management

	Action		Integrated Risk Management Policy Section number
Step 1	**Identify the risk (Risk Capture)**	Risk can be identified by anyone within the CCG. A potential risk must should be discussed with the individuals line manager and escalated to a senior manager and executive for discussion. The corporate risk register (CRR) should be checked to see if a risk already exists, governance can assist with this.	Section 7
Step 2	**Define and describe the risk**	It is important that you identify and have a clear understanding of the risks in your work area. To avoid confusion, describe each risk separately, always identifying the likelihood and impact in a clear and concise manner. The risk template in the policy will aid you with refining the risk and should be completed by the risk owner.	Appendix 4 Section 7
Step 3	**Identify Risk Owner and Executive Lead**	All risks must be allocated to an Executive Lead and have a senior member of staff as the risk owner responsible for the review and update of the risk and associated actions.	, Section 5
Step 4	**Determine Risk appetite**	This is explained in of the Integrated Risk Management policy and is the amount of risk that the CCG is prepared to accept, tolerate or be exposed to at any point in time. Appendix 1 indicates the overarching risk score and management response.	Section 6 Appendix 1
Step 5	**Score risk**	The CCG uses a 5x5 matrix to score a risk by impact and likelihood. this is further explained in the policy. See step 4 and check the risk score against the risk appetite of the CCG.	Appendix 1
Step 6	**Identify controls and assurance**	To support the risk score the risk owner must detail all the controls and assurances in place to mitigate the risk and explain the rationale for the score. Assurance and control gaps must also be added at this stage with actions to address the gaps within given timescales. Dates for the completion of these actions should be agreed and recorded	Appendix 4 Section 7

Step 7	**Determine actions**	Action must be listed to address any control or assurance gaps, actions being taken to reduce the risk score and mitigate the risk. This must include a date for the completion of the action and the name of the member of staff leading on the action.	Section 7
Step 8	**Complete risk template and gain approval of executive lead**	Executive to review the completed risk template and ensure all sections are complete and the risk is attributed to a corporate objective	Appendix 4
Step 9	**Risks scored 15 and above.**	Risks scored 15 and above will be reviewed and considered for inclusion in the assurance framework. Date for review and actions reviewed in accordance with policy. **Any risks scored 25 must be immediately escalated to the Accountable Officer**	, Section 8
Step 10	**On approval add to risk register**	A new risk must not be added to the risk register without the approval of the named executive/director Confirm that the risk or a similar risk does not already exist on the risk register. The risk will be added to the risk register by the risk co-ordinator for the directorate/team, generating an email to the governance team for review. The governance team will review and may request additional information.	Section 7
Step 11	**Monitoring and Review**	The frequency of review should be **no less than monthly** and more frequently if the risk is considered very high. Risks and actions should be reviewed and updated no less than monthly by the risk owner. Escalation of risks not reviewed appropriately will be Senior Leadership Team.	Section 8 Section 9
Step 12	**Closure /de-escalation of Risks**	All risks must be reviewed by the risk owner and the risk score reviewed along with the controls and assurances. Closure/de-escalation must be agreed by the risk owner with the executive lead. Executives to take responsibility for adding and removing risks scored 12 and below. Risks scored 15 plus will be discussed at Senior Leadership Team meetings and final approval sought from the relevant committee in line with the policy. A clear and concise rationale for closure should then be added to the risk register, prompting an email to Governance to review and include in relevant risk reports.	Section 10

NHS
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GOVERNING BODY

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

Date of Governing Body: 16th July 2020

Date of Committee covered in this report: 2nd July 2020 (Minutes of these committee meetings to be available as an addendum)

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Reports discussed and assurances received:

Members of the Committee discussed the following reports:

Commissioning:
The Primary Care Operational Group meeting report highlighting:

Raleigh contractual situation has progressed – no longer a single-handed practice – signatures of a number of other providers are on paper – the practice is now more resilient.

Plymouth prospectus- Some work streams have gone less well or slowed due to COVID issues Digital came online ahead of the rest of Devon – good use of digital tools,

BMJ recruitment programme good example of collaborative working – over the past 12 weeks 6 GPs have been appointed in Devon due to this drive.

Reports received and noted:

Transformation: The Committee undertook to gather together learning gathered from COVID ways of working in Primary Care

The Chair invited Guests and committee members to contribute their experiences over the last few months, and ideas for the future arising from them, in 3 key areas:

1. **Regular practice work**

* Ways in which practices interact with patients (general comms, appointments, specific clinics, home visits, etc.

* where work is done (home, how surgery space is used, carpark clinics)

* who does what within the practice/how staff work together?

* what has stopped and not been missed

*** anything that has been started and is good to keep**

2. **Work with others outside the practice** (pharmacies, other practices, community health care, care homes, secondary care, social care)
3. **Aspirations -** If some of these changes become part of the New Normal, will it be possible to do things that that could not be done before. I have heard mention of variable appointment lengths according to need, reduction of waiting lists for an appointment (reducing DNAs)

Data will be collated in a matrix to inform Primary Care long term strategy and enable the CCG to support GP surgeries/ Primary Care Networks in the months and years to come.

Risk Register Review (changes and areas of concern)

The Risk Register was reviewed by the Committee, 2 areas of risk have been revised and declared reduced.

No new risks have been identified.

Committee Decisions

None

Recommendations for Governing Body

None

Recommendations for other Committees

None

Terms of Reference or other committee effectiveness issues

The Committee undertook a review of its structure and efficiency.

Discussion was held over the need for and use of deputies at meetings.

A change of structure was agreed: Alternating meetings.

One focusing on reporting, monitoring, updating current work; the other on strategic issues.

Every meeting to cover– minutes, matters arising, operational matters needing quick decisions, risk report, quality report, finance report and PCOG report.

Operational/monitoring meeting – flash reports, contracting reports, highlight/location reports – once every 2 months to give more time to consider the issues but the team need prepare reports less frequently.

Strategy/discussion & ideas (at Pomona initially – as that is where most staff are- then review in a year) - deeper look at some areas when needed & include workforce, estates, etc. also twice yearly dental, optometry and pharmaceutical input from NHSE.

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.

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

Date of Governing Body: 30 July 2020

Dates of Committees covered in this report: 9 July 2020

Chair's Name and Title: Glynis Atherton, Non-executive lay member (Chair of Quality Committee)

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

The Committee received updated reports as detailed below

Reports received and noted

Quality Assurance Framework SBARS points for escalation

Acute providers - the 3 providers issues which reflect the live issues.

- **UHPT** - We continue to have concerns regarding UHPT and are supporting the provider to drive improvement and the assurances taken from their trust governance committee. We remain in an escalated position until we see a sustained improvement.

Torbay and South Devon – CQC report now published. 'Well led' remains outstanding due to COVID-19 and other services within the trust were reviewed and an overall requires improvement position.

- Internal meetings have been attended by Nursing and Quality team lead by DA on an executive level addressing the action plan which is being developed by the trust.
- Ongoing DPT patient safety processes safeguarding and leadership. working at exec level. A full report to Quality Assurance Committee next month.

System Service Specific Issues

- **Primary Care Cell –** The CCG Primary Care Quality Assurance Audit has identified key improvement areas that will support quality surveillance and assurance across primary care moving forwards. In conjunction with reviews and learning from individual practice challenges and closures experienced since becoming delegated commissioners of primary care (medical services), will aim to promote a responsive plan for oversight and early supportive interventions.
- **Elective and planned care** - Pre COVID-19 escalated quality issues require attention moving forward. These include long waiting times for elective care, with concerns and complaints evidencing patients experience. Some issues appear to be exacerbated by the pandemic. Additionally, some inconsistencies in process for elective care have come to light. The CCG is seeking assurance in relation to this from each provider, including the independent sector. However, this period has seen huge advancement in innovative models that drive improved safety and experience; the CCG is leading this transformational work across the system through the 'Restoration & Transformation Cell' 14 project groups are embedded.
- **Community Care** - The Care Home & Home Care Cell led by the CCG with membership from three Devon Local Authorities and CQC, continues to provide significant resource and support to community and social care settings and partners. Issues being managed currently include ensuring sufficient PPE, COVID testing, resource and staff training to ensure an improved, but sustained, position within care homes and domiciliary care sectors.

CCG Functions

- **Continuing Healthcare** - The CCG is overseeing recovery plans post COVID-19, to ensure a financially sustainable position is maintained, as well as on-going high-quality standards.
- **Patient Experience** - The national step down to the patient complaints process made in March 2020 will be discontinued from July with complaints services expected to return to normal. The CCG has maintained business as usual throughout the pandemic and continues to support providers. There is currently a review of the CCG complaints and PALs processes underway.
- **Safety Systems** - A review of Safety Systems processes is being undertaken in July 2020. Outcomes and recommendations will be reported through to QAC in August 2020. Consideration for any SI management changes will need to consider the pending National Patient Safety Strategy requirements. Building on the good work already done and streamlining our processes. We will be auditing our processes and learn and adapt accordingly.

Safeguarding Quarterly Report & Annual Report

CP-IS

Torbay has not implemented the Child Protection Information System (CPIS), cost and capacity given as main rationale. This has raised concerns with NHS England, the CCG and Ofsted. Detailed audits have been undertaken to gain assurance of their processes. The CCG has no evidence that this has caused problems or delays to children. MT reported that in Devon it has been found that the system has not been up to date to date as it could be. This is a supplementary system to the clinicians work however still requires clinical oversight and decision making following a presentation. MT is reviewing the audit and will be doing more work regarding the process update.

Plymouth Multi Agency Safeguarding Hub (MASH)

It has been identified that the health support within the MASH system is inadequate to meet the demands. CCG looking at what resource can be put into place along with Named Nurse UHPT and the Safeguarding Primary Care Nurses within the team to support the system.

Torbay Children Partnership

Torbay Council are in the process of undertaking a review of the combined Plymouth & Torbay Safeguarding Children Partnerships arrangements to determine whether it meets the needs of Torbay. There is a strong focus on finalising the Early Help offer within Torbay, and a commitment to embedding any new safeguarding partnership arrangements. The CCG anticipate they will want to separate the boards.

Domestic Abuse

The Domestic Abuse and Sexual Violence lead is now in post to support all the health providers across the patch. The strategy for domestic violence has not been nationally not picked up. This work needs a more robust approach and perpetrators of this to be to also be signposted to this service. Historically a lot of resource goes to females and excludes men involved in domestic abuse. MT reported we will be inclusive of men and women victims and perpetrators. The numbers of domestic abuse are different regarding men and women. 1 in 4 women and 1 in 6 men. Women are at risk of higher level of harm. Men experience long term coercion and control as opposed as physical assaults. MT to provide more information in her next report.

Looked After Children (LAC)

We are still monitoring the review of health assessments which are part of statutory timescales and targets are being monitored by health professionals very closely as part of business as usual.

Safeguarding Adult Boards

The safeguarding team continues to support the work of the three safeguarding adult boards/ partnerships. All boards suspended full board meetings and subgroup during the Covid-19 pandemic, except for executive subgroups consisting of statutory partners. This enabled continued assurance and oversight of safeguarding during the pandemic. All boards are now preparing for recovery and getting back to business as usual. Torbay and Devon Safeguarding Adult Partnerships are currently working together to explore options for future models of coworking with neighbouring partnerships.

Safeguarding Annual Report

Update to the report as the report was written prior to the COVID-19 period.

We have had a retirement of a designated nurse and we have successfully recruited to the post. Another band 7 nurse position is now vacant, and we are in the process of recruiting.

Mental Capacity Act this has been put on hold act no national rollout in October. No date has been confirmed however likely to be April 2021.

Children & Family Health Devon - Children's Services first year – Devon & Torbay
The transformation programme has started to drive forward the change needed for consistency around the leadership and capacity in the organisation. A new transformation steering group has formed, and they have some key priorities to drive forward:

- Neuro developmental pathway (Inc. Autistic Spectrum Disorder) renamed to Communication and Interaction
- Single Point of Access
- Mental Health Crisis and home treatment Service

This recognises the urgency for pace of change and increased risk of service impacts from COVID-19 whilst also seeking to learn from service innovations made as part of the incident response. It is anticipated that there will be a surge in demand for services once children return to school in areas such as anxiety, depression, communication and language as well as autism behaviors.

Equally there have been a number of service changes that have been introduced as part of the response to COVID -19 such as an accelerated implementation and access to crisis out of hours services; data sharing between NHS and local authorities to identify, risk assess and put in place support; development of online resources and use of virtual consultations which have been welcomed by some families and young people who previously may have been harder to engage. The CFHD transformation programme will seek to incorporate and build on these service innovations.

As part of the COVID response, all children and young people's mental health services have been maintained, and provision has moved to digital and telephony-based support, with face-to-face appointments being offered where this is in the best interests of the child/young person.

Only partial data for the new CFHD contract has been formally reviewed by the Clinical Commissioning Group (CCG) with the provider. Exception reporting is provided inconsistently and continues to detail workforce issues.

Collaborative work is required across the system to improve the experience of these young people, their carers, staff and patients on acute wards. For example, CAMHS support when managing complex children and young people cases on paediatric wards and local authority leadership.

Learning Disabilities Mortality Review (LeDeR) report
The report documents the progress of the LeDeR programme in Devon and the current status. The report also highlights good practice and recommendations taken from reviews archived since inception of the programme within the CCG, (June 2017).

The recommendations are shared with our Devon wide Steering Group and with our providers patient safety leads. They indicate nothing out of the ordinary for Devon.

Impact of COVID on Learning Disabilities - There was a reported increase in deaths in the learning disabilities sector nationally. However, after reviewed our data and we have not seen any increase locally. Under reporting was not considered an issue. We will continue to monitor the situation.

Maternity Services Update
The paper provided an overview of the Local Maternity System (LMS) Transformation plan and the work of the LMS as part of the incident response to COVID 19.

Tracey Reeves updated the Committee that whilst the national guidance has been to suspend the overall LMS transformation programme, in response to the COVID-19 pandemic, the local clinical teams have prioritised the safe delivery of maternity services. In order to mitigate the potential risk of significant staff absence some

different ways of working have been implemented to ensure that services could be maintained and delivered safely.

Antenatal care provision has continued during pregnancy, whilst some visits have been delivered through alternative means (e.g. Attend Anywhere video consultation). Although face to face contact appointments have reduced as a result of Covid-19, vulnerable families have remained a central focus for Devon LMS with areas of concern raised by Public Health Nursing (PHN) colleagues and addressed through the weekly incident meetings. The key messages particularly around domestic abuse, excessive crying, smoking and co-sleeping. out to women and families.

All providers have reduced face to face attendances, implemented virtual contacts and centralised service provision for example through use of Hubs to deliver postnatal care. Some of the initiatives have proved to be both efficient use of midwifery time and beneficial for service users and will be reflected in the transformation plan going forward.

Next steps are although the overall programme has been temporarily suspended the key deliverables and expectation of the programme will be reviewed and assessed in a planned virtual workshop with providers next week and from this we will review our planned resource allocation.

The Committee noted;

- The system wide response to maintaining essential maternity services during COVID including proactive work with service user representatives to facilitate clear and consistent communication.
- That the full LMS transformation programme is temporarily paused in accordance with national guidance.
- Endorse the next steps listed above to enable a re-set of the Devon LMS transformation plan as part of the overall system wide restoration and transformation plan.

IPC Update report

Jonathan Plumb detailed the key highlights from the report. There are concerns around the C. difficile rates partly because of the way they are reported and concerns around the gram-negative bloodstream infections. The Community Infection Management Service and their community nurses in each of the 4 areas are undertaking work around the gram-negative blood streams reductions. Working very hard with the COVID-19 outbreak and they have been working particularly with care homes. Flu planning will be challenging this year and we need plan carefully with social distancing and PPE. CCG support group set up to look at the challenges of dealing with delivering the programme.

Risk Register Review Updates

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

Data extracted for this report on the 23 June 2020 of which it informs the Committee of any changes since the last Quality Assurance Committee on the 18 May 2020.

The organisation has 28 risks in total and 17 of these report to QAC

- Out of the seventeen, 4 risks are categorised as very high
- 1 new risk (119) which includes the financial impact from a primary care perspective.
- 2 risks have reduced in score
- Eleven risks have been reviewed between the period of 15 May 2020 and 23 June 2020
- 1 risk (95) is being recommended for closure

Corporate Quality Assurance Risk Report data extracted on 23 June 2020

- At 23 June 2020, NHS Devon CCG has 28 open risks on the corporate risk register. There are five risks pending closure as approved by the respective Executive of which three report to this committee.
- The three risks pending closure are risks 15, 44 & 75 which will remain pending closure until a new risk is approved by the lead executive to replace them.

- There are 17 risks reporting to the Quality Assurance Committee.
- 4 high risk
- Risk 119 included due to financial impact from primary care.

Committee Decisions

- No specific decisions required.

Items of concern to be escalated to the Governing Body

- None

Recommendations for Governing Body

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

Recommendations for other Committees

- None

Terms of Reference or other committee effectiveness issues

Darryn Allcorn proposed enhancements that will enable a work plan for 2020/21 to be created and beyond that further develop the effectiveness and strategic focus of the Quality Assurance Committee.

Darryn Allcorn proposed to convene a task and finish group to develop a strategy and workplan for the Committee. To bring back a proposal in September.

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.

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GOVERNING BODY

Report title: Locality Update Reports				
Date of committee: 30 July 2020 **Date report produced: 21 July 2020**				
Author (s) Name and Title: **Locality Triumvirates**		**Supporting Executive:** **Name and Title: Dr Paul Johnson, Chair** **Contact Details:**		
		Report Approved by: **Name and Title:** Locality Triumvirates **Date 21 July 2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Southern and Western Devon Localities.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				

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

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

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

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

Key achievements/progress

- A key achievement for the Northern Locality over the past 2 months (in line with the other localities) has been the production of the Northern Devon Out-of-Hospital Capacity Plan. This significant piece of work, undertaken through the governance of the CCG's Discharge Cell, brings together both the *demand* assumptions on discharge from the NDHT along the four 'discharge to assess' pathways, and the *capacity* analysis (packages of care, community hospitals, care home need etc…) for the discharge destinations, into a modelling tool that can be adjusted for future changes in covid-19 surge or normal winter pressures. In addition, the plan also identifies key areas of priority commissioning intentions (more rehab at home, less reliance on beds etc…) by comparing the current northern 'system' with national benchmarking and 'best practice' guidance.
- Over the past month a small group of the northern locality team has been reviewing the pre-covid workstreams against the ICM programme and have started to incorporate these areas of work into both the emerging locality priorities for out-of-hospital care, and some of the key outcomes of the recent capacity planning modelling. The aim is to rapidly develop a set of high-priority actions, that will deliver maximum impact, in the areas that the northern locality deems the highest priority. This work is clinically led and will provide an informed view for the emerging Northern Integrated Delivery Group meetings.
- North Devon has been fortunate in not having had a severe initial Covid-19 spike. Levels have been low so some contingencies such as the Primary Care Covid Site (PCCS) at Petroc has not been utilised. It is not practical to keep this site available as the building is an integral part of the educational facilities.

- There are ongoing conversations around the siting of further PCCSs in the Northern Locality.
- Referrals have been a concern in the Northern Locality. Messaging from the centre about restarting referrals and which pathways are being restarted were not well enough appreciated. Collaborative Work has been ongoing to review referral figures for the Northern Locality to clarify if figures vary widely from the other localities across Devon
- In line with other localities hospital capacity levels have been running around 70% with an expectation that this may rise as elective care activity is stood up.
- Community Services have seen an increase in work loads and District Nursing Activity is also stretched due to some staff being temporarily unavailable.
- There have been concerns around a shift in workload from secondary care to primary care, such as phlebotomy, with the increase in virtual appointments happening in secondary care. Ongoing consultation is continuing between the CCG, Primary Care and Secondary Care to try and see how the patient journey can be more effectively managed in these new circumstances; the aim being to prevent patients having to travel to NDHT as a follow on from their outpatient appointment. Drive-through options are being considered.
- Collaborative redesign work is flourishing in response to the challenges raised by the COVID-19 Pandemic.
- It has been useful to have DPT on our weekly calls so that we can have a direct dialogue over mental health service provision for the Northern Locality

Key priorities for the next three months

- Work is underway to form our new Integrated Delivery Group meeting which will include partner organisations including, social care, DCC, DPT, GP Collaborative Board & PCN CDs, NDHT and the CCG. This will replace boards such as the Northern AE Boards and we hope will be a positive step for collaborative working and the development of our Local Care Partnership function
- NDHT and Primary Care are together looking at the outpatient journey.
- Both primary and secondary care are looking at how virtual clinics and revised ways of working can be embedded as we return to a more usual way of working as lockdown eases. This involves increased use of digital technology and cross organisational rebalancing of where and how services are delivered.
- We need to strengthen our resource of **Locality Clinical Advisors.** We now only have three working for the Locality, totalling six of our 10 sessions, as the fourth has now moved more into a role supporting Medicines Optimisation.

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

- We need to better understand how the lockdown and the present easing of restrictions has affected the mental health of the Northern Devon population. This needs to be not only about the sense of isolation felt during lockdown but also the present anxieties around population movement, the economic effects on our communities and the support available to people to make sure that there is financial and medical support available to help with mental health concerns and overall wellbeing.

- One Northern Devon will continue to work with local councils and the Voluntary Sector to provide support through OND's cascade system that links requests to the One Communities' and local parishes' volunteers.

Issues of concern or risk

- The concern expressed previously regarding an increase in patients presenting late with conditions that need attention is being realised with NDHT seeing an increase in patients who are presenting late.
- Care packages are an ongoing concern as we seek to ensure that people are able to access the care they need at home.
- Slow access to Information on approval of improved BCF funding for schemes for NDHT is creating delays in the Trusts ability to progress their plans
- The planning for a second wave of Covid-19 for the Northern Locality need to be enhanced as we do not have access to the Hub facility developed as part of our initial response.

- Workforce burnout is a real risk. The lockdown and extension of a new way of working has created fatigue in the system workforce and we need to look at how we can work differently but in a sustainable manner

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

- There is a concern in the Locality that a further relaxation of lockdown and an unfettered influx of visitors to the county will put an increased strain on resources and may increase the R rate for our locality. We continue to track this as a Locality and our four PCNs find the daily SitRep very reassuring as an early warning system.

- We need to establish the good work that has come out of the new ways as permanent change and to avoid slipping back into the older system working.

- The **Northern Devon Suicide Prevention** initiative, which was going to link the STP Suicide Prevention programme with the One Northern Devon Suicide Prevention Action Plan, was hindered by the pressures of adjusting to the COVID-

19 Challenge. We need to make sure that this stepped back up again as this will become more important than ever in the current situation which we are facing. Capacity to achieve this is probably absent within the One Northern Devon Core team

- Development of the One Northern Devon initiative – funding issues have necessitated reduction in the support it can provide. It is moving towards seeking Legal Status, most likely as a Company Limited by Guarantee, to be able to access supportive funding opportunities.

Support required from CCG/system or barriers to progress

There needs to be a greater recognition that paying attention to the wider determinants of health will significantly improve our populations quality of life. Increased resourcing in this area will improve peoples' wellbeing and most likely reduce longer term dependence on health services.

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Locality update report

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

Key achievements/progress

- The Eastern System Tactical Call is functioning well as the forum for information sharing and problem solving for system partners. It remains well attended and is developing a number of task & finish groups to address specific areas e.g. care homes, rehabilitation, leg ulcer pathways; and BCF to evaluate the 20/21 iBCF schemes in full and recommend 21/22 schemes for system agreement.

- Continued delivery of the Covid-19 national discharge standards and the focus of the CCG Discharge and Out of Hospital Cell has enabled a close focus on the day to day management of discharges within the Eastern system, resulting in improved discharge performance and in particular complex and challenging discharges have been progressed much quicker that would have been the experience in the past.

- The team are working on the Eastern locality out of hospital demand and capacity plan. Initial modelling revealed that RDE had a different split of discharge pathways to the national model (P0 78%, P1 11%, P2 7%, P3 4%), however the system functions well and is able to maintain flow into the community. The next phase of the plan is focussing on ensuring the correct and relevant information is collected so that an accurate view of capacity is achieved. We will then pursue improvement measures that meet the following criteria:
    - Mutually recognisable in reason and potential benefit
    - Fits with the Eastern systems priority areas

- The care homes sub-group has been working well and was has established to form an Eastern response to NHS E requirements for care homes support and DCLG requirements for Care Home Resilience plans. Three pilots of multi-disciplinary working between RD & E and PCN's are established which will support learning and planning for the Enhanced Health in Care Homes DES, working with DCC and the market management team to produce a simple support offer which will be shared via the Provider Engagement Network website and forum. The RD&E have made available their geriatrician support line to care homes to support homes with the care of people post discharge.

- Support to the "recovery and restoration" cell to initiate services following a period of learning from the provision of covid services in the locality.

- Discussions initiated by the clinical team at the RD&E to understand how to provide a covid safe ED department and service by redesigning how the care is provided in partnership local PCN's and the 111/CAS service. This redesign work will ensure the RD&E Emergency Department pathways of triage and care are aligned to the emerging national model of "Talk before you Walk" that requires people to ring 111 before attending an Emergency department unless they are experiencing a life threatening condition.

Key priorities for the next three months

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

Issues of concern or risk

- The eastern system tactical call requires highly developed and trusted relationships between partners that will take time to develop and cement. This is unlikely to be in time to meet the requirements of the developing system work expected of the East.
- Immediate issue and requirement to specify and commission leg ulcer services in response to practices notice to cease services previously provided under the Leg Ulcer LES impacting on community services and patient care.

Support required from CCG/system or barriers to progress

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

NHS
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Locality update report

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

Key achievements/progress

- Continuing effective and positive engagement with partners including UHP, Livewell, local authorities, and Primary Care Network Clinical Directors through various channels including a weekly system video-conference – rapid raising of issues and risks, developing mitigations and enabling good communication in rapidly changing and complex environment.
- All contracted organisations responded well to the national guidance and CCG's coordination of service changes early on and continuing through the COVID escalation.
- Rapid transformation in response to COVID-19 escalation and national guidance through primary, community and acute services.
- Members of the team have been contributing to the various Devon-wide cells. A high proportion of staff seconded to other organisations to support the COVID response these are now returning to the Locality and workplan priorities are being agreed.
- Agreement on use of, and funding for Covid Hot Hubs resolved.

Key priorities for the next three months

- Continuing the Integrated Care Partnership procurement, ensuring transformation and learning from COVID-19 are sustainably locked-into the local health and care system, including Care Home Liaison, Enhanced Primary Care offer and embedding of digital approach.
- Continued system escalation and response to COVID-19
- Ensuring benefits reaped from escalation and rapid transformation are locked into local system through Restoration and Transformation work, Integrated Care Partnership procurement and other service improvements
- Developments for use of Fair Shares funding, considering rapid transformation and change achieved recently and through COVID escalation.

- Continued use of the community wide capacity planning to support the system to be prepared for any expected surges in demand caused by COVID and the need to restore elective capacity.
- Review and re- prioritise demand reduction plans for urgent care linked with occupancy action plan.
- Progress PCN development in delivery of the DES including alignment of PCNs with care homes as part of the Enhanced Health for Care Homes framework
- Bed occupancy remains higher than the refined target across the system and work continues to reduce this via the occupancy action plan.
- Concern at the availability of ICU capacity with the restoration of key surgical services, the continued need for access as a necessity of the Major Trauma Unit and any escalation of Covid cases.
- Support system approach to the delivery of primary care flu vaccinations

Issues of concern or risk

- COVID-19 – system-wide risks including to patients due to non-availability of services and healthcare and social care staff and wellbeing (various mitigations being actioned and will be considered and acted upon through Restoration and Transformation process)
- Workforce capacity – nursing, domiciliary care, pharmacy, voluntary sector (being managed during COVID escalation, will require review and mitigation through Restoration and Transformation process)
- Resilience of Plymstock GP practices as a result of Barton Surgery contract hand back (contract handed back 31 December 2019)
- Community capacity for future COVID-19 peaks in activity needs to be understood as a priority.
- Occupancy in UHP and Livewell SW being managed locally through occupancy action plan with support from the Discharge Cell.
- Particular focus on admission avoidance priorities and impact of demand from ambulance conveyances.

Support required from CCG/system or barriers to progress

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

NHS
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Locality update report

Locality:	South
Period covered by update:	June – July 2020
Locality clinical representative:	David Greenwell
Locality executive lead:	Liz Cosford
Locality non-executive representative:	Judy Hargadon

Key achievements/progress

Service changes - response to COVID-19 and phase 2 recovery and restoration
The CCG had oversight of the TSDFT service change process and changes made via reports to the weekly locality Recovery meeting. This meeting is working well, with a membership that includes representation from the CCG Recovery and Transformation programme, primary care, mental health services, TSDFT, Healthwatch and the community and voluntary sector.

Following the publication of the service restart letter from NHSE/I on 29th April, the Trust has now nearly completed a process of prioritising and re-starting services.

The Trust's recovery programmes are closing down and governance is returning to business as usual.

Integrated care
TSDFT has re-established its Home First group with a wider membership, which looks across the system at initiatives which enable people to have as much care locally to their home as possible. This includes the T&SD Frailty Partnership Group which is in the midst of being established, the Enhanced Health in Care Homes programme, Technology Enhanced Care, voluntary sector, place-based care and short term services such as rapid response.

The Trust is also considering its community urgent care response and the interface between its acute and community services and with primary care. A pilot with ECIST is being prepared for, to see how community services can link with SWASFT.

The Community Mental Health Framework steering group has been re-established and the locality is looking strong position in how this work can involve community physical health services and the voluntary sector.

Long Term Conditions
Work has been underway to re-establish the Local Diabetes Improvement Group a steering group for CVD.

A steering group for Respiratory has also been established with the first meeting taking place on 22 July 2019. Southern Commissioning representation is now also on the South West Respiratory Network.

Discharge Cell
During phase 2 of the demand and capacity planning a task and finish group has been established with the Trust to clarify the data we have and understand what more we need. We have broadened our team to include finance and BI. We have reviewed our actions and feedback from phase 1 and introduced key lines of enquiry to enable us to complete this process.

Urgent care
We have established a bi-weekly south system urgent care working group, bringing together GPs, Trust colleagues, SWASFT, Devon Doctors, Healthwatch and DPT. The agenda covers community urgent care, demand management, admission avoidance, flow and performance. Terms of Reference have been agreed, and working groups agreed or established to take forward the work programme including community urgent care and “Home First” which will focus on demand management/admission avoidance work. In addition, there are escalation huddles twice a week to review weekend performance and plan ahead.

A recommendation paper has been written regarding the next steps contractually for the Health Navigator Health Coaching service currently provided at Torbay and South Devon Foundation Trust. This paper is due to be discussed at one of the CCG Executive meetings imminently.

Key priorities for the next three months

Key areas of focus for the South Recovery meeting over the next two months are winter planning, diagnostics and elective care, establishing the Locality Care Partnership and digital progress.

Discharge Cell
Completing phase 3 of the out of hospital services demand and capacity plan is the priority for this programme.

Primary Care
Newton Abbot PCN is taking part in the Population Health Management pilot, supported by a very multidisciplinary approach including district council, DPT, TSDFT and the voluntary and community sector.

Long-term Conditions
The first post-COVID meeting of the local Diabetes Improvement Group is being arranged for the beginning of September.

A steering group is looking to be established for CVD along with connections from the South to the South West Cardiac Network.

Urgent Care
The focus of the south urgent care working group will need to agree a model of urgent care which avoids ED attendance, where at all possible, in line with the SW regional priority for ED crowding prevention. This will include an enhanced community urgent care offer including an urgent treatment centre and urgent response visiting service and same day emergency care alternatives including medical and surgical assessment and direct access to specialists.

Services will need to be accessible via 111, as part of the "Think 111 first" operating model. Winter planning priorities will need to be agreed, as part of an overall approach to surge/winter planning and readiness.

We are currently working with the Emergency Care Intensive Support Team (ECIST) to pilot the "care coordination concept" with SWASFT and TSD, supporting access to community alternatives for the ambulance service via the hub and to crews on scene.

Issues of concern or risk

Service changes - response to COVID-19 and phase 2 recovery and restoration

Key challenges have been regarding the restart of essential services in the locality, whilst maintaining sufficient capacity for surge and social distancing. Diagnostics such as radiology and gastroenterology have been particular areas of concern.

Primary care
Primary care is managing a significantly additional number of patients with regard to diagnostics, MSK physiotherapy and referral to consultant and medication, as well as increased numbers of anxiety and depression.

Urgent Care
Challenges maintaining urgent and emergency care demand at 80% of pre COVID levels, to reduce crowding – particularly following the lifting of lockdown restrictions

and more holiday traffic. Practical considerations for making services available to 111 to directly book (or “herald” patients to).

Support required from CCG/system or barriers to progress