PUBLIC - NHS Devon Clinical Commissioning Group Governing Body

South West Academic Health Science Network, Conference Room 2&3, Vantage Point, Pynes Hill, Exeter, EX2 5FD

31 October 2019 14:15 - 31 October 2019 17:00

AGENDA

#	Description	Owner	Time
1	Welcome and Apologies Verbal	Chair	14:15
2	Register of Interests (ROI) Verbal DOI NHS Devon Governing Body October 2019.pdf 5	Chair	14:20
3	Minutes of the last meeting Paper 1. draft Public GB minutes 26.09.2019 v1 nc.docx 9	Chair	14:25
4	Patient Experience Story Presentation	Non-Executive Lay Member with an Interest in Patient Involvement	14:30
5	Chair's Report Paper 1 cover sheet chairs report.docx 17 2 Chairs Report October Draft.docx 19	Chair	14:45
6	Accountable Officer's Report Paper 1 Cover sheet template (002) Interim AO Report Pu... 21 2 AO Report Public Devon CCG October 2019 V2.d... 23	Accountable Officer	14:55
7	FINANCE		
7.10	Month 6 Finance Report Paper 1. FPC_Report_FPC_Month 6_FINAL_2019-20 (G... 27 2. FPC_Report_GB_Month 6_FINAL_2019-20 (GB... 31	Director of Finance	15:05

#	Description		Owner	Time
7.20	Financial Inequities Paper 1. Inequities Report for GB - cover sheet_final.docx 2 Inequities Report for GB _final.docx 3 1819 Financial Equity Update vs 20191029 GB.p...	55 59 69	Director of Finance	15:15
8	BREAK (10 minutes)			15:35
9	QUALITY AND PERFORMANCE			
9.10	Quality Assurance Committee Chair's Report Paper QAC October Public Committee Chair Report Temp...	81	Chair Quality Assurance Committee	15:45
9.20	Quality and Performance Report Paper 01 Quality and Performance cover sheet.docx 2 GB - Quality and performance report.docx	85 87	Director(s) of Commissioning	15:55
10	INFORMATION			
10.10	EPRR Assurance Paper 1 GB EPRR PAPER cover sheetv2.docx 2 GB - EPRR Core Assurance Report Oct 2019.doc... 3 20191021 Devon CCG EPRR Assurance 2019 O...	115 119 127	Board Secretary	16:25
10.20	Finance Committee Chair's Report Paper finance committee chairs report 17 10 19.docx	131	Chair Finance Committee	16:35
10.30	Primary Care Committee Chair's Report Paper Committee Chair Report - Public PCC October 19.d...	133	Chair Primary Care Committee	16:40

#	Description	Owner	Time
10.40	Locality Updates (North, East, South and West) Paper [P] 0 Locality Updates Cover Sheet.docx 135 [P] 2 Northern Locality Report Oct 2019 V2.docx 137 [P] 3 Eastern locality GB report for October 2019.docx 143 [P] 4 WL Update Report for Oct 2019 GB.docx 149 [P] 5 Locality update report- Southern - Oct 2019 v1.do... 153	Locality Triumvirate Representatives	16:45

Declaration of Interests Register - Governing Body
Report generated by the governance team on 22 October 2019

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Atherton	Glynis	Lay Member - Quality	Member Governing Body Member Quality & Assurance Committee (Chair) Member Primary Care Commissioning Committee Member of Remuneration and Workforce Committee	Consultancy for FORCE cancer charity – not CCG funded but has a relationship with RD&E hospital Trustee for St. Margaret's Hospice, Somerset Volunteer for Hospiscare, Exeter – helping at events and proof reading applications to charitable trusts Volunteer for University of Exeter – mentoring students Member of the Labour party		14/05/2019		21/05/2019	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Director - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 ,Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		10/05/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Blackford	Derek	Deputy Chief Finance Officer	Attendee of Audit Committee (Deputy for CFO) Member of Finance and Performance Committee Senior Leadership Team (SLT) Member Governing Body (Deputy for CFO)	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Lay Member - Patient and Public Involvement	Member of Governing Body Member of Quality and Assurance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	I am chair of the Devon Maternity Voices Partnership (MVP) a collective of parents (and parents to be) and organisations who support maternity services (health professionals, charities, Healthwatch, non-health professionals) working together to review and contribute to the development of local maternity care across Devon. Devon CCG provide funding to the MVP (ceased September 2019) Self-Employment business consultant from September 2019		04/04/2019		02/10/2019	Financial/Personal Interest	Direct	Resigned as Chair from the Devon Maternity Voices Partnership. (formally leaves July 2019) Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt	Partner is employed by Livewell Southwest in position of influence	26/09/2017		15/10/2018	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Coles	Anna	Director of Integrated Commissioning Seconded to CCG to Associate Director of Commissioning (Western)	Senior Leadership Team (SLT) Member Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019		12/03/2019				Plymouth City Council
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015					Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Member of Primary Care Commissioning Committee (PCCC)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015		19/06/2018	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body A & E Delivery Board (Sd&T)	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher GP Locality Clinical Director Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016		28/07/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

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

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

	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Attendee of Remunerationand Workforce Committee	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	07/09/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	STP Director of HR	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee Governing Body/Member Governing Body (Deputy for Director of Communications)	No interests declared			16/10/2018				NHS Devon CCG
	Turl	Jo	Director of Commissioning - Western	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting	DELT Board Member, CCG Devon nominated director		13/08/2015	03/09/2019	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Webber	Lorraine	Associate Chief Nursing Officer (South & West) Interim Director of Nursing (Caldicott Guradian) July 2019	Member of Quality Assurance Committee A & E Delivery Board QEIA Panel Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Member Governing Body CCG Executive Team Meeting	No interests declared		14/03/2017	29/08/2018				NHS Devon CCG
	Wheller	Kevin	Locality Chief Finance Officer (Northern & Eastern)	Attendee of Audit Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member Governing Body (Deputy for CFO) Northern and Eastern Preparatory Group		Spouse is employed as a finance manager at Castle Place Surgery in Tiverton. The Surgery is operated by the Royal Devon & Exeter NHS FT	22/10/2015	25/01/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (Non exec rem) Northern and Eastern Preparatory Group	General Practitioner at Coombe Coastal Practice in Ilfracombe (ended 10/09/2017) Member of Royal College of General Practitioners Director of One Ilfracombe Our Place Programme Chair of One Northern Devon		14/02/2017	31/01/2019	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting
Draft Minutes held in PUBLIC

Date: 27 September 2019 Time: 15:00 – 16:10

Location: Newton Abbot Racecourse, Newton Road, Newton Abbot, TQ12 3AF

Item	Discussion	*Action*	
1	**Welcome and Apologies** PJ, chair welcomed everyone to the meeting and the following apologies were noted: ST, NB, JH, SK, CD, VP, TP, SP, RH, JD – DB deputy, SMa – SS deputy		
2	**Questions from Members of the Public** There were no questions received from members of the public.		
3	**Register of Interest (ROI)** PJ directed the members to the ROI included in the pack. • PJ declared that he was no longer a GP partner at Cricketfield Practice • CB declared that she was no longer chair of Devon Voices Maternity Partnership • SMc noted that her declaration had been updated after the publication of the Governing Body papers and would show on the register for the October meeting. There were no other conflicts of interest declared pertaining to the items on the agenda. **The Governing Body received and noted the updates to ROI**.		
4	**Minutes and action log** The minutes of the last meeting held on 29 August 2019 were agreed as a true and accurate record of the meeting. Action 1 – LW noted that the mental health gap analysis was referenced in the quality assurance committee chairs report and that the performance for IAPT was included in the quality and performance report. The Governing Body were assured and therefore agreed formal closure of this action.		
5	**Chairs Report** PJ did not propose to go into this report in detail but gave a verbal update on the recent presentation at the Southwest Clinical Senate. Along with Mat Fox, GP and joint clinical lead representative for the Southern Locality they shared their experience of consultation and new models of care and learning from the implementation. This will be used and built into the clinical senate report that will be developed detailing the use and role of a community hospital in a modern setting.		

	On the 19 September at Sandy Park, Exeter, NHS Devon held their AGM which was a good opportunity to celebrate the good work not only in the CCG but with our partners over the last year In Devon. As well as people attending in person, more than 950 people watched the AGM on Facebook. LW was pleased to report positive feedback from members of staff from the nursing and quality directorate who joined via Facebook. PJ gave his personal thanks to the communication team for organising the AGM in particular the technical aspect to enable a proper celebration. **The Governing Body received and noted the contents of the Chair's report.**		
6	**Accountable Officer's Report** AM presented this report in the absence of ST and drew attention to the CCG Executive Team priorities which were discussed in detail on 12 September. He noted there was more to do as a CCG to help towards getting the organisation fit for the future but that the meeting held on the 12th was useful and that senior leadership team will now be working towards identifying leads and actions plans for the priority areas. AM reported that since the merger of the two CCGs and the creation of a new organisation we undertook an interim survey to check how we are working. Significant improvements have been seen following this change, however we still face some challenges, but the results so far have been positive. AM noted that ST will now chair the System Performance Group attended by key senior managers across the system which will have a focus on improving performance in Devon. GA congratulated the Executive Directors for their achievements over the past 6 months in what has been quite challenging at times. **The Governing Body received and noted the contents of the Accountable Officer's Report.**		
7	**Finance Committee Chair's Report** There was nothing further to add to this report. **The Governing Body received and noted the contents of the Finance Committee Chairs Report.**		
8	**Month 5 Finance Report** DB directed the members to page 33 of the report which detailed a reminder of the plant from the start of the year and he described the variances on page 41 and noted the forecast outturn (FOT) expenditure plan results in an overspend of £27m. He referred to page 52 and the assessment of financial risk at month 5 which is estimated at a total unmitigated risk of £39.5m. The CCG plan is showing £81m of efficiency savings with £45m of that on behalf of the system. There is a range of risks to delivery of our QIPP plans and cost pressures to get us to the figure of £45m plus £6m mitigations. We are currently moving through a process of reviewing each area of delivery savings to generate further financial improvement. PJ raised concerns around the QIPP plans for CHC, Primary Care and what are the plans to address these risks. DB responded and confirmed there would be a financial re-		

	assessment by teams to understand the original plans, delivered and desired benefits that could be pushed further to address the challenge. JT noted that Primary Care and Prescribing QIPP target has been £0.5m under year end and this was due to a price change and increases along with the loss of pharmacists in the system. Primary Care Commissioning will be focusing on pharmacist's workforce and acknowledged that this was a significant risk and that the Carnall Farrarr benchmarking evidence will be used to identify further opportunities. Concerns were raised around referrals and the activity summary on page 47 by organisation which did not appear to align with activity summaries for month 4. JT responded that this was due to changes in waiting lists and that monthly business intelligence reports were being developed for discussion at the local system improvement boards. This will enable us to support our providers in making sure they are meeting our aspirations. **The Governing Body received and noted the contents of the month 5 financial report as at 31 August 2019 and the level of risk to delivery of the CCGs control total.**		
9	**Audit Committee Chairs Report** GS presented this report and drew attention to the standards of business conduct policy which has been refreshed considering a national audit of the management of conflicts of interest by NHS E. GS felt this was one of the most important documents of the CCG which all individuals within NHS Devon CCG must have regarding their work and particularly mentioned the guidance relating to counter fraud, conflicts of interest and sponsorship. The Assurance Framework was appended to the report and was for information and mentioned that this would be monitored through the audit committee and that the CCG has complied with all but one internal audit recommendations. NK wondered why the assurance framework did not have any review dates against them and GS replied that this is work in progress and that when the report comes back to the Governing Body in future the review dates will be populated. It was wondered in what forum the gaps in assurance would be challenged and GS responded that each risk had a nominated executive lead and would be their responsibility for managing their risks and the challenges around gaps in assurance would be done through the governing body meetings. NK asked about risk 9 evidence-based proposals. JT provided an update and as a priority when developing our commissioning intentions where there is clear evidence-base this will be clearly articulated to help inform and in making evidence-based decisions. LW also confirmed that indirect evidence-based work is being undertaken through the Quality and Equality Impact Assessments (QEIA) to support with commissioning decisions. **The Governing Body received and noted the contents for the Audit Committee Chairs report and the attached appendices.**		
10	**Quality Assurance Committee Chairs Report** There was nothing further to add to this report.		

	The Governing Body received and noted the contents of the Quality Assurance Committee Chairs Report.		
11	**Quality and Performance Report** JT presented this report and provided and update on the following areas of performance: <u>52 week waits</u> There are currently over 200 patients waiting over 52 weeks for surgery and key actions to address this are being discussed at the system performance group: • As from 30 September the four acute trusts waiting lists for 52 weeks waits will be managed centrally through the Direct Referral Support Service (DRSS). Those patients that have been given a TCI (to come in) date will be left and the remaining patients will be offered a choice of an existing service in Devon or the Independent Sector or outside of Devon and the assumption is this will reduce the numbers by 20% which will be a significant contribution in reaching our target. There will also be a piece of work to look at those patients that are just under or nearing the 52 weeks wait. • A Standard Operating Procedure has been developed for those patients who choose to wait longer, and this has been reviewed by Primary Care and the SOP will be implemented by each acute trust. The watchful waiting patients will be put back on the waiting lists and given a date for treatment. Those watchful waits that choose not to accept a date for treatment the clinician and GP will be directly notified, and they will have direct access to be put back on the waiting list (no referral required) when they choose so. LW confirmed that the quality team have also reviewed the SOP and it does give the opportunity for patients to come back into the system as a priority. <u>Diagnostics</u> £2m has been received to support cancer waiting times and will be used to reduce waits for diagnostic tests. There will be a focus on endoscopy which has been agreed by the system performance group and a commitment of £500k for Plymouth patients with University Hospitals Plymouth to sub contract to Care UK. £1.5m will be used to fully support a mobile solution and agreement has been gained from Cancer Alliance. <u>A&E</u> A firm focus remains on Western demand management for same day urgent care and weekend early discharges. For Southern Devon the focus will also be on same day urgent care and timely discharges. We are also looking to agreement with the ambulance service whereby a paramedic would be in situ at the front door of A&E (this will be known as Halo service) to assess and understand where other alternatives that could have been put in place to divert patients away from A&E. SS mentioned the system improvement board and that we are also working with the ambulance services and communications teams in Primary Care to ensure with get discharges right. GA wondered about Winter planning and that we haven't had much respite during the summer months. Assurance was given that Winter planning has already started with specific challenges being reviewed through the local A&E delivery boards. They will review last year's plans and what went well and not so well and identify what more we can do differently this year.		

	It was noted that trusts are seeing an increase in demand through A&E and flows through the system especially in the Western System. Torbay has also seen an increase and as they are a smaller trust, it does not take too much extra demand to affect performance measures. **The Governing Body received and noted the contents of the Quality and Performance Report.**		
12	**Primary Care Committee Chair's Report** There was nothing further to add to this report. **The Governing Body received and noted the contents of the Primary Care Committee Chair's Report**		
12	**Locality Updates** <u>Northern</u> There was nothing further to add to the report, however JWo highlighted that support for A&E by RDE was proving helpful for improved performance however the picture does remain fluctuating but encouraging. PCNs are continuing to be developed. The recent CQC report has rated the quality of services provided by Northern Devon Healthcare NHS Trust as requires improvement which was a disappointment but did highlight improvements which is a good indicator of progress being made. NK asked about the development of 'Single System Services' and JWo explained the initiatives for this across three of the four PCNs. <u>Eastern</u> There was nothing further to add to this report, but GA mentioned the Eastern Locality Delivery Group who met on 4 September as an opportunity to discuss integrated care for Eastern and practical concerns for the voluntary sector. She also noted that discussions around the sustainability of the Budleigh Hub was ongoing. <u>Western</u> There was nothing further to add to this report, but SMc highlighted the GP Forum which is scheduled for 1 October and will be the first one since the establishment of PCNs. This will give an opportunity to talk about the Plymouth Prospectus which will be formally launched on this day. The Digital Accelerator Project is continuing to be rolled out and one interested GP practice is making significant progress with this. SMc noted that clinical directors are enthusiastic for organisational development and opportunities and are conversations are underway around accessing funding. JT reported there continues to be challenge for Western around performance and that an operational delivery group has been set up in Western to focus on the financial plan and performance improvement which will be chaired by the CCG CEO for the system. <u>Southern</u> The report was as read, but DG said that concerns around TSDFT performance were being acted on.		

	Since writing the report there was a major outage of IT on 22 and 23 September whereby TSDFT lost all N3 connections to the hospital and GP surgeries including no telephones, internet or clinical systems. A review of what happened is underway and that there will undoubtedly be learning from business continuity and we are looking at how we may manage IT systems without N3 connectivity by using safe and secure alternatives. This was the second IT incident over the last month and it is not sure if they are connected and that will be explored and the review of what happened would be presented back to the Primary Care Committee for discussion. LW confirmed that this latest occurrence has been reported as a Serious Incident (SI) and a full root cause analysis will be undertaken. It was acknowledged that the communications teams from the system worked well together and there will be definite learning from the process that will be used for best practice and it was also recognised that the front line staff did everything they could under very difficult circumstances and on behalf the Governing Body PJ praised them for all of their efforts. The two theatres that were closed will now be re-opening on 7 October which was a huge relief and the MIU in Dawlish will now revert to normal opening hours of 8am – 8pm. DG did mention that Totnes hospital was still finding it difficult to recruit to staff. SS reported that there has been agreement for the use of Winter Funding to be used and aligned with our Local Authorities including one process and one set of priorities and that this was a good example of partnership working. **The Governing Body received and noted the contents of the locality reports.**		
13	The meeting closed at 16:10pm		

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

Lorraine Webber (LW)**	Interim Director of Nursing, Devon CCG
Nick Ball (NB) **Vice Chair** A	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
Ruth Harrell - Dr (RH) A	Director of Public Health, Plymouth City Council
Simon Kerr – Dr (SK) A	Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc) **	Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST) A	Interim Accountable Officer, Devon CCG
Solveig Sansom (SS)	Associate Director of Commissioning – Southern Locality, Devon CCG
Sonja Manton – Dr (SMa) A	Interim Director of Commissioning – North, East and South, Devon CCG
Tracey Polak (TP) A (for VP)	Assistant Director Public Health, Devon County Council
Virginia Pearson – Dr (VP) A	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) ** **Minute Taker**	Executive Assistant, Devon CCG
Jade Quartermaine (JQ)** **admin support**	Senior Administrator, Devon CCG
Simon Polak (SP) A	Interim Director of Quality Assurance, Devon CCG
Alex Cameron (AC) **	Media and Publications Manager, Devon CCG

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GOVERNING BODY

Report title: Chair's Report				
Date of committee: 31 October 2019 **Date report produced: 24 October 2019**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive:** **Name and Title:** **N/A** **Contact Details:** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date: 24 October 2019**		
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:

- Western GP Forum
- STP Chairs and Non Executive Development Day
- Devon ICS Conference
- Governing Body Membership Update
- CCG Accountable Officer (may be removed)

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

This month has seen some definite steps in Devon's progress towards an Integrated Care System. The system non-executive workshop helped develop the governance structures and the Devon ICS conference helped progress our understanding of the function of an ICS both at a system and a place level and the role of organisations within this system. It is now important that we as system health commissioners have clarity around our role both strategically and within our four geographical places to ensure that the whole population of Devon is supported through the whole pathway of their care and health needs. To help us with that whole population approach I am really pleased that we will have a number of new Governing Body members and associated members who will bring their own unique perspective and experience and I'd like to welcome them to the CCG and look forward to working with them.

2. Western GP Forum

My thanks to Shelagh McCormick for inviting me to the Western GP Forum on 1 October. This saw the official launch of the GP Prospectus we have worked on jointly with Plymouth City Council and it was great to hear some real enthusiasm in the room and genuinely exciting ideas about the future of primary care in the western locality.

3. STP Chairs and Non-Executive Directors Development Day

I joined our non-executives on 10 October with our colleagues from acute, mental health and community providers. There was real value in developing these cross-organisational relationships and an understanding of other perspectives and priorities that will influence and shape a Devon ICS. Future governance arrangements were discussed for both system and place level, and although I believe there is still significant work to be done to ensure they promote and enable commitment and engagement from all our key stakeholders, some key principles were established particularly around non-executive engagement and political accountability. I look forward to continued working with Suzi Leather (Independent Chair of the STP) as this is developed.

4. Devon ICS Conference

On 16 October I, along with many of our Governing Body members, attended the ICS conference. We benefitted from hearing from some very experienced national leads including Niall Dickson, Chief Executive of NHS Confederation and Chris Ham, Chair of Coventry and Warwickshire Health and Care Partnership and previous Chief Executive of the Kings Fund. I was particularly encouraged to see a number of our system Primary Care Network Clinical Directors and to hear their enthusiasm for developing both their General Practice groups but also their relationships with

local health, council and community groups and play a key role in the wellbeing, prevention and social prescribing agendas.

5. Governing Body Membership Update

I am really pleased to inform Governing Body that we had a very successful recruitment process for further Governing Body members in the following roles:

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

I will provide a verbal update at Governing Body with hopefully more detail.

6. CCG Accountable Officer

This will be a verbal update.

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GOVERNING BODY MEETING

Report title: Accountable Officer's Report				
Date of committee: 31 October 2019 **Date report produced: 18 October 2019**				
Author (s) Name and Title: Simon Tapley, Interim Accountable Officer John Dowell, Director of Finance Dr Sonja Manton, Interim Director of Commissioning – North, East, South Molly Bishop, Executive Assistant to Interim Accountable Officer		**Supporting Executive:** **Name and Title:** Simon Tapley, Interim Accountable Officer **Report Approved by:** **Name and Title:** Simon Tapley, Interim Accountable Officer **Date** 18 October 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				
Executive Summary: This report contains updates on: • CCG Priorities • Major Incident in Devon • NHS Long Term Plan: Better for you, Better for Devon • EU Exit Preparations • Key meetings and visits • Integrated Commissioning Executive meeting				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				

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

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

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

NHS
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This report must be accompanied by a completed front sheet

Accountable Officer's Report

1. CCG Priorities

The CCG's Executive and Senior Leadership Team has been working on the agreed priorities, listed below, to establish the key deliverables and generate project plans and progress reports.

Performance Improvement

- 52 week waits
- Urgent Care – ED 4-hour performance
- Diagnostics

Finance

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

A CCG that is fit for the future

- Local Care Partnerships (LCPs)
- Quality Improvement and Change Management capacity and capability
- Strategic Commissioning
- Policy Drivers

It has been agreed that the Programme Management Office (PMO) will support this work with monthly reporting on progress to the CCG Executive and Senior Leadership Team. The Executive Team is reviewing the delivery and resources to these priorities on 24 October 2019 and a full report will be provided to the Governing Body in December.

2. Major Incident in Devon on 5 October 2019

On behalf of the CCG I would like to pay tribute to the response of the local emergency services and our communications team following a major incident in Devon on Saturday 5 October 2019. The public have also been thanked for their patience and avoidance of use of our emergency services unless in a genuine emergency. Our thoughts continue to be with those who were affected by this incident.

3. NHS Long-Term Plan: Better for you, Better for Devon

The first draft of our local version of the NHS Long Term Plan 'Better for you, Better for Devon' was submitted to our regulators on Friday 27 September 2019 and the CCG is working through the draft initial feedback received.

The plan aims to ensure that we are fit for the future, providing high quality care and better health outcomes for people and their families, through every stage of their life. To support the development of the plan, over 4,000 pieces of engagement have been received and Healthwatch Devon will be producing an independent report on the findings from the engagement, which will be available in autumn 2019.

4. EU-Exit Preparations

The Department of Health and Social Care and NHS England/Improvement continue to work together closely in relation to EU Exit preparations nationally and with Local Resilience Forums (LRF) locally. The local LRF met on 7 October to review how agencies across Devon, Cornwall and the Isles of Scilly are preparing for EU Exit across all government agencies, describing the governance model, methods of engagement and a current briefing on local planning assumptions. This included partners from the NHS and local government, Border Force, Highways England, Devon and Cornwall Police. The latest information available on EU Exit for partner agencies of the LRF is on a secure electronic forum (Resilience Direct) and the appropriate staff in the CCG are being provided access to this.

As part of national preparations and response, there is a requirement to provide daily EU Exit situation reports from 21 October 2019. Guidance for this has been provided to all NHS organisations and the system is being tested in advance of this. The responsibilities and process for supporting this within the CCG were agreed by the senior leadership team in September.

The CCG remains joined up with its providers and partners across Devon in providing any regular EU Exit situation reports, as directed, to NHS England/Improvement. As part of the core assurance at this time of year, NHS organisations business continuity plans are being tested and will continue to form part of our business as usual. In partnership with the national and regional teams and communications strategy, the CCG communications team has been supporting any queries or questions regarding our EU Exit preparations.

5. Key meetings and visits

- The Devon Integrated Care System Conference on 16 October 2019, which was attended by a number of national and local system leaders, to discuss our ambitions for Devon, the long-term future of health and care, integrated working and Primary Care Networks.
- The Devon Planning Review meeting with Chief Executive colleagues from the Devon System and NHS England/NHS Improvement was held on 17 October 2019 to discuss feedback on the draft submission of the Long Term Plan and priorities for the system.
- I chaired the Torbay and South Devon NHS Foundation Trust (TSDFT) System

Improvement Board, where we discussed improvement programmes for performance and finance.

6. Integrated Commissioning Executive meeting

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

Key areas of discussion recently have been:

- Draft primary care strategy
- Long Term Plan metrics and the outcomes framework
- Progress on Local Care Partnerships development and strategic commissioning, including the development of the Strategic Commissioning Programme Board
- Children's services
- Implementation of the Autism Services (Adults) business case
- Better Care Fund including the impact of schemes and the link to the Long Term Plan metrics

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GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 31ST October 2019 **Date report produced: 22ND October 2019**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date: 22ND** October 2019		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The report details the financial position to the 30th September 2019 and provides and assessment of the CCG's risk to delivering its planned deficit of £27m.

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

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

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

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

This report sets out the financial performance of the CCG to the end of September 2019 (month 6 management accounts).

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

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

None.

Key recommendations and actions requested:

The Governing Body is asked to note the month 6 position as at 30th September 2019 and the level of risk to delivery of the CCG's control total resulting in the proposed movement in the CCG's forecast going forward.

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 6 – 2019/20

Contents

Appendices

1. Executive Summary

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

The report details the financial position to the 30th September 2019 and provides and assessment of the CCG's risk to delivering its planned deficit of £27m.

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

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

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

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

Financial Position

This report sets out the financial performance of the CCG to the end of September 2019 (month 6 management accounts).

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

	Planned Deficit £'000	Actual Deficit £'000	Variance to plan £'000
Year to date position	13,500	13,500	0
Year end forecast	27,000	27,000	0

Although the overall year to date (YTD) position balances to the planned deficit of £13.5m, there are several variances to report at Month 6. These are discussed and set out in later sections.

Savings Plan

As set out in section 4, the CCG has a savings plan of £80.9m. The current assessment of deliverability suggests a saving of £35.5m could be delivered leaving a risk of £45m against the plan, therefore resulting in under delivery.

Risk

Section 5 provides further detail but after allowing for a modest level of mitigation identified through the planning round the overall unmitigated risk to delivery of the CCG's plan is assessed at £39.5m. Actions to improve the financial position through a set of recovery actions are being pursued and we had made the assumption these would reduce the unmitigated risk to £35m. Unfortunately, in year pressures in continuing healthcare, prescribing and independent sector contracts have led us to conclude that we are unable to move from the original assessment at £39.5m.

A review of the CCG's financial position has been undertaken in conjunction with NHSE and we are proposing to move our deficit position from £27m to £66.5m in month 7.

STP Plan

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

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

The STP as a whole are reporting risks to delivery of the system control total of £77m including the CCG risk of £39.5m. There is an increasing expectation that together with the CCG other organisations are at risk of missing their control totals.

2. Financial Assurance Dashboard

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

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

- Financial plan
- In Year Financial performance

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

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	13.5	13.5	0.0%	RED
3	Forecast Outturn in year deficit	27.0	27.0	0.0%	RED
4	QIPP - Year To Date Delivery (% achieved)	-27.9	-17.0	60.9%	RED
5	QIPP - Forecast Outturn Delivery	-80.9	-35.5	43.9%	RED
6	Running Costs	25.4	22.2	87.3%	GREEN
7	Risk adjustment to deficit (% of allocation)	0.0	39.5	2.3%	RED
8	Cash Position (% drawn down)	50.0%	50.8%	101.6%	RED
9	BPPC (% paid - value)	95%	99.3%	104.5%	GREEN

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

3. Detailed Financial Performance

The financial position to the 30th September 2019 by main service heading is as follows:

Month 06 September	DEVON CLINICAL COMMISSIONING GROUP					
	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES						
Acute Services	452,161	453,890	1,728	904,253	905,957	1,704
Mental Health Services	101,671	101,352	-318	203,341	202,705	-637
Community Health Services	134,471	134,515	43	269,013	269,091	78
Placements	60,953	61,230	277	121,903	122,460	558
All Other Healthcare	14,376	13,133	-1,243	98	-1,666	-1,765
Primary Care Services						
Prescribing	97,003	97,159	156	194,007	194,320	313
Other Primary Care	104,782	104,782	1	213,215	213,216	0
Primary Care Subtotal	201,785	201,941	156	407,222	407,535	313
Subtotal	965,417	966,061	644	1,905,830	1,906,082	252
CORPORATE						
Running Costs	11,215	10,572	-644	22,433	22,182	-252
TOTAL COMMISSIONED SERVICES	976,633	976,633	0	1,928,263	1,928,263	0
Allocation excl b/fwd position	963,133	976,633	13,500	1,901,263	1,928,263	27,000
2019/20 Surplus/Deficit	13,500	-	13,500	27,000	-	27,000

There are a number of YTD variances to report at Month 6 including an overspend in Primary Care, mainly due to prescribing costs, of £0.156m and £0.277m in Placements. In addition, there is a YTD overspend of £1.728m in Acute Services which relates mainly to a £1.4m overspend in Independent Sector costs due to outsourcing treatments, as well as a £0.266m overspend with Taunton and Somerset Foundation Trust. This overspend has mostly been offset using reserves and an underspend in running costs, resulting in the planned YTD deficit of £13.5m. This is discussed and set out in later sections.

When set against our available in year revenue resources of £1.901m for Devon CCG the forecast outturn (FOT) expenditure plan results in an overspend of £27m.

The detailed expenditure, contract monitoring information and an analysis of potential risks and mitigations is set out in the remainder of this report and will evolve

during the course of the financial year as further improved information and reporting becomes available.

3.1 Acute Services

Risk Share Application – Demand and Activity Management

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

The measurement of the activity and assumptions underpinning the risk sharing arrangement have been refined and agreed by the system directors of finance the application of which suggests an underutilisation of growth in the first quarter of £3.3m.

The results are to be discussed with system directors of finance with a view to establishing the progress and delivery of the targeted reductions/savings relating to acute activity growth and transformation, the ongoing measurement and forecast delivery of the savings target.

The sections below show the Month 5 position against total contract plans. The CCG continues to work closely with providers to ensure a joint understanding of activity variances.

RD&E Activity Summary – Month 5

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	4,561	3,690	-871	-19%	13,289	12,581	-708	-5%
Day Case	18,401	17,762	-639	-3%	14,068	13,787	-281	-2%
Non-Elective	19,684	19,061	-623	-3%	37,787	35,974	-1,813	-5%
A&E	37,168	37,022	-146	0%	5,065	5,274	210	4%
New Outpatients	53,492	58,261	4,769	9%	7,189	7,381	191	3%
Follow-up Outpatients	90,628	91,535	907	1%	6,315	6,270	-45	-1%
Outpatient Procedures	43,052	40,512	-2,540	-6%	7,429	7,272	-157	-2%
Drugs & Devices					6,624	6,420	-205	-3%
CQUIN					1,308	1,276	-32	-2%
Other					12,679	13,557	878	7%
Total					**111,753**	**109,792**	**-1,960**	**-2%**

The RDE Acute contract value has been agreed at £268,965k for 2019/20.

At Month 4 there is a £1,960k underspend against plan, within this there is £954k of uncoded activity within the actual position.

The Elective & Day Case activity is 7% below plan equating to an underspend of £988k. The main contributing specialty continues to be Trauma & Orthopaedics with a £451k underspend.
The Non-Elective activity is 3% below plan equating to an underspend of £1,813k. The main contributing specialty is Paediatrics with an underspend of £489k and Trauma & Orthopaedics with an underspend of £478k.

The A&E activity is 146 below plan with an overspend relating to the casemix of £210k.
Outpatient attendances are 4% over plan with a corresponding overspend of £146k. General Surgery is overspending by £135k with Ophthalmology reducing this with an underspend of £199k.
Outpatient Procedures are 6% below plan with a corresponding underspend of £157k.
Drugs and Devices are £205k below plan. Cytokine Inhibitors within Gastroenterology is the main area contributing to this position with an underspend of £219k.

CQUIN is being reported as being underplan by £32k.

The 'Other' Point of Delivery is reporting a £878k overspend against plan. This is being driven by unfunded growth being included with a negative plan of £905k with an offset from Adult Critical Care where there is an underspend of £330k.

NDHT Activity Summary – Month 5

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	1,381	1,392	11	1%	3,827	3,316	-511	-13%
Day Case	8,089	8,242	153	2%	4,185	4,362	177	4%
Non-Elective	8,946	8,796	-150	-2%	16,567	17,572	1,005	6%
A&E	19,171	18,821	-350	-2%	2,442	2,345	-98	-4%
New Outpatients	16,823	17,819	996	6%	2,794	2,787	-7	0%
Follow-up Outpatients	36,896	34,093	-2,803	-8%	2,944	2,796	-148	-5%
Outpatient Procedures	14,564	15,892	1,328	9%	1,855	1,979	125	7%
Drugs & Devices					2,480	2,370	-110	-4%
CQUIN					577	591	13	2%
Other					23,297	24,224	927	4%
Total					**60,969**	**62,341**	**1,372**	**2%**

The NDHT contract value of £145.8m has been agreed for 2019/20 (acute and community)

At month 5 there is an overspend of £1.37m. Due to the level of uncoded activity, an average speciality cost has been applied.
Elective and Day Case activity is 2% above plan with an underspend of £334k.

Non-Elective activity is 2% below plan but 6% over plan financially, the main speciality driving this over performance is General Medicine.

A&E activity is 2% under plan which equates to an underspend of £-98k

New Outpatient activity is showing a 6% overperformance against plan, mainly driven by Clinical Physiology, which is nearly exceeding double the plan at Month 5.

Follow up Outpatient activity is below plan, driven by the underperformance in General Surgery but there is an over performance within T&O.

UHP Activity Summary – Month 5

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	2,690	2,517	-173	-6%	9,065	8,474	-591	-7%
Day Case	13,513	14,163	650	5%	9,888	9,867	-21	0%
Non-Elective	17,232	16,301	-931	-5%	35,242	34,255	-987	-3%
A&E	55,570	52,617	-2,953	-5%	7,095	6,715	-380	-5%
New Outpatients	31,384	31,595	211	1%	4,668	4,710	43	1%
Follow-up Outpatients	67,946	65,805	-2,141	-3%	5,480	5,232	-248	-5%
Outpatient Procedures	29,035	32,978	3,943	14%	4,565	4,783	217	5%
Drugs & Devices					6,540	6,368	-172	-3%
CQUIN					1,056	1,044	-12	-1%
Other					8,498	9,481	982	12%
Total					**92,097**	**90,928**	**-1,169**	**-1%**

The UHP contract reporting shows an under performance of £1.2m at the end of month 5.
For Month 5 expenditure on Elective Care is 3.2% behind the financial plan and 2.9% ahead of the activity plan, the underperformance reduced by £0.1m in month 5.

The difference between the volume and value variances is due to a different casemix of patients being treated than was expected with overperformance in lower cost specialities such as Endoscopy and Dermatology, with underperformance in higher cost specialities such as Orthopaedics and Cardiology.

Non-Elective activity is behind plan in activity and financial terms by 5.4% and 2.8% respectively with an underperformance worth £1.0m. Whilst performance in month 4 was largely on plan, month 5 has seen continued underperformance against plan.

Accident and Emergency is behind plan by 5%.

Outpatient activity is ahead of plan by 1.6%. This variance is driven by UHP seeing more outpatients' procedures and non-face to face contacts and fewer follow ups, then had been expected.
First attendances are slightly over plan.

Passthrough Drugs and Devices are underspent by 2.6% or £0.2m, which is driven by passthrough drugs underperforming by £0.3m and devices over performing by £0.1m.

TSD Activity Summary – Month 5

	Activity				Cost £000's			
Point of Delivery	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	1,438	1,376	-62	-4%	5,204	4,786	-418	-8%
Day Case	14,011	13,846	-165	-1%	8,710	8,386	-324	-4%
Non-Elective	12,503	11,781	-722	-6%	27,397	26,477	-920	-3%
A&E	29,937	29,654	-283	-1%	4,515	4,469	-46	-1%
New Outpatients	31,442	30,229	-1,213	-4%	4,714	4,560	-153	-3%
Follow-up Outpatients	75,098	73,558	-1,540	-2%	5,881	5,732	-149	-3%
Outpatient Procedures	27,493	27,523	30	0%	4,156	4,063	-92	-2%
Drugs & Devices					4,685	4,510	-176	-4%
CQUIN					930	930	0	0%
Other					13,891	14,038	147	1%
Total					**80,082**	**77,951**	**-2,131**	**-3%**

For Month 5, TSDFT activity is below plan and the overall financial under performance is valued at £2.1m across all acute contract (compared to £1.8m for the previous month).
Of this £1.3m relates to admitted patient care, £0.4m relates to outpatient activity and a further £0.4m underperformance in other areas such as imaging, drugs and maternity.

Outpatient Activity, Actual activity is below plan and the financial underperformance is valued at £394k. Follow ups are not materially different from plan but for new attendances, the most the most significant specialty variances are shown in respiratory medicine (+£52k), breast surgery (+£51k), colorectal surgery (+£42k),

paediatrics (-£41k), ophthalmology (-£50k) and vascular surgery (-£84k).

Admitted Patient Care, this shows that actual activity is below plan and the financial underperformance is valued at £1.28m.
There are significant variances in day cases, mainly in cardiology (+£101k), breast surgery (+£82k), clinical haematology (+£82k), gastroenterology (-£124k), plastic surgery (-£144k) and ophthalmology (-£170k).

Elective inpatients variances occur in urology (+£106k), clinical haematology (+£85k), pain management (+£43k), vascular surgery (-£103k), colorectal surgery (-£124k) and trauma & orthopaedics (-£279k).

Non-Elective activity is under plan by 6%

Referrals

Below is a summary by provider of the NHS Devon CCG referrals to consultant led clinics for month 5 against 2018/19 YTD (TSD is reported at month 4 due to data quality issues).

Provider	Referral Source	2019/20	2018/19 Variance	
NHS Devon CCG Total	GP/Dental	88,597	2,101	2.4%
	Other	47,757	2,754	6.1%
	Total	**136,354**	**4,855**	**3.7%**
Royal Devon & Exeter	GP/Dental	32,714	436	1.4%
	Other	13,309	539	4.2%
	Total	**46,023**	**975**	**2.2%**
University Hospitals Plymouth - **Excludes Trauma & Orthopaedics*	GP/Dental	23,976	1,306	5.8%
	Other	9,976	287	3.0%
	Total	**33,952**	**1,593**	**4.9%**
Torbay & South Devon FT (month 4)	GP/Dental	15,002	311	2.1%
	Other	14,919	565	3.9%
	Total	**29,921**	**876**	**3.0%**
Northern Devon Heathcare	GP/Dental	9,839	170	1.8%
	Other	5,209	1,059	25.5%
	Total	**15,048**	**1,229**	**8.9%**
Other - **Excludes Trauma & Orthopaedics for Care UK*	GP/Dental	4,906	-197	-3.9%
	Other	1,297	106	8.9%
	Total	**6,203**	**-91**	**-1.4%**
Plymouth Orthopaedic Partnership (POP) - **Trauma & Orthopaedics for UHP and Care UK combined*	GP/Dental	2,160	75	3.6%
	Other	3,047	198	6.9%
	Total	**5,207**	**273**	**5.5%**

The NHS Devon CCG YTD position shows 3.7% growth whilst the rolling 12-month position shows growth of 3.6%. The CCG's position since the last report has shifted due to changes in reporting flows.

Plymouth Orthopaedic Partnership (POP) referrals have been split out from University Hospitals Plymouth and 'Other' to allow for like for like comparisons. The Orthopaedic pathway referrals last year were contracted to Care UK, however due to pathway improvements, referrals are flowing via a centralised route. This

combined position has seen both these providers referrals increase by 5.5% YTD (273 referrals).

RDE: Month 5 referral position is 2.2% vs last year, a slight reduction from last month. The majority of the overall growth is for routine referrals (2.6%), with 2ww showing marginal growth (0.3%) on 2018/19.
At specialty level the main areas of growth YTD are; Gastroenterology (15%), and General Surgery (13%). The largest reductions are colorectal surgery (-27%) and Neurology (-13%)

UHP: The Month 5 referral position is 4.9% growth on previous year. Routine referrals YTD have seen a reduction of -1.2%, whilst 2ww referrals have seen a growth of 23%.
At speciality level Colorectal (39%), Urology (22%) and Gastroenterology (17%) have seen the largest growth.

TSDFT: The month 4 referral position is currently 3% higher YTD vs last year. Routine referrals YTD have seen growth of 3.1% whilst 2ww referrals have slightly reduced to 2.7%.
At specialty level ophthalmology (-14%) and orthopaedics (-8%) continue to show the biggest reductions whilst gastroenterology (24%) cardiology (22%) and gynaecology (11%) are showing the highest growth.

NDHT: Month 5 is currently showing a variance of 8.9% YTD.
Routine referrals have seen a 9.5% growth in referrals YTD whilst 2ww referrals have seen growth of 6.3%.
At speciality level Cardiology have the biggest referral volume growth (17.9%) followed by Trauma and Orthopaedics (17.4%) and Ophthalmology (11.6%)

Other providers combined have seen a fall in referrals -1.4% as of month 5 YTD.

3.2 Mental Health Services

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

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

At month 6 there is a YTD overspend of £0.035m for IPPs due to LD placements on both Devon & Plymouth Out of Area beds. The position is forecast to be £0.070m overspent at the year end.

Other mental health contracts are showing a YTD underspend of £0.354m, which is a combination of 2018/19 year end accruals and slippage on current year contracts. The position is forecast to be £0.707m underspent at the year end.

3.3 Community Health Services

Community Healthcare Services include contracts with our main providers for community hospital beds and community services as well as children's services, minor injury services and the CCG's investment in the better care fund with our three local authorities. There are no significant variances to report as at M6.

3.4 Placements

Placements is overspent by £0.558m at month 6 due to client number reductions being less than anticipated. Plans to mitigate this continue to be pursued.

There is underlying risk that requires robust financial management. The key risks relate to the CHC QIPP savings target of £5m that is embedded within the budget. Further detailed plans are required to meet the full challenge and there is inherent risk around the assumption that the number of eligible clients will drop again this year.

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

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

3.5 Primary Care Services

Delegated Primary Care Commissioning

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

As at month 6 we are forecasting a breakeven position across delegated primary medical care. Although there are small pockets of overspend beginning to emerge, e.g. Other Locums and Retained Doctors, these are being covered by the contingency.

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

Primary Care Prescribing

The July data, which includes the revised Category M (CAT M) information, provides an estimated year end forecast overspend of £0.3m. Despite CAT M now being included in the forecast we still feel there is a risk of this increasing. There is also still some risk around price concessions and subsequent tariff changes which we are reporting. The combined risk is assessed to be £4m.

Work has taken place on the QIPP plans, with financial amounts allocated against most schemes now and feels like a more reliable forecast. It is currently showing an under achievement of £1.4m by year end. Work will continue to complete this plan and ensure that all schemes are included. The Data group is assisting with this to ensure we are now consistently reporting across all areas and one source is used as appropriate.

Other Primary Care Services

Other primary care services include contracts for enhanced GP services, out of hours GP services, home oxygen services and provision for GP IT costs. These are forecast to come in on budget as at M6.

3.6 All Other Healthcare

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

3.7 Running Costs

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

The forecast outturn at month 6 is estimated at £22.2m which would be an underspend of £3.2m when compared to the £25.4m allocation received.

3.8 Resource Allocation

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

	NEW Devon CCG	SD & Torbay CCG	Devon CCG
Planned revenue resources	£'000	£'000	£'000
Final allocation after place based pace of change	1,257,424	433,048	1,690,472
Other funding pace of change	2,191	475	2,666
Total recurrent revenue resources	**1,259,615**	**433,523**	**1,693,138**
Recurrent adjustments			2,336
Non recurrent adjustments			18,579
Primary care commissioning			161,805
Running costs allocation			25,405
Total revenue resources			**1,901,263**
Total forecast expenditure			1,928,263
Total revised planned overspend 2019/20			(27,000)
B/fwd 2018/19 deficit	(170,460)	(14,548)	(185,008)
Cumulative planned overspend			(212,008)

4. QIPP/Systems Savings Plan

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

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

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

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

This means that for the CCG, although the total 2019/20 QIPP savings required is £80.9m, the transformational savings plans (i.e. not contractualised) within this amount to £35.0m. All parties in the system recognise the £35.0m challenge and

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

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

A summary of the CCG's total QIPP plans and current position is as follows:

QIPP Delivery		Plan	YTD Plan	YTD Actual	YTD Variance	FOT Plan	FOT Actual	FOT Variance
Description	**Service Area**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Demand/activity management and transformation programmes (STP acute providers)	Acute Services	37,000	9,000	3,000	-6,000	37,000	7,000	-30,000
Demand/activity management and transformation programmes (Independent sector providers)	Acute Services	500	250	0	-250	500	0	-500
Reduction in spend on individual patient placements	Placements	1,000	500	367	-133	1,000	1,015	15
Reduction in spend on individual patient placements	Mental Health Services	1,000	500	0	-500	1,000	0	-1,000
Joint commissioning	Community Healthcare Services	7,000	3,500	0	-3,500	7,000	1,250	-5,750
Continuing healthcare	Continuing Care Services	5,000	2,500	1,916	-584	5,000	3,302	-1,698
Primary care prescribing	Primary Care Services	8,000	4,000	3,287	-713	8,000	6,599	-1,401
Allocations/income	Other Programme Services	10,000	2,000	2,750	750	10,000	4,200	-5,800
Further benchmarking opportunities/other flexibilties	Other Programme Services	3,896	1,948	1,948	0	3,896	3,896	0
Non-rec opportunities	Other Programme Services	6,000	3,000	3,000	0	6,000	6,753	753
Procurement/Non-healthcare contract/Admin	Other Programme Services	1,500	750	750	0	1,500	1,500	0
Total QIPP		**80,896**	**27,948**	**17,018**	**-10,930**	**80,896**	**35,515**	**-45,381**

Demand Management/Transformation Programmes

As described at the beginning of section 3.1 the system ambition is to achieve savings as a result of reducing demand and activity within the acute sector as well as delivering transformational changes that allow cost savings to be released.

The system partners have agreed a risk sharing arrangement that underpins the ambition and as at month 6 our assessment of the impact is a forecast saving of £7m.

System partners are developing plans around 7 workstreams to underpin both demand and activity reductions but also to deliver further transformational changes. The workstreams are:

- Planned Care
- Peninsular Clinical Service Strategy
- Mental Health
- Integrated Care Models
- Digital
- Workforce
- Prevention

The financial impact of the schemes within these workstreams will contribute to the £7m forecast with further savings likely to impact in the following financial year.

We have not assumed that demand and activity savings will be seen within our independent sector contracts due to the need to address the number of patients waiting over 52 weeks for treatment.

Individual Patient Placements (IPP)

The emphasis of the IPP QIPP programme is to deliver improvements in service and process. Financial savings are delivered as a result of this focus as opposed to a financially driven approach.

The total net QIPP savings target for 2019/20 is £1.0m. Plans are in place to fully deliver the savings and the latest forecast is to achieve this in full, with a year to date savings of £0.367m.

Joint Commissioning

In previous years the CCG has benefited from the application of funding from Local Authority Grants within the Better Care Funds that were targeted at NHS pressures in non-elective care. Due to priorities within the social care system in 19/20 the level of ambition is likely to fall short of the targeted £7m.

The performance of the Better Care Funds within Devon are regularly monitored and further opportunities to improve on the assessed impact are being explored.

Continuing Healthcare (CHC) QIPP

The total QIPP savings target is £5.0m with a year to date actual savings of £1.9m and the current forecast to achieve £3.3m. However further efforts are being pursued to improve this position.

Most of the current savings in CHC have been achieved by ‘Other cost avoidance measures’ such as managing inflationary uplifts, managed reductions in care costs and favourable outcomes on negotiations and financial risks.

Prescribing QIPP

The total QIPP savings target is £8.0m with a year to date actual savings of £3.3m and the current forecast to achieve £6.6m.

The current savings have been achieved in the main by cost containment and prescription reduction as well as savings through the Respiratory, Nutrition and Endocrine prescribing schemes.

Allocations/Income

The system set itself a target to identify income and allocations received in year that could be non-recurrently diverted to support the overall savings programme through slippage of the identified programmes provided this was not detrimental to the quality and performance of services.

Having reviewed the sources of in year funding received to date and projected to be received our assessment of the likely opportunity currently falls short of the £10m target.

The position is reviewed monthly through Deputy Directors of Finance.

Further Benchmarking/Other Flexibilities

We are currently achieving this target and predicting to achieve in full this year through a series of budget reviews that have released contingencies usually applied to manage in year variation at contract level.

This does increase contract risk where they are based on variable activity.

Non-Recurrent Opportunities

We are expecting to achieve this target in full following a review of non-recurrent flexibilities identified at the planning stage. These are primarily savings released form post year end settlements where estimates were used.

Procurement/Non-Healthcare Contracts/Administration

The savings target has been delivered through reductions to running costs.

5. Risks

The assessment of financial risk at month 6 is estimated at £39.5m as follows.

Devon CCG		Month 5	Month 6
Risk	**Description**	**£'000**	**£'000**
Acute Services	Latest assessment of the level of risk attached to the activity and transformation programmes being developed with system partners for delivery in 19/20. Monitoring arrangements and an appropriate risk share mechanism are being refined and implemented	27,000	28,000
Mental Health Services	Potential risk of not delivering in full the target set for the reduction in cost of out of area placements.. There is a process for monitoring and managing this area and the arrangements in place	1,000	1,000
Community Healthcare Services	Reassessment of opportunities which were explored and delivered against in 19/20 but at present don't exist for this financial year.	4,000	5,750
Continuing Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arrangements are in place through the Control Centre and this will be proactively managed during the year	3,000	0
Primary Care Services	Potential risk of shortfall in delivery against the opportunity identified which can be delivered in 19/20. Arrangements are in place to monitor delivery but the latest assessment doesn't meet the required target.	5,500	4,000
Primary Care Delegated Commissioning	Initial assessment in advance for full financial due diligence of the potential risks which may materialise in the next two years. This is currently being discussed and developed further with NHS England	1,000	0
Other Programme Services	Continuing assessment of opportunities for mitigating against some of the risk which exists in the CCG plan, including non-recurrent solutions and limiting existing exposure to cost pressures	4,000	5,050
Total Risk		**45,500**	**43,800**
Mitigations	**Description**	**£'000**	**£'000**
Acute Services	Potential sources of funding to mitigate opening plan risk being agreed with system partners	-2,000	-2,000
Primary Care Services	Estimate of the potential additional QIPP achievable	-2,000	-300
Other Programme Services	Initial reassessment of opening plan risks and potential mitigating solutions	-2,000	-2,000
Total Mitigations		**-6,000**	**-4,300**
Total unmitigated risk		**39,500**	**39,500**

Changes to the risk profile for primary care reflect an updated assessment following review of the month 6 position in this area.

The scale of the unmitigated risk represents a significant challenge to the CCG delivering its plan for 19/20. As can be seen from the previous section on QIPP delivery the likelihood of mitigating this risk is low.

The CCG has developed a set of recovery actions that will impact on QIPP delivery and has taken these actions into account in its ongoing assessment of unmitigated risk.

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 September 2019 is shown in appendix 1.

6.2 Capital

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

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non NHS Creditors - % of bills paid within target	97.13%	99.02%
NHS Creditors - % of bills paid within target	91.25%	99.34%

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

6.4 Cash

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

7 Recommendations

The Finance Committee is requested to:

Note and review the month 6 year to date performance and the forecast year end position including the current risks around delivery of the CCG's control total.

Appendices

Appendix 1: Statement of Financial Position

AS AT 30 SEPTEMBER 2019	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	2,443
Intangible Assets	6
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	2,450
CURRENT ASSETS	
Inventories	328
Trade & Other Receivables - NHS	3,980
Trade & Other Receivables - Non NHS	24,236
Other Current Assets	-
Cash & Cash Equivalents	12,284
Non-current Assets held for Sale	-
Total Current Assets	40,827
Total Assets	43,277
CURRENT LIABILITIES	
Trade & Other Payables - NHS	- 16,939
Trade & Other Payables - Non NHS	- 112,687
Other Liabilities	- 1,052
Borrowings / Cash in Transit	- 10,343
Provisions	- 231
Total Current Liabilities	- 141,252
Total Assets less Current Liabilities	- 97,976
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 95
Total Non Current Liaibilities	-
Total Assets Employed	- 98,071
FINANCED BY TAXPAYERS EQUITY	
General Fund	98,071
Total Taxpayers' Equity	98,071

Appendix 2: Cash

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

Measure	Month 6
CCGs must operate within their Maximum Cash Drawdown (MCD) *The MCD is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,923.860m for Devon CCG the year.*	50.8% of the MCD has been utilised as at month 6 (50.0% is expected based on a straight-line trajectory at month 6).
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £5,170 for September.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has not met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Financial Inequities				
Date of committee: 31 October 2019 **Date report produced: 25 October 2019**				
Author (s) Name and Title: **Warwick Heale, STP Programme Director** **John Dowell, Director of Finance** **Ben Chilcott, Deputy Director of Finance** **Contact Details:**		**Supporting Executive:** **Name and Title: John Dowell** **Contact Details:** **Report Approved by: John Dowell** **Name and Title: Director of Finance** **Date: 29 October 2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The distribution of resources invested in services across the County is a key responsibility of the CCG as commissioner of services for the population of Devon. The current distribution of, and pattern of access to those services by the populations of each of the four localities (North, South, East and West) of Devon is an artefact of many years, and reflects many complex interactions of patients and services.

In line with the ambition of the NHS Long Term Plan, The Devon STP is committed to reducing health inequalities. In pursuit of this aim, the CCG is, in turn, committed to achieving a more equitable distribution of financial investment in the pattern of services available across the County, by mirroring the approach to Resource Allocation used nationally to determine Allocations at CCG level. This process requires considerable technical expertise, and the STP has established an Advisory Group to assist the CCG in forming its Resource Allocation Policy.

This paper includes the recommendations of the STP Financial Inequities and Health Inequalities Advisory Group for the Governing Body to consider in agreeing its financial inequities policy. It should be read in conjunction with the attached presentation of the financial aspects for consideration.

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

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

Finance Committee

Key recommendations and actions requested:

The Governing Body is asked to consider and accept the recommendations of the STP Financial Inequities and Health Inequalities Advisory Group included within their report.

The Governing Body is further asked to agree its Pace of Change Policy to address the current position of each locality relative to its fair shares target over time.

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:

Presentation on Financial Equity Update

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

	If Yes, please give details	No
Quality of Services		
Health Inequalities	This is a key focus of the report.	
Equality (staff or public)		
Resource and Finance	This is a key focus of the report.	
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

Financial Inequities

1. Introduction

1.1 Within Devon there has been a debate over several years about the observed inequitable distribution of CCG funding between localities (North, South, East and West Devon). Analyses of that distribution have consistently shown the allocation to the Western Locality being below its 'fair share' as determined by application of the National CCG Resource Allocation formula. It has been the long-standing intention to address this geographical financial inequity, however, because the system in aggregate is spending more than the Resources Allocated to it for the Population of Devon, the first priority has been financial recovery – returning total spending to within the allocation for the Devon population. Addressing financial inequity in this context would have meant an even higher savings target for the CCG in order to generate additional money for investment in under-equity areas.

1.2 With the creation of the Devon Sustainability and Transformation Partnership (STP) for Devon, the Senior Leaders of all Partner Organisations who form the Collaborative Board have affirmed the importance of addressing financial inequity, and have stated an ambition that this should be achieved over 3 years, beginning in 2019/20.

1.3 The investment of the Resources allocated to the CCG for the population of Devon is the responsibility of the CCG Governing Body. The Governing Body must therefore make a decision on the policy it will adopt with regard to allocation of resources, taking due consideration of this recommendation from the STP Collaborative Board.

1.4 The STP established an expert advisory group to consider financial inequities and health inequalities. That group has completed its work on financial inequities and this report provides recommendations to the Devon CCG Governing Body to support it in developing its financial equity policy. Those recommendations cover all the key questions about financial inequities that have been raised by partner organisations across Devon in order to demonstrate that all issues have been considered and to minimise the risk of subsequent challenge. The STP Financial Inequities and Health Inequalities Advisory Group recognises that it can only make recommendations to the CCG GB and that the GB will take other issues into consideration that may lead it to take a different approach.

1.5 One of the key findings of the group was that an analysis of resource distribution since 2015/16 reveals that without a policy to address financial inequities, there is a risk that some Localities may move in the wrong direction, with the above-equity localities moving further above and the below-equity localities moving further below. Even when a policy is put in place to address financial inequities, we are likely to find that there is an underlying current that, to some extent, works against this. Therefore, the CCG should guard against constructing a policy that is too conservative or it is unlikely to achieve its objective.

1.6 In this report, the following terms are used:

National equity formula: a group of formulae for different service categories (e.g. mental health, general and acute hospital services, maternity, primary care prescribing), based on the size and characteristics of the population that is designed to measure the relative cost of providing services

to meet the health demands and needs of a population (although the formulae are based primarily on demand data there is an adjustment for unmet need).

National allocations model: a comparison of the current distribution of the national NHS budget by CCG with the 'fair' distribution as determined by the national equity formula, with rules for how additional funds should be allocated to move CCG shares of the national general allocation towards the fair distribution. It should be noted that overspends in providers or commissioners are not taken into account in this model, it is based on the allocation of funds to CCGs.

Additional allocations: monies allocated to CCGs in addition to the general allocation which have a specific focus that is not based on general population demand or need.

1.7 This report should be read in conjunction with the attached financial presentation.

2. Advisory group

2.1 The STP Financial Inequities and Health Inequalities Advisory Group membership was selected to include specific expertise on financial inequities and health inequalities, with coverage across sectors and across the geographies of Torbay, Plymouth and Devon as well as members independent of any geographical allegiance.

2.2 The group members are:

Richard Crompton – Chair, UHP (Chair)
Simon Tapley – AO, CCG
John Dowell – CCG DoF and STP Lead DoF
Warwick Heale – STP Programme Director
Ben Chilcott – Deputy DoF, CCG
Simon Chant – Public Health consultant, DCC
Ruth Harrell – Director of Public Health, Plymouth CC
Richard Blackwell – Associate Director of Insight, AHSN
Rich Smith – Deputy Pro-Vice Chancellor and Professor of Health Economics, University of Exeter Medical School
Peter Aitken – Consultant Psychiatrist and Director of R&D, DPT
David Greenwell – Joint Clinical Lead GP, Southern Locality, CCG
Tobin Savage – Operations & Delivery, NHSE/I South West

3. Financial inequities and health inequalities

3.1 As well as financial inequity, the Western Locality has higher levels of deprivation and poorer health outcomes than the other three localities and this adds to the pressure to provide additional investment in that locality to help to address those issues. It should be noted that there are populations in all localities with high levels of deprivation and poor outcomes and these are equally deserving of attention, but the higher concentrations in the West (in Plymouth in particular) increase the pressure to address the geographical financial inequity. However, we should not regard the addressing of financial inequities as if it is an end in itself and there should be much greater emphasis on addressing health inequalities across all our system work.

3.2 It is recognised that the contribution that the NHS can make to reduce health inequalities is relatively small and that other determinants of health, such as education, housing, employment, lifestyle and other socio-economic factors have greater significance. The advisory group is also reviewing indicators of health inequality and the interventions that the NHS and other agencies could make to address health inequalities.

3.3 Another important perspective is the inequity in resource allocation between services (e.g. mental health, acute, community, primary care). This is discussed later in this report, but the majority of

this report focuses on geographical financial inequity because that is the primary issue that the CCG has committed to address.

4. Scope

4.1 The scope of costs to be considered could include:

- General community, secondary and mental health services commissioned by the CCG
- Primary care services, delegated from NHSE to CCG
- Specialised services, commissioned by NHSE
- Prison health services, commissioned by NHSE
- Health services for the armed forces, commissioned by NHSE
- Public health
- Social care (adults and children)
- Voluntary and community sector

4.2 The primary question for the system has been how we should distribute the CCG allocation most fairly. Therefore, everything covered by the CCG allocation must be included. Primary care and specialised NHS services (commissioned by NHSE) should also be included in this work in order to give a more complete picture of local NHS provision. Funding for prison and armed forces health services are not distributed according to the general population allocation because prisons and armed forces bases are not equally distributed across CCGs. Therefore, spend on these services should be excluded.

4.3 The national equity formula only relates to NHS expenditure, therefore adding other costs (such as social care or public health) would mean that we would be comparing actual expenditure with an unrelated NHS measure of 'fair shares'. To address this we would have to attempt to develop our own combined model of health and local authority services' financial equity which would be a significant undertaking. There is an added difficulty with social care costs because these are means tested and therefore local authorities might spend proportionately more money in areas where people are less wealthy – potentially an inverse relationship with need.

4.4 However, wider expenditure on support for communities, such as social care and housing, will affect population need and demand for health services and therefore the costs of provision. This could form a second phase of analysis if there was agreement in the system that this was worthwhile.

4.5 **Recommendation 1: That the scope of the analysis is limited to the CCG allocation, primary care and NHSE-commissioned specialised services.**

5. Measurement of fair shares

5.1 The national equity formula has been developed over many years. It explains c.70% of the variation in health spend. The 'model' is built upon separate formulae for different services (e.g. hospital and community services, mental health, maternity).

5.2 The individual formulae include their own weightings for age, sex and deprivation. The data to which the formulae are applied are GP registered populations. These populations are mapped to the Devon localities.

5.3 It is accepted that any formula will be imperfect, but there is no better, validated alternative to the national equity formula. Any decision to amend the national equity formula would expose us to the

risk of cherry-picking or special pleading by localities and would undermine the validity of the formula.

5.4 Recommendation 2: That the national equity formula is used for assessing financial inequities within Devon.

6. Recent changes to the national equity formula

6.1 There were significant changes to the national equity formula between the 2018/19 and 2019/20 allocations. The change with the greatest impact between localities in Devon was a change to the mental health formula. This gives a greater weight to Southern and Eastern Devon in particular and a lower weight to Western. We are still awaiting a response to requests to the national allocations team for more information in order to help us understand what has produced that change.

6.2 It is uncomfortable for everyone involved, and particularly for the Western locality, that the national measure of 'fairness' can change and have a material impact on localities' positions relative to equity. However, this discomfort should not lead us to revert to the 2018/19 formula just because it paints a picture that is more familiar. If we accept that we will use the national equity formula we should use the most up-to-date version. However, until we understand the changes to the mental health formula and the reliability of the data sources, we cannot confidently rely on its outputs.

6.3 Recommendation 3: That the latest national equity formula is used for assessing financial inequities within Devon, but that this is regarded as draft until the changes to the mental health formula are understood. This does not prevent the CCG from developing its financial inequities policy, but the locality values to which this policy are applied should be regarded as subject to change.

6.4 Recommendation 4: That an explanation for the changes in the national equity formula from 2018/19 to 2019/20 is obtained and is reported to a future Governing Body meeting, along with an assessment of any risks to reliability of the formula.

7. Disinvestment or differential investment

7.1 The national allocations model does not reduce the allocation to above-equity CCGs. Instead, lower levels of growth are given to above-equity CCGs and higher levels of growth to below-equity CCGs. In this way, CCGs are moved closer to a fair share of national funding without the destabilising effect of withdrawal of funding that could lead to severe service instability or service closures.

7.2 The Devon system is running a substantial deficit and performance against many statutory indicators is below target in all localities. Over-equity localities are suffering from the effects of financial insufficiency even if this is less than the insufficiency in under-equity localities. All localities will have to make significant savings to meet their financial targets. In this context, a policy of disinvestment to address financial inequity would be even more risky than in a financially-balanced system.

7.3 As context, the Devon NHS system will receive c.£60m of growth funding per annum so it is unlikely that we would ever find ourselves in the situation where the financial inequities were so extreme that we would have to adopt a disinvestment policy.

7.4 Recommendation 5: That movement towards financial equity is made by differential investment rather than a reduction in funding for any locality.

8. Adjustments for additional allocations

8.1 The CCG receives additional funding for the following items and these relate to particular localities rather than being incorporated in the CCG's general allocation:

- Local Improvement Finance Trust LIFT
- Small hospitals/unavoidable remoteness

8.2 These items recognise unavoidable differences in cost that do not relate to the size or characteristics of the population and which should therefore be treated separately from the calculation of fair shares. The cost associated with these items is within the total current spend of each locality so in the comparison between fair shares and current spend an adjustment for these items is required.

8.3 Recommendation 6: The additional allocations for LIFT and small hospitals/remoteness are not related to population need and should be treated separately in the comparison of fair shares and current spend.

8.4 While accepting that these items represent unavoidable costs unrelated to population need, we may nevertheless separately consider whether the value attributed to these items is correct. This is a particular question in relation to the size and remoteness allocation for NDHT. The allocation is £3.9m, but the CCG and NDHT are currently assessing whether the unavoidable excess cost of services in NDHT is greater than this. If the conclusion is that the national value is too low, the CCG will have to agree whether to recognise the national value or the locally-agreed value in the local comparison of current spend with fair shares.

8.5 The advisory group considered the argument that we are accepting national formulae and values in our equity calculations in all other cases and if we recognise a higher value we will be depriving other localities of their share of the additional funding that we attribute to Northern. On the other hand, if we know the national value to be too low but use it anyway, the Northern locality will be unable to afford services to meet the needs of the population in an equivalent way to other localities.

8.6 The group noted that the financial inequities discussion should not be extended to attempt to resolve all financial issues within Devon. It was agreed that the unavoidable cost of small scale, remote services in NDHT should be agreed between the CCG and NDHT and that, irrespective of the conclusion that is reached on that point, the national valuation should be used in the inequities model in order to maintain the integrity of that model.

Recommendation 7: The value of the NDHT size/remoteness adjustment in the local fair shares calculation should be set at the national value.

9. Other potential adjustments

9.1 There may be local factors that drive unavoidable cost that is unrelated to population need and which are not included in the national set of additional allocations. We could agree to take these into account or limit our adjustments to the nationally-recognised additional allocations. Taking account of additional factors could lead to cherry-picking or special pleading by localities. To justify taking account of additional factors, they would have to conform to the principle that they represent material, unavoidable differences in cost that are unrelated to population need. They would also

need to be unrelated to unavoidable differences in cost that relate to previous years' investment decisions (e.g. failure to invest in infrastructure that now leads to greater cost could have been avoided in previous years).

9.2 An example that meets these requirements is the potential diseconomies of small-scale tertiary services at UHP as a parallel case to the NDHT remoteness/size adjustment. A report commissioned by UHP from Carnall Farrar in 2017 identified some internal productivity opportunities in tertiary services, but a £2m shortfall related to sub-scale services which would require a system solution.

9.3 The case for taking account of the NDHT adjustment is more straightforward because there is a separate source of funding that does not reduce the funding for the other localities in Devon. Recognising the diseconomies of scale of UHP tertiary services would mean a top-slice from the CCG allocation in the equity calculation, leaving a lower sum on which to calculate fair shares for all localities.

9.4 However, if we do not take these unavoidable excess costs into account the Western locality (via UHP) will bear these costs and potentially be unable to afford services to meet the needs of the population in an equivalent way to other localities. The tertiary services at UHP are provided to patients in all localities so arguably all localities should accept a top-slice for the unavoidable excess costs of maintaining local provision.

9.5 As within *Section 8*, the group noted that the financial inequities discussion should not be extended to resolve all financial issues within Devon. It was also noted that extending the list of 'special cases' beyond the additional national allocations could form the thin end of a large wedge which would invite adjustments for each locality that would soon undermine the integrity of the national model.

9.6 Furthermore, if there is a sound case for recognising the unavoidable costs of small scale tertiary services at UHP this should be a contractual negotiation between UHP and NHSE commissioners who have responsibility for ensuring access for the population of the Peninsula to specialised services. At some point the specialised services budget is likely to be devolved to CCGs and any additional funding for sub-scale services would then become a local decision.

9.7 Recommendation 8: That no adjustments to the model should be made beyond the additional national allocations.

10. Distance from target

10.1 It is accepted that the national equity formula is imperfect and therefore it should not be used as if it explains 100% of the variation in demand for healthcare resources and is not intended to be used to determine a level of relative investment with absolute precision. Therefore, there is a tolerance around the calculated fair share within which there is no attempt to move a CCG's allocation any closer to equity. The population of Devon CCG's smallest locality is similar to that of the smallest CCG nationally so the national tolerance should be appropriate to use within Devon.

10.2 For 2019/20 the national tolerance is 2.5% below and 5% above fair shares. If this was solely a statistical exercise one would expect the tolerance to be equal above and below, but these tolerances may have a pragmatic or political dimension rather than being purely statistical. We do not understand the reasons for these tolerances nor the statistical modelling that may support them. If we are to be consistent with the national model (as we have recommended in preceding sections) we should maintain that consistency in terms of distance from target.

10.3 However, the locality that has poorest outcomes is most below equity and to bring it just to 2.5% below the modelled equity position while those outcomes remain poor may be regarded as unacceptable.

10.4 We should also bear in mind that the underlying drivers of spend have led to increasing inequity (as noted in *Paragraph 1.4*) so if the CCG policy is intended to deliver no worse than 2.5% below equity and those other drivers continue to push localities away from equity the CCG will probably fall short of achieving its policy intention. The CCG will therefore need to aim higher to achieve what it intends and will probably have to continue to invest differentially in the longer term to offset the effect of those underlying drivers against equity.

10.5 Recommendation 9: When considering financial equity, the CCG should adopt the national tolerances of -2.5% and +5% around each locality's fair share of the CCG's allocation. This means that if outcome measures were similar, the CCG would be satisfied with this level of funding variation between localities.

10.6 Recommendation 10: Where there are poor outcomes, additional investment is needed and therefore we should not be content with areas with the poorest outcomes being funded at the lower end of tolerance. The CCG should aim to bring the locality with the poorest outcomes from -2.5% to 0% below target, specifically to address those unequal outcomes.

10.7 Recommendation 11: The position of each locality compared to financial equity should be reviewed each year alongside outcomes and further differential investments made to offset any drift away from equity that may occur for other reasons.

11. Financial inequity between services

11.1 The question about fair shares of health spend is generally focused on distribution between localities and this has been the primary focus of the work of the advisory group. However, the group also considered how fairly money is distributed across services (for example, primary care, mental health, acute physical health). This is included in the accompanying presentation.

11.2 Using the national equity formula to make decisions about relative investment in services goes beyond how it is used nationally. There will be relationships between services that may lead to the national model working better if used as an integrated whole rather being divided into separate service-specific formulae. The service-specific formulae could be used as one indication of service inequity if they were used with sufficient caution. There will be other sources of information that indicate whether the relative investment between services should be addressed.

11.3 Recommendation 12: The analysis of service inequity requires additional data sources and further work.

12. Should conditions be attached to the additional investment in under-equity localities?

12.1 Differential growth in funding between localities brings with it the risk that the adverse impact on populations in localities with lower growth will not be offset by the benefits derived from the additional investments in localities with higher growth. One potential mitigation would be to set conditions on the use of the additional growth.

12.2 Given the system commitment to address health inequalities as well as financial inequities, the CCG could make the additional growth for under-equity localities conditional on it being directed to those interventions that will have greatest impact on improving outcomes for disadvantaged

populations (as long as these are not outside the scope of the CCG allocation). This could include investment in improving access to services in order to improve outcomes.

12.3 Furthermore, given that there are populations in all localities with high levels of deprivation and poor outcomes, the CCG could set similar conditions for all localities.

12.4 The analysis of inequity in demand by service (see *Section 12*) could be used along with other data to direct the additional growth towards those services that the national equity formula indicates are particularly under-resourced in the under-equity localities. We should also bear in mind that achieving reductions in health inequalities is dependent upon services commissioned by agencies beyond the NHS.

12.5 However, the system also has an intention to devolve responsibility to localities and this would suggest that additional investment should be without conditions as long as it is directed by the Local Care Partnership Board (or equivalent). Localities will be in a better position to understand where there is greatest local need. Where some of the required interventions are outside the scope of the NHS budget, other agencies within the locality should be encouraged to invest to deliver those interventions.

12.6 Recommendation 13: The CCG should provide advice to localities about how any differential growth should be invested and should include an expectation that attention is given to interventions that will reduce health inequalities, but this should not be a requirement.

12.7 Recommendation 14: Any locality benefitting from differential growth should report to the CCG on how that additional money has been invested.

12.8 Recommendation 15: The CCG should communicate an expectation to all localities that they should focus on addressing unequal outcomes within their locality.

13. Impact of historic underinvestment in under-equity localities

13.1 If there has been historic underinvestment in some localities it is possible that the population will currently suffer from poorer health as a result and therefore such localities will need a greater share of resources now and in future in order to provide additional services to mitigate that effect.

13.2 However, given the financial deficit in all localities, allocating even more growth to under-equity localities for these theoretical reasons would leave over-equity localities with even lower growth which might not be manageable.

13.3 Where outcomes are poorest and there has been historic underinvestment, that would be addressed via *Recommendation 10*.

13.4 Recommendation 16: There should be no additional allocation to compensate for historic under-equity investment. However, where there are poor outcomes, *Recommendation 10* addresses this.

14. Should the CCG invest to address inequity solely in the distribution of its allocation or inequity in the distribution of wider NHS allocations?

14.1 The national pace of change policy is applied to the whole place-based budget, including the CCG allocation and NHSE's allocations for specialised services and primary care medical services. This

is based on the theory that a CCG area may be able to better cope with being below target if some of the other services are funded above target.

14.2 However, while it may be important for the CCG to understand any inequity in the distribution of NHSE's allocations as this is part of the picture of total locality NHS resource consumption, it could be argued that any inequities in NHSE resource distribution should be addressed by NHSE as they are responsible for ensuring access to specialised services for the whole population. There is a risk that if the CCG uses its allocation to address any inequity in specialised service resource use it will distort the CCG's equitable commissioning of non-specialised services.

14.3 In addition, there are some outstanding questions about the analysis of NHSE Specialised Commissioning expenditure by locality that should be addressed.

14.4 Recommendation 17: The CCG should understand total NHS resource inequity, but should only differentially invest its allocation to address inequities in the distribution of its own allocation.

14.5 Recommendation 18: There should be further analysis of the distribution of NHSE specialised commissioning expenditure compared to equity, but because of *Recommendation 17* that should not delay the CCG in developing its financial inequity policy.

15. Pace of change Policy

15.1 The STP Collaborative Board has recommended that Year 1 of the movement to equity is 2019/20 and that there should be a 3-year pace of change. This is consistent with the national pace of change. This is a policy decision that depends upon the CCG's financial and non-financial objectives and the Advisory Group therefore had no direct recommendation to make on this matter.

15.2 Pace of change policy seeks to strike a balance between achieving the objective of improving the equity in distribution of resources, without creating undue instability or uncertainty. It is also important to recognise that the formula driven target is an indication of the expected consumption of resources by a population, and not an absolute "right" answer. In this context, a margin of error is appropriate.

15.3 Taken together, Recommendations 9, 10 and 11 from the Advisory group would support a pace of change policy that protects £5m of growth investment to be differentially invested in the Western Localitiy in 2020/21, with further differential growth investment in 2021/22 and 2022/23, subject to further analysis and understanding of impact on health inequalities and overall movement towards financial equity.

16. Conclusion

16.1 The CCG Governing Body is asked to consider the recommendations in this report and to agree its pace of change policy to apply from 2020/21.

Financial Equity Update

October 2019
Initial Draft to Inequities Group September 2019
Further refined October 2019
Presented to:
Inequities Group – 04/10/19
Deputy DOFs – 08/10/19
Finance Working Group – 17/10/19
CCG Finance Committee – 17/10/19
CCG Governing Body – 31/10/19

Recap to 2017/18 and Update for 2018/19

- Devon CCG Commissioner perspective only (excludes provider deficits, non NHS spend)
- **Expenditure** is apportioned to localities at patient level where available, otherwise using local knowledge (ie at the lowest granular detail available)
- Where not available, apportioned on a weighted capitation basis so no impact on equity
- **Allocation** is apportioned to localities based on disaggregating the funding formula
- Comparison is actual spend compared to weighted capitation (equity) share of that spend, i.e. always adds to zero
- Now updated to include 2018/19 outturn (shown excluding the impact of CCG merger and new formula to evidence what had been achieved in addressing equity), and 2019/20 Plan
- Key changes driven by:
  - changes in 1819 expenditure and usage by locality
  - changes to Weighted Capitation Formula
  - changes as a result of CCG merger

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
Distance from Equity in Expenditure	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
15/16 Actual	14,803	17,158	-31,961	0	0
16/17 Actual	14,793	17,788	-32,581	0	0
17/18 Actual	14,230	7,530	-21,759	0	0
18/19 Actual (pre formula and merger)	17,504	6,014	-23,518	0	0
18/19 Actual (post formula and merger)	10,131	-10,521	-14,265	14,654	0
19/20 Plan	11,180	-10,553	-20,522	19,896	0

Summarised Changes 17/18 to 18/19

- 1718 no equity gap for South Devon as separate CCG
- The following table sets out the impact of each of the key changes identified in previous slide
- Also shows what has moved the equity position into the 1920 plan.
- Where figures are negative this is movement in equity not disinvestment (i.e. differential investment)

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
Inequity In Expenditure	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
1718 Outturn Equity Gap	**14,230**	**7,530**	**-21,759**	**0**	**0**
1819 Outturn Change	3,274	-1,515	-1,759	0	0
1920 Weighted Capitation	-4,528	-10,487	15,015	0	0
CCG Merger	-2,845	-6,048	-5,762	14,654	0
1819 Outturn Equity Gap	**10,131**	**-10,521**	**-14,265**	**14,654**	**0**

1920 weighted capitation

- The individual elements of the formula that have been updated include:
  - Practice populations from point in year to year average (impacts on population)
  - Recognition of Community specific formula (impacts on General and Acute)
  - Update to Mental Health formula (impacts on Mental Health)
  - Update to Unmet Need (impacts across all programmes)
  - Updates to Expenditure base (impacts across all programmes)
- Some expenditure contracts are allocated on a weighted capitation basis so they don't distort the equity position. Updating the weighted capitation formula changes the spread of expenditure.
- Applying the new weighted capitation formula to the total resources has a more significant impact. Essentially the fair shares of the localities are changed by the following percentages: Northern +0.4%, Eastern +0.9%, Western -1.3%. The drivers for these changes are explored further…
- There is no impact for Southern as this is analysis pre merger

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
1920 W/Cap change impact	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Expenditure Movement	258	644	-902	0	0
Allocation Movement	-4,786	-11,131	15,917	0	0
	-4,528	-10,487	15,015	0	0

CCG merger

- 1819 outturn with updated allocations and movement to 1920 weighted capitation formula for the combined Devon CCG – to show the impact of the merger
- by combining the CCGs allocations and the allocation formula £13.6m comes out of the Southern locality and is distributed between the North, East and West localities
- The top slice for remoteness is also impacted across all localities

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
Impact of Merger	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Separate CCG Allocations (1819)	1,243,194			438,413	1,681,607
W/Cap Separate CCG's	19.42%	41.27%	39.32%	100.00%	
Locality Allocation	241,367	513,055	488,772	438,413	
W/Cap Single CCG	14.51%	30.84%	29.38%	25.26%	100.00%
Locality Allocation	244,017	518,687	494,138	424,765	1,681,607
Baseline Impact	2,650	5,632	5,366	-13,648	0
Remoteness	195	415	396	-1,007	0
Total Merger Impact	2,845	6,048	5,761	-14,654	0
Weighted Populations	184,049	391,217	372,701	320,377	1,268,345

1920 weighted capitation changes

- Overall impact of revised weighted capitation formula changes locality fair shares by Northern +0.2%, Eastern +0.5%, Western -1.1%, Southern +0.4%.
- When applied to the total CCG allocation, has a significant impact on equity of fair share resources, but is driven by two things
- The changes in the formula are driven by two things:
  - Differential raw (unweighted) population changes
  - Changes to the formula
- These are exemplified on the next slide

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
1920 W/cap change impact	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
1516 Weighted Populations	175,166	371,099	373,209	304,861	1,224,334
1516 weighted capitation share	14.3%	30.3%	30.5%	24.9%	100.0%
1920 Weighted Populations	184,049	391,217	372,701	320,377	1,268,345
1920 weighted capitation share	14.5%	30.8%	29.4%	25.3%	100.0%
Change	0.2%	0.5%	-1.1%	0.4%	0.0%

Raw (unweighted) population changes

- Raw (unweighted) populations have increased in all localities between the two formula bases
- Whilst all locality populations have grown, the growth rates are differential. This has a consequential impact on the equity shares
- So for example Eastern population has increased by 4.9% but this has driven an increase in the equity fair share of 0.6%, and all other locality equity shares have decreased

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
Raw Population Change					
1516 to 1819 Raw Population Growth	3,423	18,962	7,315	7,112	36,812
Percentage Growth	2.1%	4.9%	2.1%	2.5%	3.1%
Impact on Equity	-0.1%	0.6%	-0.3%	-0.1%	

Equity change of raw population vs formula

- The overall weighted population shares have changed but this is as a result of both a raw population change and the impact of the formula.
- The impact of the formula is therefore the extent to which the overall share has changed less that driven directly by population shifts.

- In order to understand an approximation of the financial value of these shifts they are applied to a total CCG level of resource

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
Equity Impact of Population vs Formula					
Equity impact of Raw Population changes	-0.1%	0.6%	-0.3%	-0.1%	
Equity impact of Weighted Population changes	0.2%	0.5%	-1.1%	0.4%	
Equity impact of formula	0.3%	0.0%	-0.8%	0.5%	
1920 Plan Resources (£000's)	1,705,538				
Equity Impact of Population change (£000's)	-2,382	9,810	-4,966	-2,462	0
Equity Impact of Formula change (£000's)	5,859	-695	-13,755	8,591	0
Total Equity Impact (£000's)	3,477	9,115	-18,722	6,129	0

NHSE Specialist Impact

- The analysis below is based on 1819 actuals for Devon STP NHS providers, and M11 FOT for the Bristol providers
- NHSE are unable to provide population analysis of expenditure, the providers have analysed their income at practice level and reconciled back to NHSE specialised income.
- Compared to weighted capitation using the ACRA specialised commissioning formula

- This excludes providers of significant distance, such as London, Birmingham, Southampton. The usage at these providers is not likely to be material and the extent to which there is inequitable access will therefore also be immaterial.

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
1819 Specialised Services Equity	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
1819 Expenditure	38,464	71,247	78,793	60,536	249,039
1819 Equity Shares (Specialised Formula)	34,588	74,569	79,512	60,370	249,039
	3,876	-3,322	-720	166	0

Delegated Primary Medical Care

- Resources that are locality specific to cover specific expenditure is treated separately and identified to those specific localities (so is treated in the same way as the remoteness adjustment)

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
Primary Medical Care Equity	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
1819 Expenditure	22,692	50,476	47,474	37,630	158,272
1819 Equity Shares (Primary Care Formula)	21,772	49,868	44,842	38,147	154,628
1819 Locality Specific Funding		573	3,071		3,644
1819 Equity	**920**	**35**	**-439**	**-517**	**0**
1920 Budgets	23,763	53,068	49,465	39,153	165,449
1920 Equity Shares (Specialised Formula)	22,782	52,182	46,923	39,917	161,805
1920 Locality Specific Funding		573	3,071		3,644
1920 Equity	**981**	**313**	**-529**	**-764**	**0**

Pace of Change / Tolerances

- NHSE pace of change is 3 years, tolerances are 2.5% under and 5% over
- No plan to disinvest in order to move, plan to apply differential growth

	NORTHERN	EASTERN	WESTERN	SOUTHERN	DEVON TOT
Pace of Change Options					
1920 Expenditure Plans	269,841	530,792	495,201	463,216	1,759,050
Equitable Share of Spend	258,662	541,345	515,724	443,320	1,759,050
Gap from Equity	11,180	-10,553	-20,523	19,896	0
Distance from Equity	4.3%	-1.9%	-4.0%	4.5%	
Year 2 - increase West £5m					
Baseline Budget	269,841	530,792	495,201	463,216	1,759,050
Additional (Year 2 PoC)			5,000		5,000
Adjusted Year 2 Budget	259,397	542,884	517,189	444,580	1,764,050
Year 2 Gap from Equity	10,444	-12,092	-16,988	18,636	
Year 2 Gap from Equity (%)	4.0%	-2.2%	-3.3%	4.2%	
Year 3 - move to minumum 2.5% under					
Adjusted Year 2 Budget	269,841	530,792	500,201	463,216	1,764,050
Additional (Year 2 PoC)		387	5,838		6,225
Adjusted Year 3 Budget	260,312	544,799	519,015	446,149	1,770,275
Year 3 Gap from Equity	9,529	-13,620	-12,976	17,067	
Year 3 Gap from Equity (%)	3.7%	-2.5%	-2.5%	3.8%	

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee

Date of Governing Body: 10 October 2019

Dates of Committees covered in this report 10 October 2019

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

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

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

- **Quality Assessment Framework (QAF) – including Flash Reports: Devon Partnership NHS Trust (DPT); Torbay and South Devon NHS Foundation Trust (TSDFT); Children and Family Health Devon; System issues were identified as: Mortality; Emergency Department (ED) Waiting Times**
- QAC noted the key issues outlined in the flash reports, noting that quality surveillance continues. QAC noted and agreed the positions of partially assured unless otherwise stated.

- Devon Partnership NHS Trust (DPT): QAC noted the report and that regular monitoring processes are in place to include the Trust, regulators and CCG Executive. QAC supported that the assurance position will be further considered when the full report on issues is presented to QAC in December 19.

- TSDFT: QAC received assurance that the Patient Safety Quality Team continue to undertake quality surveillance to assure that safe systems are in place within the Emergency Department. The Trust declared a major incident on 23rd September 2019, in response to an IT failure which affected several IT and communication systems at the acute hospital, community sites and GP practices in the area. Safety measures were initiated under the contingency plan, so services could be maintained to an acceptable level; all outpatient activity, including planned and routine surgery, was cancelled on the day. Formal debriefs and a multi-agency approach to the incident will incorporate system providers including primary care to address the patient safety impacts. Supporting agencies were primed to respond to public enquiries and signpost appropriately. Outcomes will be reported through CCG quality reporting processes.

- Children and Family Health Devon: The CCG remains partially assured. Trajectory setting is in place and monitored through meetings with the provider. Further assurance will be provided to QAC at the November meeting. A further summary is included within regular reporting to Governing Body.

- System: Mortality: Challenges persist across Devon in relation to mortality information. To seek assurance that patients remain safe, the CCG continues to work closely with providers and attend provider mortality review committees, analyse information alongside regulators, Sustainability and Transformation Partnership variation review group and meeting including regulators, and CCG leads continue to meet to understand anomalies and escalate accordingly.

- The CCG remain clear with providers that there is an expectation for improvement to be reflected through mortality data, continue to receive assurance that patients remain safe and any learning from deaths is disseminated across all providers. An update report will be presented to QAC in November 2019.

- System: Long Waits & Quality in EDs: Long waits continue to be recorded within EDs across Devon. With a position of not assured for 12 hour breaches in Royal Devon and Exeter Foundation Trust (RDEFT) ED. RDEFT are contributing to a system working group, led by DPT to create solutions, findings are monitored through the Eastern A&E Delivery Board.

- **Safeguarding Quarterly Report**
- QAC noted the contents of the report from the integrated safeguarding team. A learning event is planned in Torbay to improve evidence, outcomes and practice. New integrated children's partnership is in place in Plymouth, inaugural meeting 11 October 2019. QAC requested an update about implementation of the Child Protection Information (national) System Work continues to support strengthening assurance across the system and shared learning between providers. Safeguarding Adult Review published this month, noting the learning for commissioners, particularly with regards to patients with learning disabilities and out of area placements. CCG are fully engaged with the (national level) action plan. QAC supported the significant learning with regards to out of area placements and associated processes which is being progressed both locally and nationally. Recruitment is underway for designated roles, in collaboration with Kernow.

- **Primary Care Quality Report – GP practice patient survey**
- QAC noted and are assured by the information presented in the report. Primary Care Committee received the results of the 2019 GP Patient Survey in August. Committee members noted consistently high levels of patient satisfaction across Devon with many indicators reporting results well above the national average. Additional areas require commissioner focus and the approaches were supported by the QAC in terms of learning from excellence and sharing to make improvements.

- **Equality, Diversity and Inclusion update**
- QAC received the report to provide the committee with assurance on the progress against the Equality Diversity and Inclusion workplan. QAC noted that the EDI Strategy had been approved by Executive Senior Leadership Team with the addition of an objective with regards to the gap being closed between the CCG workforce profile reflecting the demographic of Devon, and the wider work underway to address increasing CCG workforce diversity.

- **Experience Strategy**
- QAC noted the contents of the Strategy and that the Strategy had been approved by Executive Leadership Team with the report and are supportive of the recommendations outlined. QAC noted that individual members of QAC had been engaged in drafts, however that in future they would expect early engagement in the re-drafts of a Strategy that encompass Experience in its broadest sense.

- **Long Term Plan Submission**
- QAC noted the contents of the plan, noting the timeframe, template and regulatory requirements. QAC also noted that earlier drafts had included further reference to Quality throughout and requested that this is addressed in the final submission.

Reports received and noted

- None

Risk Register Review (changes and areas of concern)
• QAC received a report that effective risk management processes are in place to identify, assess, manage and mitigate risk and inform of any changes since the last meeting of the QAC 12 September 2019. • QAC noted that the risk data had been extracted on 26 September 2019 • QAC noted that there were currently 22 risks aligned to QAC. Of those risks, two risks are categorised in the very high category and that as of yesterday, 21 of 22 risks had received timely review. Training has been delivered to risk co-ordinators to ensure that risks are reviewed on a timely basis and a standard operating procedure is in place to support the review process. • QAC previously noted that Risk 100 has been reviewed and the risk score increased as requested by NHSE/I and to mirror the SWASFT score. Chief Nursing Officer attended the Quality Surveillance Group meeting and SWASFT are very clear that the risk remains high with anticipation that this may increase. CCG specific datasets are currently under consideration. • Update on DPT risk update provided under Quality Assurance Framework section.
Committee Decisions
• None.
Recommendations for Governing Body
• To note the reports received and positions of assurance by Quality Assurance Committee.
Recommendations for other Committees
• None
Terms of Reference or other committee effectiveness issues
• None.

Management of Conflict of interests:

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

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

NHS
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Clinical Commissioning Group

GOVERNING BODY

Report title: Quality and Performance report				
Date of committee: **Date report produced: 11/10/2019**				
Author (s) Name and Title: **Lorraine Webber – Associate Chief Nursing Officer (South & West) South** **Kelvin Grabham: Associate Director of Business Intelligence** **Karen Helliwell: Senior Information Specialist** **Contact Details: karen.helliwell@nhs.net**		**Name and Title:** **Kelvin Grabham – Associate Director of Business Intelligence** **Lorraine Webber – Associate Chief Nursing Officer (South & West) South** **Contact Details:** **Report Approved by:** **Kelvin Grabham – Associate Director of Business Intelligence** **Date 10/10/2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
For information and assurance				
Executive Summary: This report provides the latest information on key quality and performance indicators including those contained in the NHS Constitution. The report includes as an appendix the Improvement and Assessment Framework (IAF) indicators for the latest quarter.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations				

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

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

None

Key recommendations and actions requested:

For information and assurance

Impact on Strategic Objectives

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

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

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

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

Governing Body – Quality & Performance Report

October 2019

Summary

Performance summary

In order to improve services for patients in Devon the Governing Body has requested a focus on 3 key areas this year, which have been agreed as: number of people waiting over 52 weeks, diagnostic waiting times (which will have an impact on cancer waiting times) and waiting times in A&E.

Referral to treatment times

In August performance against the 18 week standard was 79% against a trajectory of 81.2%. There were 316 people waiting over 52 weeks against a trajectory of 139. The only provider on trajectory is Torbay and South Devon FT.

At the System Performance Group (SPG) in October the Trusts presented their forecasted year-end positions for number of people waiting longer than 52 weeks as follows:

- Torbay and South Devon FT (TSD) – 0
- Northern Devon Healthcare Trust (NDHT) – 0
- Royal Devon & Exeter FT (RD&E) – 50
- University Hospitals Plymouth (UHP) – 66 (spinal only)
- All Trusts plan to reach 0 by March 2021.

Updates on previously agreed actions and additional actions agreed at SPG this month to improve the 52 week position are:

- DRSS are now contacting patients waiting over 52 weeks and patients are being offered alternative provision where this exists. A dedicated 52 week team, working closely with Trusts, will now be formed to increase focus on these patients.
- The Standard Operating Process for patients unable to commit to a date is now in place and being used ahead of the start date of 1st November.
- Two audits of orthopaedic and spinal patients at UHP will be performed this month to identify if more patients are suitable for treatment in the independent sector.
- Discussions will be held this month with the Nuffield to identify if more spinal capacity can be commissioned.
- Capacity needed at the independent sector on an annual basis will be modelled in order to agree block arrangements with these providers, which will provide certainty of capacity and value for money. This is due to come back to SPG in November.
- Negotiation with Care UK to treat orthopaedic patients with a higher anaesthetic risk score will be undertaken this month.
- Due to lead in time on these actions the number of patients waiting over 52 weeks is likely to increase during quarter 3 before it improves during quarter 4.

Diagnostic waiting times

In August performance against the 6 week standard was 17.6% against a trajectory of 6.6%. The only provider on trajectory is NDHT. The main areas of concern are long waits for MRI, CTs and endoscopies.

At the System Performance Group (SPG) in October the Trusts presented their forecasted year-end positions for diagnostic waiting times as follows:

- Torbay and South Devon FT (TSD) – 7%
- University Hospitals Plymouth (UHP) – 7.4%
- Northern Devon Healthcare Trust (NDHT) – 8.5%
- Royal Devon & Exeter FT (RD&E) – 9%
- All Trusts plan to meet 3% by March 2021.

Updates on previously agreed actions and additional actions agreed at SPG this month to improve the diagnostic waiting times position are:

- £2m of cancer alliance monies are being deployed to improve diagnostic waiting times in Devon.
- Plans are now in place for a fully staffed mobile endoscopy unit to start in January 2020, for 6 months. This will enable the achievement of the year end positions above. Patients in Plymouth are now benefitting from additional capacity at Care UK.

A&E waiting times

In August performance against the 4hr standard was 85.2% against a trajectory of 89% (excluding UHP). None of the providers are meeting their trajectory. Providers are reporting increases in length of stay, which are in the main related to the increased acuity of patients who are admitted. This has a detrimental effect on 4 hour performance as many of the patients waiting over 4 hours in A&E are waiting to be admitted to beds. Staffing, particularly nursing, is also reported as an issue across all providers.

At the System Performance Group (SPG) in October the Trusts presented their forecasted year-end positions for A&E waiting times as follows:

- Royal Devon & Exeter FT (RD&E) – 85%
- Torbay and South Devon FT (TSD) – 84%
- Northern Devon Healthcare Trust (NDHT) – 84%
- University Hospitals Plymouth (UHP) – N/A
- All Trusts plan to meet 85.5% by March 2021.

Updates on previously agreed actions and additional actions agreed at SPG this month to improve the diagnostic waiting times position are:

- The CCG have commissioned a new model for the Integrated Urgent Care Service (IUCS) which started on 1st October. This will mean more patients calls are answered sooner, a greater number with receive clinical triage and therefore less are expected to be referred to ambulance and A&E services.
- All localities are currently signing-off their winter plans, including a summary of what will be different from last year building on lessons learnt.
- Monthly updates on adherence and impact of winter plans will come to SPG throughout winter.
- The CCG are setting up weekly Devon winter calls for all NHS and LA organisations at executive level throughout the winter.
- The CCG has agreed to commission a HALO service from the ambulance trust to be situated within TSD and UHP ED departments. This service will mean patients can be directed to other services at the front door and wider learning can be taken back to ambulance crews to inform future handover destinations.

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

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

Children & Young People (CYP)

The CCG continues to seek assurance that safeguarding risks previously identified as part of the mobilisation work are adequately acknowledged within the new provider organisation, Children and Family Health Devon. In addition, whilst quality information has been provided, it is not yet to the expected or agreed standard. The provider reports challenges around the embedding of new systems and processes. Some assurance was given at the September Contract Review Meeting (CRM) and in subsequent correspondence and communication between the CCG and provider. Trajectories have been set and are in place and will be monitored through meetings with the provider, including CRMs.

Mortality Overview

Challenges persist across Devon in relation to mortality information. This includes a multiplicity of complex issues which include how patient deaths are coded and the use of complex IT systems such as SALUS which is the bed management systems which can adversely affect coding of specialities. Whilst data issues may impact upon overarching 'trends', to seek assurance that providers identify learning from

deaths and that patients remain safe, the CCG undertakes actions that include: works with providers and attends their mortality review committees, analysing information alongside regulators and meeting as CCG leads to understand anomalies and escalate accordingly. The ongoing expectation is to see an improvement in mortality data, assurance that patients remain safe and that any learning from deaths is identified and disseminated across all providers. An update report will be presented to the Quality Assurance Committee in November 2019.

Emergency Department 12-hour Breach Review

Long waits continue to be recorded within EDs across Devon. This includes an increase in the numbers of 12-hour breaches. In the Eastern locality most of the breaches relate to mental health patients. The findings from a recent deep-dive will be monitored through a system working group, led by Devon Partnership Trust to create solutions, that will report through to the Devon A&E Delivery Board.

In the Western system the number of 12-hour breaches has also increased. Every breach has been thoroughly reviewed to ensure patient safety checks are present during the breach period and it has been identified that patient experience has been adversely impacted, A significant number of the breaches have also been followed up for a 14-day period with other providers and partner agencies. These reviews have also confirmed that there was no direct patient safety impacts up to 14 days after the long wait in ED.

In addition, the CCG have undertaken a series of quality reviews within all ED's. Once system wide analysis is complete, recommendations and next steps will be reported and disseminated to support improvement.

Safeguarding Adult Review into Atlas Care Homes in Devon

The Safeguarding Adults Review commissioned in 2017 by Devon Safeguarding Adults Board (DSAB) into Devon Atlas Care Homes (Atlas), was formally published on the 26th September 2019.Atlas was commissioned to provide specialist care for adults with learning disabilities whose needs were described as 'complex' and 'challenging'. The conclusion of criminal court proceedings lasting 5 years enabled this current Safeguarding Adults Review (SAR) to commence

All out of area authorities who commissioned placements at Atlas have been briefed though the SAR. All families were offered the opportunity to participate in the review and5 families felt able to take up the offer. Families were made aware of the publication plan and have been offered the opportunity to meet with panel members who would update them on the publication and recommendations of the review.

A number of recommendations have been made from the review and the action plan includes improvement areas for all CCG's and local authorities involved. The implementation, progress, embedding of actions and impact/outcomes for individuals will be monitored at DSAB.

Local Maternity System Update (LMS)

Continuity of Carer is a critical element in the delivery of the LMS commitments to meet system obligations relating to both the Better Births and the NHS Long Term Plan. Continuity of Carer is a key enabler to the successful delivery of other workstreams within our LMS plan, including Personalisation and Choice.

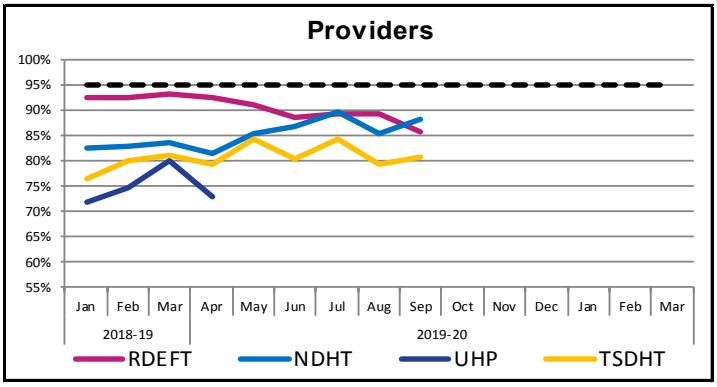
Whilst challenging and complex, work is progressing to transform services to meet the needs of women in a safe and sustainable way. This also involves nursing support for staff managing changes to the current operating models. Excellent collaborative and system level work has seen changes in our trusts and the LMS remain committed to ensuring that work on model design and transformation continues. The LMS has given assurance to NHS England that they continue to improve the current situation and move towards achieving trajectories.

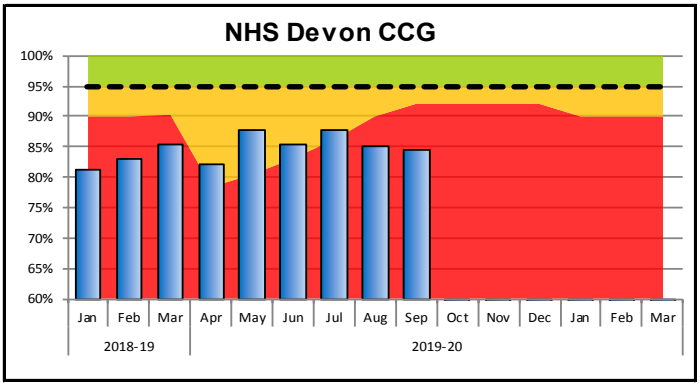
Performance and Quality indicators

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

Trust	Trajectory	September	2019/20
RDEFT	90%	85.7%	89.3%
NDHT	85%	88.0%	86.0%
UHP	85%	N/A	N/A
TSDFT	92%	80.7%	81.3%

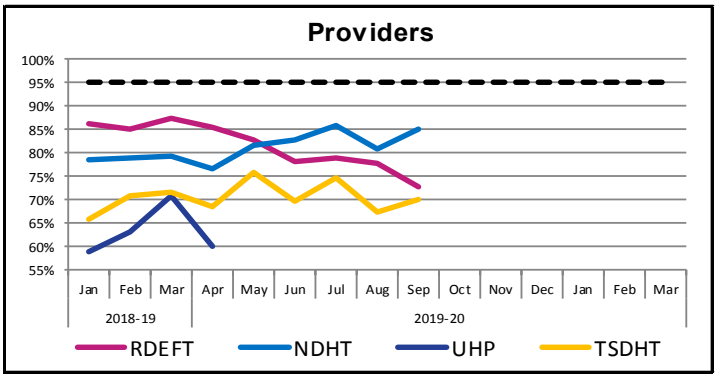
CCG	Trajectory	September	2019/20
NHS Devon	84%	84.5%	85.3%
ENGLAND		86.8%	87.2%

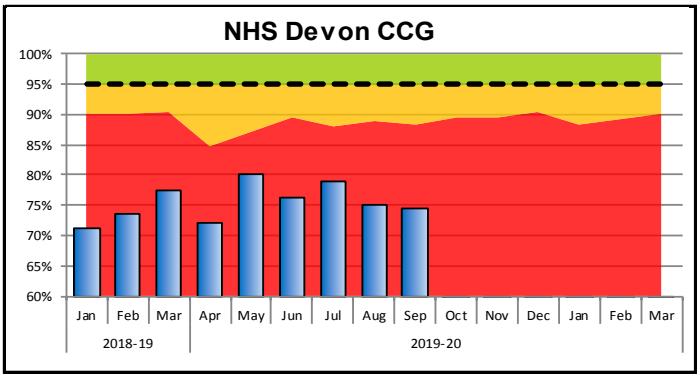




Trust	Trajectory	September	2019/20
RDEFT	90%	72.8%	79.3%
NDHT	85%	85.1%	82.2%
UHP	85%	N/A	N/A
TSDFT	92%	70.1%	71.1%

CCG	Trajectory	September	2019/20
NHS Devon	84%	74.6%	75.9%
ENGLAND		79.6%	80.3%





Performance Commentary

Performance continues to be challenging against the A&E 4-hour target. In September the STP 'all types' position was 84.5%, down from 85.2% in August, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. NDHT increased to 88.0%, RD&E fell to 85.7% and TSD rose slightly from 79% to 80.7%

Quality Commentary and Improvement Actions

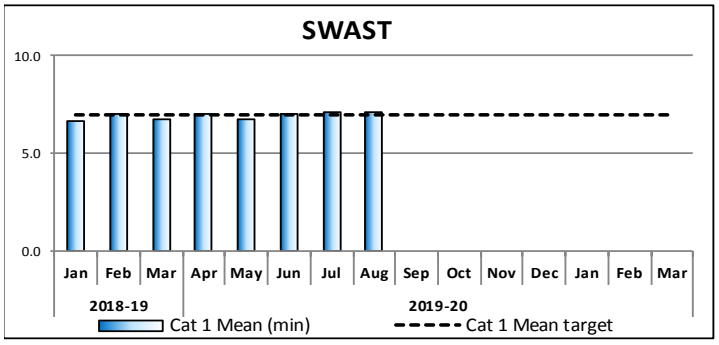
The Devon system has continued to experience increased demand impacts within the urgent and emergency care pathways, and this has had significant impact in the South and West localities which have regulatory oversight. The CCG is therefore continuing with additional quality reviews including a rolling programme of observational audits which are being undertaken across all localities. Information around patient experience, safety and effectiveness of care from this additional surveillance is shared with the providers and informs the local system escalation calls that are in place in these localities.

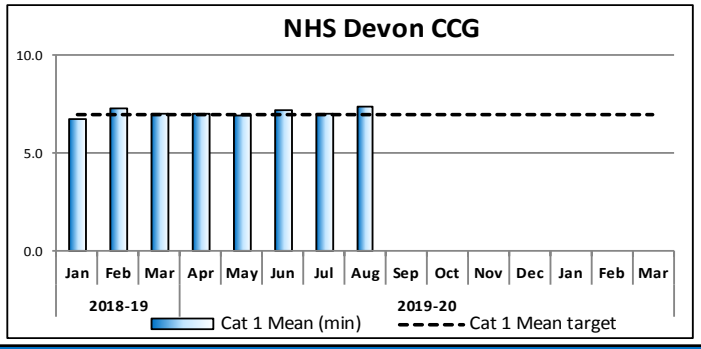
The temporary reduction in opening hours of Minor Injuries Services across the Southern and Western Localities, with impacts on Totnes and Dawlish in the South & Tavistock in the West continue. This is as a direct impact of staff availability and impact on patients has been appropriately considered by the providers. Quality, Equality Impact Assessments (QEIAs) have been undertaken and will be re-reviewed as agreed.

An update on the improvement project in the Western Locality, shows that good progress has been made and a number of staff appointments have been agreed. The ongoing process will be monitored through the Western A&E delivery board and the learning shared across the STP.

SWAST Cat 1 Mean response time

Trust	Target	August	2019/20
NHS Devon	7.00	7.40	7.1
SWAST	8.00	7.15	6.9





Performance Commentary

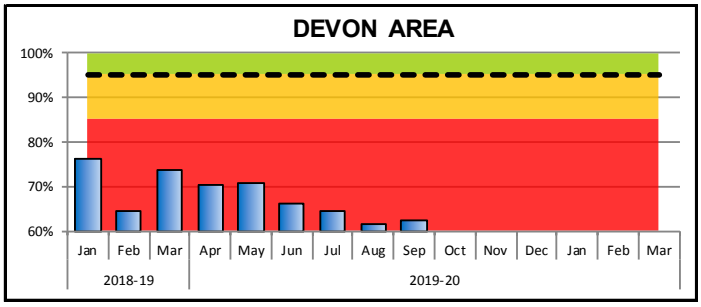
At STP level the 7-minute response time performance was slightly above target at 7.4.

Quality Commentary and Improvement Actions

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

NHS 111 answering calls within 60 Seconds

Trust	Target	September	2019/20
DEVON	95%	62.1%	66.0%
ENGLAND	95%	82.2%	84.2%



Performance Commentary

The proportion of calls answered within 60 seconds rose slightly in September to 62.1% from 61.5% in August. Performance remains well below the target of 95%.

Quality Commentary and Improvement Actions

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

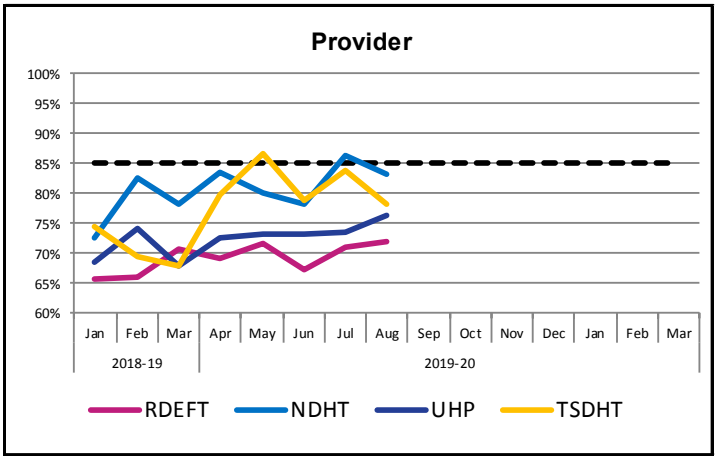
111 - The CCG quality assurance process continues to check quality intelligence sources for any adverse impact on patient care or experience as a result of delays in call answering. Incident and end to end reviews enable the CCG to understand where contacts with other services were made by patients who had been unable to access a timely response from 111.

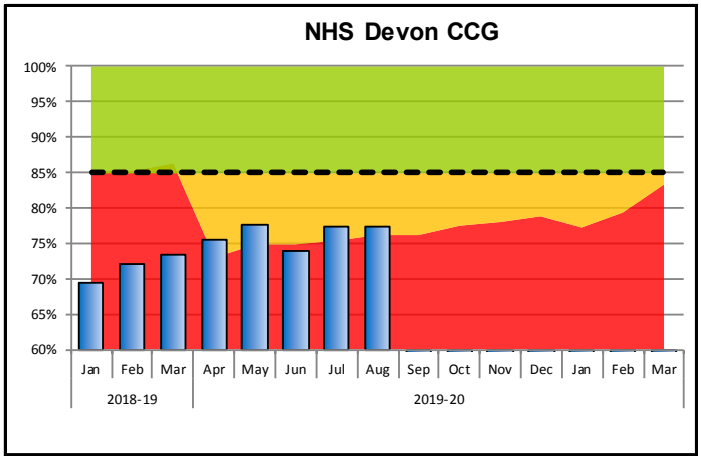
The 111 service for August was provided by Vocare on behalf of Devon Doctors Ltd. This contract and service provision returned to Devon Doctors from October 2019. The CCG and Devon Doctors are meeting regularly to manage the transition and quality measures are a key part of the transfer process. A clear trajectory for staffing the service is in place, including relevant training and development.

Cancer 62 day Urgent Referral

Trust	Trajectory	August	2019/20
RDEFT	76.5%	72.1%	70.3%
NDHT	75.1%	83.2%	82.6%
UHP	70.2%	76.2%	73.7%
TSDFT	85.1%	78.2%	81.4%

CCG	Trajectory	August	2019/20
NHS Devon	76%	77.4%	76.4%
ENGLAND	85%	77.6%	77.6%





Performance Commentary

No provider achieved the 85% target in August but there were improvements at both UHP and RD&E, rising to 76.2% and 72.1% respectively. TSD performance fell from 84.0% to 78.2% and NDHT dropped from 86.3% to 83.2%. However, UHP and NDHT met their improvement trajectory.

NDHT and TSD both saw a slight reduction in the backlog of over 62 day waits but there was a rise at UHP and RD&E increased from 205 to 238.

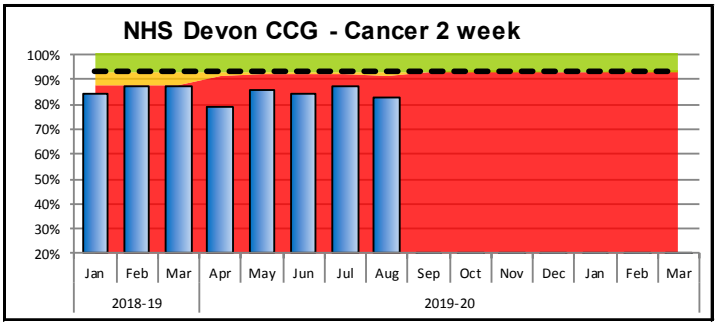
Quality Commentary and Improvement Actions

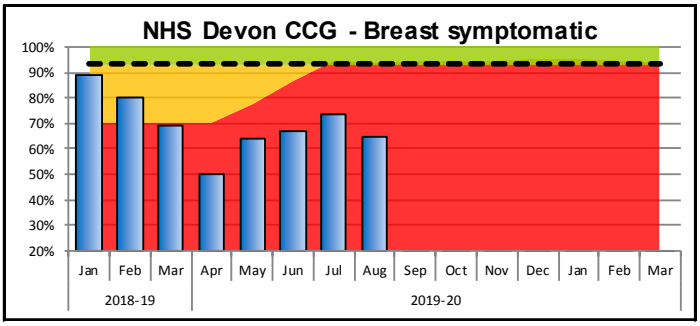
The CCG's strategic plan clearly sets out key areas of work that aim to provide sustainable achievement of the 62-day standard, leading to improved safety and experience for patients. Each provider's improvement plan is overseen by the CCG. There is growing evidence within the system of improved collaboration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

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

Cancer Targets (August-2019)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	83.0%	70.4%	94.9%	93.8%	83.4%
93%	2 week breast	64.8%	7.1%	94.4%	72.8%	98.7%
90%	62 day screening	86.0%	82.9%	100.0%	72.7%	100.0%
85%	62 day consultant	86.0%	89.4%	84.3%	65.0%	83.3%
96%	31 day first	94.9%	94.6%	96.7%	94.5%	94.7%
94%	31 day surgery	94.6%	96.6%	87.5%	92.1%	100.0%
98%	31 day drugs	99.7%	100.0%	97.0%	99.2%	100.0%
94%	31 day radiotherapy	96.3%	95.8%	97.0%	95.3%	95.9%





Performance Commentary

Overall performance against the cancer standards was comparatively good at NDHT and TSDFT but more mixed at UHP and RD&E, who achieved 3 and 4 of the 8 targets respectively.

Performance against the main 2ww standard fell at RD&E from 80.1% to 70.4% and remained static at TSD at 83.4%. NDHT and UHP continue to perform above the 93% target.

Breast symptomatic performance fell in August as RD&E dropped from 75.5% to just 7.1%. However, there was significant improvement at UHP, rising from 39.1% to 72.8%, whilst NDHT and TSD both achieved the 93% target.

Quality Commentary and Improvement Actions

All providers acknowledge the impact of delays on patient experience, including increased levels of anxiety within their harm reviews. Also included is an assessment of any physical harm as a result of an increased wait. Cancer specific action plans are in place for each provider. The system wide symptomatic breast pathway plan addresses improvement in performance, and also quality actions, for example implementing harm reviews for those patients having to wait.
The aim of the action plans is to set out clear actions to move the Trusts to sustainable achievement of the cancer standards, improving experience for patients requiring cancer care across Devon. These plans now form part of a robust monitoring process supported by NHSI colleagues.

Work with providers and primary care also continues to drive improvement. This includes a focus on improving referral pathways where conversion rates are low. The planned care group work across all localities to target and then liaise with high referring GP practices. It has been recognised that more analysis will be required to fully understand the growth in certain specialities such as lung referrals for 2WW that could impact on the patient experience The above approach if successful will be rolled out to encompass specialities and sub-specialities and the CCG is working closely with the Trust on this analysis of data.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

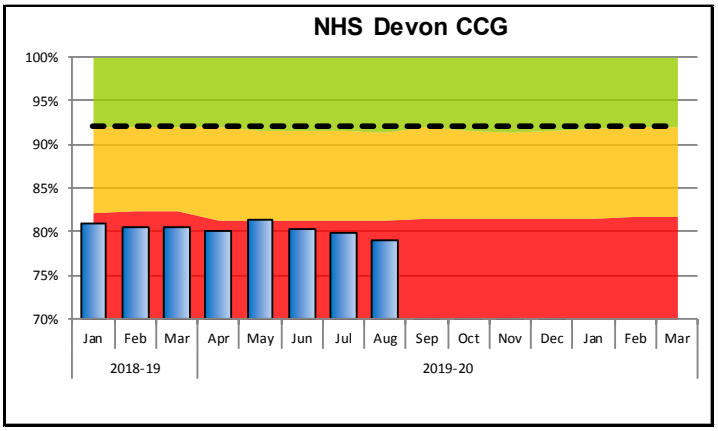
Trust	Trajectory	August	2019/20
RDEFT	82.6%	79.3%	81.0%
NDHT	79.1%	79.9%	79.8%
UHP	77.7%	76.2%	76.8%
TSDFT	81.0%	80.7%	81.2%

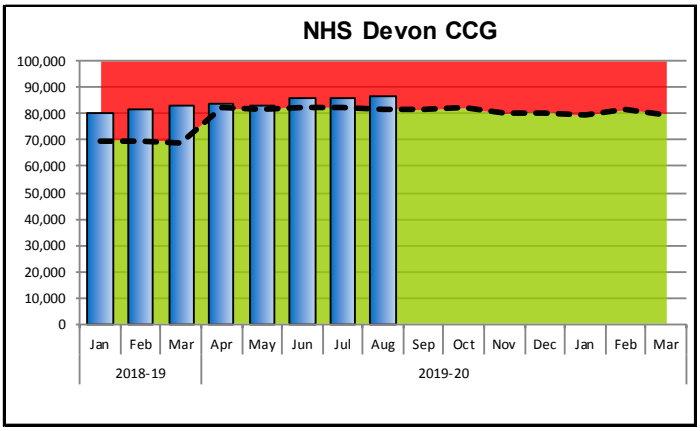
CCG	Trajectory	August	2019/20
NHS Devon	81.2%	79.0%	80.1%
ENGLAND	92.0%	85.0%	86.1%

RTT incomplete waits volume

Trust	Trajectory	August
RDEFT	33,707	36,453
NDHT	11,313	11,709
UHP	28,730	30,115
TSDFT	18,379	19,899

CCG	Trajectory	August
NHS Devon	81,730	86,788





Performance Commentary

The STP level RTT position decreased further in August from 79.8% to 79.0%. Whilst NDHT saw a slight improvement from 79.2% to 79.9%, RD&E, UHP and TSD all saw performance fall. RD&E dropped from 80.7% to 79.3%, UHP from 77.2% to 76.2% and TSD from 81.1% to 80.7%. Only NDHT remain above their improvement trajectory with RD&E now more than 3% below plan.

The incomplete waiting list rose by around 750 patients at RD&E and 400 at UHP, whilst the NDHT list was marginally higher than July and TSD slightly lower. All providers remain above their respective waiting list trajectories (TSD 9%, RD&E 8%, UHP 5% and NDHT 4%), with TSD and RD&E both underperforming against elective activity plans and referral growth at 3% for the STP.

Providers continue to monitor patients experiencing long waits, and this includes considering the patient experience.

Where harm reviews have identified adverse patient impacts providers are reporting and investigating incidents to establish if this was due to the waiting time. The CCG reviews the incidents to seek assurance that providers are investigating robustly and learning from incidents to drive improvements for patients. This includes reducing time delays as well as improving processes for checking for harm if delays are experienced.

There has been significant movement in providers working together to reduce long waits. In addition, plans to further support primary care progresses, including developing advice and guidance. The Devon Referral Support Service (DRSS) continues to work closely with providers and patients, to ensure long waits are managed and patients have a positive experience.

RTT Incomplete Pathways long waiters

40-52 week waits

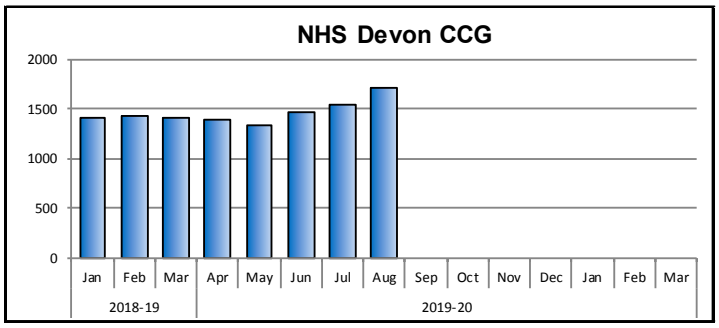
Trust	August	2019/20
RDEFT	707	2964
NDHT	154	631
UHP	786	3497
TSDFT	385	1652

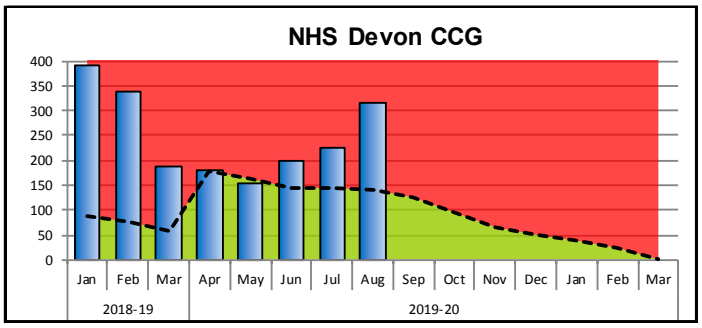
CCG	August	2019/20
NHS Devon	1716	7435

Over 52 week waits

Trust	Trajectory	August	2019/20
RDEFT	0	146	446
NDHT	0	6	49
UHP	40	111	364
TSDFT	115	105	402

CCG	Trajectory	August	2019/20
NHS Devon	139	316	1072





Performance Commentary

Over 52 week waits rose significantly in August, moving from 225 to 316 at STP level. All providers except NDHT saw increased breaches with TSD rising from 84 to 105, RD&E rising from 90 to 146 and UHP increasing from 86 to 111. NDHT fell from 8 to 6. Only TSD remain within their trajectory.

Quality Commentary and Improvement Actions

Elements of planned care work continue to be outsourced to the independent sector, with the aim of improving choice and experience and reducing potential risk from a long wait. The CCG continues to seek assurance that provider Trusts are undertaking surveillance to ensure quality is maintained when outsourcing service provision.

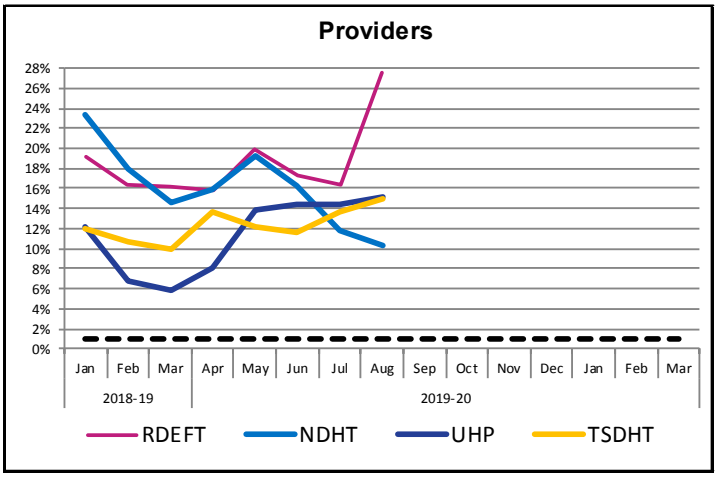
Patient choice continues to impact on this standard as some patients are choosing long waits for personal reasons. Providers evidence actions to reduce the number of patients waiting for lengthy time periods, for example through regular and effective communication with patients and encouraging them not to wait for long periods.

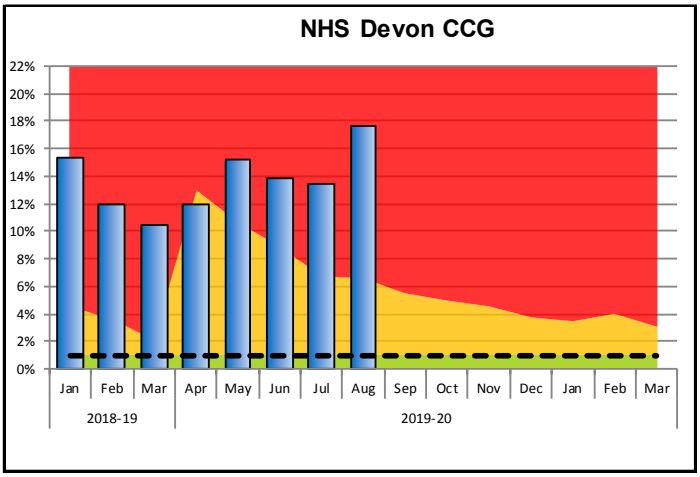
Providers working together across the system now have standard procedures in place to ensure patients remain safe when experiencing long waits, and are moving towards a centralised system for supporting all patients choosing to wait for up to 52 weeks.

Diagnostic 6 week wait

Trust	Trajectory	August	2019/20
RDEFT	3.0%	27.5%	19.6%
NDHT	13.5%	10.2%	14.9%
UHP	4.9%	15.2%	13.2%
TSDFT	9.7%	14.9%	13.2%

CCG	Trajectory	August	2019/20
NHS Devon	6.6%	17.6%	14.4%
ENGLAND	1.0%	4.3%	3.8%





Performance Commentary

The STP position rose from 13.4% to 17.6% in August, the highest level since June 2018. There were further reductions in breaches at NDHT (moving from 11.8% to 10.2%) but small rises at both UHP (14.4% to 15.2%) and TSD (13.7% to 14.9%). However, the RD&E rate rose sharply, from 16.4% to 27.4%, partly related to the identification of a reporting data quality issue. RD&E, UHP and TSD are all significantly above improvement trajectories, with NDHT moving to 4% better than plan. The majority of breaches continue to be for imaging and endoscopy.

Quality Commentary and Improvement Actions

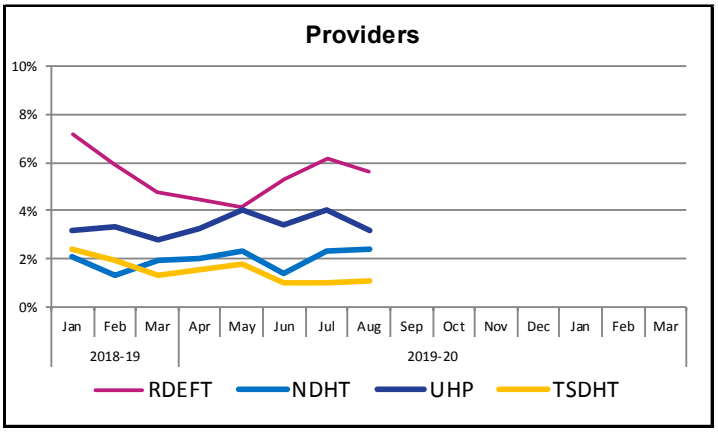
Plans to improve diagnostic pathways to ensure a more local and sustainable position are in place across Devon, with the aim of reducing risks associated with delays as well as patient experience. In the interim, all providers continue to rely heavily on external sourcing for diagnostics but have assured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

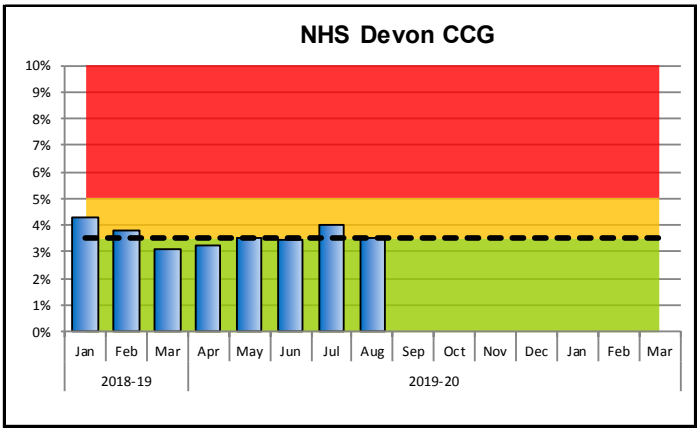
Serious incidents involving diagnostic delays are reported to the CCG through the National Incident Reporting process and full root cause analysis investigations are undertaken. Patient experiences of waiting for diagnostic tests is considered within all Patient Advice & Liaison (PAL's) enquiries and through formal complaints. In addition to routine CCG quality monitoring and sharing of themes and trends, a 12 month look back review is underway. This involves all incidents, patient complaints and concerns involving diagnostics, to understand adverse impacts associated with long waits.

Acute Delayed Transfers of care

Trust	Target	August	2019/20
RDEFT	3.50%	5.6%	6.4%
NDHT	3.50%	2.4%	2.6%
UHP	3.50%	3.1%	4.4%
TSDFT	3.50%	1.1%	1.6%

CCG	Target	August	2019/20
NHS Devon	3.50%	3.54%	4.5%





Performance Commentary

In August acute delayed transfers of care (DTOC) remained low at NDHT and TSD and reduced at UHP from 4.0% to 3.1%. The RD&E position, which had risen from 5.3% in June to 6.2% in July, fell back to 5.6% in August. The STP position improved from 4.0% to 3.54%, very slightly above the 3.5% target.

Quality Commentary and Improvement Actions

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

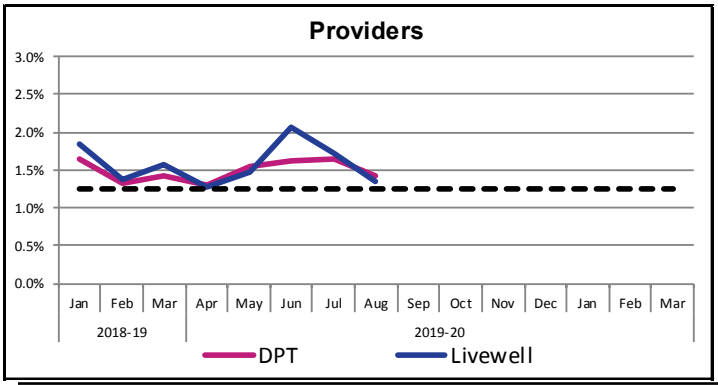
Impact of delayed transfers of care can be seen across the urgent care pathways and the CCG has sight of the position through receipt of the daily situation reports from providers. The patient and system impact of delayed transfers remains a key element of escalation discussions. Partners from across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

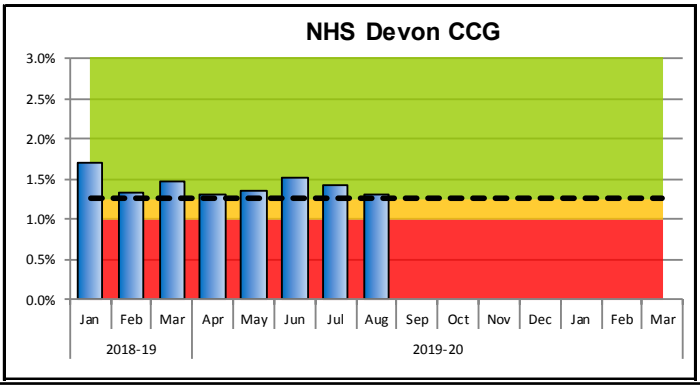
Planning for patients to be discharged during the weekend period has been difficult to successfully achieve in both South and West localities despite significant predictive work. This has adversely impacted on the onward flow of patients and demand/capacity going into the week days. Key issues being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

IAPT Monthly Access rate

Trust	Target	August	2019/20
DPT	1.25%	1.4%	7.5%
LIVEWELL	1.25%	1.34%	7.87%

CCG	Target	August	2019/20
NHS Devon	1.25%	1.3%	6.9%





Performance Commentary

Performance for the IAPT access rate indicator was above target at STP level for August with both DPT and Livewell meeting the standard

Quality Commentary and Improvement Actions

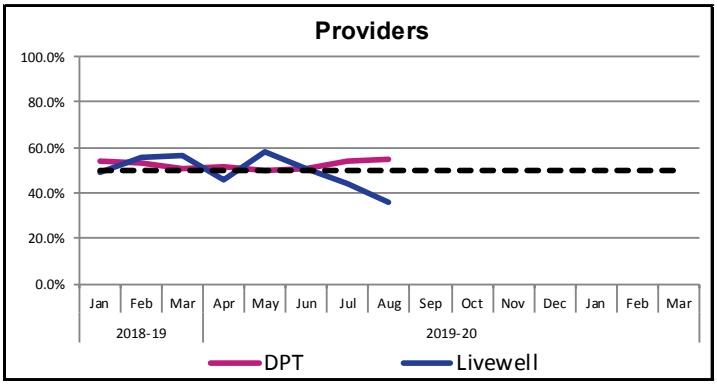
There is currently still evidence of variance across Devon in accessing some therapy services, and this potentially compromises patient quality and experience. This may also adversely impact on carers and families and is monitored through the CCG quality monitoring processes.

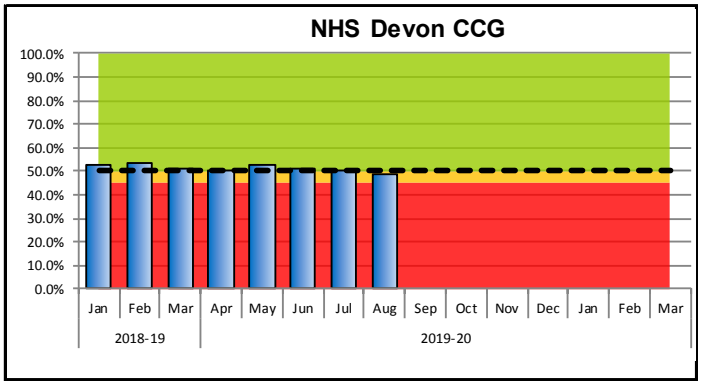
Through the Mental Health Investment Standard, local funding for mental health (excluding learning disabilities and dementia), will ensure sufficiency of staff with regards to expansion and replacement of therapists.

IAPT Recovery rate

Trust	Target	August	2019/20
DPT	50%	55.2%	52.3%
LIVEWELL	50%	36.0%	45.8%

CCG	Target	August	2019/20
NHS Devon	50%	48.8%	50.6%





Performance Commentary

The STP was under the 50% target for IAPT recovery at 48.8%, with DPT performance continuing to be above target at 55.2% but Livewell falling again to 36.0%.

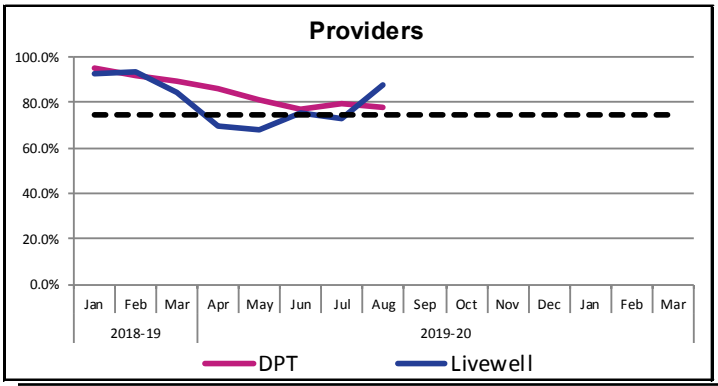
Quality Commentary and Improvement Actions

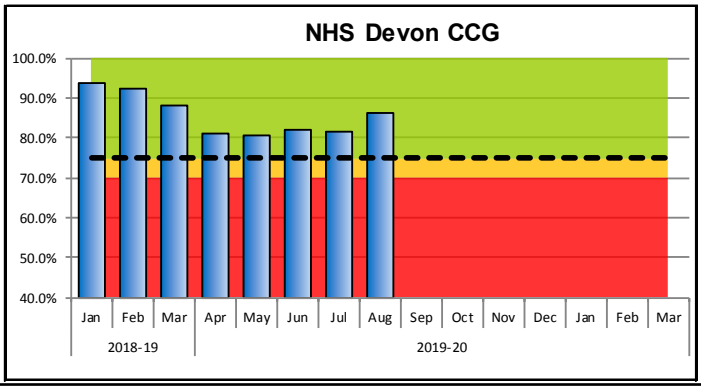
The CCG continues to review all information from provider meetings and other sources to inform the range of indicators within the quality assurance process.

IAPT waiting 6 weeks

Trust	Target	August	2019/20
DPT	75%	78.3%	80.5%
LIVEWELL	75%	87.9%	75.0%

CCG	Target	August	2019/20
NHS Devon	75%	86.4%	82.3%





Performance Commentary

DPT and Livewell achieved the target in August

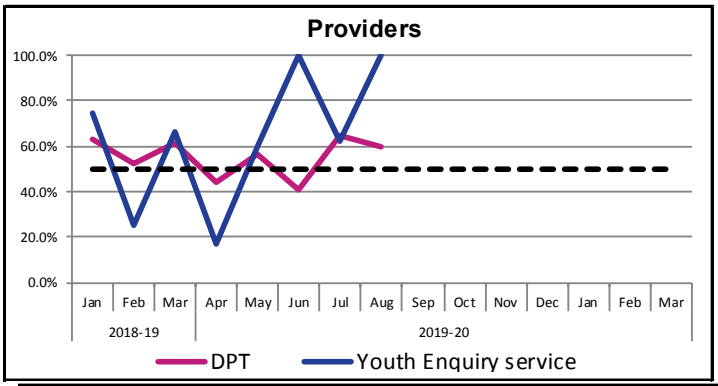
Quality Commentary and Improvement Actions

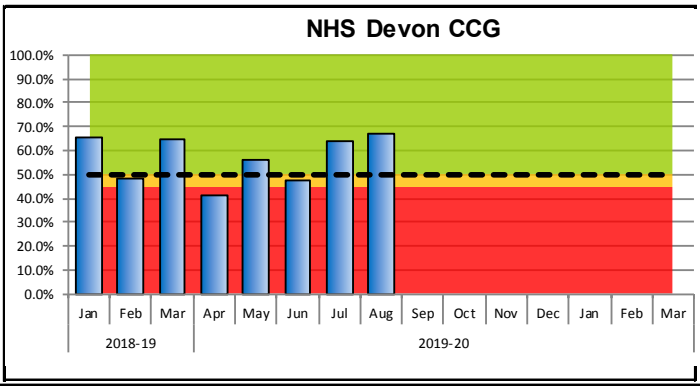
Quality assurance continues through the quality assurance framework process and the CCG is currently reviewing challenges raised by Primary Care for those patients who may not be eligible for Community Mental Health Services but present as too complex for depression and anxiety services. An update will be provided to the November Quality Assurance Committee. Livewell Southwest (LWSW) are undertaking a review of all patients that were considered not eligible for referral to their Community Mental Health Teams (CMHT). The review will focus on where the patient was alternatively referred to, whether they attended any appointments offered and what their outcomes were. This will include patients signposted to other agencies and self-help options. This review will be reported into LWSW board. The CCG will work closely with LWSW during this quality review.

Mental Health Early Intervention

Trust	Target	August	2019/20
DPT	50%	60.0%	53.1%
THE ZONE	50%	100.0%	57.1%

CCG	Target	August	2019/20
NHS Devon	50%	66.7%	54.7%
ENGLAND	50%	76.7%	75.1%





Performance Commentary

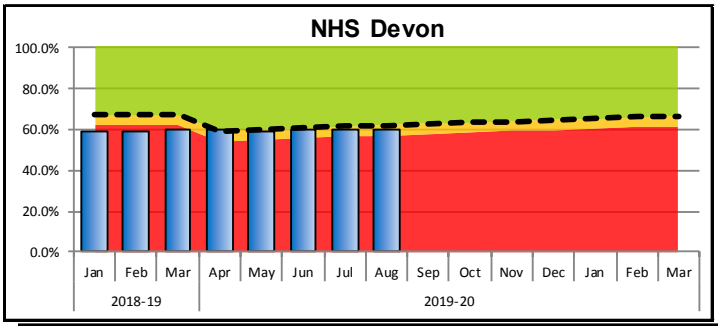
This is a two-part indicator for patients with suspected first episode psychosis or at risk mental state on a completed pathway receiving NICE-recommended care package and allocated to and engaged with an EIP care co-ordinator. Performance improved in August to 66.7%, above target with the Youth Enquiry Service (The Zone) at 100% and DPT at 60%.

Quality Commentary and Improvement Actions

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

Dementia Diagnosis Rate

CCG	Trajectory	August	2019/20
NHS Devon	62.0%	59.8%	59.6%
ENGLAND	67.0%	68.8%	68.5%



Performance Commentary

STP level performance remained static and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (41.8%), Mid Devon (49%) and Plymouth (55%). Conversely Exeter is at 71.4%, Torbay 61.6 and East Devon at 64.4%.

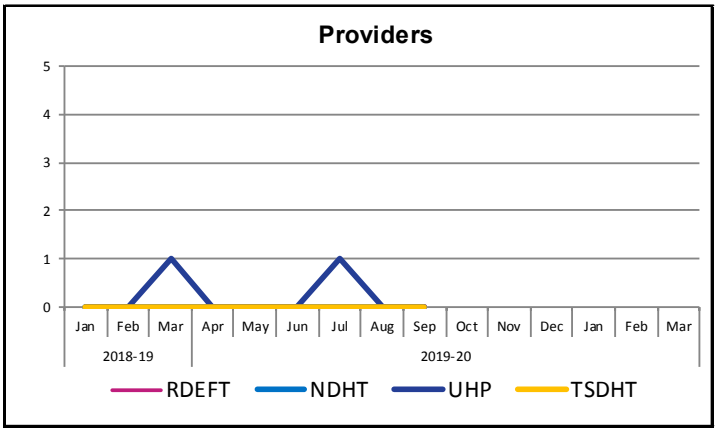
Quality Commentary and Improvement Actions

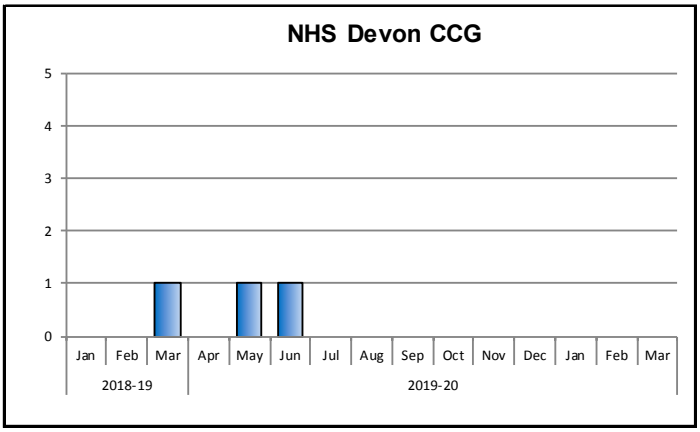
Livewell Southwest report that currently there is no backlog as referrals are being triaged daily. During the month of July 46 people were diagnosed which is very positive and the new clinical rooms are in full operational use. This will positively impact on patients referred and their families as assessments/diagnosis will be timely, enabling earlier interventions, treatments and support.

MRSA breaches

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

CCG	Target	September	2019/20
NHS Devon	0	0	2





Performance Commentary

There were no reported cases in September.

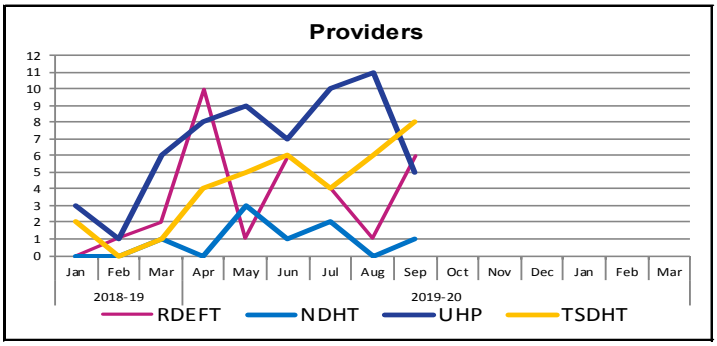
Quality Commentary and Improvement Actions

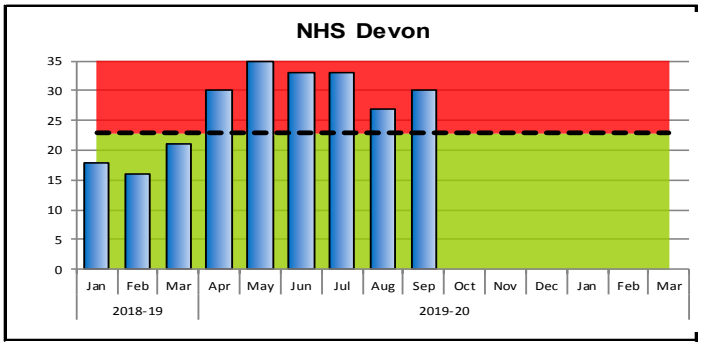
In August there was an outbreak of MRSA colonisation within a ward containing vulnerable patients in UHPT; the colonisation has been identified and all patients treated, with sources traced and environmental deep cleaning performed. The ward was closed briefly to allow for the deep cleaning and ensure further spread was prevented. No patients became infected with MRSA as a result of this colonisation.

C-Diff breaches

Trust	Target	September	2019/20
RDEFT	<31	6	28
NDHT	<9	1	7
UHP	<63	5	50
TSDFT	<36	8	33

CCG	Target	September	2019/20
DEVON STP	<274	30	188





Performance Commentary

There were 20 C-Diff cases acquired within the acute providers and 30 across the STP in September.

Quality Commentary and Improvement Actions

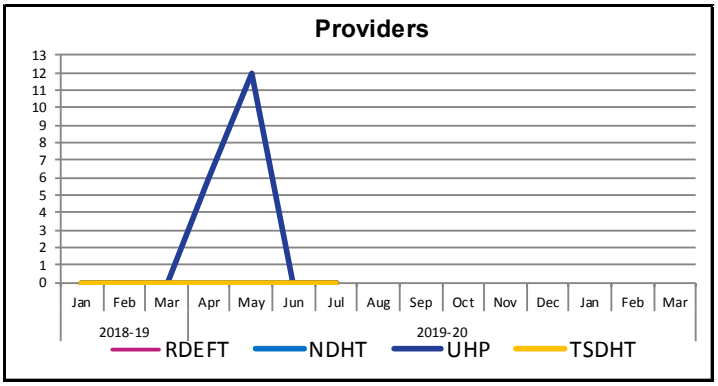
There has been a significant increase in C difficile cases across Devon since April 2019. This is largely due to changes in reporting requirements (community acquired cases <28 days post hospitalisation are now included, an increase of 40% in some areas) although there is also a national

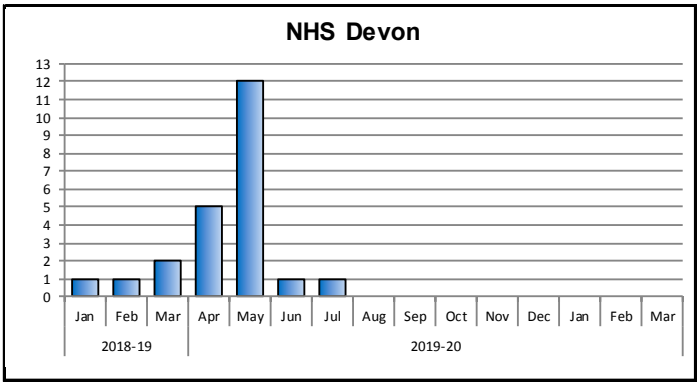
increase in cases. Historical trends indicate that case numbers will now reduce for the rest of the financial year.

Mixed Sex accommodation breaches

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

CCG	Target	August	2019/20
NHS Devon	0	0	19





Performance Commentary

There were no provider breaches in August.

Quality Commentary and Improvement Actions

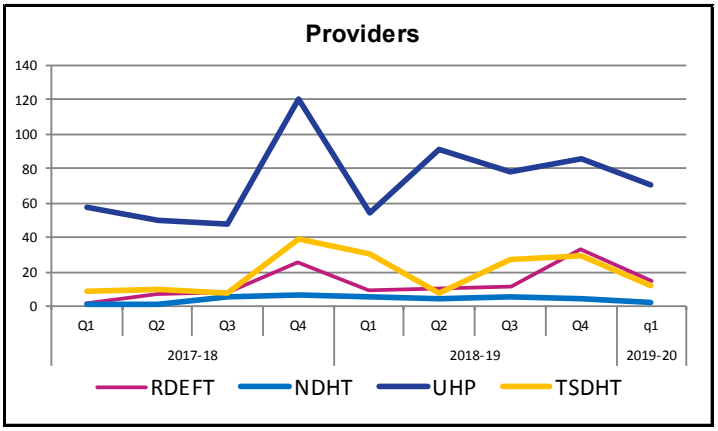
The CCG will continue to seek assurance from the provider organisations that any MSA breaches reported are clinically justifiable. Where it has been indicated that the breach was unnecessary, further assurance from the provider is sought including confirmation of any actions taken to address or lessons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

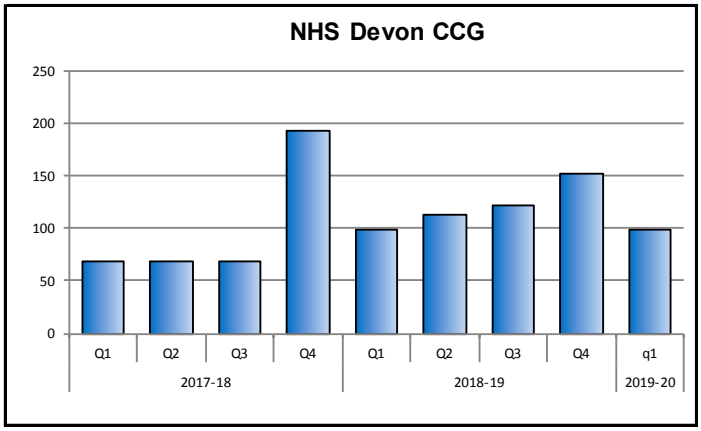
Providers submitted copies of their Locally Agreed Clinically Appropriate Breach Decision Matrices to the CCG. These have been reviewed against the national standards and the CCG is currently liaising with some providers for further information. A further update of the analysis will be provided next month.

Cancelled operations not treated with 28 days of cancellation

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

CCG	Target	Q1	2019/20
NHS Devon	0	99	99





Performance Commentary

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

Quality Commentary and Improvement Actions

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

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

NHS Northern Eastern Western Devon

Summary

Domain	Indicator	Area	Period	England value	Target		99P: NHS Northern, Eastern and Western Devon CCG	
	999a: Annual assessment	Annual assessment	2018-19				RI	
Better Health	102a: Percentage of children ..	Child obesity	2015-16 to 2017-18	34.2%			29.4%	(23/186)
	103a: Diabetes patients that h..	Diabetes	2017-18	38.7%			38.1%	(158/186)
	103b: People with diabetes dI..	Diabetes	2017-18 (2016 cohort)	8.54%			7.44%	(104/186)
	104a: Injuries from falls in peo..	Falls	18-19 Q3	2051			1690	(45/186)
	105b: Personal health budgets	Personalisation and choice	18-19 Q4	75			645	(2/186)
	106a: Inequality in unplanned ..	Health inequalities	18-19 Q2	2109			2182	(92/186)
	107a: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	0.962	0.965	●	0.984	(84/186)
	107b: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	8.71%	10%	●	9.60%	(130/186)
	108a: The proportion of carers..	Carers	2018	0.59	1.000	●	0.60	(90/186)
	105c: Percentage of deaths wi..	End of life care	2017	7.40%			6.76%	(33/186)
	121a: Provision of high quality..	Provision of high quality care	18-19 Q3				83	(35/186)
	121b: Provision of high quality..	Provision of high quality care	18-19 Q3				70	(9/186)
	121c: Provision of high quality..	Provision of high quality care	18-19 Q3				85	(10/186)
	122a: Cancers diagnosed at e..	Cancer	2017	52.2%			66.8%	(19/186)
	122b: People with urgent GP r..	Cancer	18-19 Q4	77.3%	85%	●	70.8%	(183/186)
	122c: One-year survival from ..	Cancer	2016	72.8%	75%	●	74.2%	(36/186)
	122d: Cancer patient experien..	Cancer	2017				8.9	(35/186)
	123a: Improving Access to Ps..	Mental health	18-19 Q3	51.8%	50%	●	60.8%	(119/186)
	123b: Improving Access to Ps..	Mental health	18-19 Q3	4.48%			3.87%	(148/186)
	123c: People with first episod..	Mental health	2019 Q3	75.9%	53%	●	70.8%	(140/186)
	123e: Mental health crisis tea..	Mental health	2017-18				0.00%	(114/180)
	123f: Mental health out of are..	Mental health	2019 Q2	124			675	(180/186)
	123g: Proportion of people on ..	Mental Health	18-19 Q4	30.3%	50%	●	17.2%	(155/186)
	123i: Delivery of the mental he..	Mental Health	18-19 Q4				Green	
	123j: Ensuring the quality of m..	Mental Health	2019 Q1	Null			0.84	(22/186)
	124a: Reliance on specialist in..	Learning disability	18-19 Q4				40	(48/186)
	124b: Proportion of people wit..	Learning disability	2017-18	51.4%			63.8%	(81/186)
	124c: Completeness of the G..	Learning disability	2017-18	0.49%			0.64%	(65/186)
	125a: Neonatal mortality and ..	Maternity	2016	Null			3.82	(69/194)
	125b: Women's experience of ..	Maternity	2018	82.7			84.2	(67/186)
	125c: Choices in maternity ser..	Maternity	2018	60.4			60.1	(106/186)
	125d: Maternal smoking at del..	Maternity	18-19 Q3	10.5%	6%	●	10.8%	(92/186)
	126a: Estimated diagnosis rat..	Dementia	2019 Q3	68.7%	67%	●	69.8%	(181/186)
	126b: Dementia care planning..	Dementia	2017-18	77.5%			77.2%	(123/184)
	127b: Emergency admissions ..	Urgent and emergency care	18-19 Q2	2409			2186	(68/186)
	127c: Percentage of patients ..	Urgent and emergency care	2019 Q3	86.6%	95%	●	86.7%	(84/186)
	127e: Delayed transfers of car..	Urgent and emergency care	2019 Q3	10.2			11.0	(130/186)
	127f: Population use of hospit..	Urgent and emergency care	18-19 Q2	499			427	(31/186)
	128b: Patient experience of G..	Primary care	2018	83.8%			88.0%	(13/186)
	128c: Primary care access – p..	Primary care	2019 Q3	99.8%			100.0%	(1/193)
	128d: Primary care workforce	Primary care	2018 09	1.05			1.21	(31/186)
	128e: Count of the total invest..	Primary care	18-19 Q4				Green	
	129a: Patients waiting 18 wee..	Elective access	2019 Q3	86.7%	92%	●	80.3%	(187/186)
	130a: Achievement of clinical ..	7 day services	2017-18				2	(56/186)
	131a: Percentage of NHS Con..	NHS Continuing Healthcare	18-19 Q4	6.91%	15%	●	0.00%	(1/186)
	132a: Evidence that sepsis aw..	Patient safety	2018				Amber	
	133a: Percentage of patients ..	Diagnostics	2019 Q3	2.47%	1%	●	10.6%	(192/186)
Sustainability	141b: In-year financial perfor..	Financial sustainability	18-19 Q4				Amber	
	144a: Utilisation of the NHS e-..	Paper-free at the point of care	2019 Q3	99.8%	100%	●	88.0%	(184/186)
	145a: Expenditure in areas wit..	Demand management	18-19 Q3				Red	
Leadership	162a: Probity and corporate g..	Probity and corporate governa..	18-19 Q4				Fully compliant	
	163a: Staff engagement index	Workforce engagement	2018	3.82			3.86	(21/188)
	163b: Progress against the W..	Workforce engagement	2018	0.14			0.17	(158/188)
	164a: Effectiveness of workin..	CCGs' local relationships	2018-19				82.7	(181/186)
	165a: Quality of CCG leaders..	Quality of leadership	18-19 Q4				Amber	
	166a: Compliance with statuto..	Patient and community engag..	2018				Green star	

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

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

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

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

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

Summary

Domain	Indicator	Area	Period	England value	Target		99Q: NHS South Devon and Torbay CCG
	999a: Annual assessment	Annual assessment	2018-19			RI	
Better Health	102a: Percentage of children ..	Child obesity	2015-16 to 2017-18	34.2%		30.0%	(32/186)
	103a: Diabetes patients that h..	Diabetes	2017-18	38.7%		36.6%	(184/186)
	103b: People with diabetes di..	Diabetes	2017-18 (2016 cohort)	8.54%		9.30%	(82/186)
	104a: Injuries from falls in peo..	Falls	18-19 Q3	2051		1909	(79/186)
	105b: Personal health budgets	Personalisation and choice	18-19 Q4	75		238	(8/186)
	106a: Inequality in unplanned ..	Health inequalities	18-19 Q2	2109		1832	(68/186)
	107a: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	0.962	0.965	0.969	(87/186)
	107b: Antimicrobial resistance..	Antimicrobial resistance	2019 Q2	8.71%	10%	10.8%	(171/186)
	108a: The proportion of carers..	Carers	2018	0.59	1.000	0.68	(108/186)
Better Care	105c: Percentage of deaths wi..	End of life care	2017	7.40%		7.48%	(92/186)
	121a: Provision of high quality..	Provision of high quality care	18-19 Q3			63	(35/186)
	121b: Provision of high quality..	Provision of high quality care	18-19 Q3			72	(3/186)
	121c: Provision of high quality..	Provision of high quality care	18-19 Q3			64	(26/186)
	122a: Cancers diagnosed at e..	Cancer	2017	52.2%		52.2%	(97/186)
	122b: People with urgent GP r..	Cancer	18-19 Q4	77.3%	85%	70.0%	(188/186)
	122c: One-year survival from ..	Cancer	2016	72.8%	75%	74.8%	(19/186)
	122d: Cancer patient experien..	Cancer	2017			8.0	(13/186)
	123a: Improving Access to Ps..	Mental health	18-19 Q3	51.8%	50%	48.0%	(180/186)
	123b: Improving Access to Ps..	Mental health	18-19 Q3	4.48%		2.86%	(191/186)
	123c: People with first episod..	Mental health	2019 03	75.9%	53%	66.4%	(178/186)
	123e: Mental health crisis tea..	Mental health	2017-18			0.00%	(114/180)
	123f: Mental health out of are..	Mental health	2019 02	124		889	(186/186)
	123g: Proportion of people on ..	Mental Health	18-19 Q4	30.3%	50%	30.8%	(88/186)
	123i: Delivery of the mental he..	Mental Health	18-19 Q4			Green	
	123j: Ensuring the quality of m..	Mental Health	2019 01	Null		0.94	(20/186)
	124a: Reliance on specialist in..	Learning disability	18-19 Q4			40	(49/186)
	124b: Proportion of people wit..	Learning disability	2017-18	51.4%		68.8%	(42/186)
	124c: Completeness of the G..	Learning disability	2017-18	0.49%		0.67%	(20/186)
	125a: Neonatal mortality and ..	Maternity	2016	Null		3.68	(63/194)
	125b: Women's experience of ..	Maternity	2018	82.7		87.2	(19/186)
	125c: Choices in maternity ser..	Maternity	2018	60.4		67.2	(13/186)
	125d: Maternal smoking at del..	Maternity	18-19 Q3	10.5%	6%	13.7%	(138/186)
	126a: Estimated diagnosis rat..	Dementia	2019 03	68.7%	67%	68.8%	(188/186)
	126b: Dementia care planning..	Dementia	2017-18	77.5%		78.8%	(134/194)
	127b: Emergency admissions ..	Urgent and emergency care	18-19 Q2	2409		1897	(38/186)
	127c: Percentage of patients ..	Urgent and emergency care	2019 03	86.6%	95%	81.6%	(141/186)
	127e: Delayed transfers of car..	Urgent and emergency care	2019 03	10.2		9.1	(95/186)
	127f: Population use of hospit..	Urgent and emergency care	18-19 Q2	499		387	(4/186)
	128b: Patient experience of G..	Primary care	2018	83.8%		87.4%	(31/186)
	128c: Primary care access – p..	Primary care	2019 03	99.8%		100.0%	(1/183)
	128d: Primary care workforce	Primary care	2018 09	1.05		1.20	(34/186)
	128e: Count of the total invest..	Primary care	18-19 Q4			Green	
	129a: Patients waiting 18 wee..	Elective access	2019 03	86.7%	92%	80.9%	(184/186)
	130a: Achievement of clinical ..	7 day services	2017-18			2	(58/186)
	131a: Percentage of NHS Con..	NHS Continuing Healthcare	18-19 Q4	6.91%	15%	0.00%	(1/186)
	132a: Evidence that sepsis aw..	Patient safety	2018			Amber	
	133a: Percentage of patients ..	Diagnostics	2019 03	2.47%	1%	10.3%	(181/186)
Sustainability	141b: In-year financial perfor..	Financial sustainability	18-19 Q4			Amber	
	144a: Utilisation of the NHS e-..	Paper-free at the point of care	2019 03	99.8%	100%	98.8%	(188/186)
	145a: Expenditure in areas wit..	Demand management	18-19 Q3			Green	
Leadership	162a: Probity and corporate g..	Probity and corporate governa..	18-19 Q4			Fully compliant	
	163a: Staff engagement index	Workforce engagement	2018	3.82		3.83	(41/188)
	163b: Progress against the W..	Workforce engagement	2018	0.14		0.11	(63/188)
	164a: Effectiveness of workin..	CCGs local relationships	2018-19			82.7	(181/186)
	165a: Quality of CCG leaders..	Quality of leadership	18-19 Q4			Amber	
	166a: Compliance with statuto..	Patient and community engag..	2018			Green star	

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

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

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

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

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

Appendix B. Key performance indicators – NHS Devon CCG

FIGURES FOR NHS DEVON CCG

PERFORMANCE MEASURES

INDICATOR	TARGET	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2019/20 YTD
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	>=92%	80.9%	80.6%	80.5%	80.1%	81.3%	80.4%	79.8%	79.0%								80.6%	79.4%			80.1%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	391	339	188	179	153	199	225	316								531	541			1072
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	<=1%	15.3%	11.9%	10.5%	12.0%	15.2%	13.9%	13.4%	17.6%								13.7%	15.5%			14.4%
Cancer - percentage seen within 2 weeks - urgent referral to first seen	>=93%	84.4%	87.6%	87.1%	78.8%	85.9%	84.3%	87.3%	83.0%								83%	85%			83.9%
Breast symptomatic- percentage seen within 2 weeks	>=93%	89.1%	80.0%	69.0%	50.2%	64.3%	66.8%	73.5%	64.8%								60%	70%			63.7%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	>=85%	69.3%	72.1%	73.5%	75.4%	77.7%	73.9%	77.3%	77.4%								76%	77%			76.4%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.7%	92.1%	86.7%	95.6%	89.2%	87.2%	90.7%	86.0%								91%	89%			89.8%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	87.0%	82.6%	85.5%	76.5%	81.1%	83.0%	89.8%	86.0%								80%	88%			83.7%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	94.5%	93.1%	93.2%	92.8%	95.7%	94.5%	95.7%	94.9%								94%	95%			94.8%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	88.5%	87.9%	88.4%	93.0%	92.0%	93.7%	96.0%	94.6%								93%	95%			93.8%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.7%	99.7%	99.7%	99.3%	99.4%	99.7%	99.7%	99.7%								99%	100%			99.5%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	92.9%	93.7%	91.2%	92.8%	90.2%	91.8%	96.0%	96.3%								92%	96%			93.4%
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	71.3%	73.7%	77.4%	72.0%	80.3%	76.3%	79.0%	74.9%	74.6%							76%	76%			75.9%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	>=95%	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%	87.7%	85.2%	84.5%							85%	86%			85.3%
Ambulance Category 1 Mean response Duration (min)	7	6.8	7.3	7.0	7.0	6.9	7.2	7.0	7.4								7.0	7.2			7.1
Ambulance Category 1 90th response Duration (min)	15	12.0	13.1	12.3	13.1	12.5	13.5	12.7	13.7								13.0	13.2			13.1
Ambulance Category 2 Mean response Duration (min)	18	28.5	28.3	27.3	26.0	26.1	26.3	26.8	26.3								26.1	26.6			26.3
Ambulance Category 2 90th response Duration (min)	40	58.7	59.5	56.0	53.7	54.3	54.6	56.0	54.6								54.2	55.3			54.6
Ambulance Category 3 90th response Duration (min)	120	169.7	161.3	156.5	162.4	155.1	158.4	163.4	162.1								158.6	162.8			160.3
Ambulance Category 4 90th response Duration (min)	180	220.2	214.4	200.1	196.4	186.4	197.0	207.5	197.9								193.3	202.7			197.0
Cancelled Operations - Number of patients not treated within 28 days of cancellation	0			152			99										99				99
IAPT Percentage of people entering treatment against the level of need in the general population (Monthly Access rate)	1.25%	2%	1%	1%	1.3%	1.4%	1.5%	1.4%	1.3%								4.2%	1.4%			6.9%
IAPT recovery rate - percentage of people who are moving to recovery	50%	53.0%	53.7%	51.4%	50.7%	52.4%	51.4%	50.0%	48.8%								51.5%	49.4%			50.6%
IAPT - started treatment with 6 weeks of referral	75%	94.0%	92.3%	88.0%	81.3%	80.4%	82.0%	81.6%	86.4%								81.3%	83.9%			82.3%
Mental Health - Percentage of people on CPA who were followed up with in 7 days of discharge	95%	97.7%	87.0%	97.9%	91.1%	98.3%	89.8%	93.8%	91.8%								93.5%	92.8%			93.2%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	93.7%	93.4%	93.5%	91.4%	89.0%	86.8%	90.4%	92.1%								89.0%	91.2%			89.9%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	65.2%	48.1%	64.7%	40.9%	56.0%	47.4%	64.0%	66.7%								48.5%	65.0%			54.7%
Dementia diagnosis rate	62%	59.1%	58.9%	59.6%	59.5%	59.3%	60.0%	59.6%	59.8%								59.6%	59.8%			59.7%

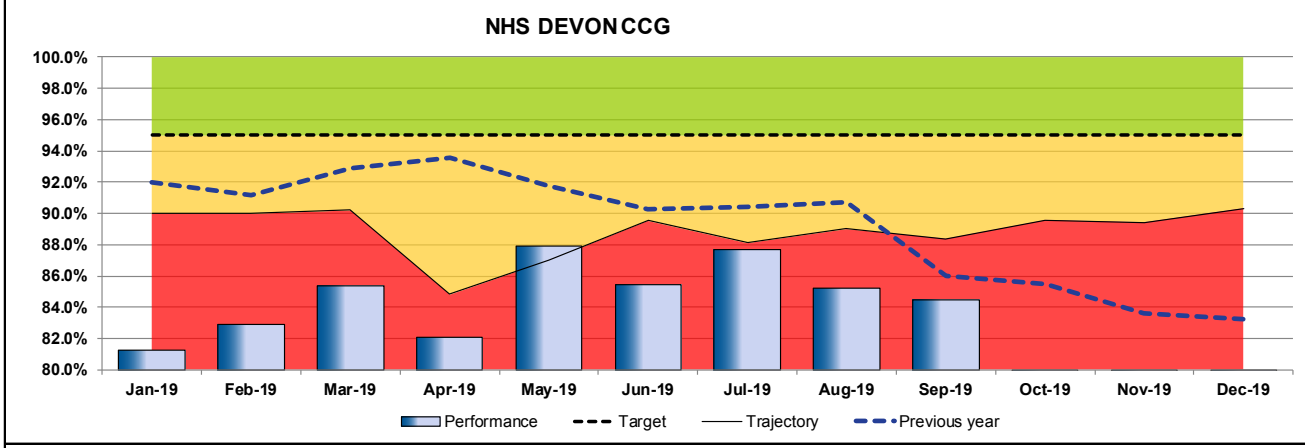
QUALITY MEASURES

INDICATOR	TARGET	Jan-18	Feb-18	Mar-18	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2019/20YTD
MRSA bacteraemia - number of hospital infections	0	0	0	1	0	1	1	0	0	0							2	0			2
Clostridium difficile - number of hospital infections	316	18	16	21	30	35	33	33	27	30							188	57			188
Mixed sex accommodation (MSA) - number of hospital breaches	0	1	1	2	5	12	1	1	0								19				19
Delayed transfers of care - patient delays as a percentage of occupied beds (Acute only)	3.5%	4.3%	3.8%	3.1%	3.3%	3.5%	3.4%	4.0%	3.5%								5.1%				4.5%
Delayed transfers of care (all) - Percentage of delays per Occupied bed	3.5%	5.3%	4.9%	3.9%	4.2%	4.7%	4.6%	5.3%	5.2%								6.7%				5.9%

4 hour waits A&E &MIU

NHS Devon CCG

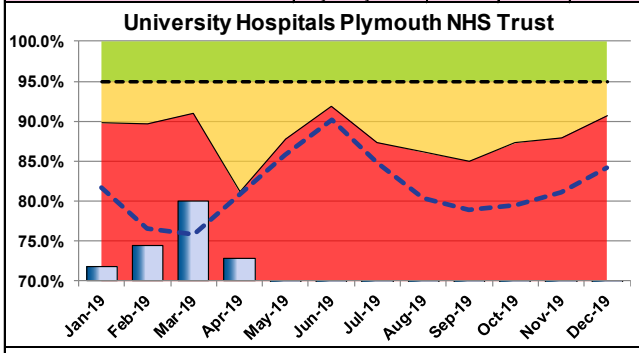
STP footprint	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>95%	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%	87.7%	85.2%	84.5%			
Trajectory		90.0%	90.0%	90.2%	84.8%	87.0%	89.5%	88.1%	89.0%	88.4%	89.6%	89.4%	90.3%
NHS England		84.4%	84.2%	86.6%	85.1%	88.0%	87.7%	87.8%	87.6%	86.8%			

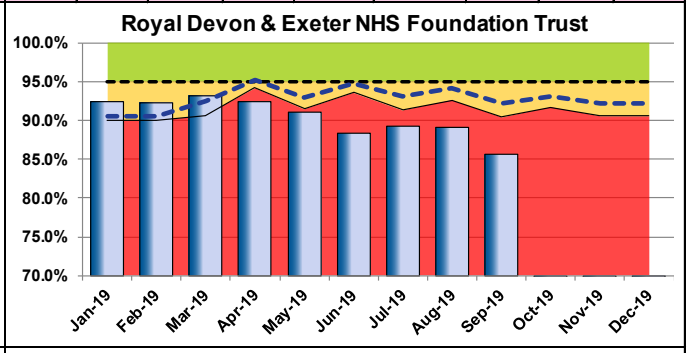


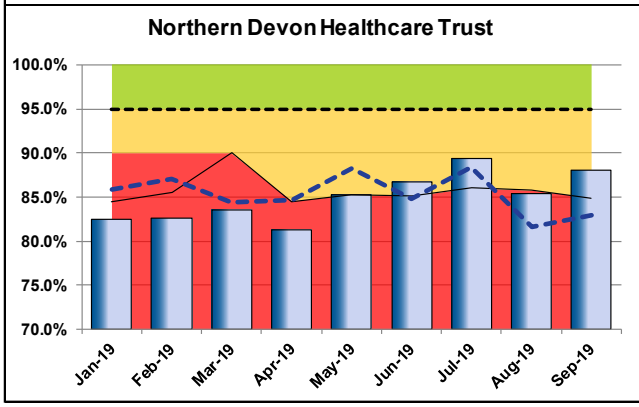
Comment:
Performance continues to be volatile against the A&E 4-hour target. In August the STP 'all types' position was 85.2%, down from 87.7% in July, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. NDHT fell to 85%, RD&E remained at 89% and TSD fell from 84% to 79%.
Provisional September data shows a similar position to August overall, although NDHT and TSD have both seen improvement whilst RD&E performance has fallen to around 85%.

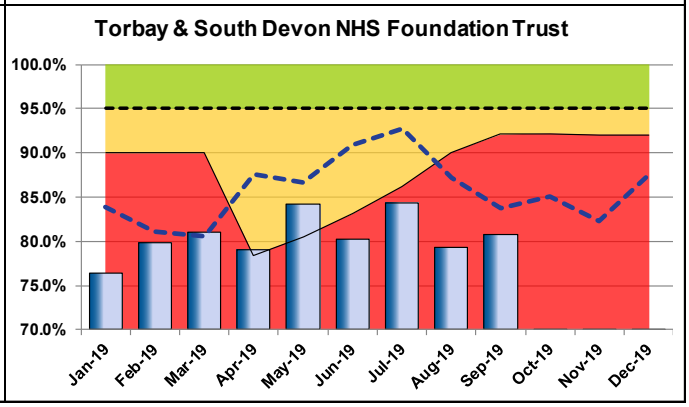
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	71.8%	74.5%	79.9%	72.8%								
	Trajectory	89.8%	89.7%	91.0%	81.1%	87.8%	91.9%	87.4%	86.1%	85.0%	87.3%	88.0%	90.7%
RDEFT	Actual	92.5%	92.2%	93.2%	92.4%	91.1%	88.3%	89.3%	89.0%	85.7%			
	Trajectory	90.0%	90.0%	90.7%	94.2%	91.5%	93.6%	91.3%	92.6%	90.4%	91.7%	90.6%	90.6%
NDHT	Actual	82.5%	82.7%	83.5%	81.3%	85.2%	86.8%	89.4%	85.4%	88.0%			
	Trajectory	84.5%	85.5%	90.1%	84.5%	85.2%	85.1%	86.0%	85.8%	84.9%	84.6%	84.4%	84.2%
TSDFT	Actual	76.4%	79.8%	81.0%	79.1%	84.2%	80.3%	84.3%	79.3%	80.7%			
	Trajectory	90.0%	90.0%	90.0%	78.4%	80.5%	83.1%	86.2%	90.1%	92.1%	92.2%	92.0%	92.0%





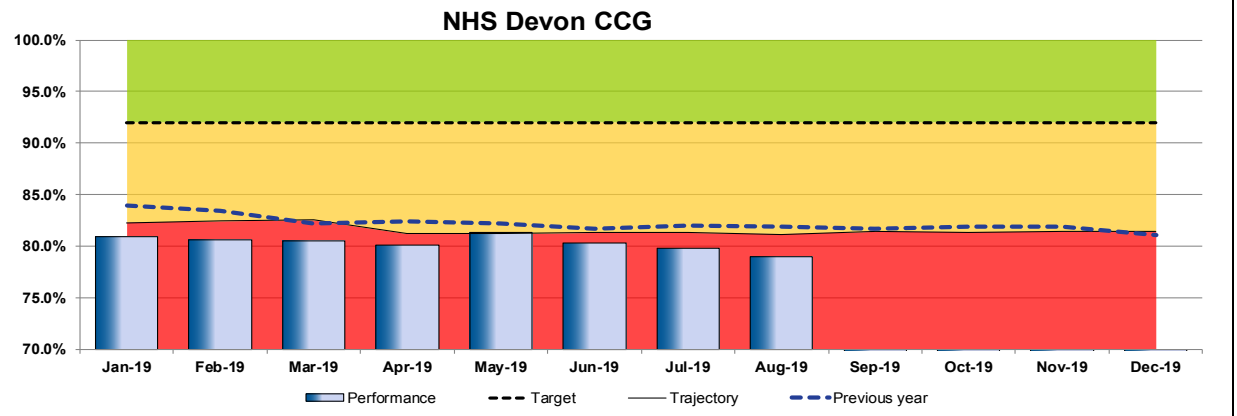




18-week RTT (incomplete pathway)

NHS Devon CCG

NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>92%	80.9%	80.6%	80.5%	80.1%	81.3%	80.4%	79.8%	79.0%				
Trajectory		82.3%	82.4%	82.5%	81.2%	81.2%	81.3%	81.3%	81.2%	81.4%	81.4%	81.4%	81.4%
NHS England		86.7%	87.0%	86.7%	86.5%	86.9%	86.3%	85.8%	85.0%				
RTT total waiting list	78,364	80,089	81,661	82,913	83,546	83,041	85,931	85,991	86,788				
Trajectory		75,616	75,353	74,733	82,086	81,536	82,603	82,054	81,730	81,454	82,036	79,922	80,442



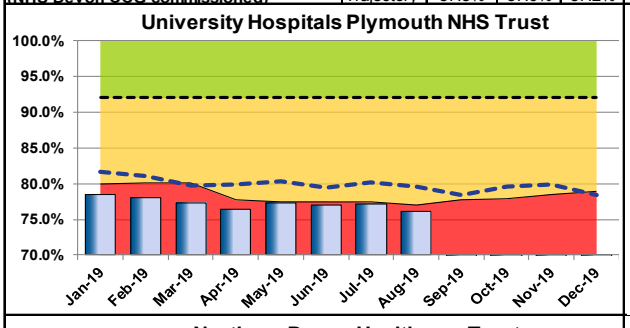
The STP level RTT position decreased further in August from 79.8% to 79.0%. Whilst NDHT saw a slight improvement from 79.2% to 80.0%, RD&E, UHP and TSD all saw performance fall. RD&E dropped from 80.7% to 79.3%, UHP from 77.2% to 76.2% and TSD from 81.1% to 80.2%. Only NDHT remain above their trajectory with RD&E now more than 3% below plan.

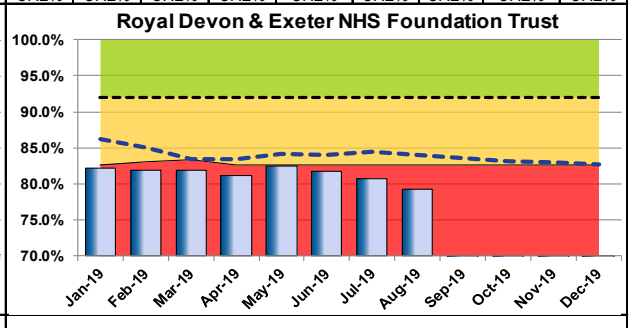
The incomplete waiting list rose by around 800 patients at RD&E and 400 at UHP, whilst both the TSD and NDHT lists were marginally higher than July. All providers remain above their respective waiting list trajectories (TSD 9%, RD&E 8%, UHP 5% and NDHT 4%), with all but NDHT underperforming against elective activity plans.

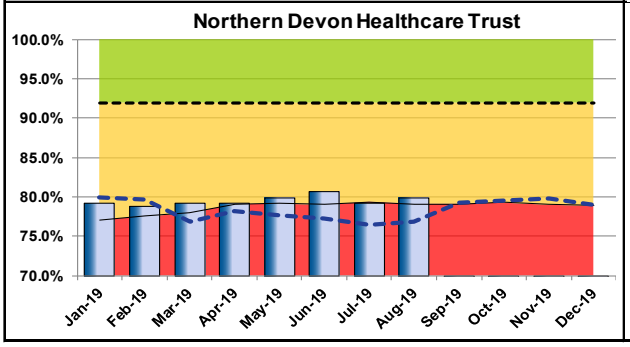
Over 52 week waits rose significantly in August, moving from 225 to 316 at STP level. All providers except NDHT saw increased breaches with TSD rising from 84 to 105, RD&E rising from 90 to 146 and UHP increasing from 86 to 111. NDHT feel from 8 to 6. Only TSD remain within their trajectory.

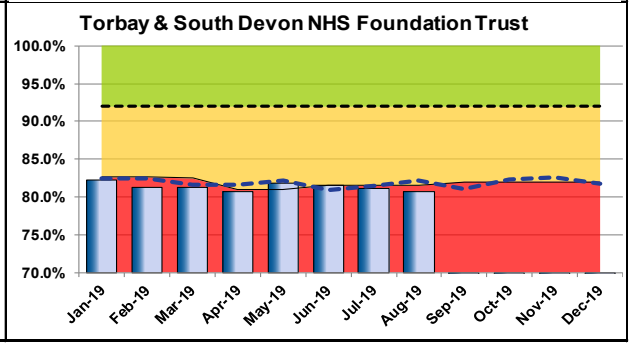
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	78.4%	78.0%	77.3%	76.4%	77.3%	77.0%	77.2%	76.2%				
	Trajectory	80.0%	80.0%	80.1%	77.7%	77.5%	77.5%	77.4%	77.0%	77.8%	77.9%	78.5%	78.9%
	Waiting list	27,356	27,872	27,922	28,195	28,611	28,899	29,702	30,115				
	Trajectory	25,772	25,725	26,347	28,351	28,476	28,496	28,533	28,730	28,354	28,277	27,927	27,703
RDEFT	Actual	82.2%	82.0%	81.9%	81.1%	82.4%	81.7%	80.7%	79.3%				
	Trajectory	82.7%	83.0%	83.3%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%
	Waiting list	33,386	33,770	34,262	33,619	35,690	36,355	35,697	36,453				
	Trajectory	30,783	30,496	30,178	34,555	33,783	34,857	34,374	33,707	33,992	35,016	33,628	34,374
NDHT	Actual	79.2%	78.9%	79.2%	79.3%	79.9%	80.7%	79.2%	79.9%				
	Trajectory	77.1%	77.6%	78.0%	79.1%	79.2%	79.1%	79.4%	79.1%	79.1%	79.3%	79.1%	78.9%
	Waiting list	11,790	11,633	11,520	11,385	11,403	11,429	11,641	11,709				
	Trajectory	13,439	13,299	13,101	11,797	11,665	11,564	11,396	11,313	11,194	11,044	10,960	10,863
TSDFT	Actual	82.2%	81.3%	81.3%	80.7%	81.9%	81.5%	81.1%	80.7%				
	Trajectory	82.7%	82.6%	82.5%	81.0%	81.0%	81.5%	81.5%	81.5%	82.0%	82.0%	82.0%	82.0%
	Waiting list	18,430	18,564	19,425	19,016	19,534	19,636	19,939	19,899				
	Trajectory	18,282	18,332	18,332	18,567	18,548	18,416	18,398	18,379	18,249	18,231	18,213	18,194
Other providers (NHS Devon CCG commissioned)	Actual	82.7%	82.2%	82.1%	81.7%	82.5%	82.0%	81.6%	0.0%				
	Trajectory	87.8%	87.9%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%	87.2%





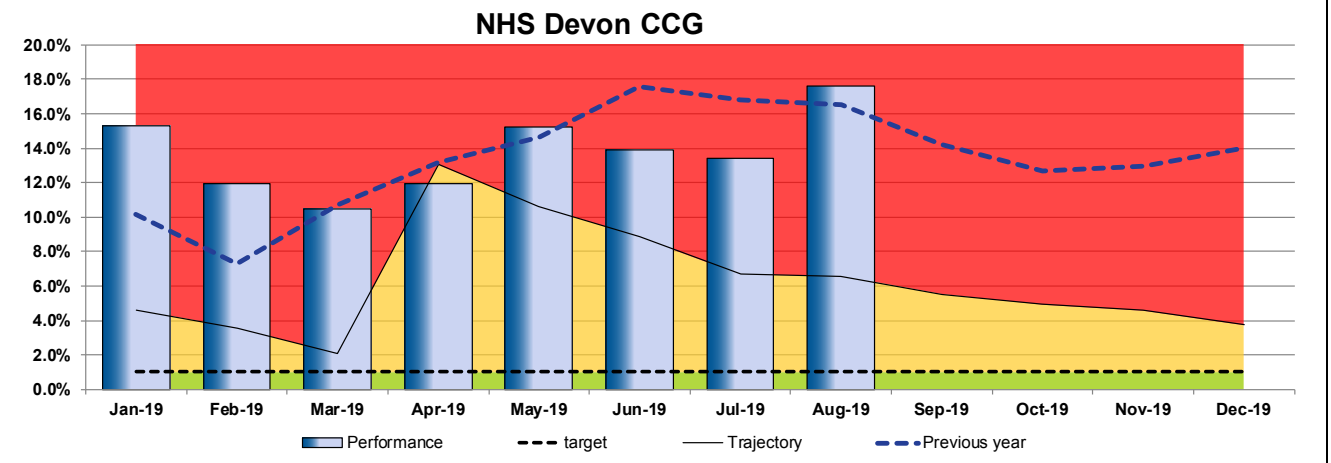




6 Week Diagnostics

NHS Devon CCG

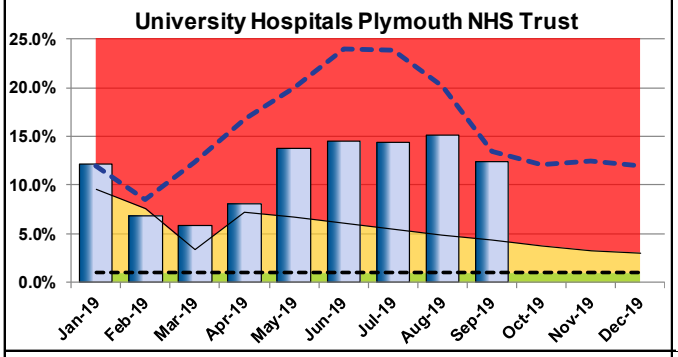
NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>1%	15.3%	11.9%	10.5%	12.0%	15.2%	13.9%	13.4%	17.6%				
Trajectory		4.6%	3.6%	2.1%	13.0%	10.6%	8.9%	6.7%	6.6%	5.5%	4.9%	4.6%	3.7%
NHS England		3.6%	2.3%	2.5%	3.6%	4.1%	3.8%	3.5%	4.3%				

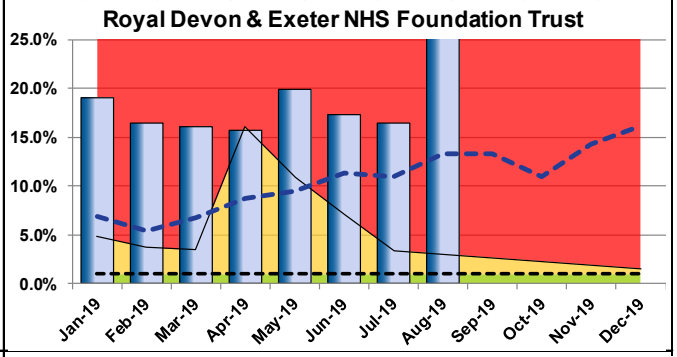


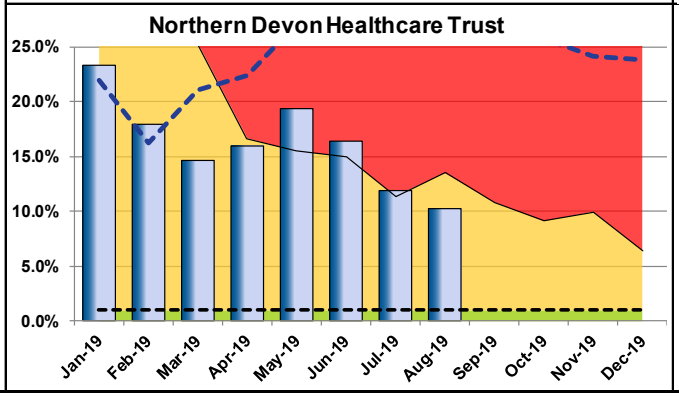
The STP position rose from 13.4% to 17.6% in August, the highest level since June 2018. There were further reductions in breaches at NDHT (moving from 11.8% to 9.6%) but small rises at both UHP (14.4% to 15.2%) and TSD (13.7% to 14.9%). However, the RD&E rate rose sharply, from 16.4% to 27.4%. RD&E, UHP and TSD are all significantly above improvement trajectories, with NDHT moving to 4% better than plan. The majority of breaches continue to be for imaging and endoscopy.

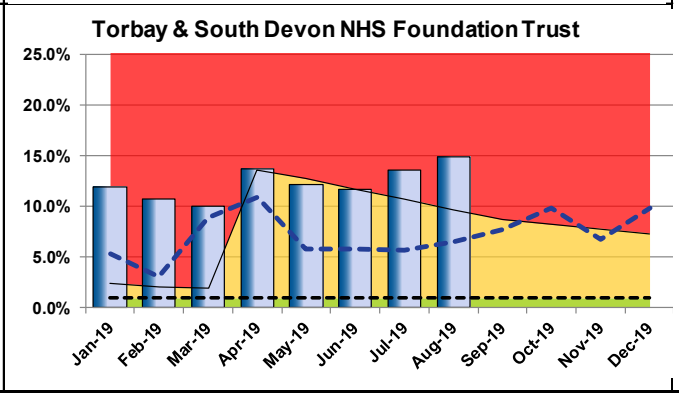
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	12.1%	6.8%	5.9%	8.1%	13.8%	14.5%	14.4%	15.2%	12.4%			
	Trajectory	9.6%	7.5%	3.4%	7.2%	6.7%	6.1%	5.4%	4.9%	4.4%	3.8%	3.3%	3.0%
RDEFT	Actual	19.1%	16.4%	16.1%	15.7%	19.9%	17.3%	16.4%	27.5%				
	Trajectory	4.9%	3.7%	3.5%	16.1%	11.0%	7.1%	3.4%	3.0%	2.7%	2.3%	1.9%	1.6%
NDHT	Actual	23.3%	17.9%	14.6%	15.9%	19.3%	16.3%	11.8%	10.2%				
	Trajectory	30.9%	28.3%	25.3%	16.6%	15.5%	15.0%	11.4%	13.5%	10.8%	9.1%	9.9%	6.4%
TSDFT	Actual	12.0%	10.7%	10.0%	13.7%	12.1%	11.7%	13.7%	14.9%				
	Trajectory	2.4%	2.1%	1.9%	13.7%	12.7%	11.8%	10.8%	9.7%	8.7%	8.3%	7.8%	7.3%
Other providers (NHS Devon CCG commissioned)	Actual	10.2%	9.1%	8.7%	11.7%	10.7%	9.8%	11.0%	12.9%				
	Trajectory												





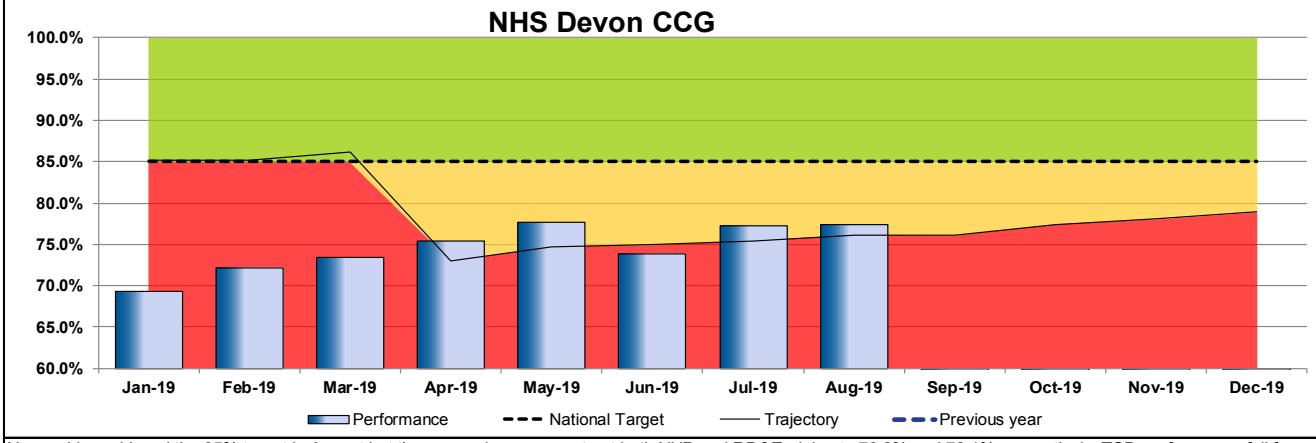




62 day standard Cancer waits

NHS Devon CCG

NHS Devon CCG	National target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	>85%	69.3%	72.1%	73.5%	75.4%	77.7%	73.9%	77.3%	77.4%				
Trajectory		85.2%	85.2%	86.1%	73.0%	74.7%	74.9%	75.4%	76.1%	76.1%	77.4%	78.1%	78.9%
NHS England		76.2%	76.1%	79.7%	79.4%	77.5%	76.7%	77.6%	78.5%				



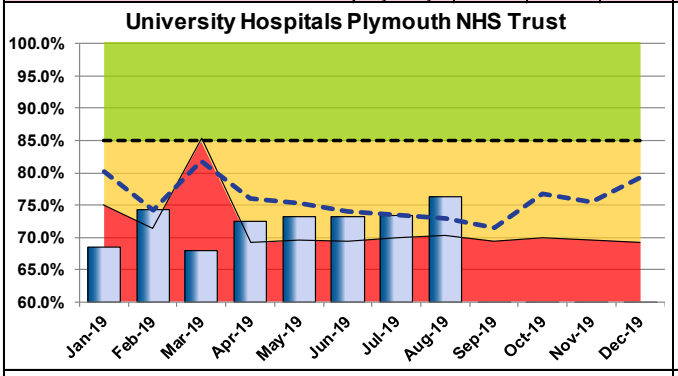
No provider achieved the 85% target in August but there were improvements at both UHP and RD&E, rising to 76.2% and 72.1% respectively. TSD performance fell from 84.0% to 78.2% and NDHT dropped from 86.3% to 83.2%. However, UHP and NDHT met their trajectory.

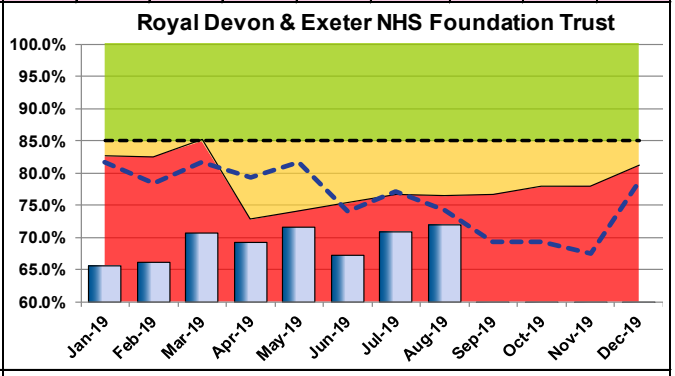
NDHT and TSD both saw a slight reduction in the backlog of over 62 day waits but there was a rise at UHP and RD&E increased from 205 to 238.

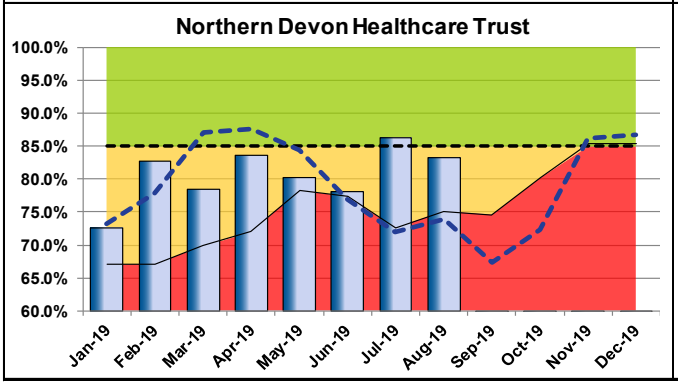
62 day standard Cancer waits……continued

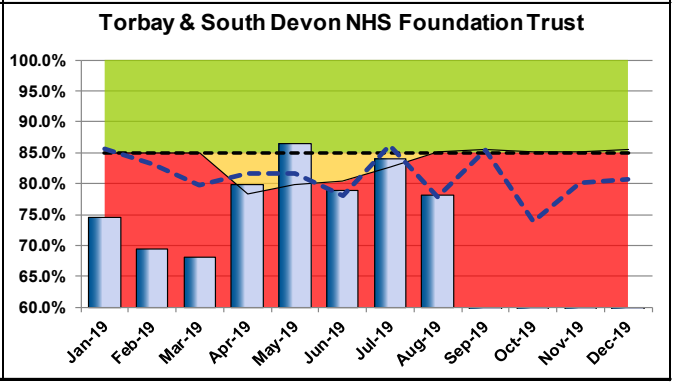
Provider level

Provider		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
UHP	Actual	68.5%	74.3%	68.0%	72.6%	73.2%	73.2%	73.4%	76.2%				
	Trajectory	75.0%	71.4%	85.4%	69.2%	69.6%	69.4%	69.9%	70.2%	69.5%	70.0%	69.7%	69.2%
RDEFT	Actual	65.7%	66.1%	70.8%	69.3%	71.6%	67.2%	70.9%	72.1%				
	Trajectory	82.7%	82.6%	85.2%	72.8%	74.2%	75.4%	76.8%	76.5%	76.7%	77.9%	78.0%	81.2%
NDHT	Actual	72.6%	82.7%	78.4%	83.6%	80.2%	78.1%	86.3%	83.2%				
	Trajectory	67.0%	67.1%	69.9%	72.0%	78.3%	77.3%	72.6%	75.1%	74.6%	80.2%	85.4%	85.3%
TSDFT	Actual	74.5%	69.4%	68.0%	79.9%	86.5%	78.8%	84.0%	78.2%				
	Trajectory	85.0%	85.0%	85.0%	78.3%	79.8%	80.4%	82.8%	85.1%	85.5%	85.1%	85.1%	85.5%









GOVERNING BODY

Report title: EPRR Core Standards of Assurance rating for NHS Devon CCG, and its Devon Providers					
Date of committee: 31 October 2019 **Date report produced: 17 October 2017**					
Author (s) Name and Title: Clare Doble, Head of Governance **Contact Details:** clare.doble@nhs.net			**Supporting Executive:** **Name and Title:** Dr Sonja Manton, Accountable Emergency Officer/Director of Commissioning **Contact Details: sonja.manton@nhs.net** **Report Approved by:** **Name and Title:** As above **Date October 2019**		
Public or Private (Governing Body only):			**Public**	✓	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**	✓	**Information**
Does this report place individuals at the centre?			**Yes**	✓	**No**

Executive Summary:

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

The assurance process grades organisations' preparedness in relation to Emergency Planning and response. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport incident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services, and where possible business as usual.

This report outlines NHS Devon CCG's assurance and that of its providers, and requests that the Governing Body notes the position and approves the submission to NHS England in readiness for the deadline of November 2019.

NHS organisations involved:
Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group

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

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

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

Key recommendations and actions requested:

1.1 NHS Devon CCG Governing Body is asked to receive and approve the position statement of its Emergency Preparedness Resilience and Response (EPRR) compliance with the 2019/20 Core standards of assurance.

1.2 The Governing Body are also asked to receive the assurance ratings of our provider organisations having regard that these outcomes have been presented to each providers Board.

Reference to other documents or accompanying papers:

None

Have the legal implications been considered?

Yes

Equality Impact Assessment:

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

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

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

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

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

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

EPRR Core Standards of Assurance rating for NHS Devon Clinical Commissioning Group, and our Devon Providers

1. Introduction

1.1 NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet.

1.2 The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met. The assurance process grades organisations' preparedness in relation to Emergency Planning and response. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport incident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services, and where possible business as usual.

1.3 This report outlines NHS Devon CCG's assurance and that of its providers, and requests that the Governing Body notes the position and approves the submission to NHS England in readiness for the deadline of November 2019.

Compliance Level	Evaluation & Testing Conclusion	Totals
FULL	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The board has agreed with this position statement.	Addresses **all** core standards
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the board has agreed.	Does not appropriately address **one to five** core standards
Partial	Arrangements are in place however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the board has agreed.	Does not appropriately address **six to ten** core standards
Non – Compliant	Arrangements are in place however they do not appropriately address eleven or more of the core standards that the organisation is expected to achieve. A work plan has been agreed by the board and will be monitored on a quarterly basis in order to demonstrate future compliance.	Does not appropriately address **eleven or more** core standards

2. Content

2.1 As part of the national EPRR assurance process for 2019/20, NHS Devon Clinical Commissioning Group are required to assess themselves against the NHSE core standards of Assurance requirements and to provide evidence to support the position stated. NHS Devon CCG has met with NHS England and undertaken the required desktop assessments.

The outcome of the self-assessment for NHS Devon CCG has rated us as **Fully Compliant** against all 43 of the core standards which are applicable to the organisation.

As part of the Assurance process 2019/20 the deep dive this year focused on Severe Weather. **Please Note:** The Deep Dive does not contribute towards the organisation's level of compliance with the NHS England Core Standards for EPRR. This year's snapshot includes five questions on Long-term Adaption Planning for climate change, which have been included at the request of, and on behalf of, the Environmental Audit Select Committee of the House of Commons.

NHS Devon CCG		**FULL COMPLIANCE**		
2019/20 *Assurance*	***Fully compliant***	Red	Amber	Green
Core standards	43	0	0	43
Severe weather deep dive	19	0	4	15
Actions:	To be achieved by April 2020, these included: **Core Standard 28** – Training and exercising. It was noted during the meeting that there was a gap in local Strategic Leadership in a Crisis Training for the executive levels. This has been addressed, with training delivered on 14th October. However, 2 of the executive team are left outstanding and these will be planned in to training locally. **Core Standard 32** – Management of Business Continuity Incidents. It is accepted that there is an ongoing refresh of BCP and action cards, which will link to Core Standard 52 for the training and exercising of BCP Leads and the revised plan. This is included in the EPRR work plan and will be reviewed when the newly appointed EPRR lead takes up post. **Core Standard 52** – Business Continuity. Whilst the comments under Core standard 32 are noted and accepted the plan has not been jointly exercised and therefore full validation of the plan has not occurred. I am assured that this will be planned in over the coming months and will be delivered by April 2020. **Deep dive:** In response to the 2019/20 deep dive for severe weather and long-term climate adaptation, NHS Devon CCG: • Are fully compliant with all 14 of the Severe Weather standards; • One standard is not applicable; and			

	• Are fully compliant with 1 of the 5 standards on 'long term adaption planning'. • It is acknowledged that the other 4 standards which are recorded as being 'partially' compliant will be addressed with the appointment of the CCGs Corporate Estates manager later this year.
Recommendations:	None noted

A full description of the core EPRR standards can be found at: http://www.england.nhs.uk/ourwork/eprr/

3. Provider Assurance

3.1 As a commissioning organisation we are also responsible for assuring ourselves and NHS England as to the EPRR core standards of assurance for our provider organisations. We have undertaken this process jointly with NHSE and our providers over the last 12 months and the provider assurances for 2019/20 are set out below:

Devon Doctors			**SUBSTANTIAL COMPLIANCE**	
2019/20 Assurance Substantially Compliant		Red	Amber	Green
Core standards	46/69	0	2	44
Severe weather deep dive	20	3	0	17
Action:	None noted			
Recommendations:	**Core Standard 15 – Pandemic Influenza – Partially compliant.** The Pandemic Flu Plan is based around the old UK Alert levels and is not aligned to the UK Pandemic influenza Strategy 2011; it is recommended that the plan be revised to incorporate the principles and phases set out in the UK Strategy. **Core Standard 22 – Protected Individuals – Partially compliant.** It is recommended that an additional process/ SOP be put in place to guide how a patient with a high public profile would have their privacy protected by the organisation.			

Devon Partnership Foundation Trust			**SUBSTANTIAL COMPLIANCE**	
2019/20 Assurance Substantially Compliant		Red	Amber	Green
Core standards	54/69	0	3	51
Severe weather deep dive	20	3	0	17
Recommendations:	**Core Standard 20 – Shelter and Evacuation – Partially Compliant**. While accepting that there are fire evacuation plans in place for each building, and plans for invacuation within sites, the Draft policy needs to better reflect the Mental Health			

	clinical requirements regarding an evacuation and there is a gap around full site evacuation. **Core Standard 32 – Business Continuity – Partially Compliant**. The Trust's assessment of Partially Compliant was accepted in acknowledgement of the work ongoing across the Trust to revised and expand Business Continuity Planning and preparedness. **Core Standard 50 – Data Protection and Security Toolkit – Partially Compliant**. The Trust's compliance with the DP&S Toolkit is registered on www.dsptoolkit.nhs.uk as *'Standards not fully met (Plan Agreed)'*.

First Care Ambulance			**SUBSTANTIAL COMPLIANCE**	
2019/20 Assurance Substantially Compliant		Red	Amber	Green
Core standards	41/69	0	1	42
Severe weather deep dive	20	5	0	15
Action:	No actions noted			
Recommendations:	**Core Standard 15 – Pandemic Influenza – Partially Compliant**. While the company's Business Continuity Plan does provide for actions relevant to a Pandemic response, further work is required and the following recommendations are made: a. That the company's plans incorporate actions to be taken in relation to the different pandemic phases set out in the UK Pandemic Influenza Strategy 2011 (i.e. the DATER phases); b. That the company incorporate sufficient information with regards to how a Pandemic Influenza multi-agency and NHS response will be co-ordinated, so as to ensure that the Company's senior leadership is informed and can co-operate effectively with the wider NHS response.			

Livewell Southwest			**SUBSTANTIAL COMPLIANCE**	
2019/20 Assurance Substantially Compliant		Red	Amber	Green
Core standards	54	0	3	51
Severe weather deep dive	20	3	0	17
Actions :	None noted			
Recommendations:	**Core Standard 17 – Mass Countermeasures – Partially Compliant**. Evidence supporting mass countermeasure not in place but is planned. **Core Standard 23 – Excess Death Planning – Partially Compliant**. Evidence of how inpatients will manage deaths during an excess death event not in place but is planned.			

	Core Standard 55 – Assurance of Commissioned Services/ Suppliers BCPs – Partially Compliant. While there is evidence that some work has been undertaken, it is not sufficient to provide the necessary assurance.

North Devon Healthcare Trust			**SUBSTANTIAL COMPLIANCE**	
2019/20 Assurance Substantially Compliant		Red	Amber	Green
Core standards	64/69	0	4	60
Severe weather deep dive	20	3	0	17
Action:	None Noted			
Recommendations:	**Core Standard 7 – Risk Assessment – Partially Compliant**. The Trust risk register has Pandemic Influenza as a 'rare' risk – this is not in line with the National Risk Register (NRR) or the local Community Risk Register (CRR); Pandemic Influenza is the highest risk on these risk registers. It appears that how EPRR risks are assessed does not appropriately reflect the timescales and likelihood of the risk occurring, with regards to the assessments provided in the NRR & CRR. **Core Standard 15 – Pandemic Influenza – Partially Compliant**. Self-assessment rating agreed. It is also recommended that: a. the plan identifies the roles of those within the Trust who should attend the Influenza Pandemic Group; b. explicitly link the Trust's response to the wider pandemic response, via the TCG, as set out in the LHRP & LRF Pandemic Influenza Framework; c. give some consideration as to how the death of staff will be handled during a pandemic response. **Core Standard 20 – Shelter and evacuation – Partially Compliant**. The plan that the Trust is depending upon requires a significant piece of work to reach compliance. It is recommended that a full evacuation plan is put in place, including guidance for the Trust's on-call staff, ICC and ward staff. **Core Standard 50 – Data Protection and Security Toolkit – Partially Compliant**. The Trust's compliance with the DP&S Toolkit is registered on www.dsptoolkit.nhs.uk as *'Standards not fully met (Plan Agreed)'*.			

Plymouth Hospital Trust			**SUBSTANTIAL COMPLIANCE**	
2019/20 Assurance Substantially Compliant		Red	Amber	Green
Core standards	64/69	0	4	60
Severe weather Deep dive	20	4	0	16
Action:	No actions noted			

Recommendations:	**Core Standard 5 – EPRR Resource – Partially Compliant**. Self-assessment rating accepted. The EPLO has other responsibilities which impact upon their ability to fulfil the role effectively. At this time there are provisional plans in place to provide support to them in delivering their workload. **Core Standard 28 – Strategic and Tactical responder Training – Partially Compliant**. Self-assessment rating accepted. The current training records are manually held and do not offer a clear overview of the training completed and required for key staff. Provisional plans to provide support for the EPLO offer an opportunity to collate these records in a more useful centralised format. **Core Standard 51 – Business Continuity Plans – Partially Compliant**. The Trust's assessment of Partially Compliant is accepted. It is acknowledged that there is work ongoing across the Trust to bring service level Business Continuity Planning and preparedness up to date. The current programme of work is scheduled for completion by June 2020. **Core Standard 55 – Assurance of commissioned providers/ suppliers BCPs – Partially Compliant**. The assurance rating for this standard is an acknowledgement that work is ongoing but there are some issues around assurances from suppliers/ contractors.

Royal Devon & Exeter			**SUBSTANTIAL COMPLIANCE**	
2019/20 Assurance Substantially Compliant		Red	Amber	Green
Core standards	64/69	0	2	62
Severe Weather deep dive	20	0	0	20
Actions:	None noted			
Recommendation :	**Core Standard 25 – Trained On-call Staff – Partially Compliant**. The numbers of On-call Directors who are current on Strategic Leadership training are not sufficient to meet the standard. A plan is in place to remedy this situation. **Core Standard 50 – Data Protection and Security Toolkit – Partially Compliant**. The Trust's compliance with the DP&S Toolkit is registered on www.dsptoolkit.nhs.uk as *'Standards not fully met (Plan Agreed)'*.			

Torbay and South Devon Foundation Trust			**SUBSTANTIAL COMPLIANCE**	
2019/20 Assurance Substantially Compliant		Red	Amber	Green
Core standards	64	0	3	61
Severe weather Deep dive	20	5	0	15
Action:	None noted			

Recommendations:	**Core Standard 50 – Data Protection and Security Toolkit – Partially Compliant**. The Trust's compliance with the DP&S Toolkit is registered on www.dsptoolkit.nhs.uk as *'Standards not fully met (Plan Agreed)'*. **Core Standard 51 – Business Continuity Plans – Partially Compliant**. The Trust's assessment of Partially Compliant is accepted. The level of Service-level Business Continuity Plans completed is a concern as the Trust is a mature organisation and we would expect to see a higher proportion of these plans in place (evidence indicates that only 65% Community and 57% Acute services have a BCP in place). Action Required: The Trust is asked to provide an Action Plan to the CCG outlining how this will be remedied and by when. **Core Standard 59 – Decontamination capability/ availability 24/7 – Partially Compliant**. The Trust's self-assessment compliance rating is accepted. The system used by the Trust to provide CBRN decontamination capability is on a voluntary basis, rather than a duty roster; however, it is noted that regular availability checks are being undertaken to monitor volunteer availability.

South West Ambulance Foundation Trust		**FULL COMPLIANCE**		
At the time of submission of this report to Governing Body, Dorset CCG the Lead commissioner for SWAfT have provided the assurance rating in Draft and will be providing a copy of the full report to NHS Devon CCG in November 2019.				
2019/20 Assurance Fully compliant		Red	Amber	Green
Core standards	49	0	0	49
Severe weather deep dive	15	0	0	15
Long term adaption planning	5	0	0	5
Ambulance Resilience	15	0	4	11

4. Recommendations

4.1 NHS Devon CCG Governing Body is asked to receive and approve the position statement of its Emergency Preparedness Resilience and Response (EPRR) compliance with the 2019/20 Core standards of assurance.

4.2 The Governing Body are also asked to receive the assurance ratings of our provider organisations having regard that these outcomes have been presented to each providers Board.

Report author and job title: Clare Doble, Head of Governance

Executive Lead: Sonja Manton

Job Title: Accountable Emergency Officer

21st October 2019

Sonja Manton
Director of Strategy
NHS Devon CCG
County Hall
Exeter
EX2 4QL

Director of Performance
NHS England and NHS Improvement South West
South West House
Blackbrook Park Avenue
Taunton
TA1 2PX

Dear Sonja

EPRR statement of compliance

In July 2019 NHS England and NHS Improvement published the NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet.

As part of the national EPRR assurance process for 2019/20, NHS Devon CCG has been required to assess themselves against these core standards.

Thank you to your team for joining the EPRR assurance review meeting on 1st October 2019 to discuss your assurance and compliance against the NHS England Core Standards for EPRR. I can confirm that following the meeting that the outcome of our assessment confirms the position NHS Devon CCG:

- will become fully compliant with all core standards by April 20.

Therefore, based on the table in tab one of the Core Standards Self-Assessment (shown at annex A), NHS Devon CCG is given an overall compliance rating of **fully compliant** with the core stands.

In response to the 2019/20 deep dive for severe weather and long-term climate adaptation, NHS Devon CCG:

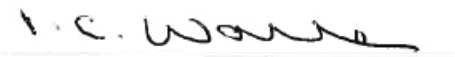
- Are fully compliant with all 14 of the Severe Weather standards;
- One standard is not applicable; and
- Are fully compliant with 1 of the 5 standards on 'long term adaption planning'.
- It is acknowledged that the other 4 standards which you are recorded as being 'partially' compliant will be addressed with the appointment of your Corporate Estates manager later this year.

As the Deep dive statements do not contribute to the organisation's overall EPRR assurance rating, they are reported on separately and do not affect your overall rating.

Your fully compliant rating will be reported on to the LHRP in November and barring any changes at that meeting will be presented at the NHS England and NHS Improvement Regional EPRR confirm and challenge meeting in December before being subsequently reported to the National NHS Board in early 2020.

We have provided a summary of the meeting findings for your information and can I take this opportunity to thank you and the team for your continued support in the delivery of this important agenda.

Yours sincerely,



Iain Wallen
Director of Performance
NHS England and NHS Improvement South West

EPRR Assurance 2019 Outcome – 1st October 2019

Organisation: NHS Devon CCG

Accountable Emergency Officer: Sonja Manton

Present at the assurance meeting:

Neil Vine – Head of EPRR NHS England and NHS Improvement South West
Clare Doble - Head of Governance and EPRR Lead NHS Devon CCG

Outcome Summary Tables

Core Standards 1 – 69 of which 43 apply to the CCG

Organisation	Red	Amber	Green	Total	Overall Rating
Devon CCG	0	0	43	43	**Fully compliant**

Notes

Core Standard 28 – Training and exercising. It was noted during the meeting that there was a gap in local Strategic Leadership in a Crisis Training for the executive levels. This has been addressed, with training delivered on 14th Oct. However, 2 of the executive team are left outstanding and these will be planned in to training locally.

Core Standard 32 – Management of Business Continuity Incidents. It is accepted that there is an ongoing refresh of BCP and action cards, which will link to Core Standard 52 for the training and exercising of BCP Leads and the revised plan. This is included in the EPRR work plan and will be reviewed when the newly appointed EPRR lead takes up post.

Core Standard 52 – Business Continuity. Whilst the comments under Core standard 32 are noted and accepted the plan has not been jointly exercised and therefore full validation of the plan has not occurred. I am assured that this will be planned in over the coming months and will be delivered by April 2020.

Severe Weather and long-term climate adaption Deep Dive

Organisation	Red	Amber	Green	NA	Total
NHS Devon CCG	0	4	15	1	20

Notes

There are currently 20 standards that are used to complete the deep dive assurance. It is accepted that the CCG will only be assessed against 19 of these standards.

- Standard 5 – Discharge - we acknowledge that this standard does not directly apply to the CCG in this instance. However, it was jointly accepted that they do have a role in supporting the provider organisations in meeting this standard.
- Standard 17 – Overheating Risk
  18 – Building Adaptions
  19 – Flooding
  20 – New build

Whilst all of these standards have been considered the CCG remains only partially compliant. I am assured that they are included in the work plan going forward and will be further addressed on the appointment of a Corporate Facilities Manager later in this finical year.

Annex A

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 31 October 2019

Dates of Committees covered in this report: 17 October 2019

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

Chair's Name and Title: David Greenwell, Southern Locality Clinical Lead

Contact Details: david.greenwell@nhs.net

Reports discussed and assurances received

- **Risk Register report**
- **Devon CCG Monthly Finance report**
- **GB Quality & Performance report**
- **STP Monthly Finance report**
- **Financial improvement plan**
- **Long term financial plan**
- **Development of capitated budgets and equity update**
- **Commissioning Service Risks and Issues**
- **Single action Wavers**
- **Procurement Register for approval**

Reports received and noted

- **Risk Register report**
- **Devon CCG Monthly Finance report**
- **GB Quality & Performance report**
- **STP Monthly Finance report**
- **Commissioning Service Risks and Issues**
- **Long term financial plan**

Risk Register Review (changes and areas of concern)

- **No changes**

Committee Decisions

• **DELT Financial performance and accounts 18/19 approved** • **Procurement Register Approved (John Dowell to sign off)**
Recommendations for Governing Body
The Finance committee would like to propose the use of a development session to discuss equity of clinical outcomes and use of resources.
Recommendations for other Committees
•
Terms of Reference or other committee effectiveness issues
•

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 31st October 2019

Dates of Committees covered in this report: 3rd October plus ratified minutes from 5th September

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

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Reports discussed and assurances received:

Members of the Committee discussed the following reports:

Finance Report

Finance report for month 5 was presented to Committee.

Digital E-consult Update

Committee members received an update from Jim Goodwin and Sian Bunce on e-consult and GP Connect. Further updates to be provided at the Primary Care Committee meeting in January.

Pharmacy Update

Committee members received an update from Jo Watson on Pharmacy Developments and Updates. Members heard that there are recruitment plans in place for pharmacists. The POD is working well, and all members were supportive of this. Contact has been made with HEE with regards to a School of Pharmacy for the South West Region.

Reports received and noted:

Members of the Committee received the following reports for noting:

Primary Care Highlight Delivery Status

Members reviewed the Primary Care Highlight report. Members discussed the Workforce Programme delivery date which has been pushed back to December 2020 from April 2019.

Locality Flash Reports

Members noted the locality flash reports. It was noted that all Locality Flash reports are RAG rated.

LMC Negotiations

Members reviewed and noted the LMC Negotiations report.

Terms of Reference – PCC and PCOG

PCOG Terms of Reference – changes were agreed by members of the committee. PCC Terms of Reference – further clarification isrequired

Contracting Report

Paul Baker presented the contracting report. Two CQC reports have been received this month with reported a rating of good.

CQC Report –

A request was made for further information on Quality to be included within CQC report, this will be included from the November report as planned.

Primary Care Strategy

A workshop took place 3 weeks ago, engagement has been extended through to November in order to capture it effectively.

Risk Register Review (changes and areas of concern)
The Risk Register was reviewed by members. No new risks and no proposed movement, closures or new risks this month**.**
Committee Decisions
The Committee endorsed decisions made at Primary Care Operational Group.
Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
None

Management of Conflict of interests:

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Locality Update Reports				
Date of committee: 31 October 2019 **Date report produced: 23 October 2019**				
Author (s) Name and Title: **Locality Triumvirates**		**Supporting Executive:** **Name and Title: Dr Paul Johnson, Chair** **Contact Details:**		
		Report Approved by: **Name and Title:** Locality Triumvirates **Date 23 October 2019**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Western and Southern Devon Localities.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				

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

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

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

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

NHS
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Clinical Commissioning Group

Locality update report

Locality:	Northern
Period covered by update:	August - October 2019
Locality clinical representative:	John Womersley
Locality executive lead:	Andrew Millward
Locality non-executive representative:	Charlotte Burrows

Key achievements/progress

- The Northern Devon
- **One Northern Devon** was successful in being offered a place for a team to attend the **Spread Academy** on Personalised Care that was supported by the South West Academic Health Science Network. They took the opportunity to work on the advancement of their **High Intensity Users** programme and to link with other partners working to address the unmet needs of this group. It is expected that this initiative will reduce repeated presentations to single or multiple partners and more importantly improve the quality of life for those affected through having meaningful conversations and addressing what really matters to them.
- The Locality recently held a **Primary Care Development Day**. The Northern Devon Dementia Pilot team talked with local GPs and the presentation of cases was well received. Local practices heard how designated Dementia Support Workers have helped patients and carers. Other topics covered included the Farming Community Network, UTI prevention and management in the elderly, an Obstetric and Gynae service update, an update from Devon Carers and finally End of Life Care.
- **Northern Primary Care Estate Investment Workshop** was held at Crown Yealm House and was part of the CCGs review of future funding opportunities and the need to produce a Devon STP primary care capital investment plan.

- **Northern GP Collaborative Board** met on 1st of October and discussed a range of topics **.** The four Primary Care Networks (PCN) are working with the CCG and other local providers to explore what services beyond traditional General Practice could be delivered by PCNs.

- There remains a strong focus on **performance**, with the OPEL status of NDHT continuing to show more stability than most other providers. Overall the Trust has performed well against the agreed trajectories in the latest August data, with significant improvements being demonstrated in Diagnostics and Cancer 62 day pathways. Cancer targets in general are being met, with good performance also evident in A&E performance, acute Delayed Transfers of Care and Dementia diagnostic rates. In addition, inpatient activity remains on plan, with day case exceeding plan. It is also noteworthy that **GP routine referrals** are currently running at **1.2% above last year**.

- The locality has recently appointed two new **Strategic Clinical Advisers,** and this take the locality total up to four. We are pleased to welcome Dr Maria Mastrantonio and Dr Kay Brennan to our team. These Clinical Advisers, along with PCN Clinical Directors, will be pivotal to providing continued General Practice input to the redesign of local Health and Social Care services as we look to meet the significant present and predicted delivery challenges.

- The **Holsworthy Community Involvement Group** continues to meet regularly and are now preparing a proposal document based on what local people have said about their service needs. They expect to publish their recommendations in the near future. The highlighted needs as identified from the quantitative and qualitative surveys are:-
  Loneliness and Isolation
  Travel and Transport
  Services in the Home
  Young People
  Carers
  End of Life Care
  Healthier Lifestyles
  Hospital in Holsworthy

Key priorities for the next three months

- Our use of **Winter Monies** has been agreed through the **Northern A&E Delivery Board**. Our schemes will be 1)Winter Emergency Cover Team. 2) Extended ED GP Service 18:00 to 22:00. 3) Proactive Care Home Visiting Service. 4)Community GP (Urgent Visiting). 5) Acute Flow Portering Support. This success has only been achieved at such pace because of the fantastic collaboration between CCG, PCNs & NDHT to make this happen so quickly. PCN support to the A&E Board is critical to its success.
  Last winter we implemented a very successful Paramedic Visiting Service but the decision has been taken to move this into a 12 months of the year service delivered through the PCN delivery systems.

- Along with our Northern A&E Delivery Board we also have our Northern **Planned Care Group** and the Northern **Integrated Care Model Group** and together these groups are the engine room of delivery in the locality. They are all multi-provider groups. The final locality delivery group we have established is our **One Northern Devon Communities Group** that is overseen by the One Northern Devon Board but is purposed to deliver self-reliant, resilient communities.

- The ICM Group is working to ratify the Northern Devon **Integrated Care Model** work plan and working on the key priorities: risk stratification and population health management, multi-disciplinary working to review the opportunity to mirror the outcomes achieved by the Southern locality Coastal locality, including joint working with the voluntary sector and working with care homes and the care provider market.

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

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

Issues of concern or risk

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

- Workforce challenges remain a significant risk to delivering safe, effective care as are the additional challenges presented by our remoteness from other acute care units.

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

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

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

- Sustainability of investment in diabetes transformation beyond 2019/2020

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

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

- **NHS Devon CCG** replied to the letter from Save Our Hospital Services (SOHS) to the North Devon Journal relating to, amongst other issues, our local services. The **SOHS** letter did not provide a complete picture of the issues facing the health and care system in Devon, and the CCG reply took the opportunity to clarify some of the information reported. It was stated that the NHS in Devon has a strong track record in effectively engaging with communities across the County and that we would welcome continued dialogue with SOHS as an alternative to exchanges through the media.

  In particular, the CCG reply commented on Performance, workforce and Financial challenges and added that there is a concern that inaccurate

information could impact on the ability of the NHS in Devon to attracting key workers to the County. The reply made clear that the starting point for the recent review of clinical services at NDDH was that North Devon requires a 24/7 emergency department and reiterated that the cornerstone of the Peninsula Clinical Services Strategy is to continue to provide core local emergency and urgent care service services and maternity services in all of Devon's four acute hospitals. Finally, the CCG took the opportunity to confirm that engagement to inform people of developing proposals will continue through various means, and the public will be provided with formal opportunities for comment through consultation as elements of the Long Term Plan are implemented.

Support required from CCG/system or barriers to progress

- Many in Northern Devon are keen for there to be greater clarity around the function of a Devon Wide Integrated Care System and the governance structures that will support this. There is a strong desire to further explore the benefits of integration at our local level and this would be easier with better established lines of responsibility.

NHS
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Locality update report

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

Key achievements/progress

Integrated care.

There is a further meeting of the Eastern Locality delivery group (ELDG) planned on 6/11//19.
It's anticipated to support the latter half of the November Eastern GP collaborative board meeting to try to enable as many GP PCN clinical directors to be in attendance to discuss Eastern winter planning and winter pressures funding allocations.
3 bids had been received for winter planning funding allocations from primary care networks this year and these have been supported to various degrees by the Eastern A+E board. The bids were largely developed collaboratively by PCN's working with their cluster service managers, however there was learning that more joined up planning at an earlier stage next year could be better enabled and proactively supported.

On the afternoon of the 6th, Primary care network directors will be enabled to meet both clinical and managerial leads from the acute and community services and there are later to be a number of commissioning presentations, which will be facilitated by clinical commissioning.

Moving forwards It's hoped to enable clinical director leads not only to be provided with datasets and a dashboard of both performance and service provision by PCN, but also to develop a greater understanding of PCN maturity scales and where commissioning can contribute both managerial and likely financially to support the improvement of these quality and performance indicators. We shall be working in partnership with primary care commissioning regarding this process.

Community leaders this time will not be invited along to this meeting, however its now planned to host a “conference” event for clinical directors and a number of community forums and groups across the locality going into the new year. This will hopefully be a timely intervention facilitating opportunities for network directors to meet with their neighbourhood community leaders just before the 5 new PCN specifications come “on line” on 1/4/20.

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We are currently continuing to review the attendees to be invited to this development group & we’ll propose to work with & in partnership with the Eastern collaborative board chair to try to ensure most productive use of limited clinical directors time schedules

Digital

The 3 GP member forums met again jointly on 18th September to discuss the digital opportunities and challenges for the locality in both primary and secondary care.
The meeting was well attended and presentations were heard regarding, “e” consult, digital first primary care, EPIC, (my care and my chart) & digitalisation of Lloyd George records.

The afternoon was well received and the proposed electronic patient record (EPR) EPIC software, planned to be installed in June 2020, initiated much debate and interest. The acute provider is confident this solution is both the best available worldwide, essential to be implemented, and that savings which will be made through it’s implementation will ensure its ultimate affordability. Considerable process management is already underway within the acute and community elements of the secondary care sector and significant learning and support is being sourced from other acute providers outside of Devon who have undergone the same IT infrastructure implementation.
A lot of assurance was provided to primary care attendees regarding how the new software would ease patient flow, information and workload, and the meeting thoroughly appreciated the transparency and clarity of direction, which was described during the afternoon. LMC representatives were also present at the meeting and were reassuringly unchallenging.

Winter planning

The eastern system continues planning for winter 19/20 through the A+E board. The eastern winter pressures monies have been identified and bids sought for ideas and projects to support admission avoidance, where clinically appropriate, and earlier facilitation of hospital discharge. Bids have been received from primary care network directors and consideration has been given to these proposals. Additional primary care clinically directed opportunities to manage non elective demand over the winter months is going to be supported and will no doubt be evaluated in 19/20 and up-scaled in 20/21 if effective.

The locality has, as usual, a broad catalogue of interventions, which are targeted to manage winter pressure demand, and conversations are being had with elements of primary care provision and commissioning regarding how perhaps extended access provision in primary care could be mobilised in parts of the locality to additionally manage demand at predicted peak days and weeks. These will be further debated at the ELDG (above) on 6/11/19

Primary care

Discussions (as above) are being had with some parts of primary care regarding how we might mobilise provision through extended access to help to manage winter demand on predicted peak winter days 19/20.
Conversations being led by Eastern A+E delivery board and primary care commissioning

Key priorities for the next three months

To further ratify the ICM work plan and working on the key priorities: risk stratification and population health management, multi-disciplinary working to seize & mirror the opportunity & the outcomes achieved by the Southern Coastal locality with Eastern primary care networks and community providers, voluntary sector and working with care homes and the care provider market.

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

To further consider the need for additional clinical advisory support in the locality following decision to “pause” the clinical service review conversations & subsequent discussions with Eastern PCN clinical directors.
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To further establish the shape of an Eastern locality care partnership structure, developing a better understanding & collaboration of the likely key stakeholders and being mindful of ICS conversations, facilitating discussion to take this forward. It may well be we need some organisational development in the locality once a clearer direction of travel is available.

To continue preparation for a Governing body (GB) development and “showcase” opportunity for November 28th in E. locality. It looks this will take place at Cullompton library and presentations regarding the implementation of ETTF

funding which facilitated the “GP connect” project through the East Devon Health Federation will be likely to be presented.

Issues of concern or risk

General & Community

Sustainability of investment in diabetes transformation beyond March 2020. Work underway to mitigate this with PCN clinical directors.

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

The utilisation of community estates in light of the DHSC Guidance for Transfers of NHS Property. Meetings and prioritising discussions have been held.

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

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

Royal Devon and Exeter Foundation Trust (RDEFT)

Unprecedented & sustained A+E performance challenges & levels of escalation going into winter 19/20, deteriorating diagnostics and 52 week wait figures, These have no doubt already been noted by GB.

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

Non-obstetric ultrasound**:** Work to improve data quality within RDEFT diagnostics has revealed a longstanding technical issue with the Trust Patient Administration

System (PAS), resulting in patients waiting for ultrasound being excluded from the data set and being recorded as “patient choice”.

12 Hour Breaches- Mental Health Patients in the Emergency Department (ED**):** Since July 2018 ED 12-hour breaches have been regularly reported by the provider. A majority of these relate to patients with a longstanding mental health condition. There are concerns about the impact of extended waits for both the patient and the whole service/ system. This is an on-going and very live issue at Eastern A+E board Oct 19. Further assurances are awaited from mental health commissioning.

Urology**:** The Trust has reported delays in some patients having cystoscopies. They have subsequently identified a possible risk to patient safety and experience. Again this is being monitored through CCG quality and safety teams and the CCG quality committee.

Primary care

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

Risk that some PCNs may not be able to recruit to additional posts. Eg: Pharmacy and MSK.

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

Support required from CCG/system or barriers to progress

Resourcing multi-disciplinary working, to the same degree as the Southern Coastal model to include GPs and the voluntary sector. This is now being better understood and has to some extent been recognised through winter pressures funding allocation discussions. Further debate is needed with acute trust colleagues going into 20/21.

Primary care commissioning support for greater clarity re working with new PCN’s. With the substantial appointment of Gill Munday as Primary care commissioning lead for East, this should be much better supported.

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

to support better integrated working particularly in Exeter. EPIC implementation will hopefully move this forwards positively.

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

NHS
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Locality update report

Locality:	Western
Period covered by update:	To 18 October 2019
Locality clinical representative:	Dr Shelagh McCormick
Locality executive lead:	Jo Turl
Locality non-executive representative:	Nick Ball

Key achievements/progress

- Primary Care Network Development including engagement between CCG, PCNs, Livewell Southwest and UHP
- GP forum held on 1 October with formal launch of the Plymouth Prospectus
- Refreshed programme plans in ICM and Urgent Care with good engagement and commitment to implementation
- Digital Accelerator project: currently in 4 PCNs with funding secured to roll out across the remaining 4 networks
- Community Pharmacist Consultation Scheme (CPCS) pilot started between St Levan Surgery and Saltash Road pharmacy

Key priorities for the next three months

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

Issues of concern or risk

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

Support required from CCG/system or barriers to progress

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

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Locality update report

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

Key achievements/progress

Integrated Care Model - Health and Wellbeing Centres

- Teignmouth: We met with NHS England on 16 September to discuss the health and wellbeing centre proposals and the development of these plans are ongoing.
- Dartmouth: The CCG is in discussion with local partners about relaunching stakeholder engagement in the lead up to the opening of the new health and wellbeing centre.

Integrated Care Model - Personal Care Sufficiency

- Last month we secured further alternative personal care capacity in the South Devon area, and we are continuing to work with Devon County Council to try to ensure a resilient supply throughout winter.

TSDFT performance

- The System Improvement Board continues to meet monthly. Four key target areas have been identified to drive improvement, and leads from across the system have developed action plans to address those key issues.
- TSDFT have reviewed and refreshed the governance and assurance processes for their recovery and improvement plans, which are being presented to the System Improvement Board in October.

Winter Funding

- Funding is being transferred for approved schemes, following A&E Delivery Board and locality care partnership delivery group agreement of proposals.

Quality

- Quality reviews of the emergency department report positive safety measures are in place. These are a short-term form of assurance whilst the Trust work on

producing the monthly “SHINE” patient safety audit to evidence key patient safety checks.
- Close links are also developing between Torbay and UHP on the delivery of routine internal/external quality assurance. Parity in physical health and mental health care for in patients in both general and mental health bed-based settings has been a focus.
- Further partnership work is underway focussing on access to tissue viability and end of life care specialist support for mental health in-patients.

Key priorities for the next three months

ICM

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

TSDFT performance

- Dawlish and Totnes MIU to return to full opening hours after temporary reduction
- Delivery of demand management action plans for emergency care, supported by commissioning managers working with the TSDFT teams, NHSE&I and ECIST

Integrated Urgent Care Services

- We continue to develop the South model for community urgent care services, including on-going development of Newton Abbot MIU as a designated urgent treatment centre.
- Continue to work with DDoC on their proposals for a more sustainable model, ensuring all relevant stakeholders are included and any risks raised in impact assessment are mitigated.

Quality

- Debriefs with regulators and system partners following the IT failure on 23 September. Along with investigation and reporting on technical issues the serious incident investigation will also focus on patient safety impacts.
- Community nursing services: Additional reviews are underway within the Moor to Sea sub locality to better understand the service demand and capacity impacts and inform the workforce development and training plans.

Issues of concern or risk

- TSDFT Performance and financial position. Despite some signs of improvement in weekend performance, this continues to be an issue and heightened governance arrangements remain in place as we head into winter.
- Personal care capacity and resilience remains a concern across Devon. Additional agency capacity has been secured and we are working on making this a viable and sustainable option.
- The short-term change to MIU provision in Dawlish and Totnes is ongoing. We continue to ensure actions are underway to deliver expected outcomes.

Support required from CCG/system or barriers to progress

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