PUBLIC- NHS Devon Clinical Commissioning Group Governing Body

MS Teams - see formal calendar invitation for joining details

25 February 2021 10:00 - 25 February 2021 11:30

AGENDA

#	Description	Owner	Time
1	Welcome and Apologies Verbal	Chair	10:00
2	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 1602202... 4	Chair	10:05
3	Minutes of last meeting and action log Paper 1 Draft Public GB minutes 28.01.2021 v1.docx 9 Copy of Master Action Log - PUBLIC v3 nc.xlsx 16	Chair	10:10
4	Chair's Report Paper 1 cover sheet chair's report.docx 17 2 Chairs Report February 2021.docx 19	Chair	10:15
5	Accountable Officer's Report Paper NHS Devon CCG - Governing Body - February 202... 21	Accountable Officer	10:20
6	PROGRAMMES OF WORK (items are recommendations for decision/approval)		10:35
6.10	Northern and Eastern Community Services Contract Paper 1 North and East Community Services GB Report v... 26 2 Appendix 1 Community Slides Feb 21 (page 6 of r... 36 3 Appendix 2 Outcomes Framework Document (pa... 68	Director of Commissioning - out of hospital	
7	ASSURANCE COMMITTEE UPDATES Paper	Committee Chair's	10:55

#	Description		Owner	Time
7.10	Finance and Performance [P] Finance Committee Chair Report 25 February 202...	71		
7.20	Quality [P] v1.0 QAC Chair Report Part 1 18 February 2021.do...	75		
7.30	Primary Care Commisssioning [P] Committee Chair Report - Public PCC - February 2...	78		
7.40	Commissioning [P] Commissioning Cttee 11.02.2021.docx	80		
8	Local Care Partnership updates Paper [P] 1 Northern Locality LCP Jan 21 report tg.docx [P] 2 Locality Update - Eastern Jan 2021.docx [P] 3 Locality Update South February 2021.docx [P] 4 Western FINAL 120221.docx [P] 5 Locality update Plymouth January 2020 DRAFT.d...	82 87 91 94 96	Locality Representatives	11:15
9	BREAK			11:30

Declaration of Interests Register - NHS Devon Governing Body

Register updated and generated by the Governance Team - 16 February 2021

Register last updated 16/02/2021

Title	Surname	First name	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Allcorn	Darryn	Chief Nursing Officer Caldicott Guardian	Member of Governing Body Member of Quality Assurance Committee Senior Leadership Team (SLT) CCG Executive Team Meeting Member of Devon JCEG Commissioning Committee (CC DOI) Member of Audit Committee Member of Primary Care Commissioning Committee (PCCC)	Honorary Associate Professor University of Exeter Seconded to NDHT (to 18 September 2020) Strategic Chief Nurse, Nightingale Hospital Exeter System Chief Nurse, Devon STP		11/05/2020		27/08/2020	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Appleby	Gaynor	Non Executive Lay Member (Allied Health Professional)	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee (PCCC) Member of Remuneration and Workforce Committee	CQC Specialist Advisor Therapy Lead for Health and Social Care for North Devon		01/11/2019		05/05/2020	Non Financial	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Atherton	Glynis	Non Executive Lay Member- Quality Geographical remit - Eastern	Member of Governing Body Member Quality Assurance Committee (Chair) Member Primary Care Commissioning Committee (PCCC) 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 Member of the Devon Ethical Reference Group		14/05/2019		01/09/2020	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
	Bailey	Helen	Associate Director, Urgent Care	Devon Urgent Care Board Senior Leadership team (SLT) Governing Body (presentation) Executive Committee (deputy) Northern Integrated Delivery Group	Owner and director of Wayside Health & Care Ltd, a provider of consultancy and interim management services.		18/11/2020		18/11/2020	Financial, Personal	Direct	Whilst employed by NHS Devon CCG, will not take on any work within eayside Health & Care, but ill remain as owner/director. No information generated by work undertaken for Devon will be disclosed to clients of Wayside Health & Care Ltd. Without the permission of NHS Devon CCG. Should any instance occur where discussions or decisions under discussion be of potential benefit to the company, Helen Bailey will declare this interest and where necessary remove herself from said discussion.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geographical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 , Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		19/11/2020	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
	Brown	Steven	Director of Public Health (DCC)	Governing Body Strategic Commissioning Partnership STP Directors ICS Partnership Board Primary Care Commissioning Committee (PCCC)	No interests declared		19/11/2020		19/11/2020				Devon County Council
	Burrows	Charlotte	Non Executive Lay Member - Patient and Public Involvement Geographical remit - Northern	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Member Primary Care Commissioning Committee (PCCC)	Self-Employment business consultant from September 2019 Associate for Research In Practice Feb 2020 Associate for Research In Practice Supplier/Associate for SWAHSN (Feb 2020) Within my role as SWAHSN associate will be part of their project team which is supporting the Think 111 project Associate for Devon Communities Together		04/04/2019		04/08/2020	Financial/Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Carroll	Jayne	Interim Chief Operating Officer	Member Governing Body Member of Senior Leadership Team (SLT) Commissioning Committee (CC DOI) Member of Finance and Performance Committee Devon Urgent Care Board	Independent member of Fostering Panel for Pathway Care.		08/08/2020		08/08/2020	Professional	Indirect		NHS Devon CCG

	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt School Governor for Tavistock Primary and Nursery School	Partner is employed by Livewell Southwest in position of influence	26/09/2017	17/09/2020	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	Locality Director - Plymouth	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning) Strategic Commissioning Partnership Meeting	No interests declared		12/03/2019	22/10/2020				Plymouth City Council
	Davis	Alison	Associate Non-Executive Director	Attendee Governing Body	Plymouth City Council – Foster panel Chair Torbay Council- Foster panel Chair Pathway Care Fostering- Ashburton- Independent Reviewing Officer University of Exeter – student mentor Somerset County Council- casual employee		19/10/2019	20/10/2020	Personal, Professional & Financial	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Strategic Commissioning Partnership Meeting	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015	20/10/2020			Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Doble	Clare	Head of Governance Deputy Senior Information Risk Owner (SIRO)	Attendee of Audit Committee Quality Assurance Committee Primary Care Commissioning Committee (PCCC) Governing Body (ad hoc) Health and Safety Group Joint Chair Staff Partnership Forum Data Protection Steering Group	Member of Taunton & Somerset NHS Foundation Trust Godmother to member of governance team's daughter Trustee for Lyme Disease Action Charity Secondment one day a week to offer strategic oversight/direction for DPT IG team whilst they recruit a DPO	Partner on secondment to CCG Business Intelligence Team	22/08/2017	26/11/2020	Non-Financial, Financial and Personal Interests	Indirect/Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dowell	John	Director of Finance	Governing Body Finance and Performance Committee CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Commissioning Committee (CC DOI) Primary Care Commissioning Committee (PCCC)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	20/10/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Finn	John	Interim Executive Director of in-hospital commissioning to 31 March2021 Substantive post Deputy Director – In Hospital Commissioning	Member of Governing Body Exec Meeting Commissioning Committee (CC DOI) Northern Integrated Delivery Meetings System Restoration and Transformation Group		Non-dependent child works for NHS111	19/01/2017	02/09/2020	Personal	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	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body A & E Delivery Board (SD&T)	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher GP Locality Clinical Director Primary Care Network - The Coastal Network	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	28/07/2019	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay and South Devon NHS Foundation Trust
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration and Workforce Committee(Non exec rem) Member of Devon JCEG	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	22/10/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Hargadon	Judy	Non Executive Lay Member - Primary Care and Prevention Geographical remit - Southern	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) (Chair) Member of Remuneration and Workforce Committee		Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	10/03/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Harrell	Ruth	Director of Public Health, Plymouth City Council	Devon STP Clinical & Professional cabinet NHS Devon CCG Governing Body Member of Devon JCEG Member of Strategic Commissioning Partnership Meeting Primary Care Commissioning Committee (PCCC)	Director of Public Health for Local Authority		26/10/2016	18/08/2020	General	Direct		Plymouth City Council

	Harris	Penny	Director - In Hospital Commissioning	Attendee of Governing Body CCG Execs and Clinical Chairs Senior Leadership Team (SLT) Strategic Commissioning Partnership Meeting CCG Executive Team Meeting Finance and Performance Committee Strategic Commissioning Programme Board Commissioning Committee (CC DOI) System Restoration and Transformation Group Devon Urgent Care Board	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training Director of Kerr Mediation ltd - working alongside LMC law taking on primary care mediations commissioned by the LMC.		23/07/2019	29/10/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	KERR Darnley Ltd
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body (Chair) Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting Commissioning Committee (CC DOI) Strategic Commissioning Partnership	GP Partner, Cricketfield Surgery (ceased August 2019) Salaried GP, Cricketfield Surgery (ceased December 2019) Member of Templar Care PCN (ceased December 2019) Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Church Warden Holy Trinity Church (ceased 2018)	Spouse works in emergency department at RDE and for Exeter Medical School	21/08/2015	21/10/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kennedy	Nick	NHS Devon CCG Governing Body Secondary Care Clinician	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) QEIA Panel Member of Audit Committee Member of Devon JCEG Commissioning Committee (CC DOI) Member of Devon Clinical Cabinet System Restoration and Transformation Group	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of national Independent Funding Request Panel NHS England Non-Executive Director GO-OP, GO-OP is a Multistakeholder Co-operative Society (Somerset Rules), registered under the Co-operative and Community Benefit Societies Acts. GO-OPGO-OP will be the UK's first co-operatively owned and run Train Operating Company Introduced PPE supplier (Orthofix International) to Devon CCG. Company part owned by my cousin Non-Executive Director of a start up limited company called LinkExec, an online business aimed at promoting start up businesses and investors. April 2020 working one day a week for Somerset CCG on their Clinical Strategy and the Taunton/Yeovil merger strategy (11 Feb 2021)		26/09/2017	14/08/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Attendee of Audit Committee Member Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Eastern Locality Delivery Group	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Manton	Sonja	Executive Director SRO for Integrated Care Partnership (Western Devon)	Member of Governing Body CCG Executive Team Meeting Joint Staff Partnership Forum Senior Leadership Team (SLT) Attendee Audit Committee Chair of Integrated Care Partnership Executive Group	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit	03/04/2017	25/09/2020	Professional & personal	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	Lead Clinical Representative (Western) – CCG Governing Body Strategic Clinical lead - Maternity Clinical Lead - Western Locality Clinical lead - Mental Health	Member of Governing Body Member of Quality Assurance Committee Member of QEIA Panel Member of Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) Member of Individual Packages of Care Panel (IPOC) Member of Local Maternity System (LMS) Board and Operational Committee	Elected member (and Deputy Chair from September 2019), South West Regional Council of BMA GP Appraiser (NHS England) Shareholder GlaxoSmithKline 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 GP Partner, Church View Surgery, Plymstock Clinical Director of Mewstone Primary Care Network(PCN)	26/09/2017	20/10/2020	Financial, Professional & Personal Interests	Direct & 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
	Millward	Andrew	Devon System Director of Communications and Engagement. Chief Communications, IT and People Officer, NHS Devon CCG	Member of Governing Body CCG Executive Team Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	04/03/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Pearson	Virginia	Chief Officer for Communities, Public Health, Environment and Prosperity/Director of Public Health, Devon County Council System Director of Population Health and Wellbeing, Devon STP	Co-opted Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Strategic Commissioning Programme Board	Member, STP Directors Group Member, STP Programme Delivery Executive Group Member, Devon Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Association of Directors of Public Health Member, British Medical Association Honorary Clinical Professor, University of Exeter College of Medicine and Health		02/02/2017	22/04/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council

	Quartermaine	Jade	Senior Administrator	Administrative support to: CCG Senior Leadership Team (SLT) Exec Team Meeting Governing Body	No interests declared		01/08/2016	20/08/2020				NHS Devon CCG
	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee of Quality Assurance Committee Attendee of Finance and Performance Committee Attendee of Audit Committee Attendee of Remuneration and Workforce Committee Attendee of Commissioning Committee (CC DOI) Attendee of Primary Care Commissioning Commitee (PCCC) CCG Executive Team Meeting Senior Leadership Team (SLT) Working with Industry and Sponsorship Group System Restoration and Transformation Group Member of Strategic Commissioning Partnership Meeting	No interests declared		22/03/2019	10/08/2020				NHS Devon CCG
	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Strategic Commissioning Partnership CCG Executive Team Senior Leadership Team (SLT) Attendee Audit and Assurance Committee (Audit Committee) Finance and Performance Committee Commissioning Committee (CC DOI)	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	21/10/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	Associate Director of HR and OD	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel CCG R&T Project Team meeting	No interests declared		16/10/2018	19/10/2020				NHS Devon CCG
	Turl	Jo	Executive Director of Commissioning - Out-Of-Hospital	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Strategic Commissioning Partnership Meeting Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Quality Assurance Committee	No interests declared		13/08/2015	19/10/2020	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee (Chair)	Co-opted Councillor on Budleigh Salterton Town Council (Independent Member – non-political)	Son employed by Care Quality Commission as an Information Analyst	16/10/2019	09/02/2021	Indirect interest		Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
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 Integrated Delivery Group	Member of One Ilfracombe Board Chair of One Northern Devon Partnership Board		14/02/2017	28/09/2020	Personal	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

Wooldridge	James	Associate Non Executive Lay Member	Attendee Governing Body	Managing Director of Recovery Devon CIC which is directly funded by Devon Partnership NHS Trust (DPNHST) Proprietor of Positive Notions. A private consultancy providing mental health training services to various organisations including but not limited to: DPNHST, University of Exeter, University of Plymouth, Livewell Southwest There may be an increased reputational benefit to my Positive Notions consultancy through membership of Devon CCG. I will advocate for various mental health groups and organisations including Recovery Devon CIC, that may be in receipt of commissioned funding from Devon CCG In receipt of individually funded treatment My general interest lies in mental health, wellbeing and recovery. I intend advocating for groups and organisations that adopt and demonstrate the values and principles associated with the recovery approach	28/10/2019	28/10/2019	Financial /non Financial Professional Interests/ General	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

NHS
Devon
Clinical Commissioning Group

NHS Devon Governing Body Meeting
DRAFT minutes held in PUBLIC

Date: 28 January 2021 Time: 10.00 – 11.12 Location: Via Microsoft Teams

Item	Discussion	*Action*
1	**Welcome and Apologies** The chair welcomed everyone to this meeting and reminded the members this was a meeting held in public. Apologies were recorded for: Dr Paul Johnson Dr Ruth Harrell Penny Harris John Dowell – Ben Chilcott deputy James Wooldridge It was noted there was no written questions submitted by members of the public in advance of this meeting.	
2	**Register of Interest (ROI)** NB referred to the ROI included in the pack and no amendments or new declarations were made. There were no conflicts of interests declared pertaining to the agenda items scheduled for this meeting. **The Governing Body received and noted the ROI**	
3	**Minutes of the last meeting** NB led a page by page review of the minutes of the last meeting held on 17 December 2020. These were approved as a true and accurate record of the meeting. **Action Log** 1. This action had been completed and it was agreed for this action to be formally closed.	
4	**Chairs Report** NB noted that two large vaccinations centres were up and running in Plymouth and Exeter and he was pleased to report they were operating smoothly. These two vaccinations were in addition to the fantastic work that was being undertaken in primary care. NB took an opportunity to register his thanks to all staff across the CCG and wider health economy for their hard work given the timescales and this was a phenomenal achievement. NB gave particular thanks to DA, chief nurse as he has done a fantastic job in leading the vaccination programme for Devon.	

	The Governing Body received and noted the verbal Chair's report.	
5	**Accountable Officer's Report** ST echoed NB kinds words and the fantastic team effort where DA has led this programme of work with focus determination and a level of pragmatism. ST acknowledge this was a mammoth task and was confident that we would meet our trajectory of vaccination numbers. ST reported that capacity had been tight over the past couple of weeks in terms of hospitals and non COVID-19 beds and flows through hospitals. The CCG were continuing to work with local authority colleagues looking at alternatives such as care hotels. We are working with regional colleagues including weekends to coordinate the response to the pandemic and there is pressure in the system in the South West and we are supporting colleagues by admitting patients into our intensive care units (ICU). The Nightingale Exeter is being used to support patients from Somerset, Dorset as well as Devon and nationally. ST expected the pressures to continue for the next couple of weeks in hospitals and flows into the community for another month. ST drew attention to the staff survey report and due to timings of when this received it was too late to include in the papers. He asked AM to provide a summary, but he was proud of the results and improvements made especially in these challenging times. AM highlighted key findings from the staff survey report which had recently been presented to staff. The staff survey was undertaken by Picker, healthcare researcher which allows us to be compared against 42 other CCG's across the country. • 85% staff filled out the questionnaire and 77 questions were asked • 63% improvement on last year • CCG shows a happier place to work and results are even more positive following the challenges staff have faced • Compared to the rest of the county Devon CCG is ranked 6th showing a bigger improvement compared to the other 42 organisations • Devon CCG is ranked 17th out of all other CCG's nationally which is a positive score AM felt the improved results highlights that the organisation has in place positive action for health and wellbeing for staff to help them at work and communicate with senior staff. He further added that the CCG is a good place to work and that the positive changes in place have been recognised by staff. NB believed this was a test ament of the strength and leadership across the CCG and wondered if there was a formal opportunity to feed this data back to NHS England/ Improvement (NHSE/I). AM confirmed that NHS E/I see the national results but that we would seek an opportunity to formally respond and reinforce improvements being made at such a unique level over the past year and continuing on this trajectory since the CCG's merged. JH referred to the CCG priorities and priority 3 in the report and asked if there was more clarity on the plan for services in the future to move the CCG back to financial balance. ST explained the strategic commissioning framework and gave more details on the community mental health framework, which is being led by Melanie Walker, CEO, Devon Partnership Trust, and that this will be presented to a future governing body meeting.	

ST noted that the hospital improvement programme (HIP2) linked to our long-term plan piece of work as part of priority 3.

ST informed the members that John Finn (JF) has been asked to step into the Director of Commissioning -In Hospital role on an interim basis to support the work of the HIP2 programme.

GAth queried oximetry at home and initial teething problems that had been experienced. ST responded and confirmed that numbers had been reviewed and was disappointed that numbers had not improved to the level the CCG were expecting to be, and that there were still some issues. These issues are being closely monitored as they come through. ST described the issues relating to COVID and range of options for people including hospital, support at home and virtual wards and these were some of a suite of admission avoidance schemes.

Following the staff survey results presentations at the last live staff briefing SK felt there was valuable information that could be used to teach primary care about looking after staff and that this was an importance piece of work to commission to build on the success of communications that have been delivered.

SK had felt that we had focused on the financial side of commissioning work and perhaps less on patients and individuals and proposed that we commission future services in a more personalised way. ST responded that out of hospital work will be how we manage and personalize for individuals and cohorts in communities and this will be the key to making out of hospital services work.

AM mentioned that the CCG is starting to explore health and wellbeing support for primary care staff and that we have also started to deliver a training programme for commissioning staff, around the commissioning cycles of engagement with local communities.

ACTION 1
AM to liaise with SK and the head of organisational development regarding health and wellbeing support for primary care staff.

CB acknowledged that everyone involved in the vaccination programme was working incredibly hard but wondered about volunteers coming through to support staff in the longer term of vaccinating. We have been overwhelmed with the number of unpaid volunteers, marshals' and returning professionals and DA noted there were teething problems with the on boarding of volunteers.

JWo asked if the areas that were not so good in the staff survey results were significant and did this require immediate focus. AM confirmed most of these were about people working at home and the impact this has had on general health and we have taken this action forward. We have reviewed arrangements for working at home, loaned, and given different equipment to help staff. AM acknowledged that there was a need to further review everyone's arrangements at home and whether we can further improve that.

The other areas for improvement was near misses and incidents and AM stated that it was important to learn from this. ST added that we had not made improvement where we would like to have around senior staff making decisions.

AM confirmed that the staff partnership forum had been engaged and had seen the results and that we are working with them on developing an action plan.

	DG asked if there was any feedback from the overview and scrutiny meeting regarding modernising services in Teignmouth and raised concerns around leases for vaccinations sites. ST was pleased to report the overview and scrutiny meeting went well and included robust questioning from the members and that they were informally satisfied of the work that had been done. The CCG is awaiting formal notification and the members would be updated when that has been received. DA confirmed that conversations with local and large-scale vaccination sites are underway and that we are working with our regional colleagues on a long-term plan to serve all our communities. SMC wondered if we were still employing full use of the independent sector. JF confirmed that from 29 January there would be a 4-week period of complete control of the independent sector in Devon, and that we were the only successful system in the South West to have this. A clear plan has been developed for each locality for phase 2 and 3 and this has been discussed at the dynamic decision-making group (DDMG). JF agreed to send around the details of the levels of quantity of activity for this 4-week period and noted the importance to embrace the robust process that has been granted and that a capability review has put in place for two weeks. He also noted that value for money (VFM) will also be assessed. **ACTION 2** **JF to circulate to the members the details of the levels of activity for the independent sector for the 4-week period.** **The Governing Body received and noted the contents of the AOs Report.**	
6	**Assurance Committee Reports** <u>Audit</u> NB drew attention risk 38 lack of clarity around sustainable transformation partnership (STP) and that the audit committee will be commissioning another piece of work on governance arrangements for the STP. Once completed a report will be presented to the governing body. NB noted that a revised assurance framework was included in the pack and GS confirmed that this revised framework was in line with our objectives. She noted sub objectives had been developed against risks. The assurance framework had been largely populated but was work in progress. It was expected that a completed assurance framework would be presented to the next audit meeting where it will be monitored and will be reported to the governing body through the audit chair's report. NK felt it was a good framework easy to read and understand. He did have some questions about the content, and it was agreed this would be discussed with GS outside of this meeting. **The Governing Body:** • **Approved the Board Assurance Framework, format and sub objectives and risks identified** <u>Finance and Performance</u> Firstly, GT thanked ST and the team on the staff survey results and gave assurance to the members that these results and an action plan would be further analysed in detail at the remuneration and strategic workforce committee. GT referred to the report included in the pack which covered two committees and highlighted the following:	

	• Performance reports - December and January was a fast-moving situation regarding the surge in COVID-19 and that some performance figures well out of date and had dropped in some areas for understandable reasons. • Continuation of delays with ambulance handovers for UHP • Finance – forecast of financial balance for the second half financial year which was excellent but was cautious not to be complacent. Expecting guidance from region. JD and colleagues are working on a financial plan across the system and encouraging for the plans to be presented to each provider board • Finance and performance committee asked for clarification around workforce numbers which had increased. This had not been wholly explained and more information has been requested and the governing body will be updated in due course • There was a minor change to the finance and performance terms of reference (ToRs). To improve clinical lead representatives, work in other parts of the NHS the clinical membership has been reduced from 2 to 1 which has resulted in a change to quoracy. The ToRs were attached to the chair's report and approved by the finance and performance. **The Governing Body:** • **Noted and approved the updated and amended Terms of Reference which were agreed at the January finance and performance committee.** SK noted that there had been a drop in performance around staff sickness. GT acknowledged that this had been identified and some of this related to COVID-19 and self isolation, as well as issues around stress and anxiety. He assured the governing body that a further breakdown and analysis of the data has been requested in a nonintrusive way to understand what is going on in peoples lives and to build on the excellent results of the staff survey. ST also confirmed that commissioning services to support our staff to recover properly to get them back to where there need to focus remains a top priority. GT noted that he is interested in seeing the feedback and comments from providers board on the system financial plan and was encouraged that all finance directors are working with the CCG in developing an action plan which has been submitted to region. <u>Quality</u> There was nothing further to add to this report. <u>Primary Care Commissioning</u> There was nothing further to add to this report. <u>Commissioning</u> There was nothing further to add to this report and nothing to escalate.	
7	**Locality COVID-19 Updates** NB gave each locality clinical lead representative an opportunity to provide a further update in their respective locality which had not been covered elsewhere in the agenda. <u>Eastern</u> • Clinical directors involved in the Exmouth telecentre have delivered several thousand vaccinations	

	• Vaccinations are also being delivered in many surgeries and most people over the age of 80 and in care homes have received theirs. Vaccinations will now be delivered to the housebound and extremely vulnerable • Positive feedback had been received however resilience has been an issue and practice staff have been enthusiastic and involved DA acknowledged there had been a glitch with national and local invitations for people in receiving their vaccinations and that messages are now being managed in letters to eliminate any further confusion. <u>Western</u> • In the West there are four GP sites with the largest being Plymouth Pavilion's which is running like a military operation • Staff welfare and sufficient volunteers is being monitored • Most care homes have been vaccinated and there has been agreement around the delivery of vaccinations to those that are housebound • Pleased to report there has been a fantastic effort in the West in supporting the vaccination programme <u>Northern</u> • 3 large vaccinations centre's set up in the North with x2 Primary Care Network (PCN) based and 1 in hospital with all working effectively and efficiently. • There is enthusiasm in the Trust and the NHS system with an eagerness to get back to normal life and there is encouragement in looking at outreach practice services • Early in the vaccination programme it recognised the need for coordination even local coordination and all stakeholders have shown example of healthy relationships locally to get things done. • COVID-19 has spared some high activity levels in other areas and in the system outpatient departments (OPD) have seen higher levels of activity than the previous years and these have been delivered virtually and face to face. • Concerns around two weeks wait referrals lower than normal figures and the data is being investigated at greater detail Southern • At peak of outbreak Torbay and South Devon NHS FT (TSDFT) admissions had been high • Vaccination programme underway and working well x3 PCN. Most care homes have been vaccinated and now looking to administer vaccinations to the over 75s • A webinar summit has been arranged for 2 February 12.00 – 13.00. This will be to look at best practice in primary care and secondary care interface and learning that has accrued over the last few months.	
8	**Any other business** There were no further business items raised for discussion.	
9	**The meeting closed at 11.12**	

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*

Alison Davis (AD) **	Associate Non-Executive Director, Devon CCG
Andrew Millward (AM) **	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Darryn Allcorn (DA) **	Chief Nurse, NHS Devon CCG
David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Gaynor Appleby (GApp) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT) **	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG
James Wooldridge (JW) A	Associate Non-Executive Director, Devon CCG
Jayne Carroll (JC)**	Chief Operating Officer, Devon CCG
John Dowell (JD) A	Chief Finance Officer, Devon CCG
John Finn (JF) **	Interim Director of Commissioning – in hospital, Devon CCG
John Womersley – Dr (JWo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Commissioning - out of hospital, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF) A (in absence of DG)	Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **	Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **	Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) **Chair** **	Clinical Chair, Devon CCG
Penny Harris – (PH) A	Director of Commissioning in hospital, Devon CCG
Ruth Harrell - Dr (RH) A	Director of Public Health, Plymouth City Council
Simon Kerr – Dr (SK) **	Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc)**	Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST)**	Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **	Executive Director and SRO for Integrated Care Partnership (Western Devon), Devon CCG
Steve Brown (SB) **	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) ** **Minute Taker**	Executive Assistant, Devon CCG
Ben Chilcott (BC) ** (in absence of JD)	Deputy Director of Finance, Devon CCG
Minutes approved | Date:	Signed by chair:

GOVERNING BODY - PUBLIC ACTION LOG										
Action Number	**Date of Meeting**		**Target Date**	**Lead**	**Progress on action**	**Assurance required to close action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential order	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action is very clear to the owner and the committee members	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertaken Yes/No confirmation if all actions	The most up to date information to be provided for assurance that all elements of the action have been completed.	Date action formally closed	This will be the lead or person to whom the action was designated	Confirmation that committee that raised the action is content the action has been completed	Confirmation if action complete
1	28-Jan-21	AM to liaise with SK and the head of organisational development regarding health and wellbeing support for primary care staff.	25-Feb-21	Andrew Millward	17.02.2021 - meeting booked to include Andrew Millward, Simon Kerr and Katy Kerley, Head of Organisational development to discuss health and wellbeing for primary care staff.					**FOR CLOSURE**
2	28-Jan-21	JF to circulate to the members the details of the levels of activity for the independent sector for the 4-week period.	25-Feb-21	John Finn	18.02.2021 Devon Independent surge plan update circulated to governing body for information.					**FOR CLOSURE**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Chair's Report				
Date of committee: 25 February 2021 **Date report produced: 18 February 2021**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive: N/A** **Name and Title:** **N/A** **Contact Details: N/A** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date:** 18 November 2020		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

- Introduction
- Mass vaccination programme
- Integrated Care System (ICS) designation submission
- Integrated Care System (ICS) government white paper
- Shadow Integrated System (ICS) partnership board

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 our objectives
(Delete as applicable) 1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes 2. Improve service performance 3. Achieve financial sustainability 4. Effective, well-led organisation with an empowered and inclusive workforce 5. Lead the system's response to the coronavirus pandemic
Reference to other documents or accompanying papers:
None
Does this report have implications in any of the areas highlighted below?

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY – CHAIRS REPORT

1. Introduction

As I reflect on where we are as a CCG and wider system there is much to be positive about at the moment – which is really important for us to recognise given the protracted impact the pandemic has had on our patients and our staff. In the here and now, we are seeing real success in the vaccination programme and the hope that brings, and looking beyond the pandemic we can see how much progress we have made in our ambition to deliver integrated services and care and the future opportunities that we have both through our current ambitions, our progress towards a formal ICS and the enablers within the white paper. There will be much for us to do to maximise these opportunities, but the outcome, if we get it right, will be much better for the population we serve.

2. Mass Vaccination Programme

The vaccination programme for Devon has been a success in so many ways. Not only have we been able to offer the vaccine to everyone in the top four priority groups within the challenging time frame set by the Prime Minister but we have also seen exceptional levels of collaboration across PCNs, between NHS and Local authority and with volunteers and local businesses. Having been to a number of PCN vaccination sites and the large site at Home Park, Plymouth it is clear just how much is involved in planning and delivering this programme and how so many people have gone above and beyond to do so. For many patients and staff, vaccination clinics are a hugely emotional time and genuinely offer us all hope that numbers of deaths will start to fall, fewer people will need to be admitted to hospital, and we will find a way out of the restrictions this pandemic has required.

My thanks to all staff and volunteers who have and continue to make this possible.

3. Integrated Care System (ICS) Designation Submission

The Devon health and care system continues to make significant progress in its desire to work more closely together for the benefit of the population. On 9 February we met with NHS England to discuss our ICS submission and based on informal feedback we are well on course to be formally designated an Integrated Care System by NHS England on 1 April 2021 and this is the next stage on our journey to bring health and care, commissioners and providers, community and hospital care and physical and mental health together.

4. Integrated Care System (ICS) Government White Paper

NHS England has been engaging with key stakeholders and organisations on the best way to progress health and care integration through the established ICSs. This has culminated in the Government White Paper (*hyperlink).* We have had the opportunity to discuss this as a Governing

Body, within the senior CCG leadership and amongst the Devon NHS Chairs and Local Authority Leaders. There is much that is positive about this proposal which, if agreed, will see CCG functions being undertaken by the ICS as a statutory NHS organisation, but doing so much more closely with provider organisations and local authorities. Devon is in a good place in many ways, having already merged the CCGs in 2019 and with many joint roles already established with local authorities and with the STP. Our opportunity and challenge is to ensure that all the experience, skills and good practice within the CCG continues through this transition and any organizational change doesn't distract us from the priorities we need to focus on over the next year.

5. Shadow ICS Partnership Board

The shadow ICS Partnership Board met on 3 February with senior executive and chair / leader membership of all health organisations and local authorities. Key topics of discussion included updates on the system Integrated Performance Report, incorporating the agreed outcomes framework with key system performance metrics. There is still some development required and particularly a focus on how we measure performance in areas such as community services and primary care. Other items discussed include updates on the Population Health Management pilots, the community mental health framework and LCP updates. As a whole the agenda reflected the breadth of key current work that will help focus our integration and service design and provision.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Accountable officer report				
Date of committee: 25 February 2021 **Date report produced:** 17 February 2021				
Author (s) Name and Title: Simon Tapley, accountable officer Sam Cush, internal communications manager		**Supporting Executive:** **Name and Title:** Simon Tapley, accountable officer **Contact Details:** **Report Approved by:** **Name and Title:** Simon Tapley, accountable officer **Date:** 17 February 2021		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

1. Integrated Care System proposals
2. Coronavirus vaccinations
3. CCG corporate objectives
4. Oximetry at Home

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

N/A

Key recommendations and actions requested:
This report is for information only.

Impact on our objectives
(Delete as applicable) 1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes 2. Improve service performance 3. Achieve financial sustainability 4. Effective, well-led organisation with an empowered and inclusive workforce 5. Lead the system's response to the coronavirus pandemic

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		x
Health Inequalities		x
Equality (staff or public)		x
Resource and Finance		x
Legal		x
Engagement and Consultation		x
Risk		x

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.

Accountable officer's report

1. Integrated Care System proposals

The publication of the Government's 'Integration and Innovation: working together to improve health and social care for all' White Paper on 11 February is the next logical step in our journey.

It will enable us to better deliver higher-quality care to our population, in a way that is less legally bureaucratic, more accountable, and more joined up.

Devon has been preparing to become an ICS for the past few years, and has made changes to how our organisation works to strengthen partnership and system working, which mean we are in a good position to implement the proposals in the White Paper.

This includes:

- merging our two CCGs in 2019 to enable us to commission services more effectively across the whole county of Devon.
- updating our senior leadership team structure last September to prepare for integrated commissioning.
- building strong partnerships with our partner organisations – including working towards having joint posts with all three of our Local Authorities and the integration of services in some areas.
- relocating our offices in Exeter so we could work even more closely with Devon County Council.
- establishing a Partnership Board for Devon chaired by Dame Suzi Leather (system Independent Chair) to bring partners together to address challenges and set priorities.

The proposals, which are expected to be in place by 2022, will see a statutory ICS to be formed in each ICS area, made up of a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, local government, and partners.

The ICS NHS body will undertake the commissioning functions of the CCG and some of those of NHS England within its boundaries.

Although the ICS will take on many of the CCG functions, its remit will be much broader and have a much greater system role.

NHS trusts, foundation trusts and local authorities will be full and active partners in the leadership of the ICS and could also delegate some of their functions into the collaborative arrangements in the system.

Each ICS will also have a "unitary" board accountable for NHS spend and performance within the system.

The proposals will strengthen our commissioning functions and therefore make our role more influential within Devon's system.

As part of the changes, a commitment has been made to support staff by:

- Not making significant changes to roles below senior leadership (Board) level
- Minimising the impact of organisational change to staff
- Preserving terms and conditions to the new organisation (even if not required by law) to help provide stability and to remove uncertainty

Clinical staff and non-executives will continue to play a significant role within the ICS. As well as planned primary care representation on the NHS ICS board, clinical leaders representing primary care will sit in place-based partnerships reflecting their important part in place-based planning and local leadership.

We're discussing the proposals with our staff, and we will share more detail on the plans as they are developed.

2. Coronavirus vaccinations

Devon has begun to see a reduction in the numbers of people in hospital with coronavirus, which is positive news and thanks to the dedication of health and care staff, and local communities.

Although the figures have fallen, there are still more people in hospital than there were in December, so we're continuing to encourage people to stay at home as much as possible, and, if they do have to go out, to minimise journeys and following the national advice on social distancing, hand washing and face coverings.

Thanks to the tireless work of staff across our county, more than 300,000 of Devon's most vulnerable people have now received a first dose of the vaccine – including more than 96% of those aged 80 and over.

The programme continues to gather pace with around 12,000 people being vaccinated every day in Devon.

On Monday 15 February, we began vaccinating the next two cohorts (5 and 6) – that is people aged 65-69 and those who are clinically vulnerable.

The priority groups and the order in which people are vaccinated are set nationally, and we are following them closely to make sure we vaccinate those at greatest risk from the virus first.

Only those who are in the highest priority groups should be vaccinated right now – those who are aged 65 and over, care home residents and staff, those who the Government have identified as being clinically vulnerable, and frontline health and social care workers who come into contact with vulnerable children and adults.

The vast majority of school and early years workers don't fall within this criteria, so it is important that this group and others wait for when it is their turn to be called.

In addition to the 20 GP-led sites, covering all 123 of Devon's GP practices, vaccinations are now being delivery from several sites across our county, including:

- Two large-scale vaccination centres in Plymouth (Plymouth Argyle Football Club's Home Park Stadium) and Exeter (Westpoint)
- Three community pharmacies in Westward Ho!, Plymouth and Exmouth

The two main ways people can book an appointment is through the national booking service, or via their GP practice.

Anyone who cannot or does not want to travel to one of the large-scale sites or community pharmacies can be vaccinated by their local GP service.

Local GPs and community teams have now visited nearly all of the care homes across Devon, while the vast majority of people who are housebound and in the eligible groups have also been vaccinated.

GP-led services are holding day clinics at additional practice sites to help make access to vaccination services easier for people living in rural or isolated areas.

3. CCG corporate objectives

For the first time, staff have helped develop the CCG's new corporate objectives, which set out our priorities between now and March 2022.

Thanks to the involvement of staff and our Governing Body, they have been made more specific and include timeframes for delivery.

The objectives will be reviewed quarterly by Executives and Governing Body to assess progress, with staff kept updated regularly.

Many of the objectives have begun to be actioned, including increasing the focus on staff wellbeing.

Everyone will play a part in delivering our new objectives over the coming year, so we're encouraging staff to discuss them in teams and consider how to support them.

4. Oximetry at Home

We're encouraging people in Devon with coronavirus (COVID-19) to ask their GP about a potentially life-saving device that they can use in the comfort and safety of their own home.

Under a new NHS scheme called COVID-19 Oximetry at Home, people can be given pulse oximeter – a small device that measures levels of oxygen in the blood – during the first 14 days of their symptoms.

The service is available to patients who have coronavirus or are symptomatic, and are over 65 or on the clinically extremely vulnerable (shielding) list, including people living in care homes.

One of the dangers of coronavirus is that it causes levels of oxygen in the blood to drop dramatically without any obvious symptoms, such as shortness of breath of feeling very unwell – known as silent hypoxia.

This can result in patients going to hospital too late to be treated effectively, sometimes leading to death.

By regularly monitoring oxygen levels, it can be easier to spot if coronavirus symptoms are getting worse and identify if someone needs treatment or support.

High risk patients who contract coronavirus are provided oximeters by their GP. Patients use the small medical device, which is put on the tip of the finger, to measure their oxygen saturation levels three times a day.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Northern and Eastern Community Contracts				
Date of committee: 25th February 2021 **Date report produced: 12th February 2021**				
Author (s) Name and Title: **Barbara Jones, Head of Contracting** **Tim Golby**		**Supporting Executive: Jo Turl** **Name and Title: Director of Commissioning - Out of Hospital** **Contact Details: jo.turl@nhs.net**		
		Report Approved by: Jo Turl **Name and Title: Director of Commissioning - Out of Hospital** **Date 16 February 2021**		
Public or Private (Governing Body only):	**Public**	**x**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: **This paper sets out the recommendation for a direct award to take effect from September 2021 for a period of 10 years with a 5 year extension for the northern and eastern community services, with a break clause after 2 years. The reasons for this recommendation and risks of doing so are explored.**				
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:				
Executive Group				

Key recommendations and actions requested:

The CCG Governing Body is asked to:

1. Make a direct award of a contract for general community services to RDEFT and NDHT for 10 year with potential for 5 year extension, with a clear proviso that contract will be terminated after 2 years if satisfactory progress is not made on a number of defined issues;

2. Agree implementation proposal;

3. Provide senior leadership for this work to be prioritized to ensure sufficient resource is available to deliver the required outcomes;

4. Agree Commissioning Committee will oversee the project, receiving updates no less frequently than every 3 months for next 3 years.

Impact on our objectives

1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes
2. Improve service performance
3. Achieve financial sustainability
4. Effective, well-led organisation with an empowered and inclusive workforce

Reference to other documents or accompanying papers:

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

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

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

Northern & Eastern Community Contracts

Executive Summary

The purpose of this paper is to seek endorsement from Governing Body of the outline agreement by NHS Devon CCG Executives to make a long term direct award of contracts for the Northern and Eastern Community Complex Adult Health Services to Northern Devon Healthcare NHS Trust (NDHT) and Royal Devon & Exeter NHS Foundation Trust (RDEFT).

The Executives proposed a long term contract (10 years + 5 year extension) on the understanding several key issues needed to be addressed. These are:

- The review of current quality measures will be more explicitly stated
- The outcomes framework developed for Western Integrated Care Partnership (ICP) will be used in every locality
- A clearly defined break clause setting out expected outcomes will be built in for year 2

This paper sets out the details of these proposals and seeks confirmation to proceed with negotiations with the Provider.

The Western ICP has been set for 10 years with a 5 year extension. It is proposed that the contracts for Eastern and Northern are awarded for the same length.

It is proposed that this negotiation will be within existing funding envelope.

Strategic Direction

The NHS Long Term Plan sets out the intention to move to delivering health and care through integration, forming Provider Collaboratives. This is further developed in the (anticipated) national proposal for the development of ICS. The development of integrated services within the northern and eastern localities of Devon will seek to overcome competing objectives and separate funding flows through collaboration as this is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

The local NHS in Devon has a strategy to develop vertical integration in each of its localities in order to support collaboration at Place. This has been in place in Southern for many years and the Western ICP formalises the provision in the Plymouth area. Vertical integration has been in effect in northern and eastern Devon in recent years, although this has been on a temporary basis and a long term direct award would strengthen this.

With the development of Integrated Care Systems centering on collaboration and integration, the continued delivery of services in an integrated Trust will best meet the needs of service users within both localities. Key data standards reflect that patients currently receive positive outcomes from the existing providers, and a continuation of services would build upon existing strong relationships in the Northern and Eastern Local Care Partnerships.

The Devon health system needs to prioritise the use of its resources, a requirement that has been brought into sharp focus through the COVID pandemic. The CCG therefore seeks to maximise use of resources on the direct delivery of care rather than back office functions such as new organisational structures and procurements.

The services under review have been provided by the organisations running the acute hospitals for some years and the CCG wishes to minimize any disruption to these services for its population.

Links with all local Primary Care Networks are paramount. This development will build on existing relationships and maximise opportunities to further develop and address current limitations.

A further strategic ambition is to ensure resources are focused on improving the health of our population. An element of procurement legislation refers to proportionality. It is believed that the disruption that would be caused by a competitive procurement would not add value and limit staff from all organisations focusing on delivering required healthcare.

Current Contracts

The extant contracts in scope are detailed in the table below. Both contracts expire at the end of September 2021 and are currently within enacted extension periods.

Provider	2019/20 Annual Contract Value
RDEFT Community Contract	£55,785K
NDHT Community Contract	£29,755K

NB: The above values are reflective of 2019/20 contract values, and the Committee should note providers are being paid in 2020/21 under the provider Cv-19 block arrangements (calculated based on 2019/20 AoB M9 submissions for M1-M6, and a nationally calculated allocation framework for M7-M12).

The extant Eastern Community Services contract was competitively tendered in 2015/16, resulting in the award of a 36-month contract (with the option of a 24 month extension (enacted)) to RDEFT. It should be noted that NDHT held the contract for the relevant services in scope prior to that competitive tender.

The extant Northern Community Services contract was directly awarded to NDHT on the basis the provider was the Single Capable Provider in 2015/16.

Patient Safety and Quality

Reviews undertaken to date indicate efficiency is very good and no safety concerns have been identified through SIRI or complaints or similar routes.

There are areas for improvement in relation to all community service delivery locally, with the national initiatives around Enhanced Health in Care Homes, Urgent Community Response and Population Health Management being particular areas for focus and development. The enclosed PowerPoint highlights a number of secondary indicators that indicate efficiency with existing services, albeit there are a lack of standardised primary outcomes measures available for review.

An area that requires focus for any new contract would be to increase the visibility of community services outcomes, including in relation to performance quality and experience. For example, short term services capacity and waiting lists for therapies.

There is an expectation for the providers to be involved in, and report on, national initiatives and to establish true integration across acute and community services, working with primary and secondary care, mental health, social care and third party providers seamlessly. Organisations would be required to demonstrate how they offer choice and options to their populations, facilitating preventative strategies and reducing health inequalities.

The attached PowerPoint (appendix 1) shows that in 19/20 NHS Devon emergency SAR (standardized admission ratio) was in the bottom quartile and 2nd lowest in the comparator group, with bottom quartile SAR for over 65s. Locality data shows Eastern having the lowest rate. Together the data suggest effective out of hospital services in preventing admission.

Acute bed usage very low compared to national position in Northern and Eastern. Acute Length of stay is relatively low across whole age profile in Northern locality, in Eastern it is slightly below average across the majority of the age profile although it rises for peopled aged over 80 years.

RDE have a higher than expected rate of length of stay over 21 days, NDHT have the lowest, suggesting the latter locality is more effective at discharging patients earlier. This is an aspect to be developed in future service models. Similarly the delayed transfers of care have been highest art RDE, whereas rate in NDHT is very low. While waits for care packages in own home and access to residential homes are an issue in both localities RDE have a significant proportion waiting for community hospital beds, indicating this is an areas for further work. Readmission rates at RDE are just outside the lowest quartile and NDHT around national average.

Friends and family feedback shows a positive experience of care in both northern and eastern localities.

The lack of consistent community data set limits the comparisons that can be made. It is proposed further work should focus on:

- community hospital bed use and length of stay
- Admission avoidance effectiveness
- Discharge / rehab and reablement effectiveness
- Community services activity and cost
- Long term condition management

Outcomes Framework

Attached is the ICP framework (appendix 2) as currently agreed for ICP in western.

Reporting process for the outcomes needs to be agreed.

Some changes to the outcomes framework agreed for use in the Western ICP are proposed in order to reflect that mental health services are not included in these contracts. Consideration should be given to replacing mental health indicators with those that will cover the specialist services such as community musculoskeletal, bladder and bowel services.

The outcomes framework will need to be developed in conjunction with the proposed provider(s). We will need to be clear what the impact on the health of out population will be as a result of delivering the outcomes specified.

There is no proposal to change the scope of the current community services to include new areas such as mental health or children's community care; these are covered through other contractual arrangements.

It is suggested that we involve academic support for the development and review of the outcomes framework.

Break Clause

It is proposed that the contracts will be awarded containing a clearly articulated commitment for the CCG to serve notice to the providers at the end of year 2 should a pre-agreed set of criteria not be satisfactorily met.

It is proposed that the following areas are included (this is not an exhaustive list and will be developed prior to, and during contract negotiation):

- Demonstrated commitment to working effectively with system partners (especially but not exclusively primary care and mental health providers) to develop services around the needs of people with regard to system financial affordability
- The lowest bed usage / length of stay is in localities with the largest relative community service base. But this comes at a cost so there needs to be further work to determine the most cost-effective model of care.
- Inclusion of the lower limb therapy service within community services contract, or agreement of clear reasons why this is not the most effective way of commissioning the services
- Development of services to support long term conditions
- Agreement of service specifications and nominal financial allocation to each area within the community block

- Development of organisational form to ensure community services are given appropriate priority within each organization, for example through having appropriate board level representation

It is proposed that the contract structure of an SDIP (Service Development & Improvement Plan) is used to document the details of this agreements.

Commitment by commissioners to maintain this process will need to be maintained throughout the development and initial two-year period. This will be a significant commitment, although it is recognised that immediate actions (February and March 2021) will be less. This will need to occur irrespective of evolving Commissioner roles and contract monitoring practice within the Devon Integrated Care System.

A suggested proposal is:

Year 1
Using the SDIP structure and outputs, a written report will be given to providers identifying areas requiring further work at end of year one.

Year 2
At the end of the third quarter a report will be presented to (TBC – Commissioning Committee/Execs) detailing the progress made by the providers and/or any outstanding items and a recommendation for satisfactory or unsatisfactory completion of the above criteria. Execs (TBC) will be asked to agree the assessment and corresponding contract result. A written explanation of the assessment and corresponding contract result will be sent to the providers, including instructions for any required remedial action plans with clear achievement timelines.

Risk Assessment

Although the value of these contracts is high, there are no significant quality concerns and no contract performance notices have been issued to the current Providers. Lack of comparable data has prevented a more detailed value for money or quality assessment, although no indications have been identified. No formal market assessment has been undertaken recently. When the services were tendered previously no alternative bidders were identified. Direct awards of these service contracts to our system partners is in line with national Long-Term Plan and Devon draft Long Term Plan and they will support the development of ICSs.

As such the risk of successful challenge to a direct award of these contracts is assessed as low.

Implementation Proposal

If the proposal for a long-term direct award is supported a detailed implementation plan will need to be developed and implemented. Broad issues and timelines are:

Feb – March
Develop break clause
Undertake SAW

April – Aug
Negotiate with Providers in order to agree:

- outcomes framework
- service specifications
- financial envelope
- relationships with other elements of health system, e.g. PCNs

Complete contractual and procurement requirements

September 21 – September 23
Implement – to include ongoing monitoring and management to ensure objectives are realized
Development & Implementation of Community dataset

This will be a significant program of work and needs to be resourced accordingly, although little additional resources are expected to be required immediately (February and March 2021), there will be an ongoing need for significant resource over several years.

At Place level there will be a requirement for commissioning expertise. At System level this must be supported by strategic commissioning, finance, nursing & quality, strategic intelligence, contracting and communications.

We need to ensure learning is spread across the CCG, so some functions must be addressed at system level and others at place.

Regular reporting to Commissioning Committee throughout the development and implementation of this proposal.

Conclusion and Recommendations

The CCG Governing Body is asked to agree the following:

1. Make a direct award of a contract for general community services to RDEFT and NDHT for 10 year with potential for 5 year extension, with a clear proviso that contract will be terminated after 2 years if satisfactory progress is not made on a number of defined issues;

2. Agree implementation proposal;

3. Agree senior leadership for this work to be prioritized to ensure sufficient resource is available to deliver the required outcomes.

4. Agree Commissioning Committee will oversee the project, receiving updates no less frequently than every 3 months for next 3 years

Comparing Outcomes

STRATEGIC INTELLIGENCE

Measuring Outcomes

Issues

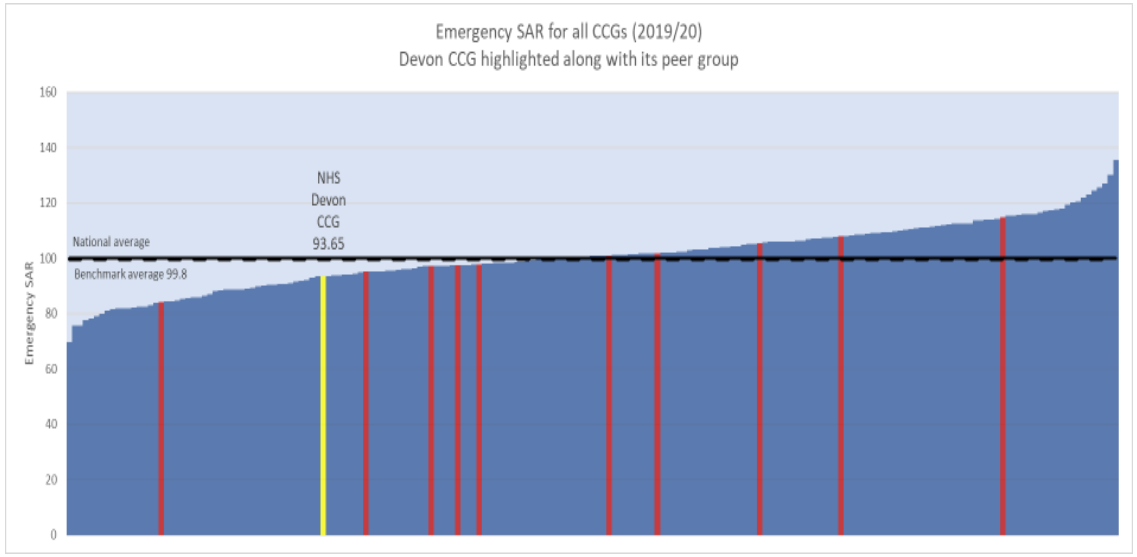
- There is a lack of good quality, comparable data about the direct contribution of community services
- Health outcome measures are influenced by many factors, meaning it is difficult to separate out the impact of community services

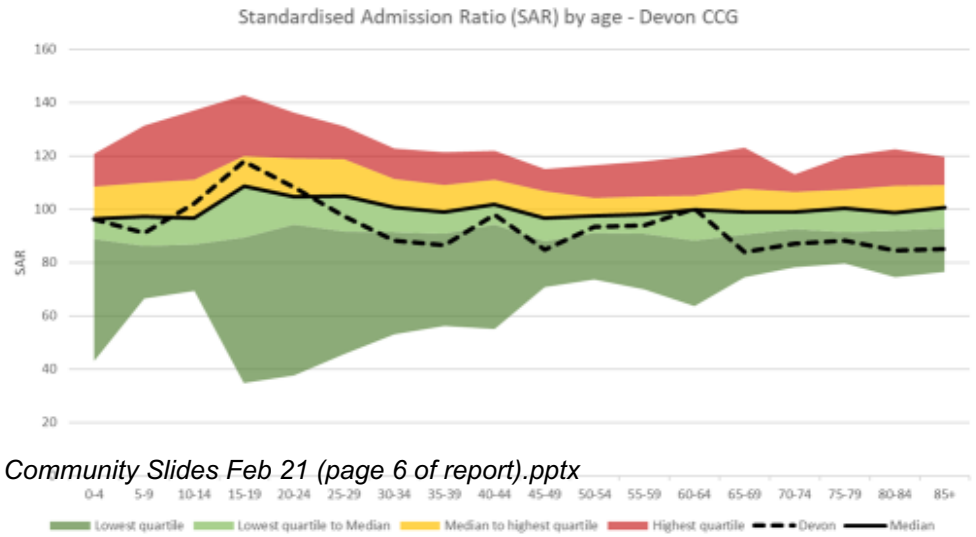
Approach

- The primary aim of many community services is to prevent acute admission or to facilitate effective discharge and as such acute measures such as comparative emergency admission rates, length of stay and readmissions are valid indicators of the effectiveness of community services
- Measures of patient experience of community services also offer insight into the perceived quality
- Benchmarked spend per head of weighted population gives an indication of value for money and financial equity

PREVENTING ACUTE ADMISSIONS

Emergency admission SAR comparison

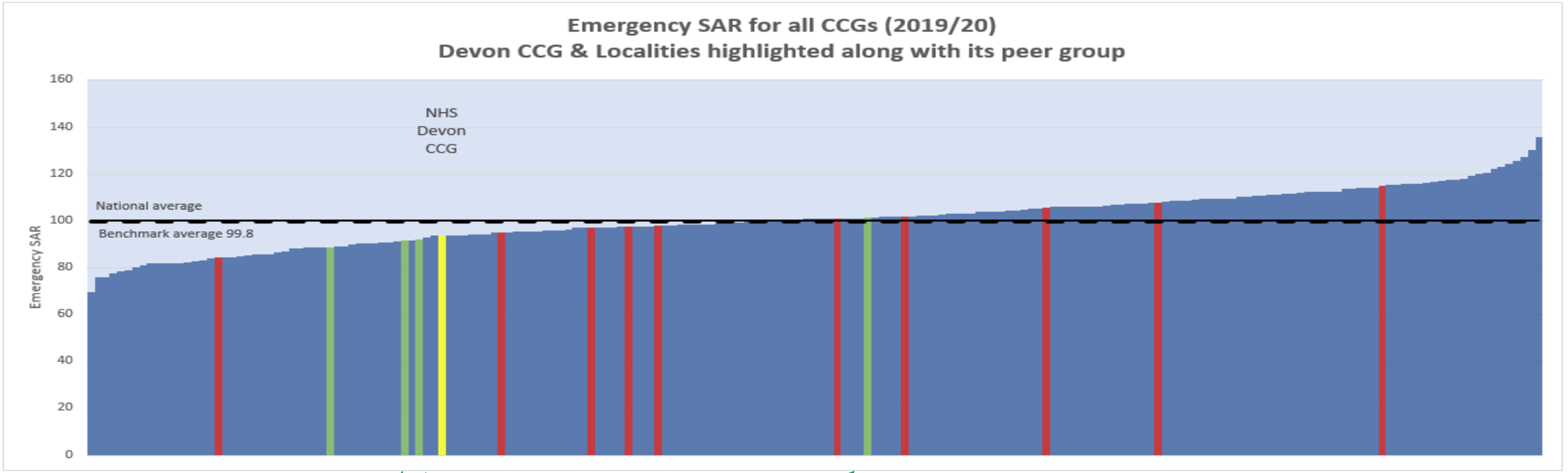




- The top chart shows Standardised Admission Rates (SAR) for emergency admissions and compares all CCGs nationally
- Comparator peer groups are highlighted in red
- This excludes mental health beds, maternity beds and zero day length of stay
- 19/20 emergency SAR was in the bottom quartile and 2nd lowest in the comparator group
- SAR by age (bottom chart) shows the rate of emergency admissions in Devon compared to England across age ranges
- This shows around average attendances for children & young people and a low SAR for over 65s (bottom quartile)

PREVENTING ACUTE ADMISSIONS

Emergency admission SAR comparison by locality

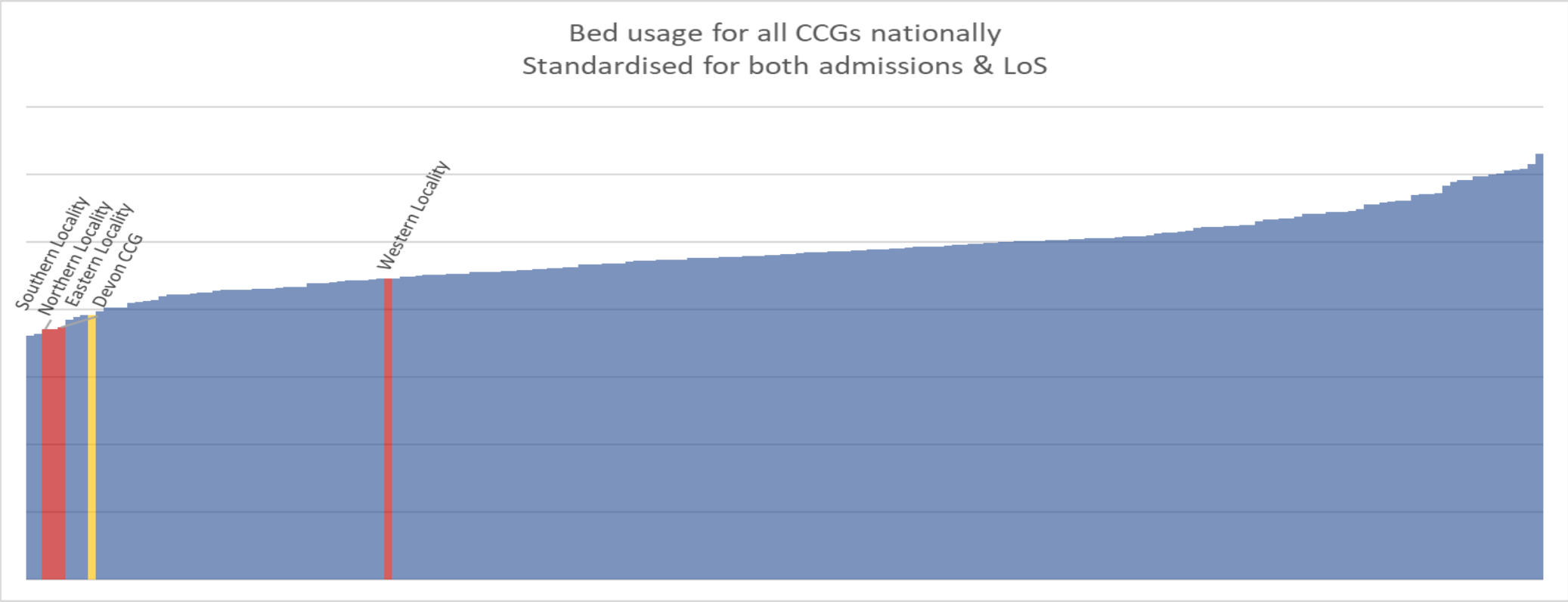


Eastern, Northern and Southern all see low emergency admission rates for their population, with Western at average levels

This suggests effective out of hospital services in preventing admission

PREVENTING ACUTE ADMISSIONS

Acute bed usage



- Beds usage is calculated by comparing admissions and LoS
- Southern, Northern and Eastern Devon all see very low acute bed usage compared to the national position. Western is also lower than the England average.

PREVENTING ACUTE ADMISSIONS

Acute bed usage - locality benchmarking of bed variation

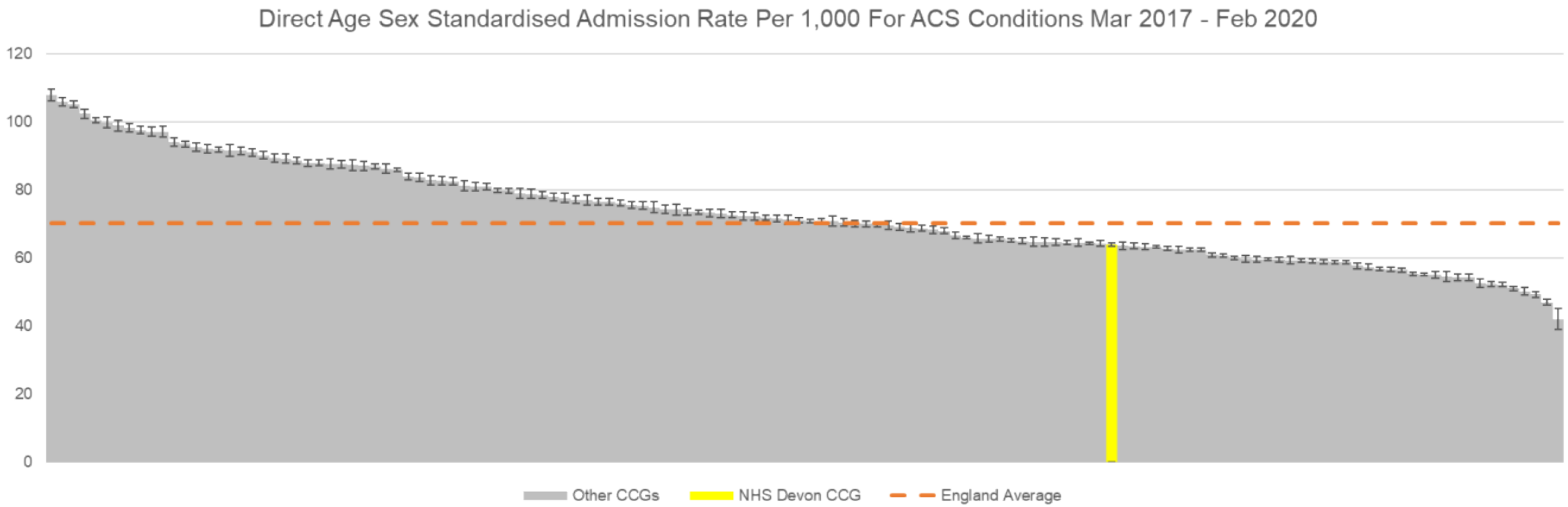
Table: Variation in occupied beds by locality compared to national average

	SAR variation	LoS variation	Total bed variation
Southern Locality	-10.70%	-12.7%	-23.4%
Eastern Locality	-14.62%	-5.4%	-20.0%
Western Locality	1.85%	-6.4%	-4.5%
Northern Locality	-4.93%	-17.0%	-22.0%
Devon CCG	-7.64%	-9.3%	-16.9%

- Devon CCG uses 16.9% less beds than expected compared to the national average
- Both SAR and LOS are lower than the national average in Eastern, Northern and Southern Devon

PREVENTING ACUTE ADMISSIONS

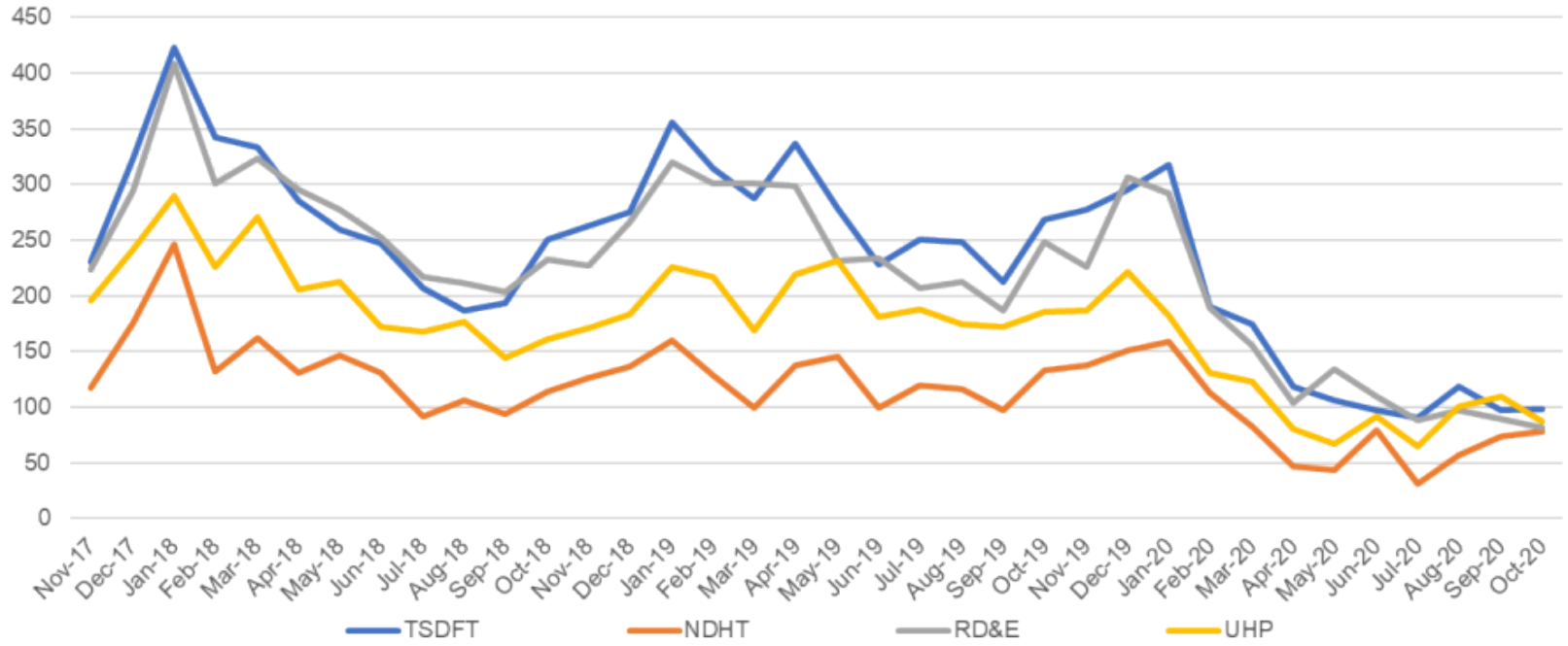
ACS conditions



- Devon CCG is below the national average rate for emergency admissions for patients with ambulatory care sensitive (ACS) conditions

PREVENTING ACUTE ADMISSIONS

Over 65s ACS conditions

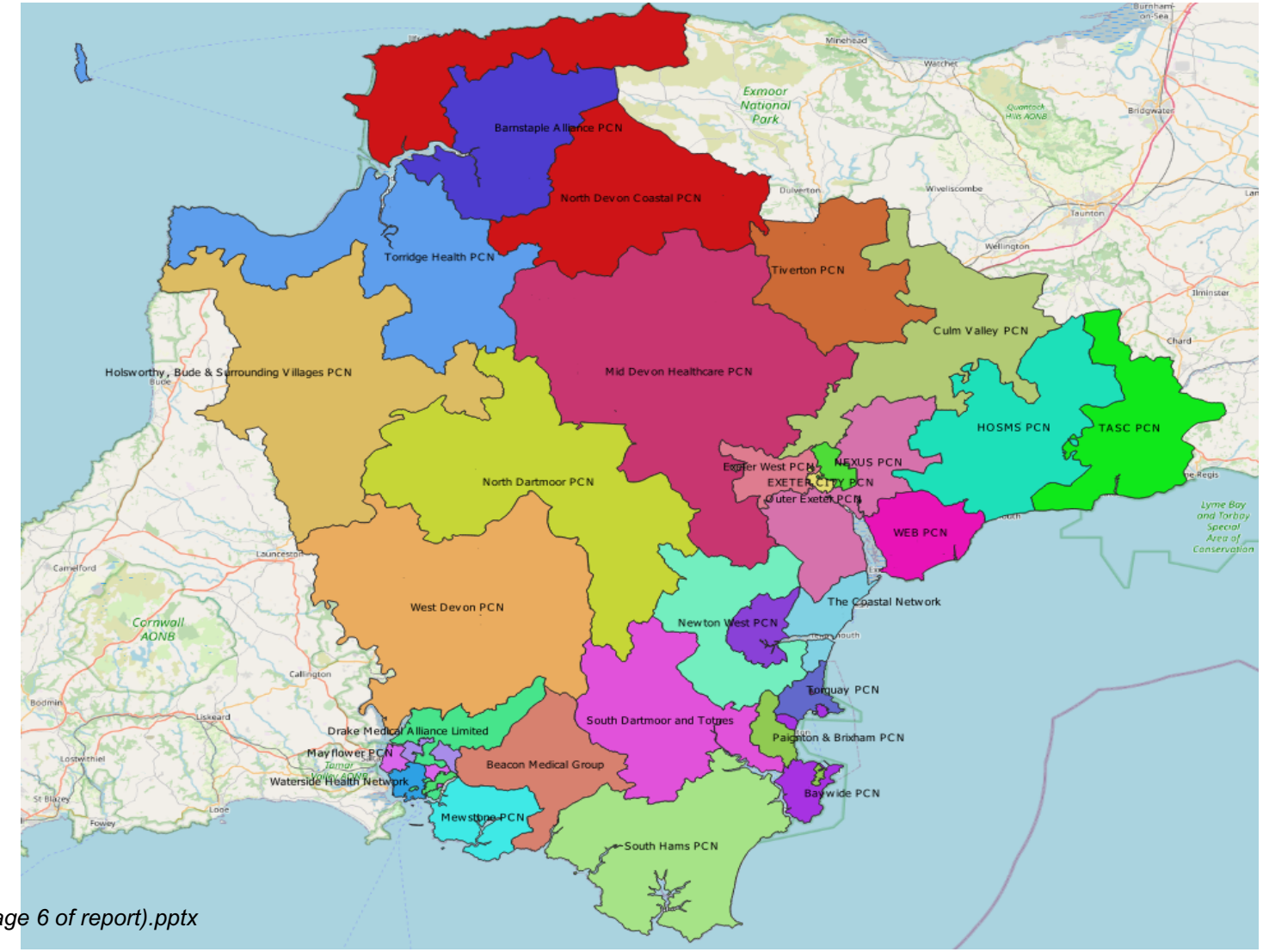


- Community services should help prevent Ambulatory Care Sensitive admissions
- TSD sees a comparatively high number of admissions for ACS conditions whilst NDHT sees a low level
- All providers saw a relatively flat trend prior to the impact of Covid

PREVENTING ACUTE ADMISSIONS

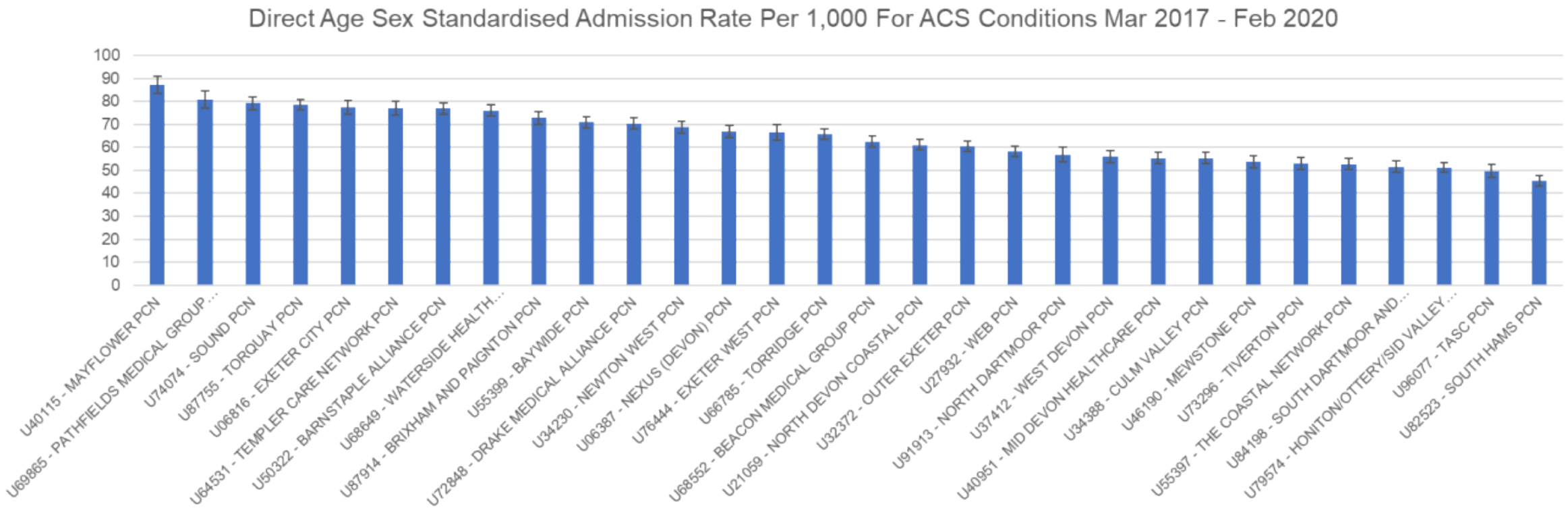
PCN level view of selected indicators

For context, this map shows the PCN boundaries in Devon



PREVENTING ACUTE ADMISSIONS

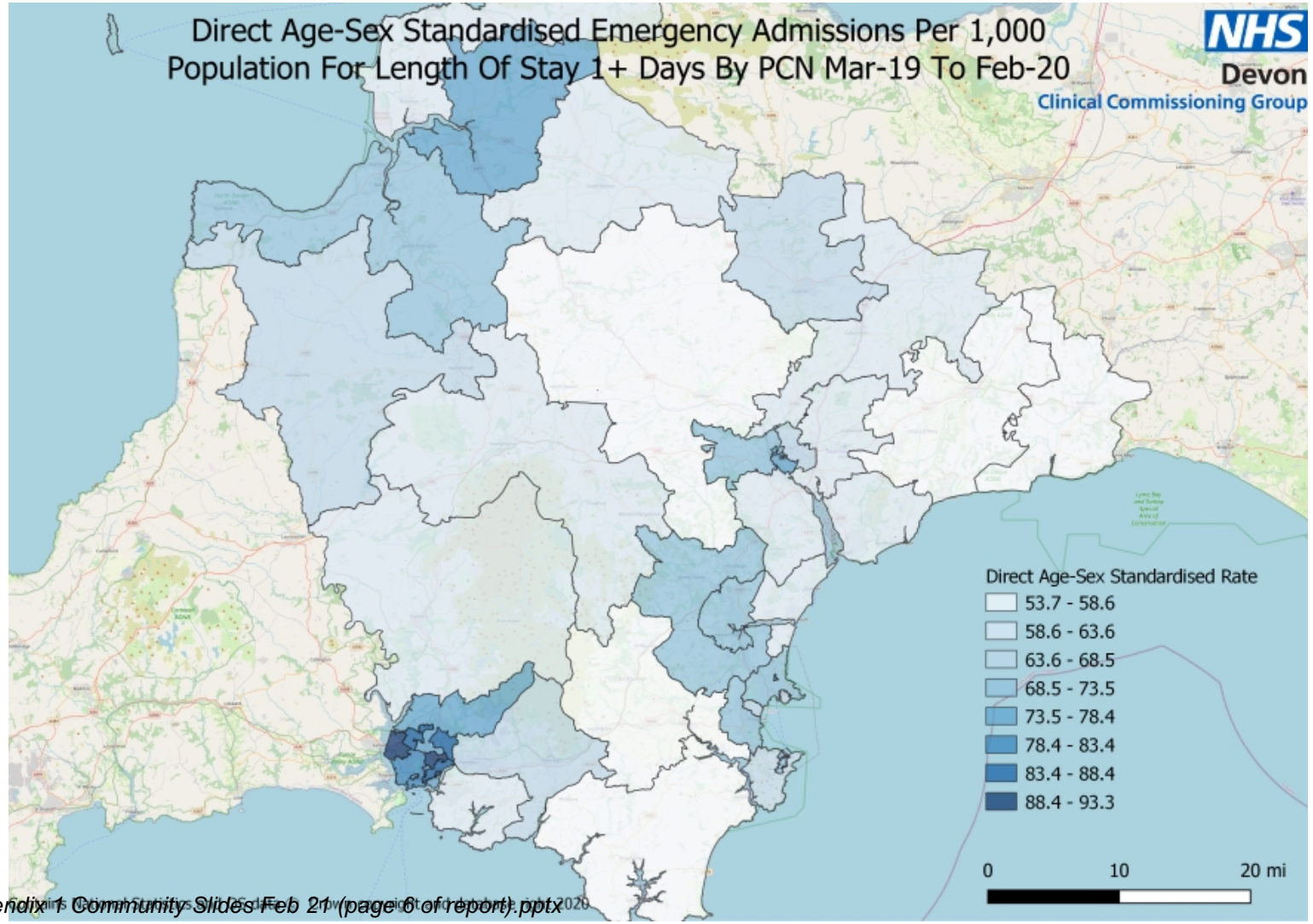
ACS conditions



- Mayflower and Pathfields PCNs see the highest rate of ACS conditions with TASC and South Hams PCNs seeing the lowest level in Devon. There is considerable variation across Devon.

PREVENTING ACUTE ADMISSIONS

Emergency Admissions Rate By PCN (+1 LOS)

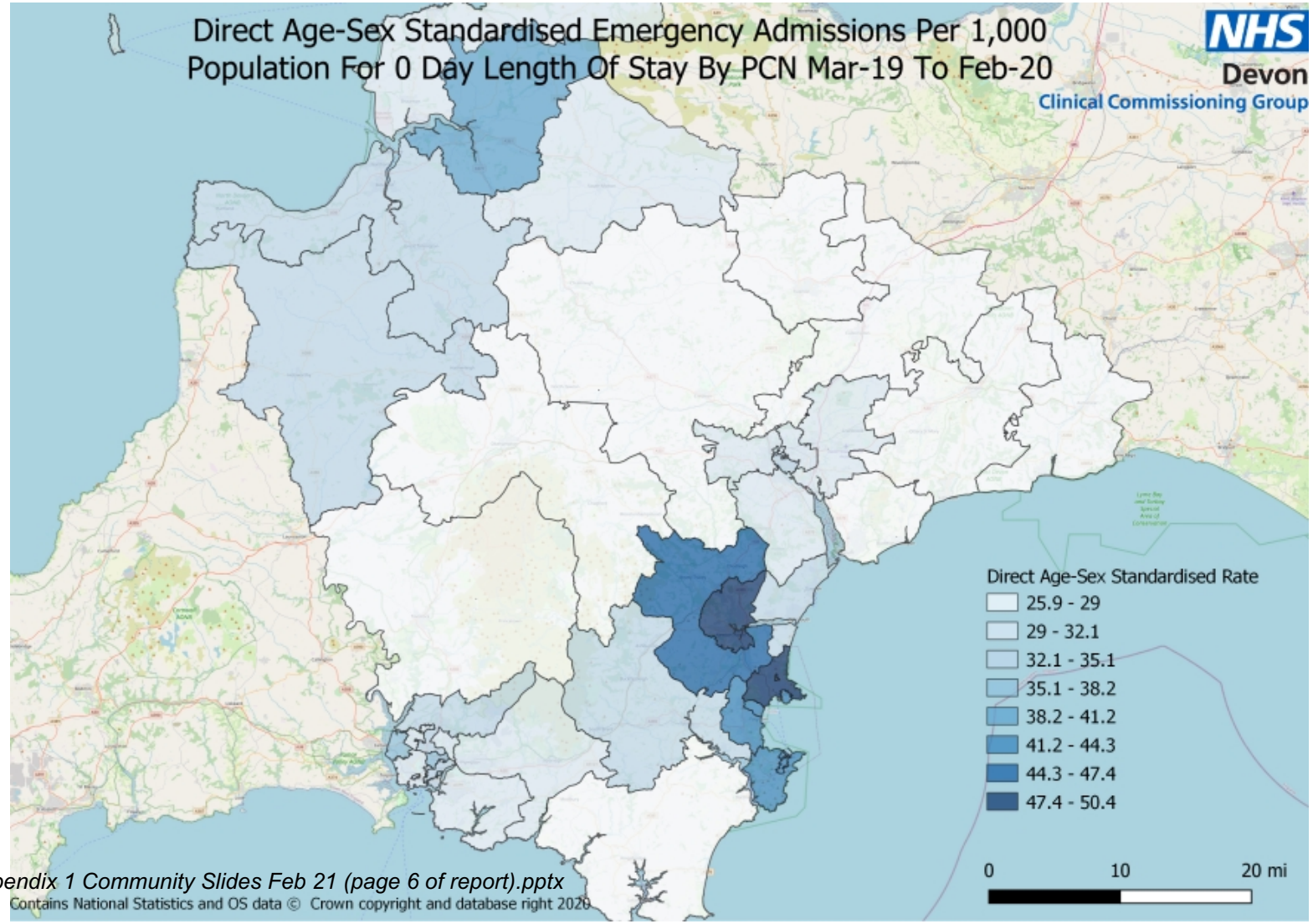


Mayflower and Pathfields PCNs see the highest rate of emergency admissions compared to their population, with PCNs in Plymouth generally seeing higher rates.

Honiton, Ottery St Mary & Sid Valley PCN and TASC PCN – both in East Devon - and South Hams PCN see the lowest rates (for lengths of stay greater than 0 days)

PREVENTING ACUTE ADMISSIONS

Emergency Admissions By PCN (zero LOS)

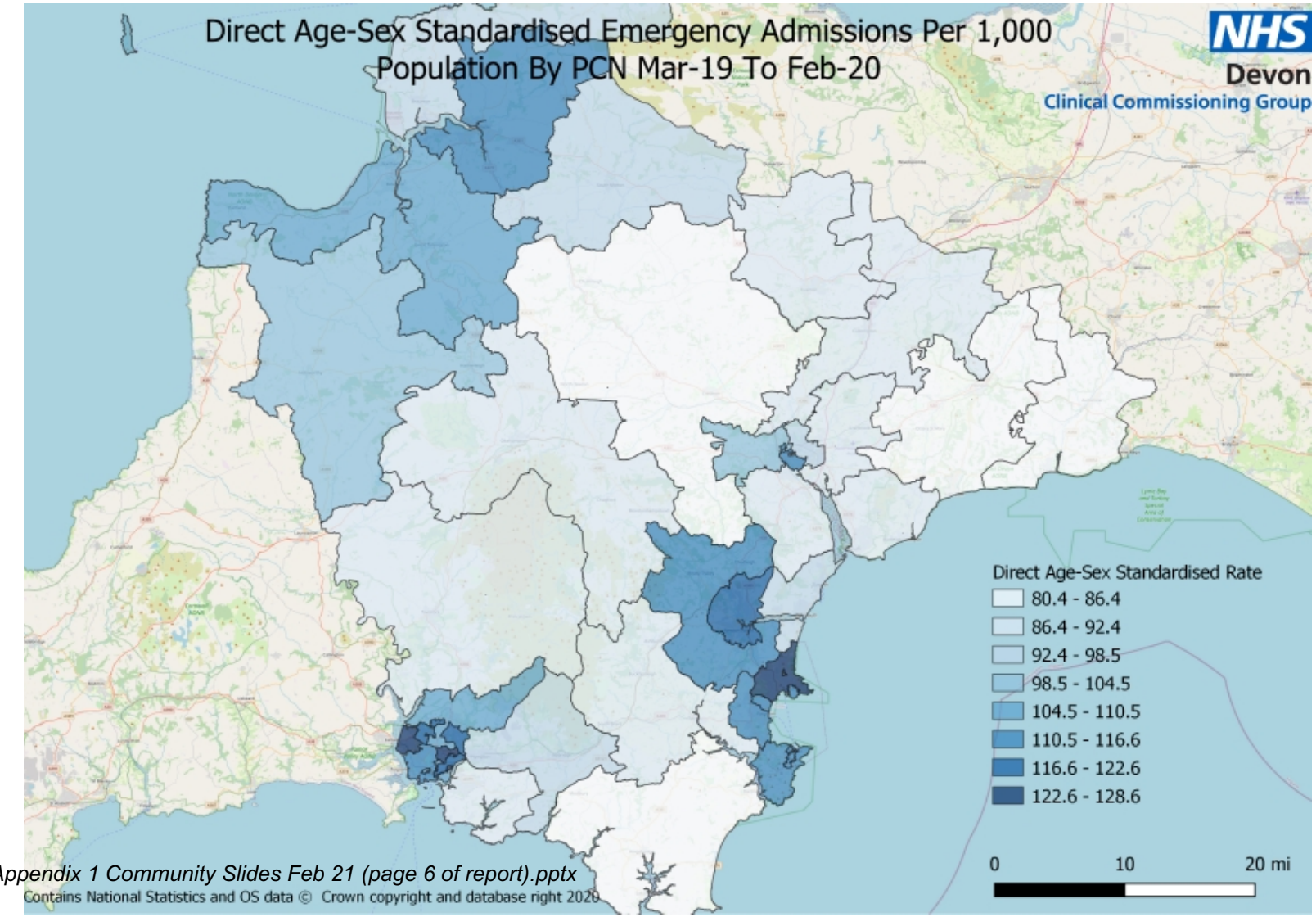


Templer Care and Torquay PCNs in South Devon see the highest rate of emergency admissions for zero length of stay patients, with TASC and North Dartmoor PCNs seeing the lowest

Note: 0 day length of day is susceptible to bias caused by differences in provider assessment unit activity recording

PREVENTING ACUTE ADMISSIONS

Emergency Admissions By PCN – all LOS



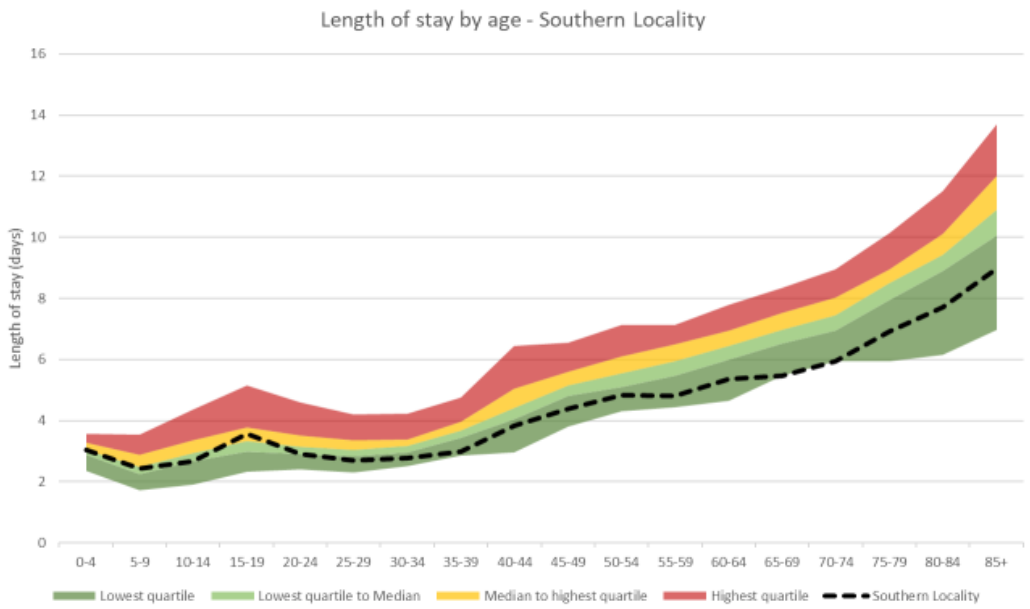
Mayflower and Torquay PCNs see the highest rate of overall emergency admissions (all LOS), with higher rates generally seen in Plymouth and Torbay.

Honiton, Ottery St Mary & Sid Valley PCN and South Hams PCN see the lowest overall rate.

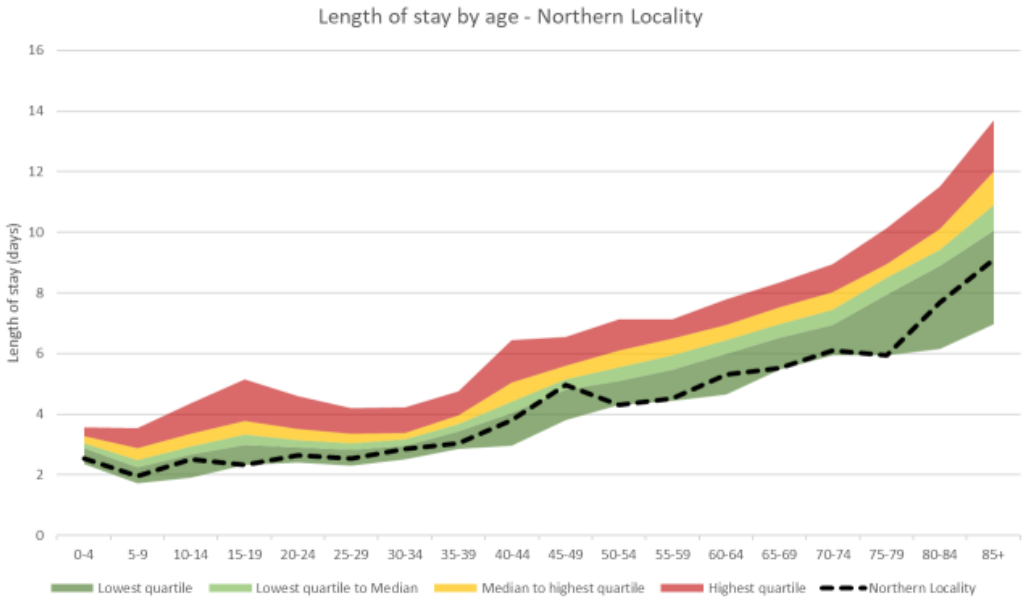
Note: 0 day length of day is susceptible to bias caused by differences in provider assessment unit activity recording

FACILITATING DISCHARGE

Length of Stay (1)



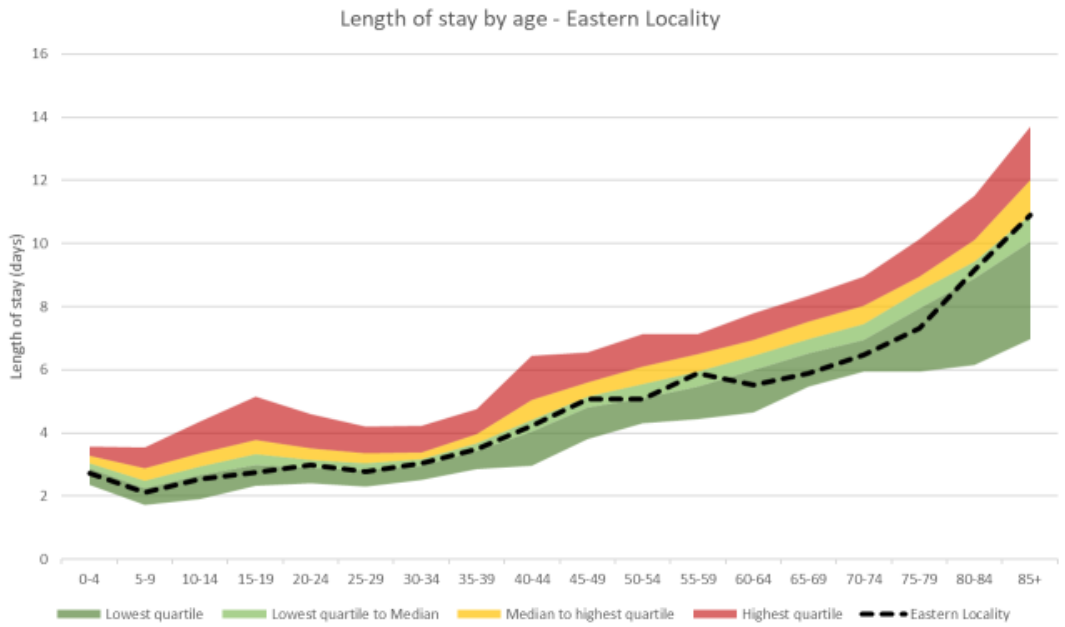
LOS increases with age. However, the relative LOS by age for the Southern locality is comparatively low across the whole age profile. It is particularly low for those around 65 and just below average for late teenagers



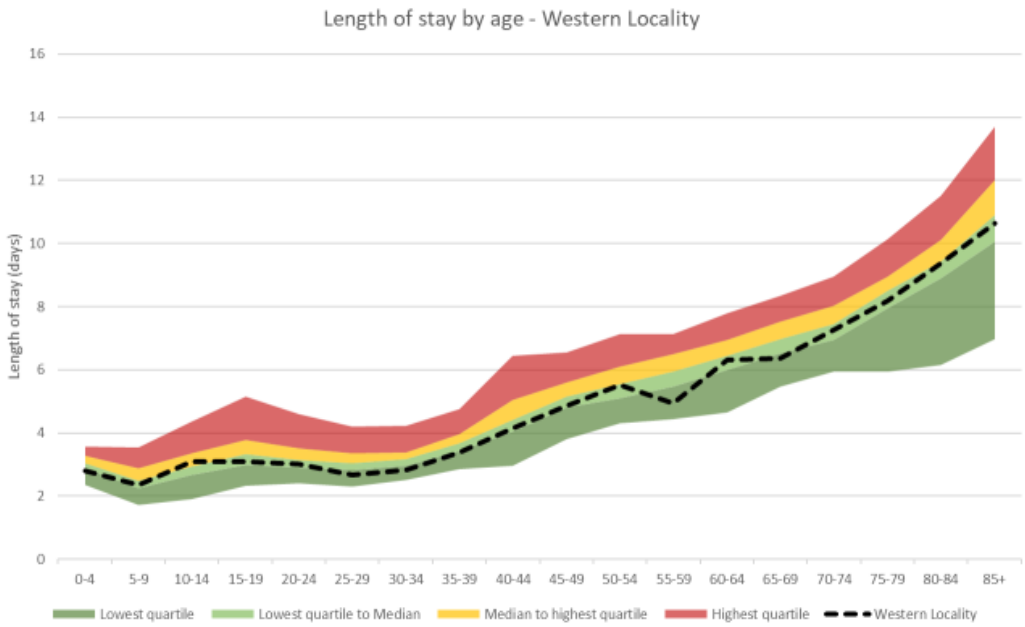
Similarly the relative LOS by age for the Northern locality is comparatively low across the whole age profile. It is in the bottom quartile across the whole age profile and effectively the lowest for people aged 50-80

FACILITATING DISCHARGE

Length of Stay (2)



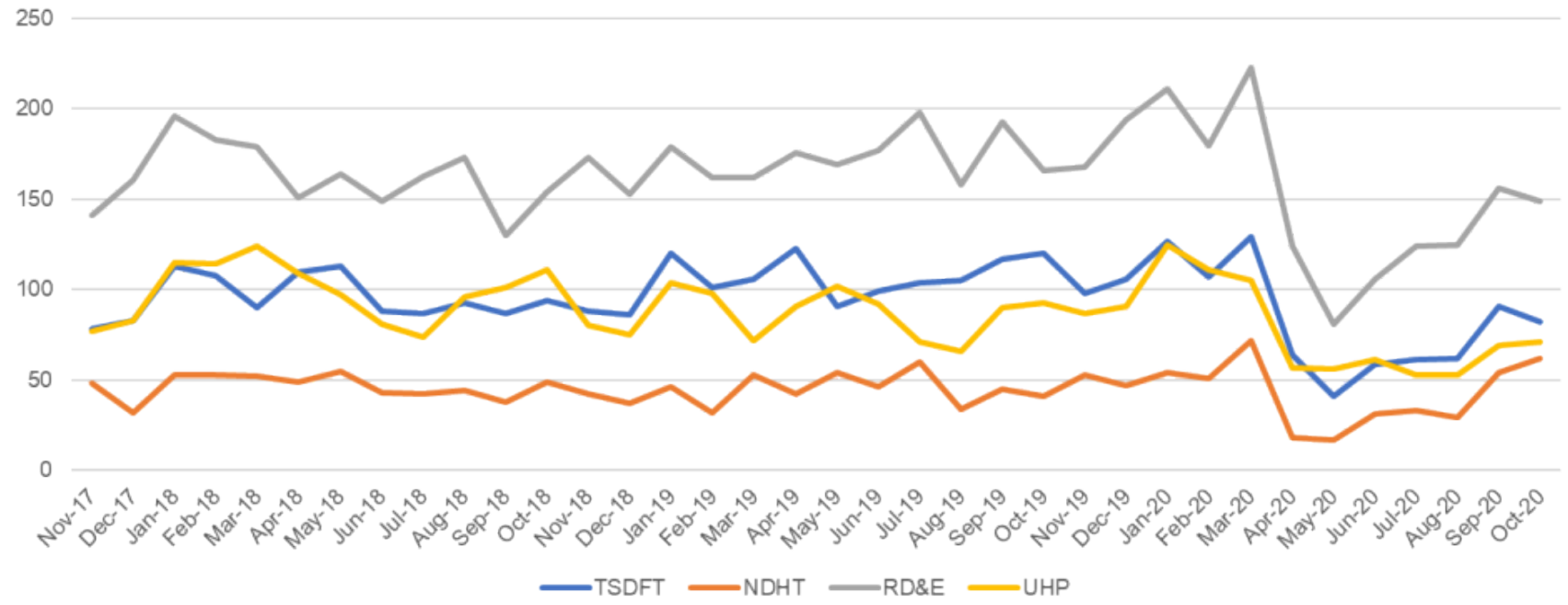
The relative LOS by age for the Eastern locality is slightly below average across the majority of the age profile although rises for patients 80+ years old.



The relative LOS by age for the Western locality is very similar to the national average across the whole age profile.

FACILITATING DISCHARGE

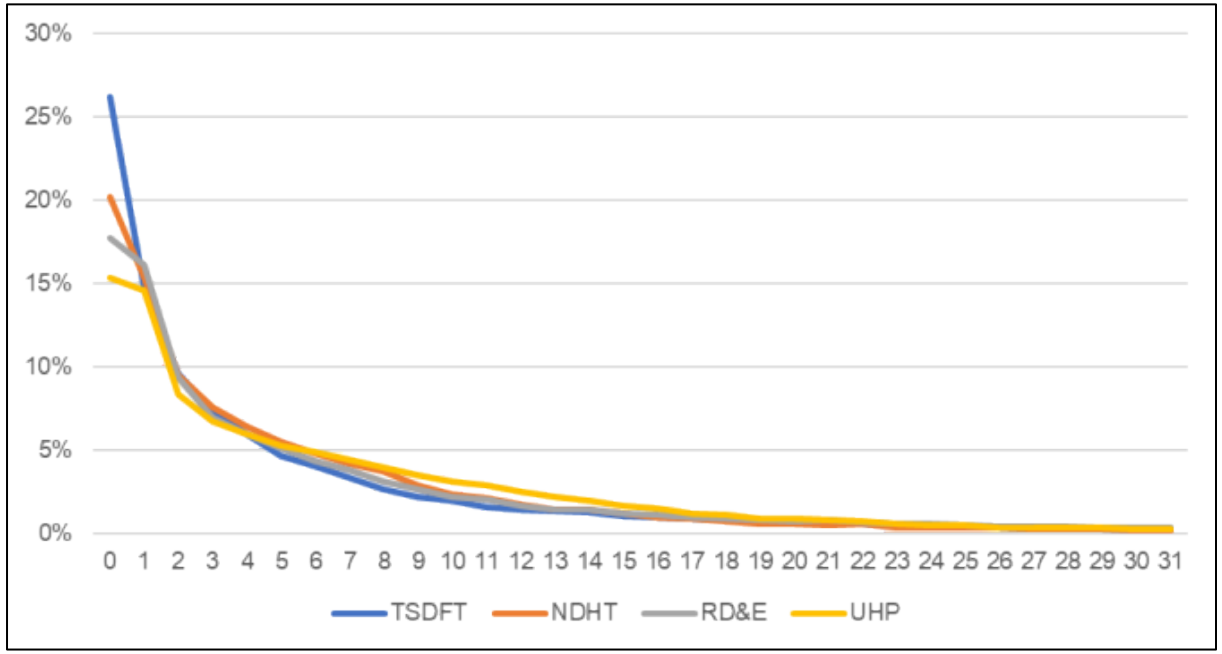
21+ day Length of Stay

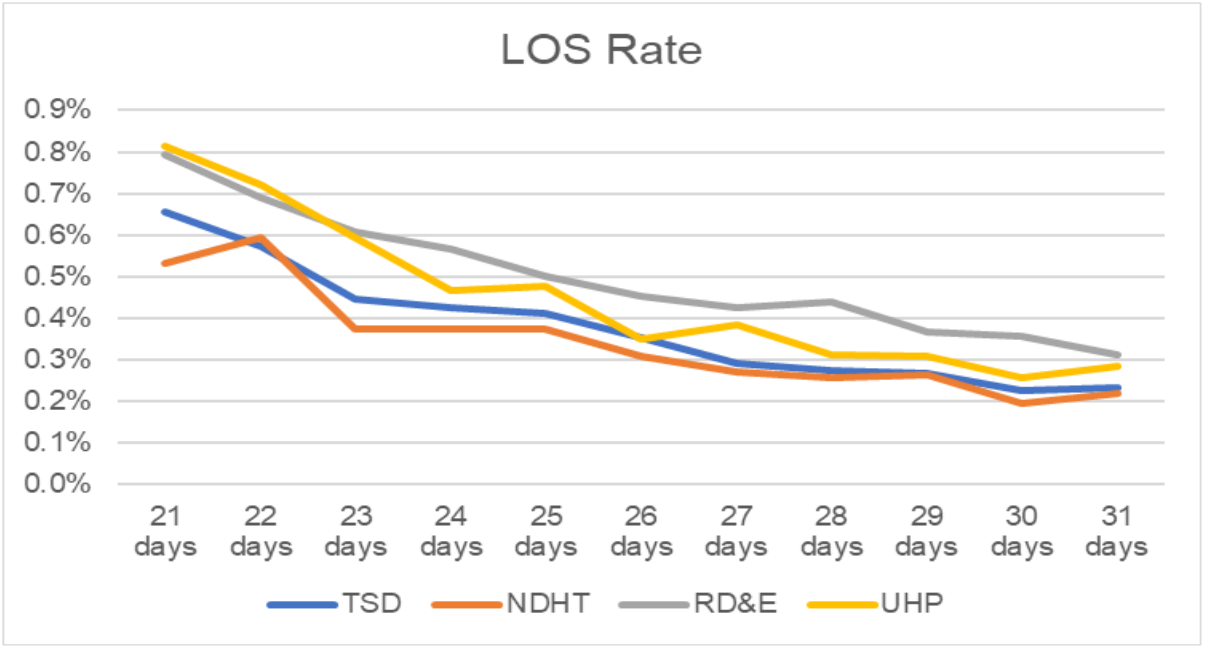


- Over 21 day LOS has remained relatively static across all providers since 2017

FACILITATING DISCHARGE

21+ day LOS



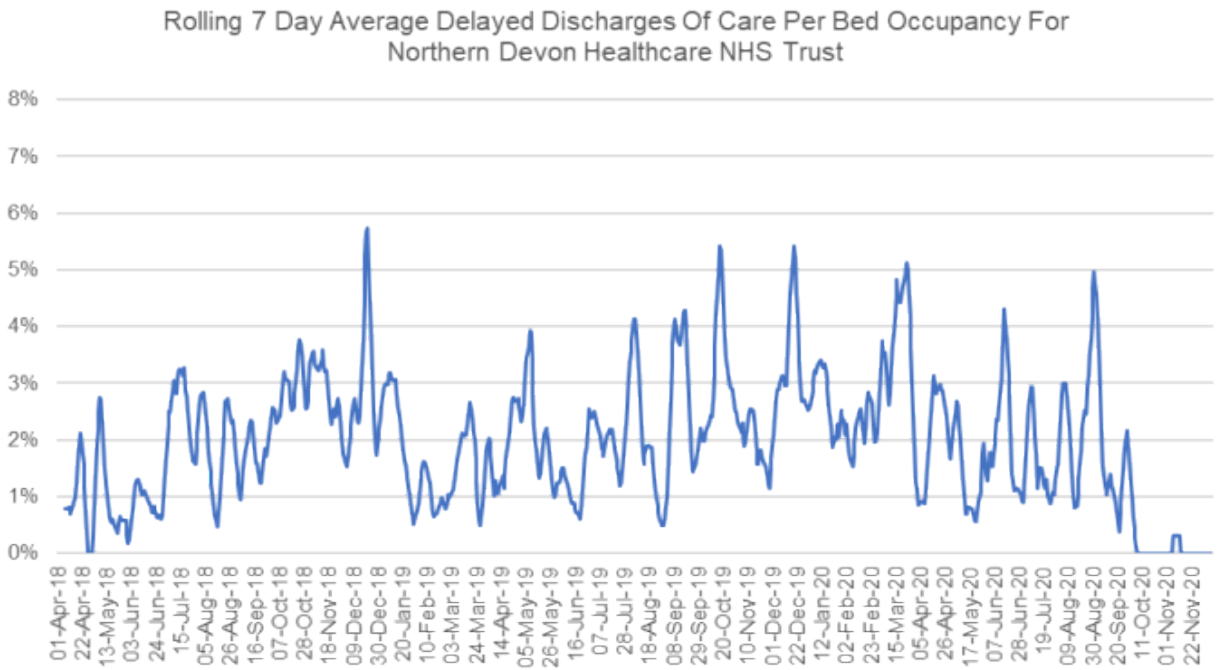


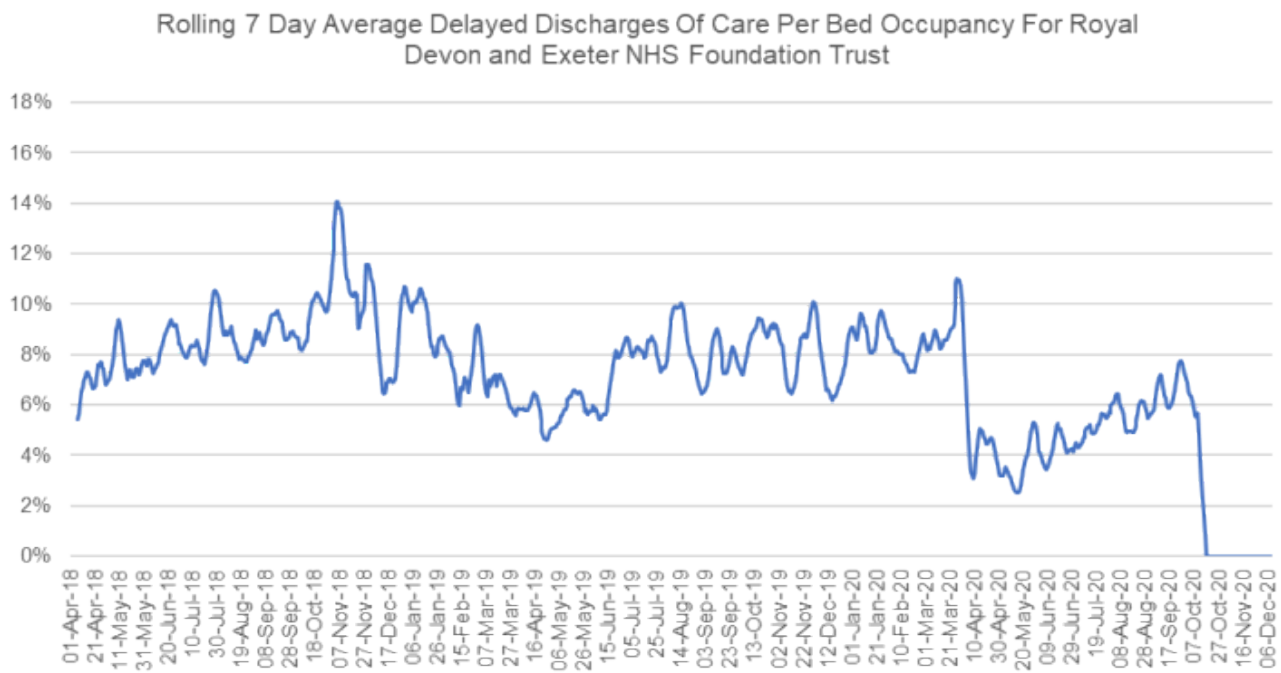
- The chart above shows the rate of LOS by provider
- TSD see a higher rate of zero and one day LOS, potentially a higher proportion of unnecessary admissions or differences in recording of assessment unit activity. Longer LOS is generally lower at TSD.

- The chart above focuses on the LOS over 21 days
- RD&E have the highest rate of long waits and NDHT the lowest, suggesting the latter locality is more effective in discharging patients earlier

FACILITATING DISCHARGE

Delayed Transfers of Care (DTOC) 1

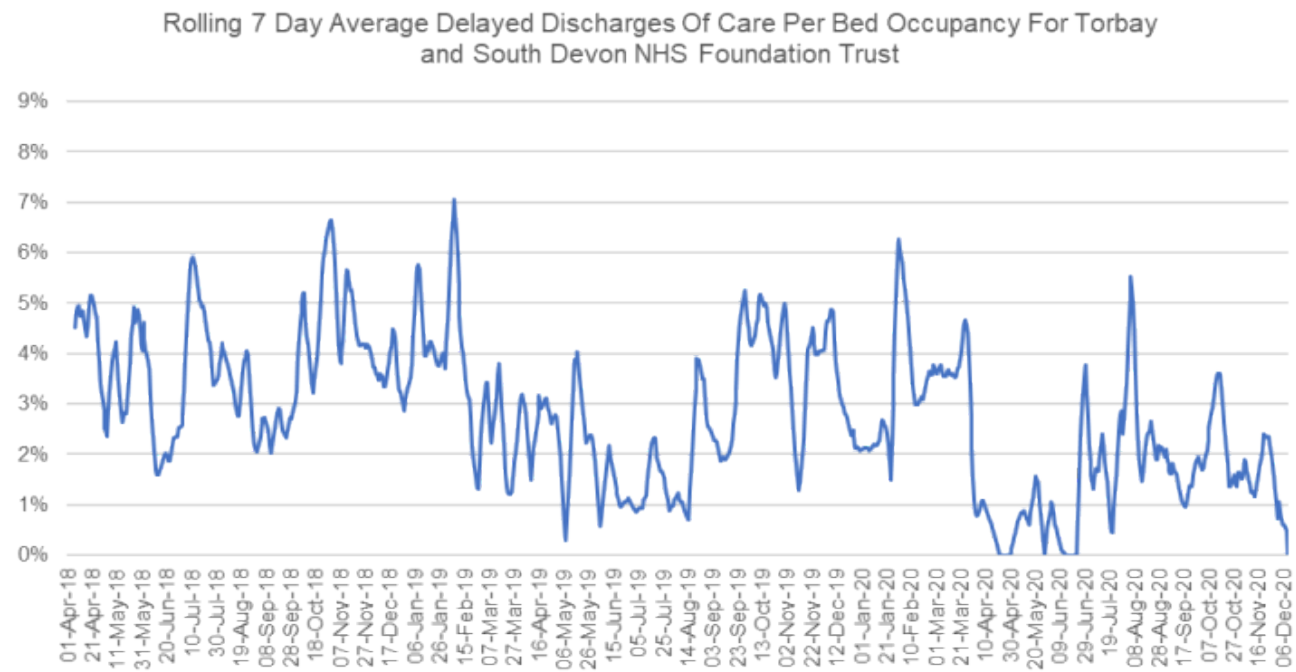


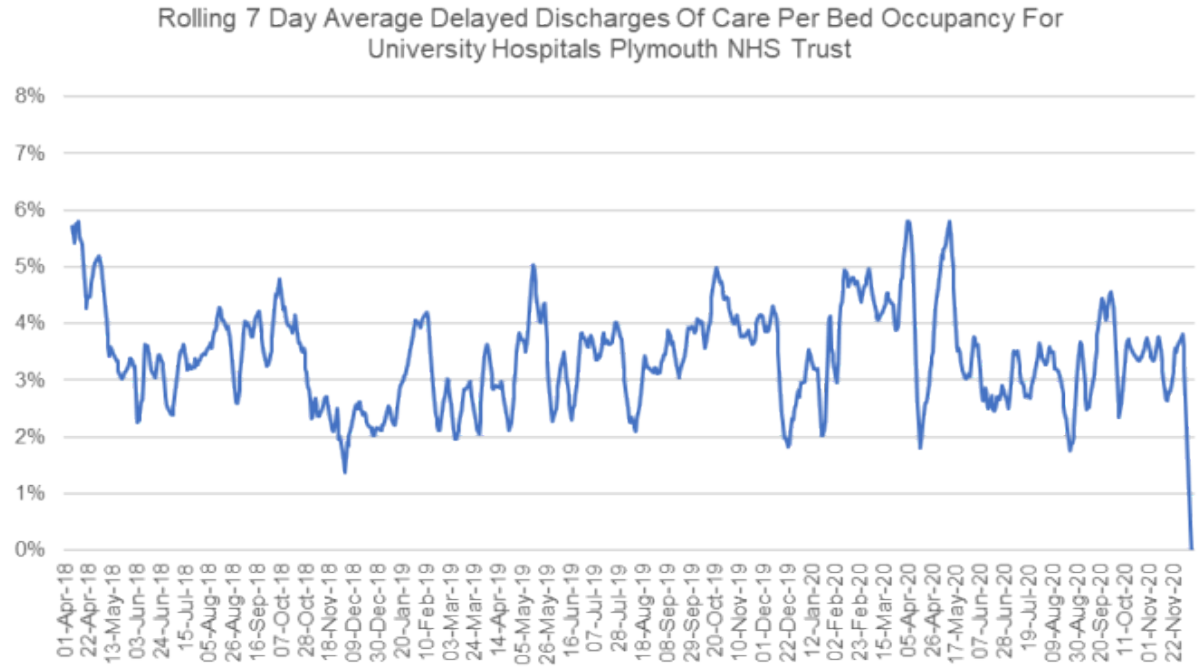


- The charts above show delayed transfers of care since 2018 for NDHT and RD&E
- DTOC have consistently been highest at RD&E since 2018. NDHT continue to see very low levels of DTOC, both in numbers and in the rate of DTOC to occupied beds

FACILITATING DISCHARGE

Delayed Transfers of Care (DTOC) 2

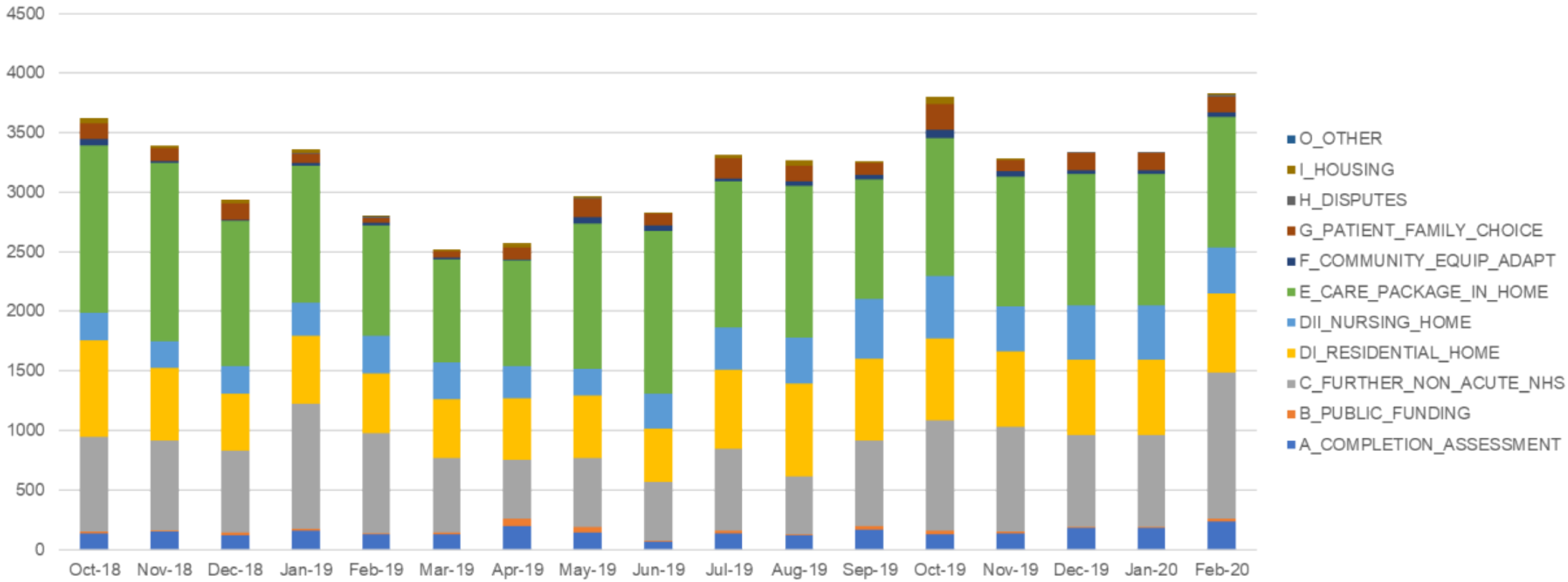




- The charts above and before show delayed transfers of care since 2018 for TSD and UHP
- TSD continue to see very low levels of DTOC both in numbers and in the rate of DTOC to occupied beds.
- UHP see an average of 3.5% of beds delayed, which has been relatively static since 2018.

FACILITATING DISCHARGE

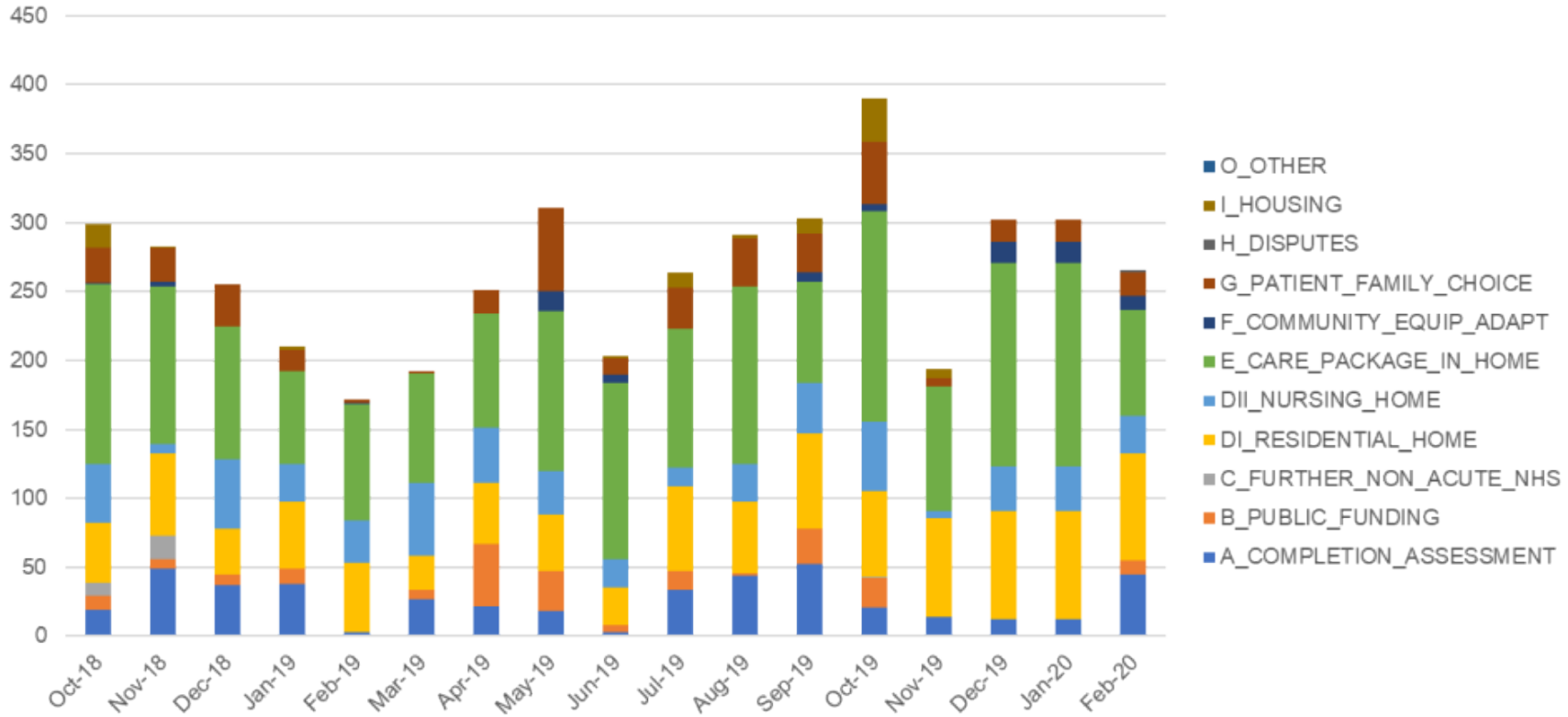
DTOC reason (Devon total)



- The main reasons for DTOC across Devon are shown in the chart above
- DTOC are consistently highest for patients waiting for care packages, further non-acute NHS care (community hospital beds) and residential homes

FACILITATING DISCHARGE

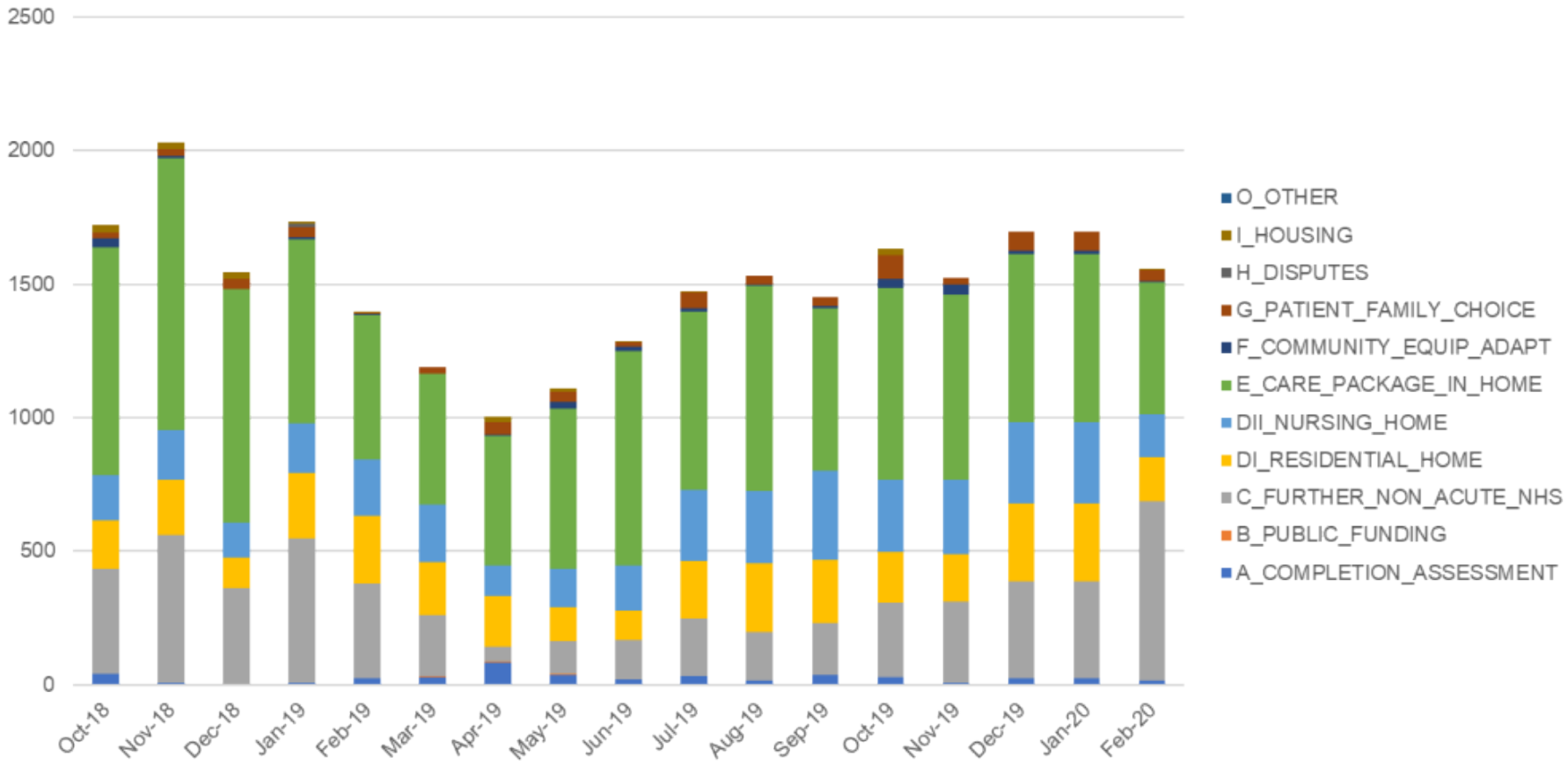
DTOC reason by provider - NDHT



- The main reasons for DTOC at NDHT are care packages and residential homes
- Delays linked to waits for community beds are very low

FACILITATING DISCHARGE

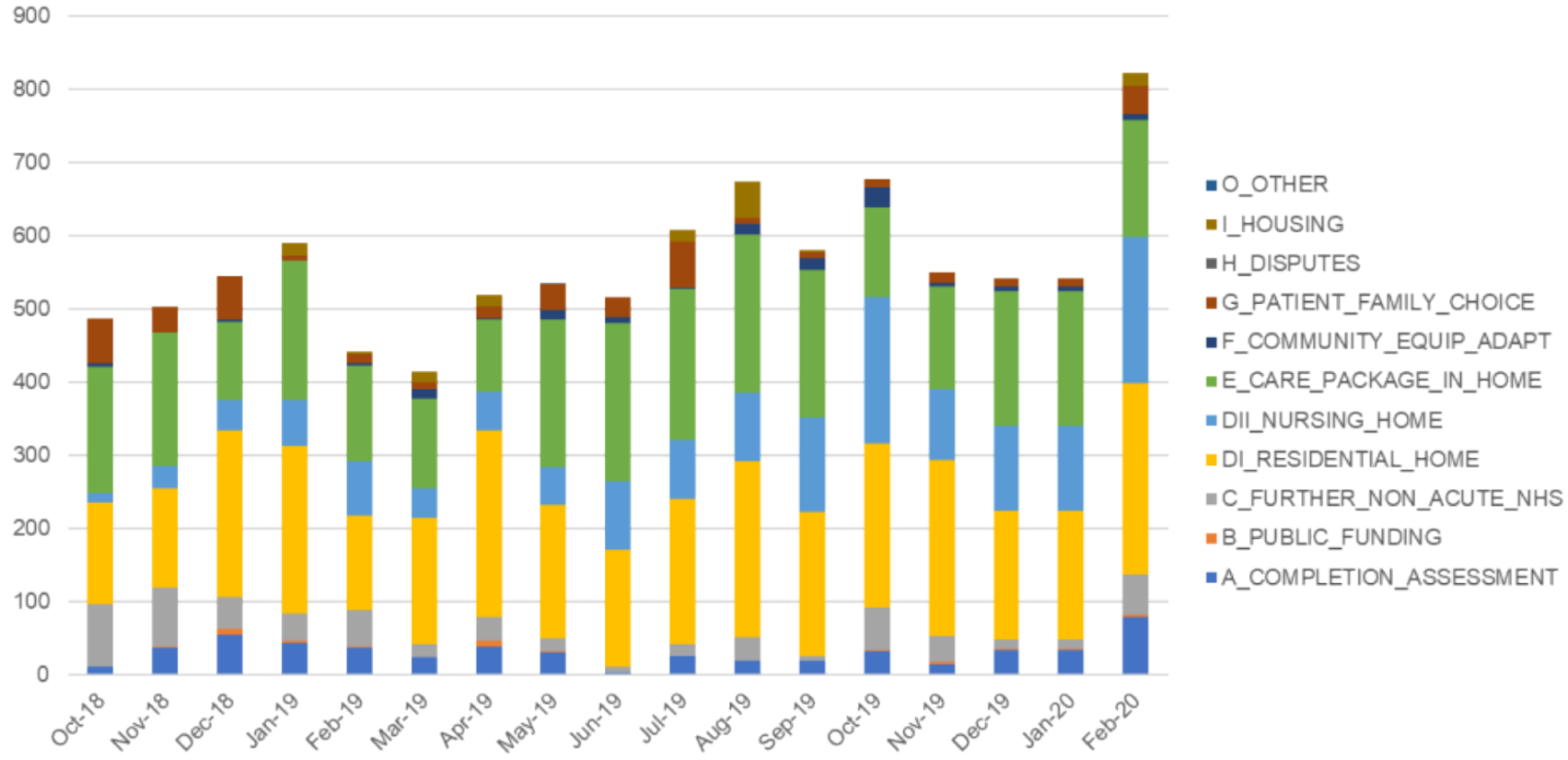
DTOC reason by provider – RD&E



- The main reasons for DTOC at RD&E are waits for care packages, further non-acute NHS care and residential homes

FACILITATING DISCHARGE

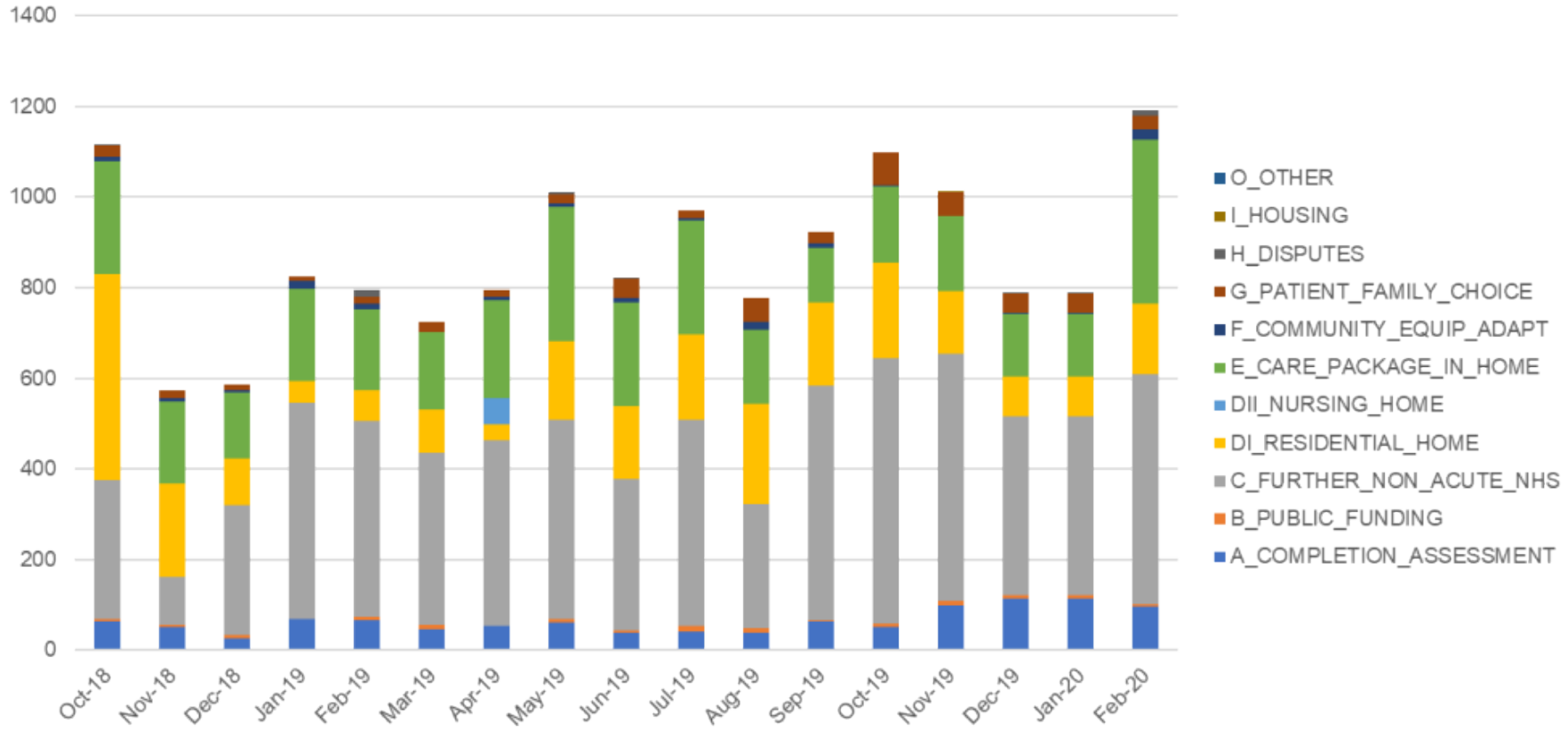
DTOC reason by provider – TSD



- The main reasons for DTOC at TSD are care packages, residential and nursing homes
- DTOC for community beds are generally low

FACILITATING DISCHARGE

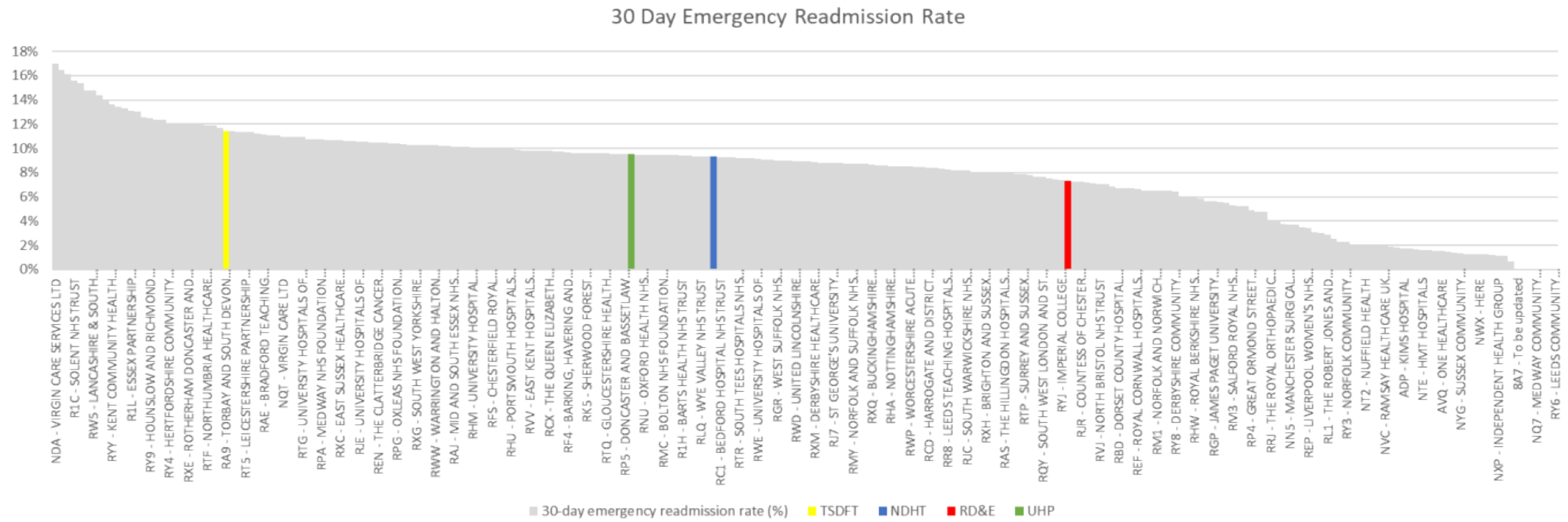
DTOC reason by provider – UHP



- The main reasons for DTOC at UHP are largely for further non-acute NHS care, followed by care packages and residential homes

FACILITATING DISCHARGE

Readmissions



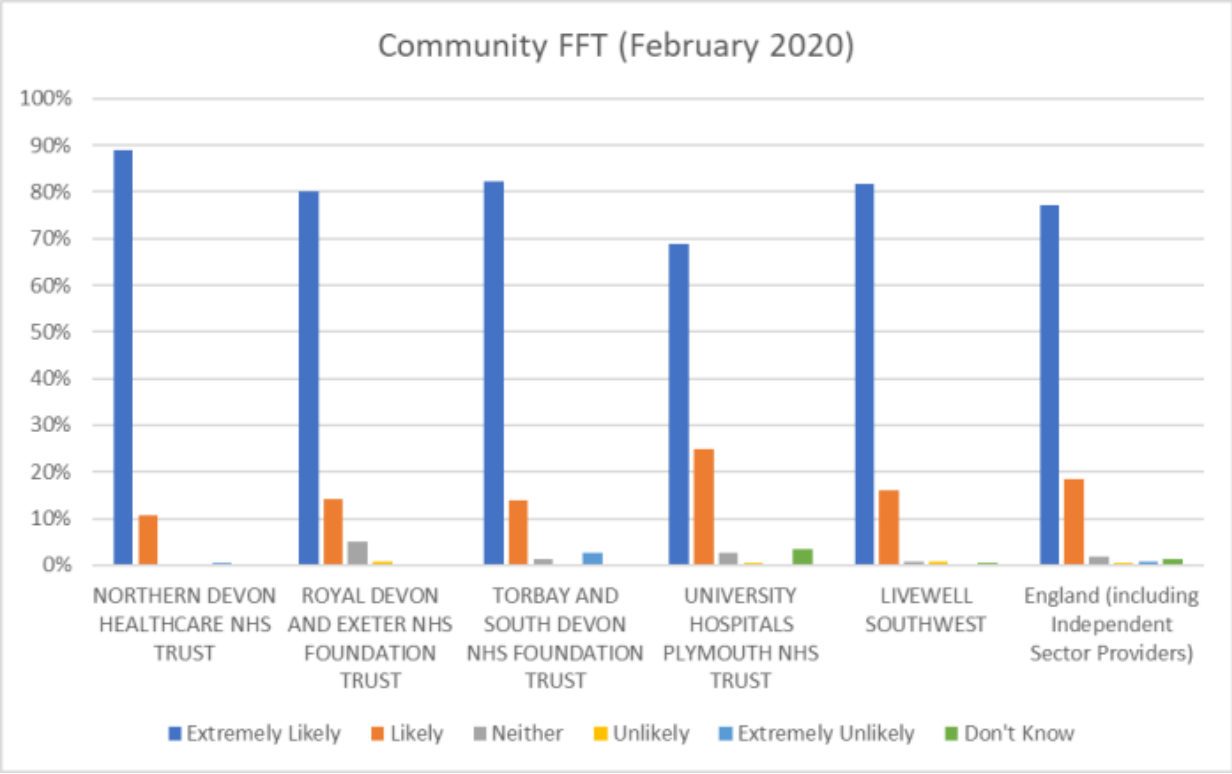
- TSD has a relatively high emergency readmission rate compared to other providers.
- UHP and NDHT are around average, whilst RD&E sees a rate just outside the lowest quartile.

2 Appendix 1 Community Slides Feb 21 (page 6 of report).pptx

PATIENT EXPERIENCE

Friends and Family Test (FFT) – February 2020

The FFT asks patients how likely they are to recommend NHS services to friends or family. The Community Health FFT dataset includes FFT responses for the latest month from providers of NHS funded community health services. Data is submitted monthly by providers and is available to service category level. The figures below show the latest monthly data.



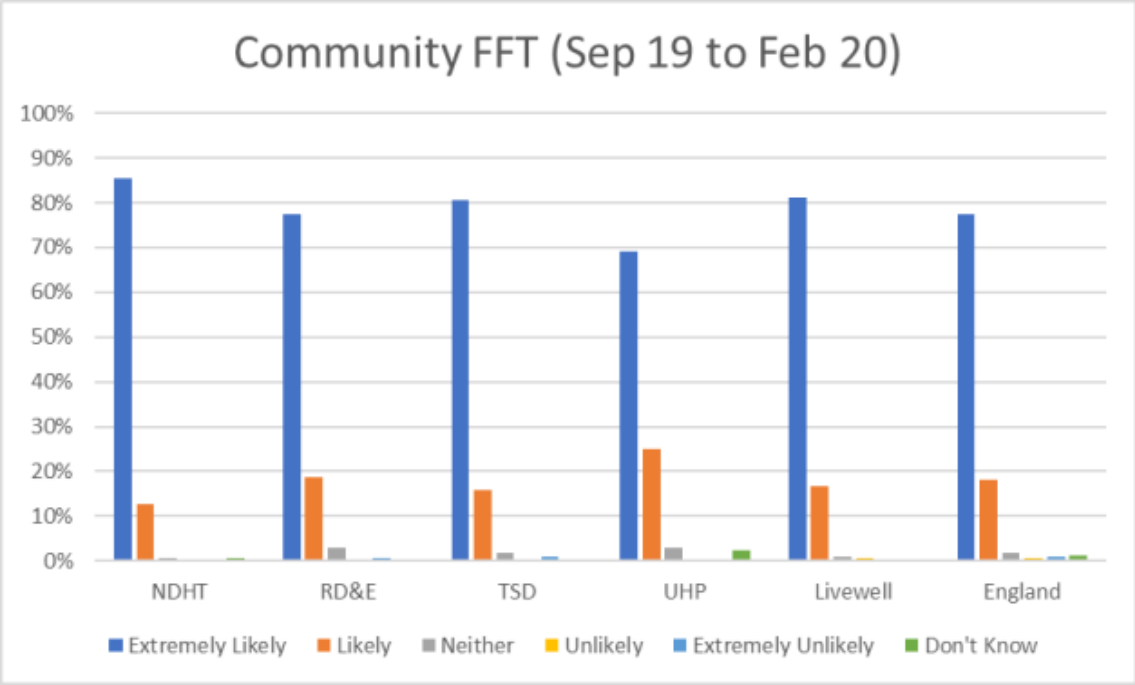
Trust Name	Total Responses	Percentage Recommended
NORTHERN DEVON HEALTHCARE NHS TRUST	179	99.4%
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	121	94.2%
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	79	96.2%
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	234	93.6%
LIVEWELL SOUTHWEST	693	97.7%
England (including Independent Sector Providers)	105,566	95.6%
England (excluding Independent Sector Providers)	83,749	95.8%

Devon providers all perform well against the community FFT, with NDHT receiving comparatively very high levels of positive responses for it's services.

PATIENT EXPERIENCE

Friends and Family Test (FFT) – Sept 19 to Feb 20

Looking at a six month period of FFT responses reduces the impact of small numbers. The latest available six months (prior to the Covid pandemic when FFT was suspended) shows consistently high scores achieved across all Devon providers and a positive comparison to the England position.

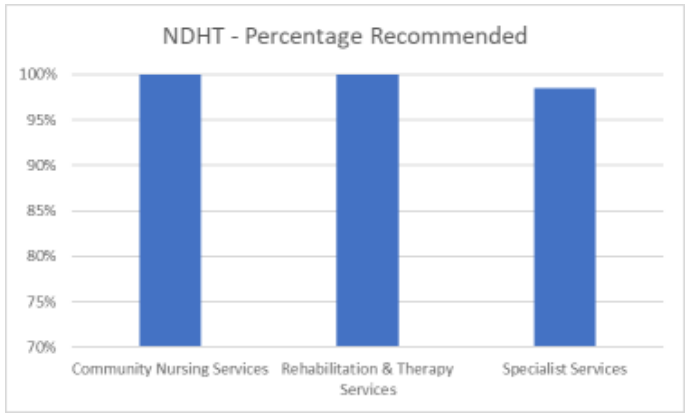


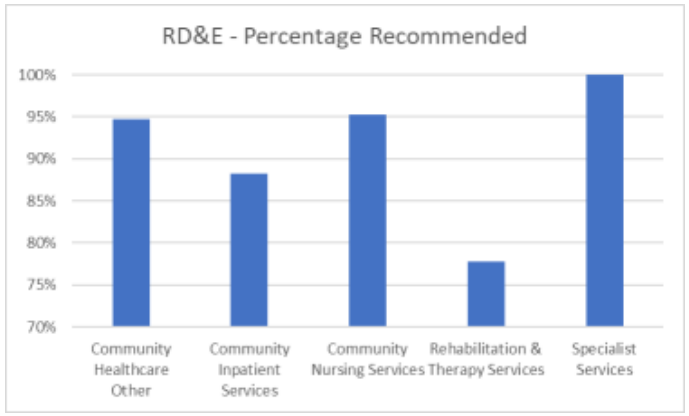
Trust Name	Total Responses	Percentage Recommended
NORTHERN DEVON HEALTHCARE NHS TRUST	1,192	98.2%
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	715	96.2%
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	482	96.5%
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	1,495	94.3%
LIVEWELL SOUTHWEST	4,257	97.8%
England (including Independent Sector Providers)	653,134	95.6%
England (excluding Independent Sector Providers)	504,842	96.0%

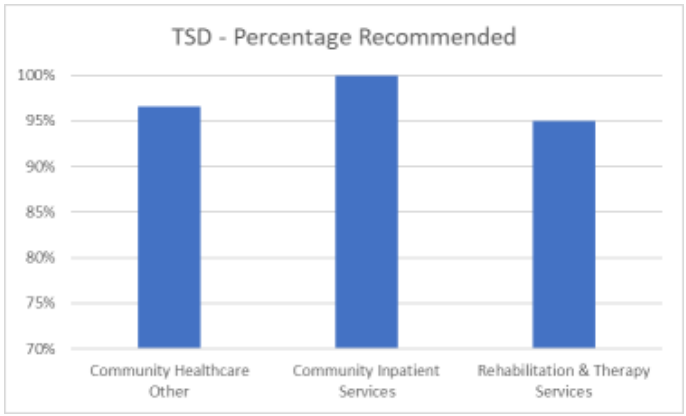
PATIENT EXPERIENCE

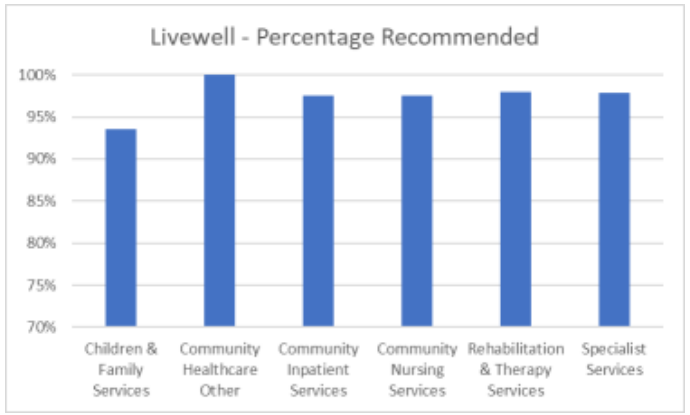
Friends and Family Test (FFT)

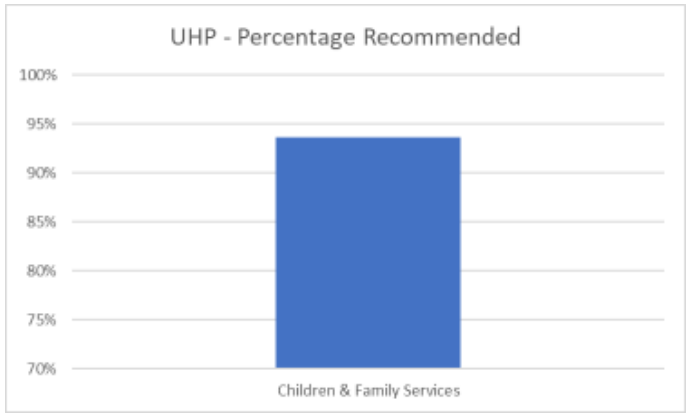
The FFT splits down by service as shown below (Feb 2020). Smaller numbers mean there is monthly variability in results.







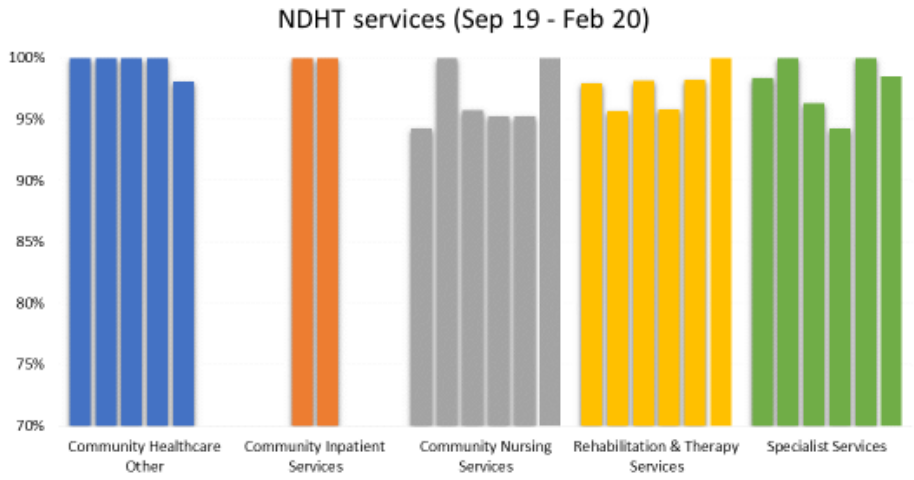




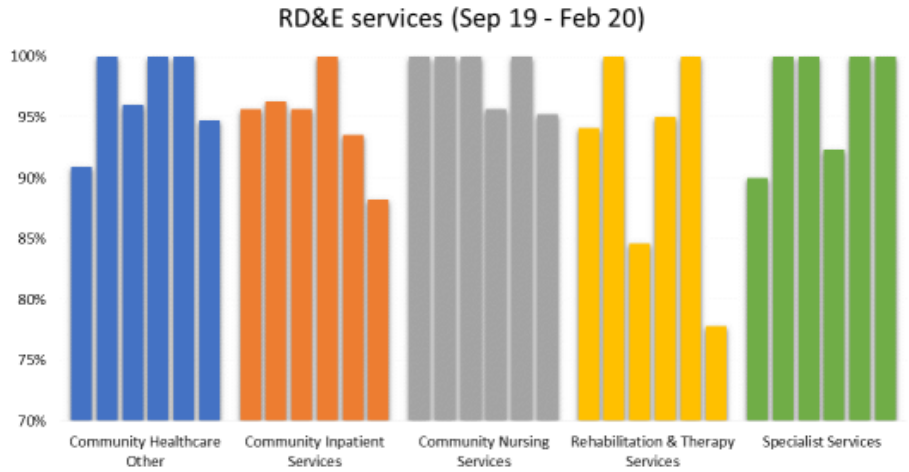
Scores are broadly positive and above 90%, although there are a few exceptions. The RD&E rehab score was based on only 9 responses.

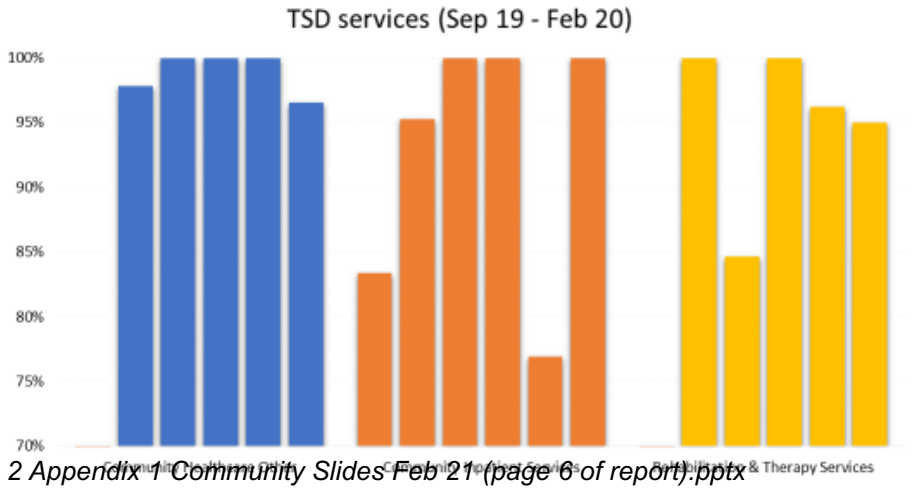
PATIENT EXPERIENCE

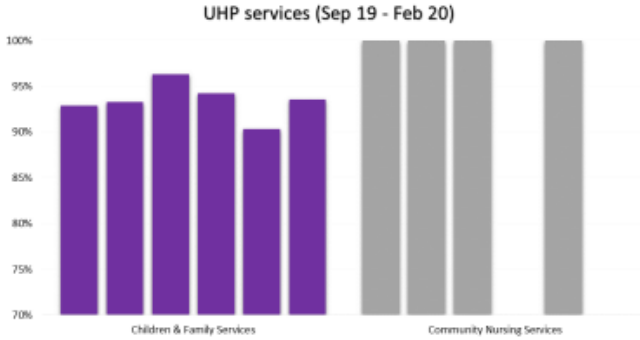
Friends and Family Test (FFT)

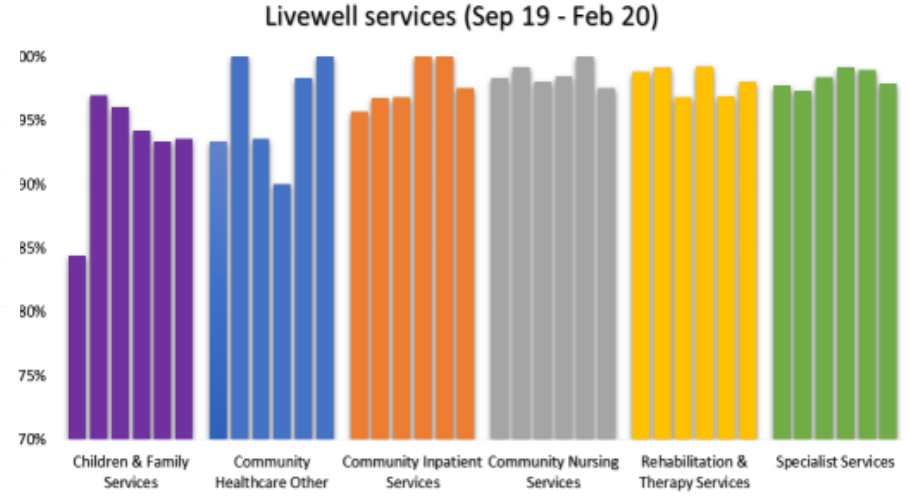


These charts show the monthly FFT trend for each service from September 2019 to February 2020.





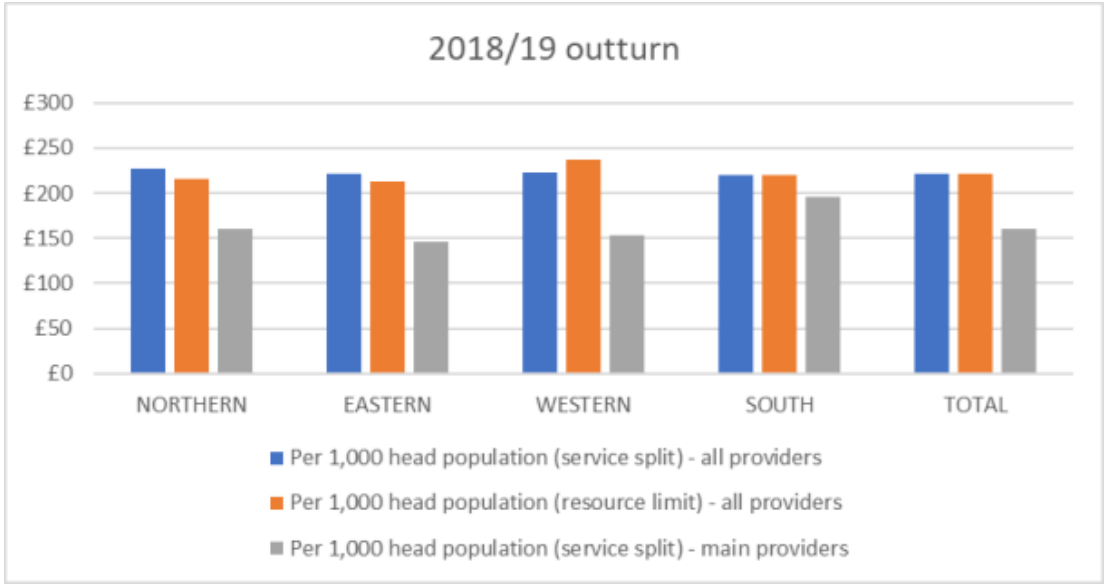


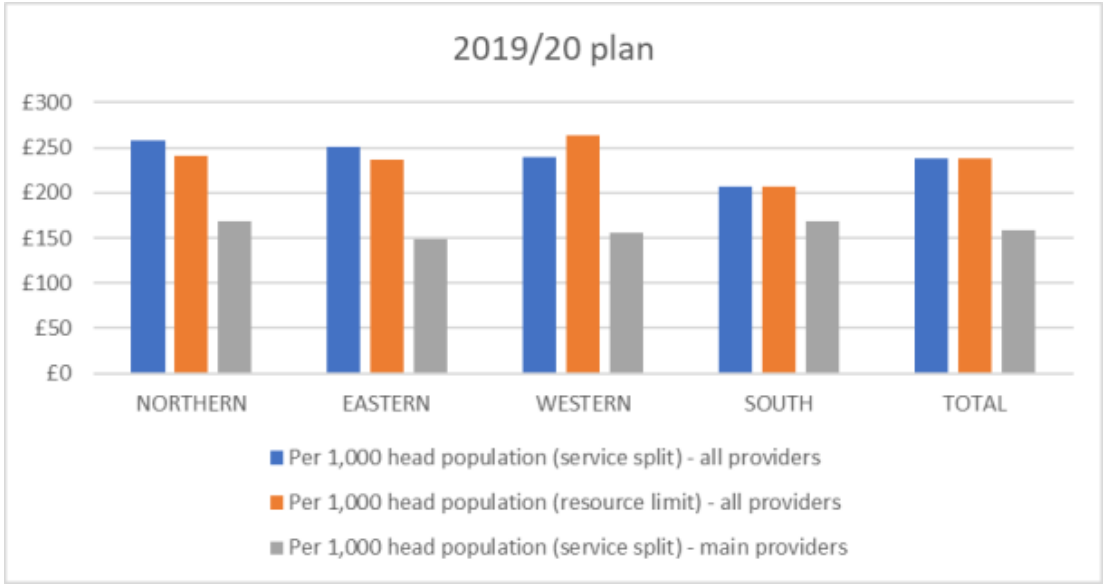


SPEND

It is difficult to accurately compare community spend in Devon due to the number of contracts held with multiple community providers in different parts of the county, the varying scope of each contract (in terms of services provided and geographical coverage) and the level of detail contained within each contract.

At an overall locality level the 2018/19 outturn shows that community spend was fairly even when all providers are taken into account, with a range from £227 per head (North Devon) to £219 per head (South Devon).





SUMMARY

- Devon sees a relatively low emergency admission SAR rate compared to the rest of the country and peers, particularly in the East, South and North. This could suggest effective out of hospital services in preventing admissions, particularly as the SAR is in the bottom quartile for over 65s.
- Relative length of stay (LOS) in North and South Devon is in the bottom quartile across the whole age profile and effectively the lowest nationally for people aged 50-80. The relative LOS by age for East Devon is slightly below average across the majority of the age profile although rises for patients 80+ years old suggesting more could be done to discharge the oldest patients from RD&E, whilst the position in West Devon is very similar to the national average across the whole age profile
- Over 21-day LOS has remained relatively static for all providers in Devon although RD&E have seen a slight rise Since Q1 2019. Above 21 days RD&E have the highest rate of long waits and NDHT the lowest, suggesting the latter locality is more effective in discharging patients earlier.
- Acute bed usage based on a combined view of SAR and LOS, is in the bottom decile nationally for East, South and North Devon and also comfortably below the average in West Devon. This means Devon uses around 17% less beds than expected compared to the national average, suggesting effective admission avoidance and discharge processes.
- DTOC have consistently been highest in Devon at RD&E since 2018 when the UHP number reduced. NDHT and TSD continue to see very low levels of DTOC, both in numbers and in the rate of DTOC to occupied beds
- The main reasons for DTOC across Devon are waits for care packages and residential / nursing homes, although for RD&E and UHP waits for further non-acute NHS care are also a factor.
- There is variation in the rate of ambulatory care sensitive condition admissions across Devon but South and East Devon typically see comparatively low numbers, North and West Devon are around average for their populations but Plymouth see higher rates.
- 30-day readmissions are in the top quartile at TSD, around average at NDHT and UHP, whilst RD&E sees a rate just outside the lowest quartile nationally.

SUMMARY (2)

- To maintain a comparatively low acute bed base, emergency admissions, LOS and overall bed usage North, South and East Devon seem to have effective out of hospital admission avoidance and discharge facilitation. West Devon is also under the national position but to a much lesser extent.
- Areas for potential improvement in East Devon are quicker discharge for 80+ patients at RD&E, reduced stays over 21 days and lower DTOC rates. North Devon could reduce admission of patients with ACS conditions and lower readmission rates, although they are not outliers for either measure. South Devon performs well across the range of indicators, with only readmissions being an area for improvement. West Devon has potential for improvements in length of stay for all age ranges, the level of ACS conditions and DTOC rates.
- As a general point consistent data on community services would enable better comparison of the benefit of the different approaches employed within Devon.
- Whilst the outcome measures suggest broadly effective out of hospital services across the system, the relative cost vs benefit needs to be further reviewed. However, a detailed, comparable breakdown of the cost of community services is not currently available.

ICS Outcome	Ref	ICP Outcome (Schedule 4)	Frequency of reporting	Denominator - schedule 6	Numerator - schedule 6	Baseline	baseline period	Target/ threshold	ICP Notes
More care will be available in the community and less people will need to visit or be admitted to hospital	1.1	Reduced number of hospital admissions for people from care homes and other residential settings (Western Locality)	Monthly	Monthly number of referrals from care homes and residential homes		Agree baseline in Yr1	20/21	Reduce from 20/21 baseline	
	1.2	Reduced number of emergency admissions patients aged 18 and over .	Monthly	Number of emgerency admissions per 100,000		Agree baseline in Yr1	20/21	Reduce from 20/21 baseline	
The health care system will be equipped to intervene early and rapidly to avert deterioration and escalation of health problems	2.1	Increased caseload for Community Crisis Response Team	Monthly	CCRT Caseload		Agree baseline in Yr1	20/21	TBA	
	2.2	Increased number of avoided GP visits for people in Crisis due to the intervention by Advanced response practitioners	Monthly	Number of patients in crisis seen by ARPs	Number of patients seen by ARP who are in crisis and are not referred to a GP	Agree baseline in Yr1	20/21	TBA	
	2.3	10% of women access the specialist perinatal mental health service (as a % of live births)	Annual	Number of live births	Number of women accessing specialist perinatal services	National measure	20/21	7.10%	National measure. 21/22 8.6%, 22/23 - 10%, 23/24 - 10%
	2.4	All patients with a mental health condition who are in crisis are managed within appropropriate timescales (as set out in the national triage scale)	Monthly	Number of patients with a mental health condition who are in crisis	Number of patients with a mental health conditions who are in crisis who are seen within appropriate timescales	Agree baseline in Yr1	20/21	Increase from 20/21 baseline	
	2.5	Reduce number of section 136 detentions for people with mental heath conditions	Monthly	Number of 136 detentions for people with mental health conditions		Agree baseline in Yr1	20/21	Reduced from 20/21 baseline	Thresholds to be reviewed given considerable reduction already achieved.
	2.6	Increased percentage of patients who have mental health conditions and are identified as high intensity users who have a co-ordinated care plan in place.	Monthly	Number of patients with mental health conditions who are identfied as high intensity users	Number of patients with mental health conditions who are identified as high intensity users who have a co-ordinated care plan	Agree baseline in Yr1	20/21	Increase from 20/21 baseline	DQIP
People who have health conditions have the knowledge, skills and confidence to better manage them	3.1	Increased numbers of people with LTC will be supported by IAPT by integrated physical health pathways, colocated with physical health colleagues, with treatment delivered by IAPT stafff who have attended the IAPT- LTC/MUS top up training	Monthly	Number of people with LTCs supported by IAPT by integrated physical health pathways, colocated with physical health colleagues, with treatment delivered by IAPT stafff who have attended the IAPT-LTC/MUS top up training		Agree baseline in Yr1	20/21	Increase from 20/21 baseline	DQIP
	3.2	The numbers of people from BME communities supported by IAPT to reflects the demographic of the city	Monthly	Number of people from BME communities supported by IAPT		Agree baseline in Yr1	20/21	TBA	
	3.3	Increase the percentage of people with with health conditions who report that they have the knowledge, skills and confidence to better manage them	Annual	Number of people surveyed	Number of people survey who said that they had the knowledge, skills and confidence to better manage their health	Agree baseline in Yr1	20/21	Increase from 20/21 baseline	DQIP
	4.1	Reduced number of inappropriate acute out of area placements	Monthly	Number of inappropriate acute patients placed out of area		Agree baseline in Yr1	20/21	TBA	

People who need treatment will be treated effectively and in the most appropriate setting	**4.2**	All Care Treatment Reviews are attended by representatives of Community Teams, Social Workers/Case Co-ordinators	Monthly	Number of Care Treament reviews	Numbers of Care Treatment reviews attended by representatives of Community Teams, Social Workers/Case Co-ordinators.	Agree baseline in Yr1	20/21	Increase from 20/21 baseline	
	4.3	Increased number of complex patients diagnosed with a dementia who have a behaviour support plan	Monthly	Number of complex dementia patients with a behaviour support plan		Agree baseline in Yr1	20/21	Increase from 20/21 baseline	
	4.4	Reduced number of rejected referrals for mental health services	Monthly	Number of rejected referrals for mental health services		Agree baseline in Yr1	20/21	Reduce from 20/21 baseline	DQIP
People will go into hospital when necessary and will be discharged effectively and safely with the right support in their community	**5.1**	The percentage of delayed transfers of care (occupied bed days) is at or below target	Monthly	Occupied bed days	Bed days occupied by DTOC patients	Agree baseline in Yr1	20/21	TBA	To be updated in-line with National guidance
	5.2	The percentage of Mental Health delayed transfers of care (occupied bed days) at or below target	Monthly	Occupied MH bed days	Bed days occupied by DTOC patients	Agree baseline in Yr1	20/21	TBA	To be updated in-line with National guidance
	5.3	Reduced delayed Transfers of Care that are attributable to Adult Social Care per 100,000 (ASCOF)	Monthly	Size of adult population (aged 18 and over)	The average number of delayed transfers of care (for those aged 18 and over) each day attributable to adult social care	Agree baseline in Yr1	20/21	TBA	To be updated in-line with National guidance
	5.4	Reduced delayed Transfers of Care per 100,000 (ASCOF)	Monthly	Size of adult population (aged 18 and over)	The average number of delayed transfers of care (for those aged 18 and over) each day.	Agree baseline in Yr1	20/21	TBA	To be updated in-line with National guidance
	5.5	Reduced average length of stay for patients in community hospital beds	Monthly	Average length of stay for all patients admitted to an acute hospital bed		Agree baseline in Yr1	20/21	<14 days	
	5.6	Increased number of people discharged to the home first service	Monthly	Number of people discharged to home first		Agree baseline in Yr1	20/21	TBA	
	5.7	Reduced percentage of people who declared medically fit but are are still in hospital 24 hours after .	Monthly	Number of people declared medically fit	Number of people declared medically fit who are still in hospital 24 hours later	Agree baseline in Yr1	20/21	TBA	DQIP
People will have far greater control over their health services and will be equal partners in decisions about their care	**6.1**	Increased number of people offered a Personal health budgets	Monthly	Number of patients offer a personal health budgets		Agree baseline in Yr1	20/21	Increase from 20/21baseline	DQIP
More people will be living independently in resilient communities	**7.1**	Reduced the proportion of people who's long term adult social care support needs are met by admission to residential and nursing care homes (65+) - Plymouth	Monthly	Size of adult population (aged 65 and over)	The sum of the number of council supported older adults (aged 65+) whose long-term social care support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)	Agree baseline in Yr1	20/21	Reduce from 20/21 baseline	
	7.2	Reduced the proportion of people who's long term support needs are met by admission to residential and nursing care homes (65+)	Monthly	Size of adult population (aged 65 and over)	Number of patients with long term adult needs which are met by admission to residential and nursing care (65+)	Agree baseline in Yr1	20/21	Reduce from 20/21 baseline	
	7.3	Reduced the proportion of people who's long term adult social care support needs are met by admission to residential and nursing care homes (18 to 64) Plymouth	Monthly	Size of adult population (aged 18 to 64)	The sum of the number of council supported younger adults (aged 18 to 64) whose long-term social care support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)	Agree baseline in Yr1	20/21	Reduce from 20/21 baseline	
	7.4	Reduced the proportion of people who's long term support needs are met by admission to residential and nursing care homes (18 to 64)		Size of adult population (aged 18 to 64)	Number of patients with long term adult needs which are met by admission to residential and nursing care (aged 18 to 64)	Agree baseline in Yr1	20/21	Reduce from 20/21 baseline	

	7.5	Increased number of adults with Mental health conditions who access individual placement and support services	Monthly	Number of adults accessing individual placement and support services		Agree baseline in Yr1	20/21	Increase from 20/21 baseline	DQIP
	7.6	Increase the number and percentage of people (that can transition) with a learning disability who have a completed joint assessment of need before their 17th birthday	Monthly	Number of patients with a learning disability in transition	Number of people with a learning disability in transition who have a completed joint assessment of need before their 17th birthday	Agree baseline in Yr1	20/21	Increase from 20/21 baseline	DQIP
	7.7	Increase the number and percentage of young people (that can transition) using CAMHs services who have a completed joint assessment of need before their 17th birthday (how the adult service participates in this)	Monthly	Number of young people using CAMHS in transition	Number young people using CAMHs services in transition who have a completed joint assessment of need before their 17th birthday	Agree baseline in Yr1	20/21	Increase from 20/21 baseline	DQIP

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GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 18 February 2021

Dates of Committees covered in this report 25 February 2021

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

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

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- **Risk Register Reports – see Risk Register review below.**

- **<u>Quality & Performance Report</u> – the Committee received information on key quality and performance indicators for the period 1 April to 31 December 2020, including those contained in the NHS Constitution. The Committee acknowledged the context of the system responding to the combination of the second wave of the COVID pandemic and winter pressures, and noted the work of the System wide Dynamic Decision Making Group (DDMG) in using a risk assessed approach to minimise the impact on safe and effective delivery of services for Devon patients.**

- **The following areas were highlighted: -**

    - **The STP position against the 62-day standard fell from 79% to 77%, after an improved performance in November 2020. Only NDHT achieved the 85% target. Performance against the main two-week wait standard continues to be below target, but has improved slightly from 74.7% in November to 75.9% in December. All providers are below target, with NDHT falling from 93% to 85.8%, RDEFT improving slightly to 58.4%, TSDFT falling from 83.6% to 78.9% and UHP improving from 85.1% to 88.4%. The Committee noted with concern the very low levels of performance at RDEFT, especially the breast symptomatic 2 week waits.**

    - **In terms of elective care, providers are working together as a whole system, to understand each other's risks and develop system solutions, including mutual aid. The independent sector (IS) continues to play a role in maintaining elective care for patients in all localities, through an NHSEI contract.**

    - **Referral to treatment times – December data shows a worsening position for RTT 18-week performance, falling from 61.5% to 60.3% at an STP level, compared to the target of 92% and national performance of 68.2%. However, long wait patients continued to increase, with over 52 week waits rising quickly at all providers in December.**

    - **Diagnostic waiting times have been significantly affected by the Covid-19 pandemic. Performance has worsened slightly this month, with the STP position of 63.4% remaining**

well below the 99% target and below the England position of 70.8%, and further deterioration is expected.

- **The numbers of COVID19 patients in hospitals at the end of December exceeded the volumes seen in the first wave and surged further in January.**

- **A&E waiting times - December saw a slight improvement in performance against the 95% national four-hour standard – at 80.7% for all types and 74.2% for type 1 attendances, slightly above the England position at 73.7%.**

- **Up to and including 27 January 2021, UHP recorded 1,050 ambulance handover delays (that is handover times of more than 15 mins). This led to a lost resource time of 365 hours. By comparison, NDHT had 149 delays and lost 16 resource hours, RDE had 439 delays and lost 44 resource hours and TSD had 375 delays and lost 62 resource hours. SWASFT is participating in national work looking at the harm impact of handover delays on patients; it is anticipated that this will be reported in the near future. There is an internal UHP plan to reduce delays, but these are being thwarted by rising numbers of COVID19 cases, and capacity within the hospital – daily work continues to reduce delays against the original plan.**

- **111 performance fell in January due to significant sickness as a result of Covid abstractions (sickness and self-isolation). Compared to December, call answering performance dropped on average 10% and call abandonment increased by 2%, although both metrics are slowly starting to improve as sickness rates reduce. Nevertheless, Devon Doctors performance has drifted from national average to the extent that exception reports have been provided for the previous four weeks.**

- **The Committee asked the Executive to consider whether the focus of future reports could be reviewed, for example to include primary care. It was noted that the system of future reporting of finance, performance and quality information was under review by the CCG Chair.**

Reports received and noted

- **<u>Devon CCG Monthly Finance Report</u> - the report again reminded the Committee of the draft budget previously agreed (a deficit position of £47.8m with a savings requirement of £22.6m). This draft budget had not received approval by NHSE, who had instead put in place a temporary financial regime for the period 1 April to 30 September 2020, with an expectation that CCGs would break even during this time.**

- **A revised financial framework has been published for the period October 2020 to March 2021 and the allocation calculation methodology for the CCG is generally consistent with the approach used for the first 6 months, although this now includes system top-up and COVID19 allocations, previously paid directly to providers. In addition to this CCGs will continue to be reimbursed for eligible costs in relation to the Hospital Discharge Programme.**

- **Assuming the CCG is reimbursed for the NHSE approved Hospital Discharge Programme costs that the CCG has and will incur then we are forecast to balance our position for the year ended 31st March 2021. Any potential surpluses at the year-end may be dealt with on a regional basis.**

- **The STP has submitted a system plan for the period October 2020 to March 2021, which shows a deficit of £7.8m, based on the funding envelope allocated. The shortfall relates entirely to lost private and commercial income. At month 9, due to 2020/21 untaken staff holidays within Trusts the system forecast outturn moved to a £22.4m deficit for the year ended 31st March 2021. It is**

currently anticipated that the drivers of the forecast overspend will either be funded nationally or excluded from the measurement of financial performance against plan.

- **<u>STP Monthly Finance Report</u> – the paper was presented for information to the Committee, outlining the position at Month 8.**
    - **The STP moved into phase 3 of the financial framework for months 7-12 of 20/21.**
    - **The STP submitted a plan for months 7-12 which showed a deficit of £7.8m relating entirely to a shortfall in private / commercial income. The new plan includes an adjusted block contract payment to each provider.**
    - **A system allocation for COVID was received, but costs relating to Nightingale, COVID testing, PPE and Hospital Discharge Programme will be funded separately. An elective incentive scheme, whereby a penalty is enacted based on a shortfall in activity, was estimated to be £7.8m at the planning stage.**
        - **As at month 7 the Devon system had a YTD favourable variance of £2.6m.**
        - **The forecast outturn at M7 showed a £0 variance to plan.**
        - **As at M8, there has been £92.2m of COVID related spend, with an additional £26m spent on Nightingale and £2.2m spent on virus testing.**
        - **M8 year to date overspend on bank of £2.7m (M7 £1.1m), forecast overspend on bank is £3.7m (M7 £2m)**
        - **YTD overspend on agency £1.5m (M7 £1.1m), forecast overspend on agency £3.1m (M7 £2m).**
        - **The spend on substantive staff is underspent by £8.2m as at M8 (M7 £3.7m) and forecast to be underspent by £1.8m at the year-end (M7 £2.5m).**
        - **System capital spend is £4.7m over plan as at M8. (M7 £2.9m under plan)**
        - **Forecast system capital departmental expenditure limits (CDEL) spend is on plan, although the system has only been allocated £80.3m. There is a risk that the £19.7m over commitment will reduce future years' system capital allocation.**
        - **As at M8 total risks to the system are £32m (M7 £32.9m) with mitigations of £29.3m (M7 £29.5) leaving a net risk of £2.5m. (M7 £3.4m).**
- **<u>Quarterly Report Procurement (including Single Action Waivers and Conflicts of Interest</u>) – the Committee received an update on the Procurement Paper previously considered and referred to Commissioning Committee in August 2020, and noted a series of Single Action Waivers. The Committee asked for an update report for assurance to its meeting in March or April on the issues which had been raised in August 2020 in a report prepared by the Executive on Commissioning for Contracts in 2021.**

Risk Register Review (changes and areas of concern)
• **There have been no risks recommended for closure, and no new risks added. The risk score for risk 124, Delivery of Control Total, was reduced from 12 to 4 (L = 1 I = 4), as the current forecast spend indicates that the possibility of breaching the control total for the final 6 months of the year is unlikely. The Committee asked for this risk to be kept under review.** • **A new risk, agreed by the Committee in January, will be added to the corporate risk register shortly, to cover concern regarding 2021/2022 financial delivery - with the operational planning process suspended for 2020-21 and the emergency financial framework in place, it is unclear at present whether any worsening in underlying position will, as a result of the current climate, be mitigated in part or in full with a revised settlement for the CCG and system for 2021-22.** • **The Committee noted that the COVID incident risk register is being reinstated.**
Committee Decisions
• **None.**

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

Management of Conflict of interests:

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

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

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GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee (QAC) Public Part 1

Date of Governing Body: 25 February 2021

Dates of Committees covered in this report: 18 February 2021

Chair's Name and Title: Glynis Atherton, Non-executive lay member (Chair of Quality Committee)

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

The Committee received updated reports as detailed below

Reports received and noted

Quality and Safety Report

Highlights from the report are:-

- University Hospitals NHS Trust (UHPT): Significant concerns with worsening performance metrics in ambulance handover times, cancer targets, long waits and follow up backlogs.
- Independent Sector (IS): The CCG has always sought assurance on quality and safety within the IS and, whilst the above contract is with NHSEI directly, plans are being developed to enhance quality support where appropriate, due to the additional demands on IS providers at this time.

Young Devon Engagement report – Autistic Spectrum Disorder

Highlights from the report are:-

- An online survey was sent to families who have children on the ASD assessment waiting list in 2020.
- Overall families gave extensive evidence of the negative impact that children/young people and parent/carers can experience whilst being on the ASD assessment waiting list for long periods of time, without regular and appropriate communication, information or support.
- Families said they want better, more regular communication and wanted the opportunity to talk to someone about the process.
- Families said waiting times and what happens during and after an ASD assessment were the most important information for them. They also want access to contact information for CFHD so they can get in touch, details of how to get advice and support, signposting to other services, online learning and support groups. Families also told us they would like an online resource.
- Recommended that a flow chart be created to outline how and when families will be communicated with, what information will be shared with them and what support they can access whilst they are on the ASD assessment waiting list. This should be in accessible formats and be supported by a communication plan make sure families and staff are aware of it.
- Recommended that CFHD review the current access to telephone support via the Single Point of Access and improve and promote it as a helpline for families to ring for verbal advice and signposting to other resources and services.
- For those yet to be referred to the ASD assessment waiting list **-** It is recommended that a leaflet should be developed for those not yet referred to the ASD assessment waiting list to signpost them to the relevant information.

SBAR COVID-19 Vaccination Programme in Devon: Patient confidence in the roll out of the vaccination programme within Devon continues to remain high. Where a patient challenges their eligibility for vaccine and raises a complaint, this is managed through the CCG complaints process and the patient experience team.
Safeguarding Children Policy: The policy was **approved** by the Committee.

Risk Register Review Updates

Quality Risk & Assurance Report including Risk Register:
Risk Register Review (changes and pertinent areas). Data was extracted for this report on the 3 February 2021 of which it informs the Committee of any changes since the last Quality Assurance Committee (QAC) on the 21 January 2021. Fifteen risks report to QAC.
The Committee

- **Agreed** two new risks,142 and 143
- **Noted** that one risk has moved in score, decrease in risk 119 Flu vaccination programme 2020/21.
- **Agreed** to close risk 119 Flu vaccination programme 2020/21. The flu vaccination programme is now drawing to a close and uptake has been high in all eligible groups.

Committee Decisions

- None

Items of concern to be escalated to the Governing Body

- None

Recommendations for Governing Body

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

Recommendations for other Committees

None

Terms of Reference or other committee effectiveness issues

The Committee **approved** the amendment to the quoracy for the committee to reflect the below:

The Quality Assurance Committee meetings will be quorate when the following are present:

- At least one Non-Executive lay member
- Chief Nursing Officer (Executive) or nominated deputy
- Governing Body GP Clinical Quality Lead or nominate deputy

The Committee **approved** to add the role of Secondary Care Doctor to the voting committee membership.

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: 25th February 2021

Date of Committee covered in this report: 4th February 2021 (Minutes of this committee meetings to be available as an addendum

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

This was a shortened form of PCCC meeting to approve 4 items only. The usual PCCC meeting was stepped down due to pressures on the capacity of the Primary Care Team during their support of Primary Care during priority COVID Vaccination

Reports brought to Committee for information

Associate Director's Report:

Updates on:

1 COVID Mass Vaccination

2. Work Plan and Governance

3. Medicines Optimisation Team

4. Interim Leadership Arrangements

5. LMC Negotiations Committee Key outcomes from meeting held 22 January 2021:

6. Letter of thanks to GPs and Practice Managers from the Devon System

7. Leaders for their role in the mass vaccination programme

The Committee noted a verbal update on the work being done on the resilience of General Practice and the Primary Care system during the lengthy Mass Vaccination period.

Committee Decisions

None

Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues

Management of Conflict of interests:

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NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Commissioning Committee

Date of Governing Body: Thursday 25th February 2021

Dates of Committees covered in this report: Thursday 11th February 2021 (Minutes of the committee meeting are to be available as an addendum)

Chair's Name and Title: Dr Claire Hooper, Strategic Lead for Planned Care

Presented by Dr Nick Kennedy, Independent Secondary Care Clinician

Contact Details: claire.hooper2@nhs.net / nick.kennedy3@nhs.net

Reports received and noted

None.

Risk Register Review Updates

The Committee endorsed the recommendations within the risk report to:

- **Support the risk coordinators to ensure all risks are recorded, updated, and have all the assurances, controls and mitigating actions recorded with regular reviews undertaken by all the teams.**
- **Identify any risks reporting to the Commissioning Committee that need to be added to the risk register or amended.**
- **Consider the adequacy and effectiveness of the controls and assurances identified in the management of risk including measures to address gaps in controls and assurances and identify any further action that should be taken to manage the key risks.**
- **Are assured and approve those risks highlighted as having increased or reduced in score.**
- **Note the COVID Incident Risk Register**

Committee Decisions

Terms of Reference

The Committee approved the minor change within the Quoracy section of the Terms of Reference. The Committee agreed to reduce the number of three executive members to two executive members, while the number of clinical members would remain at three to constitute a quorum.

Spinal Services Update

The Committee approved the recommendation made within the Spinal Service update paper, as outlined below:

- **That commissioners review the provider activity in relation to the spinal injection activity in March 2021 with the caution that due to the disruption of services it is expected that a low level of activity is likely.**

Long Covid Update

- **The Committee were provided with a verbal update on Long Covid. The committee were made aware that there had been a change in the Multi-Disciplinary Team which had been established at locality level. It was noted that there will likely be national guidance on the Multi-Disciplinary Teams moving forward and this will help with making the Long Covid service viable. The committee approved the pathway change that was proposed.**

Items of concern to be escalated to the Governing Body

None.

Recommendations for Governing Body

North & East Community Contract

The Committee endorsed the recommendations made for the North & East Community Contract, that will be taken to Governing Body at the 28 February 2021 meeting for decision, as long as there is reassurance that the risks have been appraised in a non-bias way and that the key metrics were built into the new contract. The recommendation proposed is outlined below:

- **Make a direct award of a contract for general community services to Royal Devon & Exeter Foundation Trust and North Devon Healthcare Trust for 10 year with potential for 5-year extension, with a clear proviso that contract will be terminated after 2 years if satisfactory progress is not made on a number of defined issues**

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.

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Together for Devon

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Locality ICS Partnership update report

Locality:	Northern Devon
Period covered by update:	Dec 2020 - Jan 2021
Person completing template:	Tim Golby

Key achievements/progress

One Northern Devon (OND) continues to progress its programme of work within its three pillars: person-centred services, place-based and system co-ordination.

This month the Programme Manager and Community Partnership Manager have been focussed on securing funding for the new financial year to ensure the sustainability of the programmes of work alongside co-producing two expressions of interest for national programmes – The Health Foundation's Economies for Healthier Lives for Northern Devon and The Ministry for Housing and Local Government's Changing Futures programme.

Programme updates

Person-centred

The 'Flow' model of personalised support is being delivered in four work areas:

Flow

The 'team around the person' model is currently being used as Barnstaple PCN's Population Health Management intervention and three GPs will be testing this approach in January. An evaluation framework has been created.

High Flow

The OND High Flow Case Worker continues to work with 10 of the people nominated by partners who were nominated as being the high frequent, complex or high risk service users.

We now have demand data from the Police, SWAST & NDHT. In the 9 months that the clients have been receiving High Flow support:

- SWAST demand has fallen by 31%
- offender investigation and police logs reduced by 16%
- 30 fewer A&E attendances and 5 fewer inpatient admissions

collectively resulting in £17,000 cost saving.

Youth Flow

We now have 24 young people on our OND Youth Flow programme working with our Youth Progress Coaches. The young people have all been referred by Jobcentre Work Coaches due to being 'furthest from the labour market'. The Workplace Wellbeing programme is being piloted and co-produced with a local business and Dr Kay Brennan.

4 businesses are now engaged with the Youth Flow programme
3 young people have now been employed
2 young people have work experience placements
The first Youth Advisory Panel (YAP) meeting has taken place.

Community Flow
All One Communities are involved with the connecting communities programme whereby volunteers visiting people from clinical referrals will connect them with the support available in the community. This is being co-ordinated at NDHT by a multi-service volunteer co-ordinator and continuation funding will be sought from NDHT and DPT.

Place-based

Town Councils have been asked if they would like to contribute to the funding of the Community Developers next year and NHS Charities Together and Awards for All lottery funding is also being sought.

Recommendation from Holsworthy Community Involvement Group to develop a One Holsworthy group. Meetings currently taking place to progress this and discussions are around the cross-border nature of the PCN.

System Co-ordination
Survey has just been carried out with our social prescribing teams where we asked regarding our social prescribing network 'To what extent do you feel these meetings are vital to future development of your role?' 11 people responded, 9 agreed and 2 strongly agreed.

Population Health Management

- Population Health Management - following the successful pilot of the new Population Health Management programme in the Barnstaple area, the locality team are now engaged to start planning the roll-out of the programme across the wider PCNs in Northern Devon. Recognising the current winter and COVID priorities across the system, a concise project plan is currently being drawn up, with the aim of sharing a locality-specific summary at the next Northern Integrated Delivery Group in February, followed by wider dissemination of the programme plans to both the Northern GP Collaborative Board and One Northern Devon group in March

Patient Stakeholder Network

- It is pleasing to report that the Northern Locality has continued to keep contact with the local Patient Stakeholder Network colleagues and we meet virtually every 2 months. This has been a useful conduit of views between the CCG and the general public

Minor Injury Units

- The primary care network has worked closely with the NDHT team to put in place temporary medical cover by local GPs to undertake minor injury activity whilst the Ilfracombe and Bideford MIUs remain temporarily as a result of staffing challenges brought on by the COVID-19 pandemic

COVID-19

- The weekly Northern System Cell call continues to great effect brining system partners together for fast resolution of hot issues. The group will continue these for the foreseeable future. The Group is already effectively functioning as an LCP and will continue. Most recent focus has been on Coordinating Vaccination programmes both in the Acute and the community setting, in line with national policies. Work is underway to review other areas such as cancer care and elective care provision.

Northern 20/21 iBCF Winter Schemes

- There are discussions under way between northern locality commissioners and representatives from DCC on the roll forward of the 2021 ibcf schemes into 21/22. Arrangements for this will be signed off at the next IDG in early February. There is continued monitoring of efficacy of schemes under way. As described previously these schemes include:

Scheme Name	Scheme Description	Key benefits
Weekend Discharges	Increasing weekend discharges to community	Expected outcome increase weekend discharges to 50% of discharges Monday to Friday
Weekend Discharges	Discharge Coordination and Infrastructure to support weekend discharges from NDHHT	Expected outcome increase weekend discharges to 50% of discharges Monday to Friday
Social Care Assessments – Discharge to Assess	Speeding up ASC assessments and agreeing needs for patients	Additional 16 assessments , arranging care and case management per month Daily Social Work in-reach into NDDH
7 Day Discharges	Personal care market capacity	Increasing market capacity with provider approx. 7-9 visits per day
Primary Care urgent visiting service	Increased Urgent GP visits to home and care homes	support discharge and prevent admissions

Proposed Leadership arrangements

The Northern LCP Executive group has met and committed 2 senior leaders to the Northern LCP and the exact roles and support they will offer is currently under discussion. They are Jennie Stephens (Director of Adult Social Services at Devon County Council) and Melanie Walker (Chief Executive, Devon Partnership Trust).

Retaining and enhancing the role of One Northern Devon (OND) as the grouping that draws in system partners beyond health and care is an important issue and needs consideration. Preliminary conversations are underway and progress will be updated in future reports.

Key priorities for the next three months

- COVID-19 Vaccination programme
- Contributing to Mutual Support arrangements with the Devon system.
- Increasing community capacity in response to COVID wave 3
- Securing funding for the core ICS partnership team for 2021/22.
- Agreement and adoption of the draft 'place' arrangements across Northern Devon
- Agreement and absorption of the ICS partnership governance and leadership arrangements
- Securing funding for the projects that have demonstrable return on investment
- Working with Councils, Education and Business regeneration leads on the long-term strategy and vision for Northern Devon.
- Ensuring that the One Towns (neighbourhood level) engagement continues and they remain engaged in the development of plans and community development
- Build Back Fairer engagement programme to understand what local people think covid recovery plans should focus on.
- Submit Economies for Healthier Lives EOI.

Issues of concern or risk

- **Staff-Covid impact**: the impact of contact isolation and actual staff COVID infection has a double impact of firstly reducing staff levels and secondarily tiring and sometimes demoralising staff remaining.
- Demands of responding to the pandemic is resulting in longer waits for elective, non-urgent care
- Incorporating elected members into the LCP governance is underway and is likely to take time to work through fully
- Immediate organisational priorities impede progress of LCP partnership working beyond health and social care agenda
- The need to identify further local resource (not just from NHS) to support and co-ordinate the delivery of the Northern LCP priorities and objectives

Support required and/ or barriers to progress

- The need for an on-going resource to support and co-ordinate locality development and delivery.

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Locality Update Report

Locality:	Eastern Devon
Period covered by update:	January 2021
Person completing template:	Tim Golby

Key achievements/progress

- Royal Devon & Exeter (RD&E) Acute services experienced rising Covid patient numbers during December, and the system was able to enact escalation protocols swiftly to meet increased demand whilst simultaneously experiencing extremely high staff sickness. System colleagues supported the Trust to bring this position under control during January and were able to provide bed capacity to Covid patients from elsewhere in the country.

- Nightingale Hospital Exeter (NHE) continued to provide additional capacity for patients with a positive Covid test, extending to 70 beds open at the height of pressure. NHE has also provided capacity to the wider region, receiving a number of patients from neighbouring counties to support their pressured systems.

- As Covid numbers in Acute and Community have continued to decrease into February, the system has begun to enact de-escalation plans and will be looking to be responsive to recovery and restoration of other required services.

- Acute and community hospital flow has been an area of focus by the NHS England/Improvement national teams, and a series of close monitoring of the data reporting for this area begun in January. This has been able to build upon the CCG Discharge Cell scrutiny that has been maintained throughout the year and is currently daily meetings and data reporting.

- As part of the response to the increased demand for discharge services, winter block booked beds, additional personal care agency resource and recruitment into the Eastern Urgent Community Response team have been invaluable additions to the system. This capacity will be reviewed during

February to agree a set of recommendations to inform capacity decisions beyond 31st March 2021.

- New daily monitoring meetings have been instigated with the Eastern operational teams in 'Help Me Home' meetings, where the health and social care teams review every patient medically fit for discharge and ensure a plan is sourced, meets the best needs of the patient and acts as a live problem solving opportunity to ensure flow is as swift as possible. This additional focus has improved discharge speeds significantly and has embedded positive system working.

- The Community Urgent Care project group facilitated a clinician workshop in February to review the proposed model of care across mid and East Devon. This was unanimously agreed and will be developed into activity modelling to inform an options appraisal. The Northern locality continue to develop a partnership model of community urgent care between PCN's and NDHT. Both models of care will incorporate the most recent national guidelines and be signed off by the 111 First programme board.

- All three groups within the LCP architecture are established and now meeting regularly.

- The Eastern Locality Forum (ELF) is clear on its purpose and has a collective and agreed understanding of the health and care priorities of Eastern Devon and the focus of its work which will be:
    - Carers
    - Mental Health, with a particular focus on loneliness and isolation

- Local examples of Population Health Management are being showcased, understood and encouraged across the Eastern LCP

- Collective agreement to deliver an Eastern LCP conference in spring/early summer to engage community leaders.

Key priorities for the next three months

- In line with NHS Devon CCG's prioritisation matrix, commissioning focus remains on Priority 1: Pandemic response and vaccination programme, Priority 2: Think 111 First, Long Covid, Maintain essential services.
- Maintain focused attention on discharge data reporting in line with national expectations.
- Continued development of the community urgent care options appraisal paper to inform the final commissioned service options within the approved timeline.
- Further development of engagement with community leaders and the development of proposals for a conference in the spring
- Identifying the role and arrangement at sub 'place' across such a large locality
- Embedding the learning from the Population Health Management pilot to other areas of Eastern Devon
- Establishing the Northern and Eastern Contract framework

Issues of concern or risk

- The timeliness for reform and the capacity and desire of health and care organisations to invest time and resource during the current escalation of COVID-19 alongside winter and the UK exiting the Customs Union.
- Immediate organisational priorities impede progress
- The need for an on-going resource to support and co-ordinate locality development and delivery
- There is not a single Eastern Devon identity that resonates across a single population. Sub 'place' level arrangements, leadership and deliver will be important

Support required and/ or barriers to progress

The need for an on-going resource to support and co-ordinate locality development and delivery.

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Locality update report

Locality:	South
Period covered by update:	February 2021
Person completing template:	Derek Blackford – Locality Director

Key achievements/progress

Local Care Partnership (LCP) development: The LCP Executive Group have been reviewing the leadership arrangements, infrastructure and development of the emerging themes and priorities for the locality. The work done suggests a set of initial priorities that would include a focus on Discharge to Assess, Population Health Management and the Community Mental Health Framework. Specific areas for inclusion include self-harm, suicide and alcohol to deliver against once the final priorities have been agreed. Following a brief review, the Delivery group will shortly be reinstated with clarity in relation to membership and purpose. The team are also currently working to develop an engagement plan.

System flow: Hospital flow has been an area of focus by the NHS England/Improvement national teams, both in relation to acute and community settings. A mini review/'deep dive' sessions monitoring the data began in January. This has helped build upon the CCG Discharge Cell scrutiny approach maintained throughout the year and is currently operating daily meetings and reporting. A specific focus remained on creating capacity to support hospital discharge appropriately.

Population health management: agreed cohort of patients (18-25 with contact with MH services) being reviewed by Newton West practices. MDT stakeholders engaged in designing collaborative process and identifying potential offers of support. Work to assess next phase of development, expressions and resourcing requirements is being considered.

Vaccination Programme: Links established with Vaccination programme and planning for cohorts 5 and 6.

Urgent Care: Managing the winter and Covid-19 pressures are the day to day focus for Urgent Care; daily reporting continues into the CCG and regional escalation processes. The focus on implementing SDEC (Same Day Emergency Care) and Think 111 First continues along with the MIU (Minor Injury Unit) LES (Local Enhanced Service). A workshop is planned to take place shortly to take forward the delivery of urgent community response requirements.

Proposed Leadership arrangements

Leadership arrangements have been under review with membership of the LCP Executive clear and with the lead role previously being performed by Joanna Williams, Director of Adult Social Services, Torbay Council. The arrangements moving forward, subject to review during the next 6 months, will be that Simon Tapley, CCG Accountable Officer will take the role of the Chair with Liz Davenport, Chief Executive, T&SDFT, being vice-chair.

Key priorities for the next three months

The locality commissioning context/profile previously shared with both the Delivery and Executive Groups needed further development, data sources updated and verified and redrafted in a way which aids ease of assimilation and helps support and distil key themes and messages. This work is nearing completion and the output will be used to help inform the development and agreement of priorities, through engagement with the Delivery group and respective stakeholders.

The Terms of Reference, including membership and remit of each of the groups will be updated and shared back for consideration and approval. This will also include a consistency check with the approach in place with neighbouring LCPs.

The development of a local strategy, locality work programme and engagement plan will follow, alongside the formalisation of priorities and governance arrangements. This will be set in the context of a timeline to provide visibility and clarity.

In addition, it is recognised that the following need to be addressed with confirmation and/or further development:

- Local Performance Information/scorecard and sub-group arrangements.
- Supporting the arrangements in respect of the rollout of the vaccination programme in conjunction with primary care networks and system partners.
- Further development of the Locality Risk Register.
- Maintain focused attention on discharges and the robustness of associated data reporting in line with national expectations.
- Embedding the learning from the Population Health Management pilot to other network areas.

However, the immediate focus in line with NHS Devon CCG's prioritisation matrix, the commissioning focus remains on areas included as **Priority 1**: Pandemic response and vaccination programme, followed by **Priority 2**: Think 111 First, Long-COVID and maintaining essential services.

Issues of concern or risk

The capacity to manage respective priorities and pace; maintaining focus on the development of the LCP priorities alongside those in relation to our response to COVID-19, winter & operational pressures will be key. The commitment and capacity of health and care organisations and partners to invest time and resource as a result will be important to our success and is well understood.

Support required and/ or barriers to progress

The need for on-going commitment and resource to support and co-ordinate locality development and delivery is being reassessed at present.

NHS Devon Clinical Commissioning Group

Locality update report

Locality:	Western
Period covered by update:	February 2021
Locality clinical representative:	Dr Shelagh McCormick
Locality Director:	Anna Coles
Locality non-executive representative:	Nick Ball

Key achievements/progress

- Ongoing due diligence and assurance activity with NHSE/I and Preferred Bidder for Integrated Care Partnership procurement
- Locality winter plan in delivery phase monitored through Urgent Care Forum.
- Ongoing focus on discharge from UHP to maintain flow including additional capacity via Care Hotel, flexible utilisation of community hospital beds across Devon, Plymouth and Cornwall, twice daily tracking of patient flow, Executive oversight of long delays, additional DE step down capacity via LWSW and redeployment of staff to stabilise capacity in Home First.
- Covid vaccination began before Christmas in line with national requirements for priority patient groups and health and care staff positive examples of integrated working between PCNs, community and acute providers and commissioners delivering strong rates of vaccination. Initiatives have included launching site at Pavilions, West Devon, Mewstone and Beacon. Direct 111 booking live for in hours Primary Care.
- Plymouth/Western embracing Devon-wide approach for Long COVID clinic with Livewell South West coordinating the triage Devon-wide. Further focus to improve pulse oximetry take up across the locality
- National agreement to ‘surge’ contract with IS providers giving full access to NHS patients which will support clinically urgent procedures continuing
- Recruitment of new Head of Urgent and Emergency Care (operational) to the team, commencing late February 2021.
- Successful procurement of Sherford Primary Care provision - awarded to Beacon Medical Group

Key priorities for the next three months

- Conclude the Integrated Care Partnership procurement in line with assurance requirements
- Continued focus of discharge performance through increased community capacity building and onward flow.
- Continued focus on Admission avoidance initiative through ECIST programme of activity with UHP/LWSW and SWAST.
- Support UHP with alternative to ED work by introducing clinical GP leadership in the Cumberland UTC development and support Think 111,
- Joint work with Public Health and Local Authority at place to support continuing roll out of vaccination programme roll out.
- Implementation of the local Lower Back and Radicular Pain pathway in line with the agreed specification.
- Finalise the Plymouth Locality Profile and West Devon Locality Profile
- Continuation of work for Plymouth Place Population Health Management when appropriate (timetable for which has been amended given service pressures and operational priorities)

Issues of concern or risk

- Staffing capacity across the commissioning team to manage priorities and operational demand including increased reporting requirements
- Impact of the number COVID positive on the configuration of beds in the western system
- Workforce capacity across all Providers including nursing, domiciliary care, pharmacy, voluntary sector
- Community capacity for future COVID-19 peaks including Care Homes, surge beds and community care as outbreak numbers increase
- Cornwall capacity across community both Care Home provision and Dom Care which impacts on flow from UHP.
- PCNs may not be able to recruit to additional roles effecting their ability to deliver the DES requirements
- PCNs ability to continue vaccination programme and business as usual.

Support required from CCG/system or barriers to progress

- Continued deployment of additional capacity to support Integrated Care Partnership (ICP) procurement
- Locality capacity returned as we move back to recovery phase

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Locality update report

Locality:	Plymouth
Period covered by update:	January 2021
Person completing template:	Anna Coles

Key achievements/progress

The Plymouth LCP Executive meeting was stood down in January 2021 due to COVID and Winter operational pressures.

The focus locally has been on:

- Establishing care homes to support flow
- Multi Agency responses to care home outbreaks
- Standing up shielding again (Caring for Plymouth)
- Supporting “Everyone In” through the winter Months
- Progressing the Integrated Care Partnership procurement
- Implementing the Mass Vaccination Programme
- Scoping out a review of Children and Young People and the impacts of COVID
- Progressing the Cavell Centre
- Establishing LCP Delivery Grp

Proposed Leadership arrangements

Together For Plymouth Exec Group meeting monthly.
Membership includes

- Devon CCG
- Livewell Southwest
- Plymouth City Council
- Primary Care Network Representation
- University Hospital Plymouth

It has been agreed that Tracey Lee will act as Chair initially with Ann James as Vice Chair, with rotation after 6 months. This will provide further capacity and resilience to leadership arrangements.

Other exec members will be assigned Leadership Portfolios to support distributive leadership mode.
The TFP Executive Group will maintain effective and efficient governance links with other statutory boards. Specifically the Executive group will report to the Health and Wellbeing Board quarterly through a Chairs Report.

Key priorities for the next three months

The forward plan until March is set out below:

February	Priority Reporting: Enhanced Health in Care Homes Update Priority Reporting-Frailty Digital Priority Reporting: Caring For Plymouth Performance Reporting including Outcomes Framework
March	Framework for COVID-19 Inequalities (Health and Wellbeing Board) Discussion Topic: Engagement with PCNs Equalities and Diversity Discussion Topic: Interface Discussions with Partners (Cornwall/Western)

Issues of concern or risk

Maintaining a focus on developing the LCP at the same time as managing a response to COVID-19
Winter Pressures and operational challenges across all providers
Support for Primary Care Networks to play a full role in the LCP

Support required and/ or barriers to progress