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

MS Teams - please refer to formal invite for joining details

25 March 2021 09:30 - 25 March 2021 11:40

AGENDA

#	Description	Owner	Time
1	Patient Experience Verbal	Debbie Francis, CEO The Project	09:30
2	Welcome and apologies and questions from members of the public Verbal	Chair	10:00
3	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @1103202... 5	Chair	
4	Minutes of the last meeting and action log Paper 1 Draft Public GB minutes 25.02.2021 v1 nc.docx 10 Copy of Master Action Log - PUBLIC v3 nc.xlsx 18	Chair	10:05
5	Schedule of what the Governing Body is to achieve at this meeting Paper Schedule of what GB is to achieve .docx 19	Chair	10:10
6	Chair's Report Paper 1 cover sheet chair's report.docx 21 2 Chairs Report March 2021.docx 23	Chair	10:15
7	Accountable Officer's Report Paper Governing Body - March 2021 - AO report FINAL.d... 25	Accountable Officer	
8	PROGRAMME OF WORKS - items for recommendation, decision and assurance		10:30

#	Description	Owner	Time
8.10	Recovery and Transformation Paper Cover restoration Governing Body March 21.docx 30 Restoration In Hospital Commissioning for Governi... 32	Interim Director of Commissioning - in hospital	
8.20	Current position of Minor Injury Units (MIUs) and out of hospital urgent care Vebal	Interim Director of Commissioning - in hospital	
9	LOCAL CARE PARTNERSHIP (LCP) REPORTS Paper(s) 3 Locality Update South March 2021.docx 42 4 Plymouth LCP Update Feb 2021 v0.02.docx 45 5 Plymouth Locality Report for GB - March 2021.do... 48		11:00
9.10	Deep Dive - Northern and Eastern 1 Northern Locality Mar 21 report V3.docx 50 2 Locality Update - Eastern Feb 2021.docx 56	Joint Locality Director - North and East (Health and Care)	
10	ASSURANCE COMMITTEE CHAIR'S REPORTS including items of escalation Paper(s)	Assurance Committee Chair's	11:20
10.10	Audit 0 Audit Committee Chair Report 10.03.21.docx 59 1. Audit Commitee Risk Report 10 March 2021 v1.... 62 2 Appendix 1 Risk Reporting to Audit Committee... 68 2.1 Appendix 2 Corporate Risk Regsiter Significant... 72 3 Appendix 3 Risk 38 Lack of clarity and visibility re... 82 4. Appendix 4 Board Assurance Framework with Su... 84 5 Appenidx 5 COVID Incident Risk Register - Wave... 111		
10.20	Finance and Performance Finance Committee Chair Report 25 March 2021 v... 116		

#	Description	Owner	Time
10.30	Primary Care Commissioning [P] Committee Chair Report - Public PCC - March 2021... 174		
10.40	Commissioning [P] March GB - Commissioning Committee Report 11.0... 176		
10.50	Quality [P] v1.0 QAC Chair Report Part 1 18 March 2021.docx 180		

Declaration of Interests Register - NHS Devon Governing Body

Register last updated 11/03/2021

Register updated and generated by the Governance Team - 11/03/2021

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 Board	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	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG

	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) Member of Vacancy Control Panel	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	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
	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 Equality, Diversity and Inclusion Group		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 Primary Care Commissioning Committee (PCCC)	Director of Public Health for Local Authority		26/10/2016	18/08/2020	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.	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 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	16/02/2021	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
	Masters	Susan	Deputy Chief Nursing Officer	Quality Assurance Committee (QAC) Member of Audit Committee Member fo Governing Body (Deputy for CNO)	Trustee Director of HQIP (Health Quality Improvement Partnership)		01/03/2021	01/03/2021	General Interest	indirect		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
	Milligan	Jane	Accountable Officer (Start date April 2021)	Member of Governing Body CCG Executive Team Meeting	Non Executive Peabody Housing Association House of St Barnabas Charity member	Partner Trustee for Action for Stammering	04/02/2021	04/02/2021	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

	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 Equality, Diversity and Inclusion Group	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
	Sargeant	Lincoln	Co-opted member of Governing Body	Member of Governing Body Member of Strategic Commissioning Partnership	Director Public Health, Torbay Council		24/02/2021	24/02/2021			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
	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	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 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 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 Board	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: 25 February 2021 Time: 10.00 –11:35 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. On behalf of the Governing Body, the chair, gave congratulations to Charlotte Burrows, non-executive director on the birth of her new baby. The chair formally welcomed Lincoln Sargeant (LS), director of public health, Torbay Council as a member of the Governing Body. LS introduced himself to the members and noted that he was looking forward to working with social and healthcare partners. The chair conveyed his thanks to Caroline Dimond for her commitment, active participation, input, and valued wisdom as a member of the Governing Body and wished her well for her retirement. Apologies were recorded for: Dr Shelagh McCormick Penny Harris Charlotte Burrows Caroline Dimond It was noted there was no written questions submitted by members of the public in advance of this meeting.	
2	**Register of Interest (ROI)** PJ 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. NK noted that he had recently taken up a role with Somerset CCG working on their clinical strategy and the merger of two trusts. This declaration had recently been added to the register of interests. **The Governing Body received and noted the ROI**	
3	**Minutes of the last meeting**	

	PJ led a page by page review of the minutes of the last meeting held on 28 January 2021. 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 formal 2. This action had been completed and it was agreed for	
4	**Chairs Report** PJ did not propose to go through this report in detail but highlighted and express his thanks for the work that ST and the system chief executive officers had contributed in support of the Integrated Care System (ICS) submission. PJ was pleased to report that NHS E region commended the meeting which described the ICS journey which was presented as a system. The positive comments were welcomed given the challenges faced as a system and NHS E particularly praised the offer of support for mutual aid for which were delivered in a coordinated way and the way the Nightingale Exeter has been run. Thanks, were passed to DA and his team who have been involved in Nightingale Exeter since its inception 90 days ago to maintain the care of patients. This has been a success story where the Nightingale Exeter served its purpose in delivering a diagnostics services before caring for patients and this had been acknowledged by NHS E as to how partners have pulled together to work as a system. PJ noted that the ICS Government white paper, would be covered in more detail through the Accountable Officer's report. **The Governing Body received and noted the contents of the Chair's report.**	
5	**Accountable Officer's Report** ST referred to the vaccination programme and wanted to record his thanks for this excellent partnership working which has been undertaken through the leadership of DA and support from Karen Barry and others. There has been an excess of 400 thousand people in Devon vaccinated including 96% of the over 80's which has been a phenomenal effort over a short period of time. This shows what can be achieved with great partnership working. ST noted that our objectives were agreed last month and that the Governing Body would receive a quarterly report on progress with the first one being in April. **ACTION 1** **CCG objective quarterly reports to be added to the forward planner from April 2021 onwards. Post meeting update this action has been completed and recommended for closure.** ST informed the Governing Body members that further detail from the government regarding the ICS white paper was awaited. JH felt that as this was a nature of change and something that the Governing Body should be actively involved in, she suggested a small Governing Body working group to be shaped. NB described how a board oversight group was formed and worked when the two CCG's merged reporting and making recommendations back to the governing bodies. ST agreed there was a need to progress with how we can make sure our statutory duties remain safe over the transition period and an oversight group would be a good place for non-executive involvement. It has also been agreed with Dame Suzi Leather (DSL),	

	STP independent chair for a small working group to look at the ICS governance proposals to ensure there are suitable levels of assurance for statutory functions to be handed over to the new organisation. PJ informed the members that DSL had requested to be part of the March Governing Body development session and this was seen as a positive given the transition of the ICS and CCG and an opportunity to ensure we are aligned as a planned process for a smooth transition. SK asked about mitigation for staff resilience and the continued provision of vaccination services when we are out of lockdown. ST responded to confirm that contingency plans for buildings are in place and acknowledged the risks for primary care and that there would be continued support for coordination of GP practices. Two thousand volunteers have been identified; however, it was acknowledged that the training and checks were taking time to be completed. DA added that we are working with each locality to build a sustainable model which will be mapped against all available workforce not just volunteers and including returners and non-medical vaccinators. DA was confident that working at locality level we will have a resilient workforce to sustain the delivery of vaccinations. A dedicated piece of work is underway around estates and plans are being developed and will be shared with primary care next week along with a modelling tool for cohorts including second doses of the vaccine. PJ asked for DA to describe the risks and mitigation and process in place for assurance DA described the cell process which feeds into weekly meetings such as a programme board including system partners for a check and challenge and routes of escalation through the Accountable Officer and system CEO's. DA gave assurance that there was an enthusiasm to get the vaccinations delivered and once we move towards lower levels of illness and infections it is the expectation that vaccinations will be normal work and the same workforce used as business as usual. JWo asked about the management of infection rates during the holiday period and would there be robust track and trace in place to contain infections. LS replied and reassured the Governing Body that there will be track and trace cross border follow up and that we have the capability for a local enhanced contract tracing. RH further assured the members that the Health Protection system exercised over the last year has the capability to manage outbreaks as they arise. **The Governing Body received and noted the contents of the AOs Report.**	
6	**Northern and Eastern Community Services Contract** *Tim Golby (TG) joined the meeting.* JT drew the members to paper in the pack which set out the detail, context, and recommendations for Governing Body. The paper had been presented to the commissioning committee and executive directors with the recommendation for contract approval award for 10 years plus 5 to bring in line with the procurement for Western. JT noted the reason for this was in line with our strategy for vertical integration for the CCG and system, long term plan and national strategy.	

	JT drew attention to the slides attached to the paper and the quality and performance indicators and admission rates. Overall, Devon is performing very well, and work continues to improve delayed transfers of care. JT acknowledges there was further work to be undertaken from now until September where the commissioning committee and clinical overview will be considering approval of the specification and moving forward for further assurance this will be discussed at the quality assurance committee. PJ suggested recommendation 4 should be adjusted for additional assurance for the process to go through the quality assurance committee. LS applauded the long-term approach and integrated services and wondered about the gap break clause. JT confirmed that a 2-year break clause has been included and confirmed that providing notice within the contract, or mutually agree varying something in contract could happen at any time. TG was confident that collaborative system working has been established and he explained the community partnership work. There is a desire from councillors and councils to be informed of the process along the way and that there has been useful engagement at councillor level. JWo felt it was important for collaborative working to ensure the voluntary sector are included and AM confirmed that a paper was being developed to strengthen engagement for patients, public at Local Care Partnership and local level. He also mentioned there was an intent to gather more intelligence around patient experience which will go beyond the family and friend's test. GAth endorsed the tools for collecting patient experience but for quality assessment of services the measures need to beyond performance measures they must include quality, and these will need to be looked at carefully especially around end of life (EOL) to ensure this is improving. GT supported the longer-term contract with setting and aligning timescales the same as Western but raised concern around the break clause. JH was not clear on the sense of expectations of improvement and where we want things to be different or more measures and was there sufficient staffing to undertake all the work for this proposal. ST responded and gave assurance that we have the right skills and capacity to do the work. There will be a period to work with partners and Governing Body colleagues to identify base line metrics and setting an improvement framework that would support a break clause and the specification. JT acknowledged the lack of data and reminded the Governing Body the specification used for Western and outcomes framework has been tailored for Northern and Eastern. JT said there was an expectation of the team as part of Local Care Partnership to describe the outcomes framework and partnership input into all to the understand benefits. She confirmed that EOL quality measures will be reviewed and there will be an intent, rigor, process and regular touch breaks built in for Governing Body assurance. The commissioning committee will agree the outcome framework process. TG described the delivery group responsibilities including the work programme and timelines. There is clear focus around the specifics and system ownership architecture and a desire to this happen over the next two years once the process and approach has been agreed.	

	NK mentioned that the commissioning committee are keen to keep a close eye on the outcome metrics and areas of concern will be escalated to the Governing Body. GApp asked about the capacity to deliver based on current staffing in the community or will there be investment for additional staff. ST referred to his earlier comment around CCG staffing and was confident there was capacity and skills to undertake this work but was not able to answer the staffing required for managing community patients. ST recognised that we need to improve our data collection around individual services to commission at a better level and Population Health Management (PHM) is really important and turning this into a dashboard to manage at Primary Care Network (PCN) level will ensure we have the right interaction with all community teams. He added that there is an additional piece of work to draw together and think about enhanced primary care in the right way to ensure we don't miss people and keep them healthy and well and manage them appropriately going in/ out of crisis. **Following discussing Governing Body:** • **Supported the making of 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;** • **Agreed the implementation proposal as set out in paper including agreement outcomes framework commission committee update outcomes to Governing Body for assurance in May** • **Supported the provision of senior leadership for this work to be prioritized to ensure sufficient resource is available to deliver the required outcomes.** • **Agreed for the Commissioning Committee to oversee the project, receiving updates no less frequently than every 3 months for the next 3 years and for the quality committee to provide assurance and non-executive oversight of community services** The Governing Body unanimously approved the adjusted recommendations and there were no abstentions. The chair thanked TG for attending the meeting today and his hard work and contribution in developing the Northern and Eastern Community Services Contract.	
	Assurance Committee Updates <u>Finance and Performance</u> GT highlighted the forecast of balanced position for the current financial year and reminded the members that the CCG would move back into the normal financial regime for 2021/22 along with associated financial challenges. GT pointed out the performance issues relating to cancer treatment waits, 52 week waits at the Royal Devon and Exeter, ambulance handovers at University Hospitals Plymouth which was detailed in the Quality Assurance Committee Chair's report. The Finance and Performance Committee requested that performance and quality targets would be reviewed in a triangulated way in future with the Quality Assurance Committee for synergy. GS confirmed she was working with the two chairs of these committees to see what this looks like and to get the balance right and she was confident that both committees would be providing assurance on behalf of the Governing Body.	

	It was confirmed that data including information on referral data would be included in performance reports and that Governing Body members would have access to this information. JW asked about the shift for month 7 and 8 around system capital spend and JD responded that this was month on month variation and added the year end forecast was on plan to deliver capital spend/ <u>Quality Assurance Committee</u> There was nothing further to add to this report. AD asked about the Young Devon Engagement report and assisting families with Autism Spectrum Disorder (ASD) recommendations. GAth confirmed that a steering group has been formed who have been asked to report to the Quality Assurance Committee to ensure the recommendations are implemented. <u>Primary Care Commissioning Committee</u> JH noted that at the last meeting there were discussions around the sustainability for Primary Care in managing the mass vaccination programme and that a formal report would be presented at the next meeting held in early March. <u>Commissioning Committee</u> There was nothing further to add to the report. NK noted that there were a few minor changes to the terms of reference including: • the delegated decision-making function • quoracy which had been reduced from three to two executives • change in wording relating to the clinical members **The Governing Body received and noted the contents of the Assurance Committee Chair's Reports.**	
7	**Local Care Partnership (LCP) Updates** PJ referred to the Local Care Partnership updates for the ICP (shadow) Partnership board which will be used for the Governing Body. In moving forward, the Governing Body will focus on locality work and for the March meeting the focus will be for Northern and Eastern. There was nothing further to add to the reports included in the board pack. JH pointed out that the reports were for the new localities except for Western. ST acknowledge this was due to a timing issue around the production of the papers and that there would be a first Western LCP report for the next meeting. It was recognised that Western LCP development was behind, but there was a commitment to support and help them with their development. NB wondered whether a document could be developed that summarises the LCP locality structure to understand how they relate to the CCG and the ICS including the membership of the locality boards. ST briefly explained the LCP executive, delivery and stakeholder groups that have been set up and the representatives and agreed that the development of this document would be helpful. **ACTION 2**	

	LCP locality structure document to be developed for the North and East as a test. GT asked about the impact of the closure of Minor Injury Units across Devon. ST confirmed there had not been any adverse reporting and that there is a planned review of MIUs and the current position of out of hospital urgent care and asked for JF to develop a briefing for the Governing Body in March. **ACTION 3** **Briefing paper on MIUs and the current position of out of hospital urgent care to be developed for the Governing Body meeting to be held in March by JF.** JWo added that the temporary closure of Ilfracombe and Bideford was due to staff crisis and good mitigation had been put in place, including discussions with the GPs who were happy to take on the extra work as a safe and secure temporary solution. **The Governing Body received and noted the contents of the LCP update reports.**	
8	**Any other business** There were no further business items raised for discussion.	
9	**The meeting closed at 11:35**	

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) A	Director of Public Health, Torbay Council
Charlotte Burrows (CB) A	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Darryn Allcorn (DA) **	Chief Nurse, NHS Devon CCG
David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Gaynor Appleby (GApp) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT) **	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG
James Wooldridge (JW) **	Associate Non-Executive Director, Devon CCG
Jayne Carroll (JC)**	Chief Operating Officer, Devon CCG
John Dowell (JD) **	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
Lincoln Sargeant (LS) **	Director of Public Health, Torbay Council
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) **		Director of Public Health, Plymouth City Council
Simon Kerr – Dr (SK) **		Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc)[A]		Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST)**		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
Tim Golby (TG) ** **item 6 only**		Joint Locality Director, North and East (Health and Care) DCC and Devon CCG
Minutes approved	Date:	Signed by chair:

NHS Devon Clinical Commissioning Group

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	25-Feb-21	CCG objective quarterly reports to be added to the forward planner from April 2021 onwards. Post meeting update this action has been completed and recommended for closure.	25-Mar-21	Nikki Coombes	02.03.2021 This agenda item has been added to the Governing Body forward planner. Recommendation for formal closure of this action.					**FOR CLOSURE**
2	25-Feb-21	LCP locality structure document to be developed for the North and East as a test.	25-Mar-21	Jayne Carroll/ Tim Golby						**OPEN**
3	25-Feb-21	Briefing paper on MIUs and the current position of out of hospital urgent care to be developed for the Governing Body meeting to be held in March.	25-Mar-21	John Finn	02.03.2021 this agenda item has been added to the Governing Body forward planner for 25 March 2021.					**OPEN**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Schedule of what the Governing Body is to achieve at this meeting				
Date of committee: 25 March 2021 **Date report produced: 17 March 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:** 17 March 2021		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The Governing Body is asked to:

- **Receive and note** the contents of the Chair's Report
- **Receive and note** the contents of the Accountable Officer's Report
- **Receive and note** the contents of the Restoration of in-hospital commissioning and **support** the detailed actions
- **Receive** the verbal update on the current position of Minor Injury Units (MIUs) and out of hospital urgent care
- **Receive and note** the contents of the Local Care Partnership (LCP) Reports and **participate** in the discussions with regards to the deep dive of the Northern and Eastern area(s)
- **Receive and note** the contents of the Assurance Committee Chair's Reports

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.
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

Report title: Chair's Report				
Date of committee: 25 March 2021 **Date report produced: 18 March 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 March 2021		
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:

- Mass Vaccination Programme
- Integrated Care System (ICS)
- Shadow ICS Partnership Board
- Governing Body – voting member change
- Primary Care Partners
- Thank you and welcome

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 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		√

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GOVERNING BODY – CHAIRS REPORT

1. Mass Vaccination Programme

The vaccination programme in Devon has been a huge success. Over half a million people have received their first dose and nearly all those most vulnerable have been vaccinated as well as those who care for them. The challenge, particularly in Primary Care, of delivering the vaccinations and continuing to care for patients has been significant. I would like to express my thanks for their hard work, energy, enthusiasm and versatility in being a key part in protecting our older and extremely vulnerable residents. We continue to plan and adapt to the opportunities and availability of vaccines to ensure that every vaccine that arrives in Devon gets to those who most need it.

2. Integrated Care System (ICS)

As we continue our transition to integrated care systems and await the outcome of the White Paper proposals, it is important we get the governance of the wide system and commissioning functions right. To this end, the shadow ICS partnership Board has established a task and finish group to develop a proposed governance model that will help in this next 12 months of transition and be ready to potentially take on statutory functions next April. I will be part of that group and will be working with Governing Body colleagues to ensure the learning from CCG governance and clinical leadership shape the output from the group.

3. Shadow ICS Partnership Board

The shadow ICS Partnership Board met on 3 March. Items discussed include the PCN development program, current ICS submission progress and the Devon 'Long Term Plan' implementation plan. In order to continue to align ICS Board and CCG Governing Body business and priorities, I have invited Suzi Leather, Independent Chair, to join the CCG Governing Body and I am sure you will join me in working with her to ensure we work collectively across the ICS for the benefit of our population.

4. Governing Body – voting member change

As you know Charlotte Burrow's, our non-executive director for patient and public engagement has started a period of maternity leave. In the absence of Charlotte, Alison Davis, associate non-executive director has agreed to cover Charlotte's membership of the Quality Assurance Committee. As such I am formally asking the Governing Body to approve for Alison to be a voting member of the Governing Body during Charlotte's period of maternity leave.

5. Primary Care Partners

Within the White Paper there is the possibility of further delegation of Primary Care commissioning passing to the Devon system, opening up the opportunity to work more closely with wider primary care providers. To that end I am pleased to have been invited to both the Local Pharmaceutical Committee, who I met with on 3 March, and the Local Optical Committee to discuss both our Covid experience and the potential that ICS brings. Both are very keen to explore how we can work more closely together and this brings yet more opportunity to integrate the care and support we provide.

6. Thank you and welcome

Lastly, this is the last Governing Body with Simon Tapley as Accountable Officer. He is remaining with the CCG and will continue to provide significant and vital leadership for us, but it is important we pause and thank him for everything he has done since stepping into this role at a time when we needed some stable and clear leadership and guiding us to what is a much stronger position. Thanks to his hard work we are in a really good place to welcome Jane Milligan who will be taking over that Accountable Officer Role from 1 April.

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Clinical Commissioning Group

GOVERNING BODY

Report title: Accountable officer report				
Date of committee: 25 March 2021 **Date report produced:** 17 March 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 March 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. Half a million people in Devon now vaccinated
2. Lockdown restrictions begin to ease
3. Working with local communities to increase vaccine up-take
4. Supporting staff wellbeing
5. Devon Together newspaper reaching thousands

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. Half a million people in Devon now vaccinated

The 500,000th person in Devon received their first dose of the COVID-19 vaccination on the weekend of the 13th of March – a remarkable achievement in just 14 weeks.

Half of our adult population, 95% over 65s and a quarter of people aged 16-64 years have now been vaccinated since Kathleen Viney became one of the first people in Devon to have the jab on 8 December.

I am incredibly proud at how staff across the CCG have pulled together as one team to support the programme, including providing clinical assurance at vaccination sites, booking patients into clinics, and ensuring local people have the right information.

I'd also like to recognise the invaluable role of our partner colleagues, community organisations and volunteers across our county.

At the start of March to mark a year since Devon's first COVID-19 case, senior leaders from across our system and I posted a series of messages on Twitter.

The campaign highlighted some of the things we have achieved during that time, including treating 3,834 COVID-19 patients, carrying out more than 7 ½ million coronavirus tests, delivering 493,574 online consultations and supporting more than 40,000 people a month with mental health issues.

2. Lockdown restrictions begin to ease

The Government took the first steps in easing lockdown restrictions on Monday 8 March with schools reopening.

It also means two people from different households can meet up outside and one nominated person can visit a care home resident, providing they wear personal protective equipment (PPE) and take a COVID test, which I know will be welcomed by many.

While restrictions have been eased slightly, the virus is still as serious as ever and spreads very easily. So, we're continuing to encourage our staff and the public to stay home as much as possible, and only leave for work (if they can't work at home), to take children to school, essential shopping, exercise, or medical appointments.

The success of the vaccination programme and the efforts from people in following government guidance around testing, social distancing and isolating when needed has meant this relaxation can start to happen.

The easing of restrictions will be guided by data, not dates, to avoid a surge in infections, hospitalisations and deaths. For that reason, all the dates in the roadmap are indicative and subject to change.

There will be a minimum of five weeks between each step: four weeks for the scientific data to reflect changes and for these to be analysed, followed by one week's advance notice of further changes.

3. Working with local communities to increase vaccine up-take

We are working with people from black, Asian and minority ethnic communities (BAME) and those who have learning disabilities to increase take up the coronavirus vaccination.

Recent engagement work we led suggests that the reasons for vaccine hesitancy locally mirror concerns identified nationally. And, like other areas of the country, take-up of the vaccination in Devon among some BAME communities is lower than in the overall population.

Among the outcomes of the work were that people taking part in the engagement had concerns regarding vaccine safety and side effects.

On a positive note, feedback from people from BAME communities included wanting to set a positive example to the wider community, while no one expressed anxieties about the actual vaccination process or needles

Acting on suggestions made during the engagement, 'vaccine ambassadors' representing different BAME communities will be working with local groups to provide information and reassurance so people feel confident to accept an offer of vaccination when they are called as part of the national programme.

Other initial support measures we've put in place locally include:

- Asking people from communities where uptake is low or concerns are high to get in touch with the local NHS so support can be offered
- Translating key information about registering with GPs into different languages, with further translated materials to follow
- Developing a film in partnership with a Devon equality organisation to address concerns people may have
- Using social media advertising to reach groups who may be vaccine hesitant with reassurance messaging

Those with learning disabilities who took part in the engagement felt that:

- Information about what to expect at the vaccination appointment would help allay anxieties
- Delivering vaccinations in safe and familiar environments would support vaccine uptake
- Clear information in accessible formats were required.

Following this feedback, we're developing Easy Read leaflets and have published a short film to allay anxieties and support people with learning disabilities to have the COVID-19 vaccination.

The joint project between the CCG, NHS England and The Turning Tides Project features 'Michelle' and her carer 'Holly' who were filmed at Mid Devon Healthcare Primary Care Network's vaccination site at Lords Meadow Leisure Centre in Crediton.

4. Supporting staff wellbeing

Supporting our staff to stay well has, and continues to be, one of our top priorities throughout the pandemic.

Over the past few months, our wellbeing champions have held one-to-one check-ins with three-quarters of our staff so far to see how they're feeling and for them to suggest how we can improve their wellbeing.

The feedback, which is currently being collated into themes, will be used to improve how we support staff.

We're also encouraging staff to take regular breaks from their desks, and recently promoted Devon's Let's Walk Challenge, which sees teams across the county aiming to walk as many steps as possible throughout March.

11 CCG teams are taking part, including our executives, safeguarding and nursing teams, but it's our contracting team who are leading the way at the moment with an impressive two million steps.

5. Devon Together newspaper reaching thousands

I'm pleased that we have published a community newspaper containing essential information on coronavirus vaccinations, testing, safety and local services to hundreds of thousands of people across the county.

The 16-page colour newspaper, which was jointly commissioned by the CCG, Devon County Council and Devon and Cornwall Police and Crime Commissioner's Office, is being included as a pull-out supplement in more than 100,000 newspapers published across Devon.

It is also being delivered free directly to homes as well as being offered in selected supermarkets and other publicly-accessible settings.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Restoration in Hospital Commissioning				
Date of committee: 25th March 21 **Date report produced:** 12th March 21				
Author (s) Name and Title: **John Finn** **Interim Director In Hospital Commissioning**		**Supporting Executive:** **Name and Title:** John Finn, Interim Director In Hospital Commissioning **Contact Details:** john.finn@nhs.net **Report Approved by:** **Name and Title:** John Finn **Date**		
Public or Private (Governing Body only):	**Public**	√	**Private**	

Executive Summary:

The governing body is asked to note current position for the areas impacted by this and support the actions to restore required capacity levels for 21/22 through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation.

Management of Conflict of interests:

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

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

None

Key recommendations and actions requested:

To note the report and support detailed actions

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.

Restoration of In Hospital Services 21/22

1. Introduction

In line with the December 2020 spending review the Devon system continues to restore non-Covid services, in a way that reduces variation in access and outcomes locally and between different parts of the country. To maximise this restoration an aspiration was set nationally and supported In Devon that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems detailed to have the greatest opportunity for improvements: e.g. ophthalmology and MSK/orthopaedics and continue restoration of diagnostic and cancer pathways. To support recovery of in hospital capacity in 21/22 the Devon system is using national best practice via the GIRFT programme, increasing productivity via the Adapt and adopt programme and implementing agreed evidence based local pathways via our intensity gradient programme. NHS performance in Devon will improve over time, once impacts of the pandemic are factored in - bringing down operating waiting times and improving access to cancer pathways.

The governing body is asked to note current position for the areas impacted by this and support the actions to continue to restore required capacity levels for 21/22 through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation.

2. Elective Care. RTT and 52-week recovery

Summary of work programme and impacts on 21/22

Elective Recovery RTT

	% of WL > 52 weeks				
	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Devon	4.60%	5.51%	6.61%	7.37%	8.43%
South West	4.03%	4.62%	5.25%	6.02%	7.48%

In March 2020 the CCG received a National Directive to postpone all non-urgent elective operations and providers across Devon responded to this request. Many staff were redeployed, particularly theatre trained staff and a number of theatre recovery areas were converted into additional capacity for intensive care facilities. During the summer months, when the Covid numbers were reduced, elective services were restored but the throughput was impacted by the need for Infection Prevention Control measures. Priority was given to those patients with the greatest clinical urgency rather than those with the longest wait.

When subsequent Covid surges have arisen, we have maintained as much surgical throughput as possible, but clearly this has been significantly lower than normal levels resulting in a significant increase in incomplete pathways and an increasing proportion of those patients waiting over 52 weeks.

Patients waiting for routine elective procedures were most impacted by these decisions. Devon surgeons have undertaken a review of patients on their waiting lists, prioritising them in to four categories – with P1 being those patients in need of immediate life or limb saving surgery, P2 those patients needing treatment within a month with significant risk of progression of disease, P3 those patients who need treatment within the next 3 – 6 months or risk progression of disease such that a more extensive procedure would be required and P4 patients able to wait longer with little risk of significant progression or harm. The majority of patients on the surgical wating lists have been classified as P4. Through this process we will continue to prioritise patients with the greatest clinical need. As the Devon acute providers continue to decompress their COVID capacity further elective capacity is becoming available to support operational planning for the first two quarters of 21/22.

The Independent Sector were commissioned under a National Agreement to provide support to the NHS – Devon were recognised nationally for making best use of this opportunity with an outstanding degree of support and collaboration from all the IS providers across the county. This additional capacity to support the NHS has been a critical aspect of enabling the continuation to treat those patients most in need during the pandemic and will continue to provide essential restoration capacity into 21/22. Prioritising this capacity for patients waiting over 52 weeks on current acute waiting lists will be a key part of our planning.

Devon has participated in an exercise to contact all patients on surgical waiting lists to ensure that patients were aware of the lengthened wait experience and to ensure that they still wanted to remain on the list. In line with other parts of the country, we are in the process of developing a single waiting list which will ensure that there is equity of access across Devon. This work will complete in the second quarter

A weekly meeting of senior surgeons and management leads have been meeting to review the numbers of patients waiting, and to agree some common themes across Devon to support restoration planning. This has been the vehicle for discussions to resolve areas of concern and to offer mutual aid. The weekly surgical meeting is overseeing the development of implementation plans to improve productivity in four key areas with the aim of meeting national best practice. These are.

- Ophthalmology: cataracts to deliver 8 (with training) / 10 (no training) cataracts per 4-hour session
- Orthopaedics: primary hip and primary knee moving to a significant proportion of day case (20%) to one day Length of Stay (45%) and achieving 4 or more joints per full day list
- Urology: TURBT >80% day case rate; trans perineal prostate biopsies under Local Anaesthetic; Bladder outflow obstruction system to day case (80%)
- Upper GI: Lap chole day case > 80%

The improved productivity measures alone will not be sufficient for Devon to begin to address the backlog of patients on the waiting lists. A Demand and Capacity model is helping us to

understand the scale of the backlog and the non-recurrent measures that will be required to address this such as emerging plans for the Nightingale to undertake elective activity subject to local and national agreement .

3. Outpatient Activity

Summary of work programme and impacts on 21/22

The Long-Term plan set out how the NHS will move to a new service model in which patients get more options, better support, and joined-up care at the right time in the optimal care setting. The document states that GP practices and hospital outpatients currently provide around 400 million face-to-face appointments each year. The ambition set was that, over a five year period, every patient will have the right to online 'digital' GP consultations, and redesigned hospital support will be able to avoid up to a third of outpatient appointments - saving patients 30 million trips to hospital, and saving the NHS over £1 billion a year in new expenditure averted.

The transformation of Outpatient services has been both hindered and helped by the Covid 19 pandemic the backlog of patients is significant, with extensive waiting times in some specialties. There is a pressing need to risk assess patients waiting and to treat patients according to clinical need and secondly chronologically according to waiting time in a consistent manner across Devon. It is important to recognise the speed at which services adopted the use of the Attend Anywhere platform to continue to deliver outpatients appointments virtually and by telephone during COVID as it is also important that this progress is built upon and continued to restore outpatient capacity to the address backlogs.

To support restoration a number of key outpatient schemes/deliverables have been developed to manage demand and maximise productivity as part of Phase 3 planning and the Adopt and Adapt recovery programme. These are as follows:

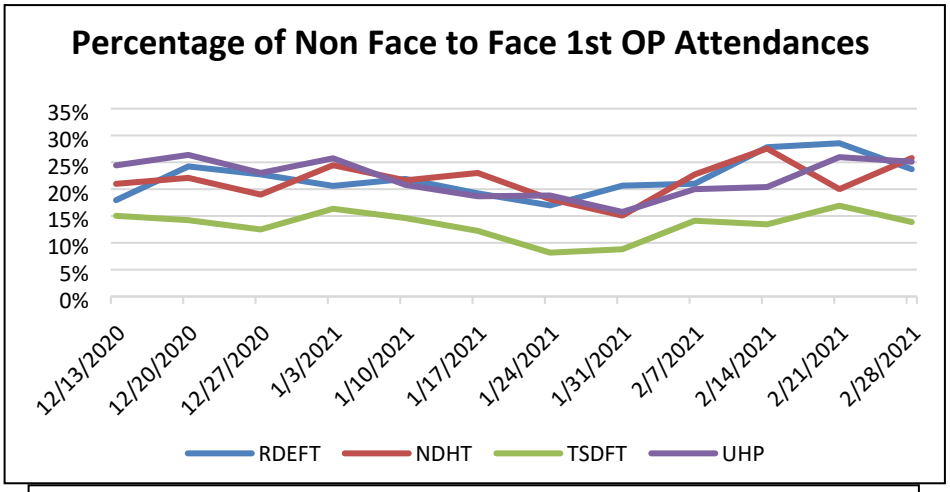
- **Digital Technology and optimise virtual appointments** - where an outpatient appointment is clinically necessary, 25% of all 1st appointments and 60% of all follow ups should be conducted by phone or video.
- **Rationalise use of follow ups** – Follow ups by exception only.
- **Patient Initiated Follow up (PIFU) -** Give patients more control over their follow up care by adopting a PIFU approach across all major specialties.
- **Reducing numbers of patients waiting by clinical validation of existing referrals and OP waiting lists**

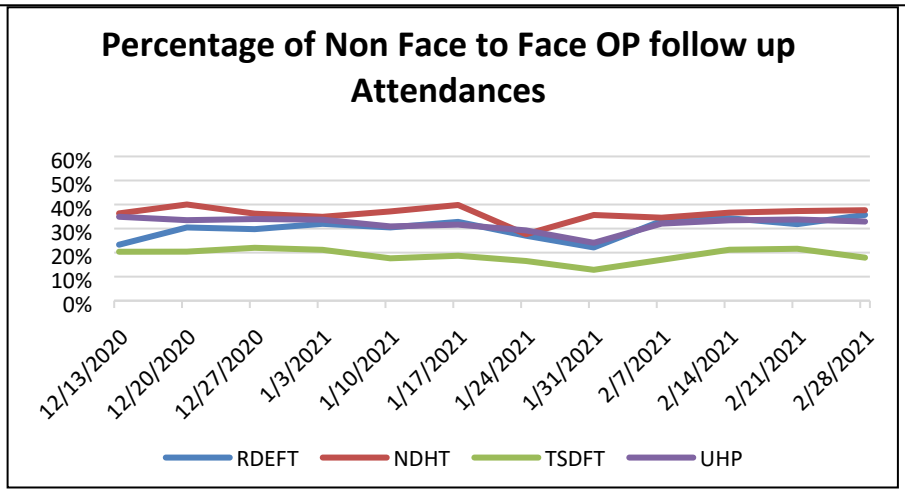
Implementation and progress against plan have been monitored by the System Outpatient Steering group. The Steering group is attended by OP clinical and managerial leads from each Trust, the STP digital lead and a GP representative. The group is chaired by the CCG OP clinical lead alongside the OP management lead.

1. Digital Technology and optimise virtual appointments - where an outpatient appointment is clinically necessary, 25% of all 1st appointments and 60% of all follow ups should be conducted by phone or video

The implementation of digital technology and use of virtual appointments supports more productive use of consultant time and enables the capacity of outpatient clinics to be used more efficiently.

It has been noted that Devon providers have performed the greatest number of OP 1st and follow up appointments across the region. This is extremely positive in terms of recovery. However, Devon is lagging behind other systems in use of video/phone (non face to face) consultations. The Outpatient Steering group is investigating this and looking at solutions including provider to provider support.





2. Rationalise use of follow ups – Follow ups by exception only.

Reducing the number of unnecessary follow ups is absolutely crucial to reducing the numbers of patients waiting. The Elective Care mandate is currently awaiting sign-off by the Devon elective board will set a requirement for Providers to commit to this in all major specialties. It is important to recognise that the current baseline has been distorted by the impact of Covid 19 therefore 19/20 numbers will be used as the planning baseline for follow ups.

3. Patient Initiated Follow up (PIFU) - Give patients more control over their follow up care by adopting a PIFU approach across all major specialties

PIFU can play a key role in enabling shared decision making and supporting patients to self manage by helping them know when and how to access clinical input. Used alongside clinical waiting list reviews, remote consultations and a 'digital first' approach it will support restoration of services .

All Devon providers are progressing with implementing PIFU or similar models of patient-initiated access. Plans are in place to increase the number of specialties using PIFU however will need to be expanded in both cover and usage to meet the restoration needs of our system. Please see table below showing where PIFU is actively being used in each Trust:

Provider	Specialties that have implemented PIFU
UHP	Trauma and Orthopaedics, Dermatology, Neurology, Pain, Rheumatology, Gastro, Thoracic Medicine, Plastic Surgery
RDE	Paediatrics
NDHT	Urology, Rheumatology, Thoracic Medicine, Podiatry
TSDFT	Trauma and Orthopaedics, Gynaecology, podiatry

4. Reducing numbers of patients waiting by clinical validation of existing referrals and OP waiting lists

It is essential that existing referrals and waiting lists are clinically reviewed to ensure that all patients waiting are still in need of an appointment and, if so, are prioritised correctly. There is evidence that waiting list reviews can remove significant numbers of waiters, particularly from pending lists.

There is a programme of work being developed by NHS England focused on clinical validation of OP lists. Devon providers have been asked to feed into this. In the meantime, the all Trusts have been tasked with scrutinising their lists of patients that are 'not yet seen'. These are patients that are waiting for a first outpatient appointment and potentially have had no clinical review of their referral. These patients pose a key safeguarding risk so are being reviewed as a matter of priority

4. Diagnostics

A Devon-wide imaging diagnostic and endoscopy group have met weekly since March 2020 focusing on restoration of services. The Devon acute Trusts and the CCG have worked together to maintain services throughout the pandemic, sharing best practice and providing peer support and mutual aid. The STP as also fully engaged in the Adapt and Adopt initiative to restore diagnostic capacity and as services start to restore further, there is a continued focus on planning recovery as the operating environment improves.

Diagnostic services have been severely impacted by the Covid IPC requirements, particularly endoscopy which is an aerosol generating procedure.

For diagnostic services all available space within Trusts and the Independent Sector has been in use. Capacity has been reduced due to IPC requirements combined with loss of staff who had moved to the Covid rota and those shielding. Services have been offering waiting list initiatives and utilising insourcing companies to increase capacity as referrals returned to pre Covid levels.

For endoscopy to support restoration standardised triage of non 2ww referrals has been in place based on clinical risk following results of a FIT test in the same way as have those on surveillance waiting lists. FCALP testing has been introduced to assess those patients symptoms that are indicative of IBS or IBD. Trans Nasal Endoscopy has been in use for the frail/elderly not suitable for an endoscopy. Pilot schemes have been initiated to assess the viability of using capsule endoscopy and ‘cytosponge’ technologies in assisting recovery. 2ww endoscopy referrals from Torbay are being undertaken at PPG in Plymouth. All these interventions support both restoration of services and the required increases in capacity required in 21/22.

Cystoscopy services have utilised disposable and sheathed scopes to accelerate clearance of surveillance waiting lists and a cohort of Torbay patients attended for their rigid cystoscopy procedure in UHP. Training for all Trusts in the use of sheathed cystoscopes was provide by the RD&E which has supported this workstream

Use of the Nightingale site for CT, MRI and Non-Obstetric Ultrasound is being reinstated as part of recovery with the CT and MRI enabled to accept referrals from all five Peninsula Trusts. Further use of the Nightengale for increased diagnostics is in planning aligning to the national strategy for community diagnostic hubs . The use of the CCG AQP Ultrasound contract to support backlog clearance in 20/21 was successful and will continue in 21/22 A process is being agreed to IPT the longest waiting patients from Trust waiting lists to the CCG’s provider to ensure equity of access based on clinical need rather than chronology to ensure patients with the greatest clinical need are prioritised.

Work at system level has continued to implement image sharing software for imaging diagnostics and the roll out of home working to improve reporting performance has been completed in UHP and is in planning for the remaining Trusts. This again will both improve productivity and increase capacity.

Elective Recovery: diagnostics		Week ending 21/02/21						4 Week average up to W/E 14/02/21				
		19/20	20/21	P3 Plan	% Recovery	Variance		19/20	20/21	P3 Plan	% Recovery	Variance
CT	Devon	2742	2367	2435	86.3%	-2.8%		2697	2510	2445	93.0%	2.6%
	South West	**13116**	**11964**	**12370**	**91.2%**	**-3.3%**		**12956**	**11865**	**12635**	**91.6%**	**-6.1%**
MRI	Devon	1437	1158	1305	80.6%	-11.3%		1377	1107	1320	80.4%	-16.1%
	South West	**6267**	**5236**	**5720**	**83.5%**	**-8.5%**		**6156**	**5118**	**5875**	**83.1%**	**-12.9%**
Endoscopy	Devon	889	526	845	59.2%	-37.8%		861	648	843	75.3%	-23.1%
	South West	**2927**	**2404**	**2900**	**82.1%**	**-17.1%**		**2968**	**2534**	**2955**	**85.4%**	**-14.3%**
Colonscopy	Devon	345	216	305	62.6%	-29.2%		329	251	303	76.1%	17.2%
	South West	**1077**	**1005**	**1065**	**93.3%**	**-5.6%**		**1054**	**997**	**1065**	**94.5%**	**-6.4%**
Flexi Sigmoidoscopy	Devon	150	87	140	58.0%	-37.9%		148	98	145	66.1%	-32.8%
	South West	**595**	**404**	**535**	**67.9%**	**-24.5%**		**622**	**409**	**560**	**65.8%**	**-26.9%**
Gastroscopy	Devon	394	223	400	56.6%	-44.3%		385	300	395	78.1%	-24.0%
	South West	**1255**	**995**	**1300**	**79.3%**	**-23.5%**		**1291**	**1128**	**1330**	**87.4%**	**-15.2%**

5. Cancer

5.1 Summary of programme and impacts

Elective Recovery: Cancer												
Area		2WW (CWT.WAR)			62 Day Treatments (PTL)			Backlog: 63 days+ (PTL)			Backlog: 104 days+ (PTL)		
		WE 16.02.20	WE 14.02.20	as a % of last year	WE 16.02.20	WE 14.02.20	as a % of last year	WE 16.02.20	WE 14.02.20	as a % of last year	WE 16.02.20	WE 14.02.20	as a % of last year
South West		5580	4792	86%	248	410	165.0%	1427	1556	109.0%	248	303	122%
Devon STP		1506	1342	89%	109	112	103.0%	484	446	92.0%	109	80	73%
TSDFT		343	322	94%	19	11	58.0%	106	109	103.0%	19	11	58%
NDHT		180	95	53%	16	6	38.0%	67	61	91.0%	16	6	38%
RD&E		488	424	87%	50	43	86.0%	208	194	93.0%	50	51	102%
UHP		495	501	101%	24	52	217.0%	103	82	80.0%	24	12	50%

A core Cancer Alliance group involving all system partners initially convened in March 2020 and have worked together to maintain cancer services for patients throughout the pandemic. As services begin to restore there is a continued focus on recovery.

In support of the national drive for people to continue to visit their GP with potential cancer symptoms. The Cancer Alliance have an early diagnosis lead working across the system to co-ordinate responses to this challenge. The clinical leads have taken part in a local media campaign encouraging symptom identification and attendance and there has been regular GP communication and provision of resources to continue to support patients accessing their GP for potential cancer symptoms.

A single system wide weekly 2WW summary report is used to identify if rates for specific tumor sites are at variance to support understanding of reasons and develop targeted solutions where possible. If as a system, we are seeing an increased rate of referrals in a tumour site we know about it on the Monday of the following week so can mitigate any potential risk rather than wait a month until the national data is available . An example of this is an increase in 2ww endoscopy has resulted in a planned been diversion of patients to the independent sector or when rates of lung 2ww were identified as not recovering as expected the system delivered ae focused media campaign in support of getting patients with symptoms to contact their GP

To recover achievement of the 62-day targets from GP referral to definitive cancer treatment the Cancer Alliance and system acute trusts are following all national guidance. In addition, a weekly Cancer Prioritisation Group with Peninsula cancer clinical leads takes place. The aim is to manage the real time pressures across the system including provision of mutual aid and coordination of surgical activity across NHS and IS capacity.

In addition, there are regular cancer Site Specific Groups to support rapid clinical change where required. An example is the breast pathway where we have agreed one Devon wide 2ww referral form due to launch in March that puts patients onto the correct pathway for their symptom presentation or a further example is the colorectal teams agreeing to the expansion of the use of FIT testing in the absence of national guidance and agreeing the clinical thresholds to assess risk.

To support operational delivery there are regular meetings in place with Cancer Services Managers, trust COO's, weekly meetings with diagnostic clinical and operational leads to ensure prioritisation of available capacity to cancer patients and there is regular learning and sharing with the national cancer teams.

To ensure patients are treated in order of clinical priority standardised triage has been introduced supported by adopting innovation to prioritise patients and diagnose earlier e.g. FIT testing. To create capacity there has been piloting and adoption of innovation to treatments that speed up the patient journey e.g. Local Anesthetic Trans Perineal Biopsies, use of Trans Urethral Laser Ablation. In dermatology services dermatoscopes and training in their use has been rolled out across the Peninsula supported by a digital platform that delivers the images into the Trust IT systems to aid advice and guidance support for primary care and triage for the secondary care team.

John Finn
Interim Director In Hospital Commissioning
March 2021

Together for Devon

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

Locality update report

Locality:	South
Period covered by update:	March 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 the development of community based urgent care.
A workshop has been held 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.
- Delivering sustainable community urgent care services

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.

Support required and/ or barriers to progress

Together for Devon

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

Locality update report

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

Key achievements/progress

- The establishment of the LCP Delivery Group which has brought together wider system partners including voluntary sector and Healthwatch
- Further development of the Locality profile to greater reflect Children and Young People and the Market position in the locality
- Establishing care homes and care hotels to support flow
- Multi Agency responses to care home outbreaks
- Standing up shielding again (Caring for Plymouth) including the extension of the CV criteria
- Supporting “Everyone In” through the winter Months
- Ongoing due diligence and assurance activity with NHSE/I and Preferred Bidder for Integrated Care Partnership procurement
- Implementing the Mass Vaccination Programme with a particular view on how to ensure hard to reach groups are engaged in the City
- Scoping out a review of Children and Young People and the impacts of COVID
- Progressing the Cavell Centre including completion of 2 Stakeholder sessions, confirmation of SRO responsibilities and development of the programme team and workstreams to support the business case development
- Development of policy and delivery framework to provide an overview of how plans align to LCP priorities
- Engagement with Collaborative Board and development of a support proposal to ensure Primary Care is represented appropriately

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.
LCP Delivery Group- Chair TBC. Membership includes Livewell South West, Healthwatch, St. Lukes, PCN Rep, University Hospital Plymouth, Plymouth City Council, AgeUK and wider voluntary sector. This group will provide co-ordination and oversee the development of the integrated work programme and monitor and drive delivery. It will also embed engagement activities to ensure developments are co-designed with stakeholders and the population it servies.

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-Population Health Management 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

NHS
Devon
Clinical Commissioning Group

Locality update report

Locality:	Plymouth
Period covered by update:	March 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
- Ongoing focus on discharge from UHP to maintain flow
- COVID vaccination programme continues to demonstrate 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. Ongoing success of Covid vaccine rollout across 4 PCN sites; local solution to allow patient booking into UHP site via AccuRX
- 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.
- Independent Sector (IS) providers came out of 'surge' status at the beginning of March meaning that the NHS no longer has access to 100% of the IS capacity. The IS providers will return to full 'Business as Usual' from the beginning of April and the CCG is working with all providers to restore full elective services and assess the requirements for recovery of performance.
- Care Hotels, evaluated and de-commissioning underway
- Cavell Centre 2nd Stakeholder workshop completed, investment objectives agreed and shared with LCP Executive. Model of Care work commenced.

Key priorities for the next three months

- Conclude the Integrated Care Partnership procurement in line with assurance requirements
- Model of care stocktake and engagement for Cavell Centre to support development of Business Case
- Partnership work with providers to develop the Urgent Care Locality improvement plan to address key performance challenges including ambulance handover delays.
- Locality planning to ensure a sustainable COVID vaccine delivery programme and joint work with Public Health and Local Authority at place to support continued roll out of vaccination programme for hard to reach communities.
- Implementation of the local Lower Back and Radicular Pain pathway in line with the agreed specification.
- Finalise the Plymouth 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)
- Restore all planned care services as redeployed staff return to their substantive roles and gain a better understanding of demand, capacity and non-recurrent solutions required to address the backlog.
- Phase 4 operational planning

Issues of concern or risk

- Staffing capacity across the commissioning team to manage priorities and operational demand including increased reporting requirements
- Workforce capacity across all Providers including nursing, domiciliary care, pharmacy, voluntary sector
- Cornwall capacity across community specifically Care Home provision which impacts on UHP Length of delay performance.
- 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.
- Recruitment to vacant positions within Locality

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

NHS
Devon
Clinical Commissioning Group

Locality update report

Locality:	Northern Devon
Period covered by update:	January - February 2021
Localiy Clinical representative	Dr John Womersley
Locality Executive Lead	Andrew Millward
Locality Non-executive representative	Charlotte Burrows

Key achievements/progress

1. One Northern Devon

One Northern Devon (OND) Partnership continues to progress its programme of work within its three pillars: person-centred services, place-based and system co-ordination. There is a willingness for OND to provide the LCP engagement requirement for an interface between partners connected with the social determinants of health and statutory Health and Social Care providers at locality level.

OND Programme Manager and Community Partnership Manager continue to focus 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:

OND Partnership has initiated a report designed to looking at current work programme benefits. This first iteration was well received, and it is intended to add further data as it becomes available. Future ICS outcomes will be added once clarified and agreed by the wider system. The report will be tabled at every OND Board meeting.

The 10 Projects within the Quality of Life Theme now reporting through a standard template.

Reports found within OND Partnership Board Papers HERE

The four OND Partnership Theme Development Teams are;

Health and Wellbeing. Funding has been secured to develop a programme called Leading Collaboratively with professionals and citizens.

Projects

1. Obesity / Healthy Weight
2. Loneliness
3. Crisis Prevention & Support. (High Flow, Suicide Prevention & GP Homeless Access programmes)
4. Child Poverty- meeting with Plymouth city council child poverty team

Safe, Clean & Sustainable Places

Projects

5. Fuel Poverty - Strategy agreed
6. Climate Emergency
7. Strong and resilient emergencies

Economy, Employment & Skills

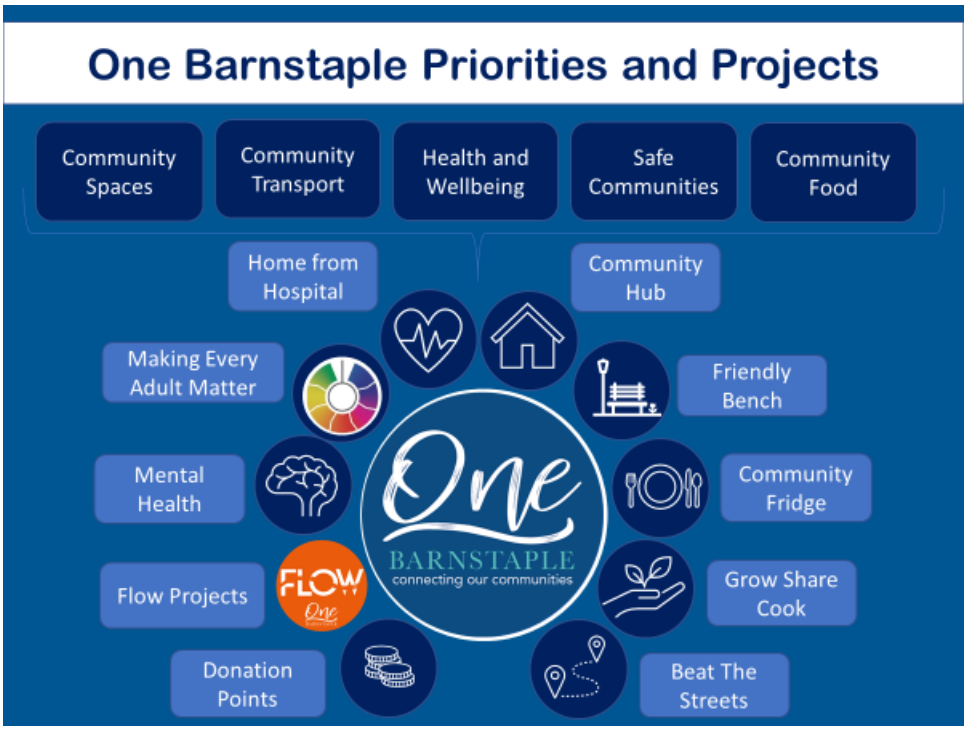
Projects

8. Supporting Local Employers
9. Local Supply Chain Development
10. Increasing Employment Opportunities – Youth Flow with DWP

Health & Social Care Integrated Delivery Group

NHS & Soc Care (LCP services delivery and performance review)

Examples of a ONE Community followed by wider work streams activity.



- Wellbeing at Work programme/Youth Flow. Now piloting a support package with a local business that has taken on a Your Flow apprentice. This includes an initial wellbeing survey, mental health first aid training, a mental health and wellbeing staff champion support package and incorporation of the reduced carbon agenda with staff carbon training in development and promotion of active travel. Active Devon and One Small Step involved. Connections made with Live Well South West and PHE's Worklessness and Wellbeing network. SW Academic Health Network involved with evaluation. Funding yet to be sourced.
- Continued promotion of MECC training. Kay Brennan developing links with DPT and community mental health workforce with aim to educate and empower increased physical activity promotion and healthy lifestyle conversations.
- First meeting of the Strategic Devon Food Partnership in early Feb. Aims of building sustainable access to locally sourced food for all, resilience and resourcefulness of communities across Devon and embedding food in top tier policies. Support from Food Matters and University of Exeter/Plymouth.
- Active travel group reviewing community base cycling proficiency training for all ages and aggregating/mapping Local and Neighbourhood plans.
- PHE Weight Management Services Mapping workshop had OND representation. Ongoing data gathering on how best to respond to COVID impacts, the new developments from the NHS Long Term Plan and learning from moving to digital/virtual face to face sessions and the need to address health inequalities.
- All leisure providers continue to struggle given further lockdown measures post-Christmas. Parkwood has highlighted the Healthy weight and physical activity forum on national funding reduction for leisure provision but were very grateful for support from Sport England. They are very keen to continue to engage with OND to develop links and can offer rooms to hub groups when they are able to reopen again.
- The Healthy Weight and Physical Activity forum will be seeking more citizen leadership and VCSE input/members in 2021 with support from Mark Doughty from Kings' Fund and OND health and wellbeing facilitator.
- Beat the Streets. The Police are happy to provide match funding for this community engagement activity project, but due to current COVID difficulties the scheme would be deferred until later in 2021.
- An Active Devon Workplace Walking Campaign called 'Let's Walk' will be starting in March (depending on current guidance) which OND is fully supporting and linking into many campaigns.

<u>Challenges</u>

- To develop the Wellness at Work programme requires a robust evaluation and the ability to scale up. It's potential to expand is limited by funding.
- Funding for North Devon freedom centre rough sleeper work is only for one year.

- Ability to link with DPT during a challenging time on promoting activity for prevention and management of mental health conditions and co-morbidities as focus on effects of COVID on community mental health.
- Limited ability to influence and support rural communities to increase active travel as central focus on larger urban areas.
- Uncertainty on economic support for VSCE and when and how re-opening of society will occur means campaigns and public health awareness measures on wider determinants of health finds it hard to gain traction.
- Worsening of health inequalities during lockdowns

2. Northern COVID-19 Cell

- 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.

- **COVID-19 Vaccination Programme**
  Vaccinations are taking place in primary care and pharmacy sites as well as at Barnstaple Leisure Centre. Cohorts 1-4 have been covered and North Devon is to begin vaccinating the next cohorts - people aged 65 years and over (cohort 5) and those aged 16-64 with underlying health conditions (cohort 6) in the next few weeks.

  The CCG and primary care providers are meeting regularly to review the process and resolve any difficulties or concerns.

3. Population Health Management (PHM)

Following the successful pilot of the PHM programme in the Barnstaple area, the locality team are looking at how the programme can be rolled out across the wider PCNs in Northern Devon. This work has been paused while the central PHM team are supporting the COVID-19 and winter pressures priorities across the Devon system.

4. Northern 2021/22 iBCF schemes

Agreement was reached at the February Northern Integrated Delivery Group (IDG) to roll over last year's schemes into 2021/22. Running the schemes for the additional period will allow time for the schemes to be properly embedded after the delays in some recruitment and allow a more thorough evaluation of schemes.

Discussion will be taking place soon regarding the additional £43,000 prevention BCF.

5. Urgent Care Northern

- As of mid-February NDHT has no COVID-19 inpatients.
- Previous issues of staff COVID-19 absence have greatly reduced.
- The Trust has been at OPEL1 continuously for over 2 weeks, with daily figures of empty beds ready to take emergency admissions in the double figures.
- The improving picture has allowed the Trust to improve urgent care performance. As of the end of January the Trust:
  - Has the lowest cumulative ambulance handover delays in the South West.
  - Whilst still fragile the most consistent delivery of the ED 4 hr %-target over the last 6 months
  - A large reduction in patients with delayed discharge due to waiting for either a package of care or a temporary or permanent Care Home bed.
- Whilst not at pre-COVID levels the Trust has maintained a small but steady flow of elective surgical work for most of the second and third waves of the pandemic.

6. 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 closed temporarily as a result of staffing challenges brought on by the COVID-19 pandemic.

Key priorities for the next three months

- Continue with the COVID-19 Vaccination programme
- Contributing to Mutual Support arrangements within 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
- Facilitate discussions re role of primary care and PCNs at place and system.
- 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

- 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.

Together for Devon

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

Locality Update Report

Locality:	Eastern Devon
Period covered by update:	February 2021
Locality Director:	Tim Golby

Key achievements/progress

- The Eastern system experienced steadily decreasing Covid numbers throughout the month, with community hospitals reducing to zero Covid patients, the acute site to nearly single figures and the Nightingale Hospital Exeter (NHE) to zero. Outbreaks within the community also reduced steadily in line with this trend which has relieved a significant amount of pressure on patient flow throughout the system.

- NHE transferred their final patients at the end of February and the hospital is now returned to ready standby. A large number of staff have been involved in the set up and ongoing running of the unit and their efforts have been invaluable to the Devon system.

- Acute and community hospital flow continues to be an area of focus by the NHS England/Improvement national teams, and a series of close monitoring of the data reporting continues. This has been able to build upon the CCG Discharge Cell scrutiny that has been maintained throughout the year and is currently daily data reporting. The Eastern Flow Programme Board is being established and will have oversight and governance of the ongoing work programme.

- An assessment is underway for what care market capacity will be required after the national Discharge to Assess funding ends on 31 March 2021. The focus will likely remain on rehabilitation and reablement services. 18.6 WTE staff have already been recruited to the Urgent Community Response teams and will facilitate the system to transition away from agency usage.

- 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 Governing Body approved the direct award of the Eastern Community Services contract to Royal Devon & Exeter NHS Foundation Trust. Commissioners will be focusing on working in partnership with the Trust and

other system partners on the further development of these services to ensure the best possible care for patients in the locality.

- Commissioners are exploring the possibility for a health and wellbeing hub development in Crediton, following an opportunity arising from the new build Crediton surgery site that has the potential for a second building. It could provide the opportunity for bringing together community health and care services from the local area.

- All three groups within the Local Care Partnership (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 and the Eastern priorities 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.

- Primary Care contribution in the LCP is being actively discussed with the Eastern Collaborative Board. At the time of writing its expected that the Executive group will have 3 PCN Directors in attendance (representing the 3 eastern sub-localites). This would mirror arrangements in the LCP Delivery Group which has had this level of PCN input over the past year.

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 an Eastern Locality Forum Conference in the Autumn.

- Understand how as an LCP we can shape and influence the priorities across Eastern Devon, including those within the Community Mental Health Framework and the Integrated Care Model.

- Understand what the ICS Strategic Outcomes Framework and the COVID-19 Framework mean across Place and at the neighbourhood level and how our work and priorities are impacted.

- Refining processes that ensure co-production at place. Identifying the best way to facilitate bottom-up influence so statutory organisations are connected to place and the priorities of communities and neighbourhood.

- Embedding the learning from the Population Health Management pilot to other areas of Eastern Devon

- Establishing the Northern and Eastern Contract framework

- Restoration of elective services

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

- District Authority engagement at place

- Will need to understand how the recent Health white paper will impact arrangements at system and place level.

Support required and/ or barriers to progress

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

NHS
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GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: 25 March 2021

Dates of Committees covered in this report: 10 March 2021

(Minutes of these committee meetings are available as an addendum on request)

Chair's Name and Title: Judy Hargadon, Non-Executive Director

Contact Details: Judy.hargadon@nhs.net

Reports received and noted

- Risk Report – The committee was asked to note the corporate risk register is being monitored in accordance with the risk management framework policy as appropriate, this is being overseen by the Governance Team. Three new risks have been added to the corporate risk register**.** The Covid risk register is due to be stood down**.** Concerns were raised in relation to risk 105 Devon Doctors call stacking and it was agreed to take this through Quality Assurance committee.

- Draft Board Assurance Framework (BAF)– The audit committee was asked to note the current position of the BAF which is now populated with risks from all executives.

- Draft Annual Report - The Committee was requested to note this draft annual report for review and comment.

- Draft Annual Audit Committee Report – The committee was requested to note the draft report which gives an overview of the committee's work and will be amalgamated into the committee effectiveness review.

- Incident Report – The audit committee was asked to note the bi-annual report of internal incidents and be assured of the processes in place to ensure that incidents are managed appropriately, and lessons learned taken forward

- Losses and Special Payments Report – The committee was asked to note three payments, two of which will be written off and the third approved via discussion with Chief Finance Officer and Chief Executive.

- Going Concern Report – The committee was asked to review, consider and approve the appropriateness of the CCG preparing its financial statement on a going concern basis.

- Accounting Policies – The committee was requested to review and approve the accounting policies in line with the going concern work.

- Internal Audit Update Report – The internal audit service provides a service in accordance with the requirements set out in the mandatory Public Sector Internal Audit Standards, comprising the Definition of Internal Auditing, the Code of Ethics and the International Standards for the Professional Practice of Internal Auditing. The Audit Committee received an Internal Audit Update Report of work carries out since January 2021**.** Head of Internal Audit Opinion is drafted and will be shared this week.

- Proposal for value added, support, ICS and Consortium wide work report – The committee was asked to review and approve proposed value added work. The committee recognised the need for value added work and agreed the proposal in principle. The committee requested the proposal is taken through execs to review and agree what work is priority with a limit of £50,000 be put on these pieces of work.

- External Audit Progress report – The Audit Committee received and noted the report on progress in delivering Grant Thornton's responsibilities as the CCG's external auditors. A new Code of Audit Practice comes into effect from audit year 2020/21. The Code introduces a revised approach to the audit of Value for Money.

- Mental Health Investment Statement - The committee was asked to note the statement and confirm if the letter of representation should be signed. The paper is presented to the audit committee for awareness and is to provide NHS England the assurance that the CCG are doing the work they should and spending the correct amount of money in relation to Mental Health.

- Counter Fraud Progress report - The report provided an update for the CCGs in respect of counter fraud activity. The Cabinet Office NFI team have now released the data set reports via their secure website, in respect of payroll and creditor data. On 29 January 2021, NHSCFA published its adaptation of the Government Functional Standards, the Government Functional Standards for NHS Organisations which comes into effect on 1st April 2021

Risk Register Review Updates

- Summary review of updates to corporate risk register as at 23 February 2021 were reviewed at this meeting and is available as appendix to this report.
- Board Assurance Framework was reviewed at this meeting and is available as an appendix to this report.

Committee Decisions

The Audit Committee

- Noted Risk Report
- Noted the Board Assurance Framework
- Noted the Draft Annual Report
- Noted the Draft Annual Audit Committee Report
- Noted the incident Report
- Noted the losses and special payment report
- Approved the Going Concern proposal
- Approved the Accounting Policies

• Noted the Internal Audit Update Report – **the committee have requested the value added proposal be reviewed by execs before being approved.** • Noted the External Audit progress report • Noted the Mental Health Investment Statement and agree for this to be signed by Simon Tapley. • Noted the Counter Fraud Progress Report
Items of concern to be escalated to the Governing Body
• N/A
Recommendations for Governing Body
• N/A
Recommendations for other Committees
• N/A
Terms of Reference or other committee effectiveness issues
• N/A

Management of Conflict of interests:

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

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

NHS
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AUDIT COMMITTEE

Report title: Risk Report				
Date of committee: 10 March 2021 **Date report produced: 23 February 2021**				
Author (s) Name and Title: Theresa Farris, Risk and Governance Manager theresa.farris@nhs.net		**Supporting Executive:** Ginny Snaith, Board Secretary **Contact Details: g.snaith@nhs.net**		
		Report Approved by: As above		
Public or Private (Governing Body only):	**Public**		**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This paper provides the Audit Committee with relevant assurances regarding the risk process that is embedded within the CCG through the risk management framework policy. The data for this report was accessed on 23 February 2021.

The Audit Committee is presented with a report from the corporate risk register of risk reporting to this committee (Appendix 1) and risks scored as significant (Appendix 2) showing status and management of these risks at this time.

Risk 38, Lack of clarity and visibility regarding STP and its governance has been reviewed as requested by the committee and is included as appendix 3.

The corporate risk register is being monitored in accordance with the risk management framework policy as appropriate, this is being overseen by the Governance Team. The corporate risk register is reported to the Senior Leadership Team meeting monthly, Audit Committee bimonthly and to Governing Body through the Audit Chairs report.

In the reporting period three new risks (141, 142, 143) have been added to the corporate risk register reporting to the Primary Care Commissioning Committee and Quality Assurance Committee. These risks are summarised in section 2.2 of this report and will be operationally managed to seek assurance that mitigating actions and controls are in place.

Following the approval of corporate objectives for the period December 2020 to March 2022 a revised board assurance framework (BAF) has been agreed and is being reviewed with executives. The BAF is included as appendix 4 for the committee's review and to provide assurance that these risks are being actively managed.

A COVID risk register (Appendix 5) records all risks relating to the current incident, updates are provided to the Risk and Governance Manager to ensure that the COVID risk register meets requirements for this current wave of the pandemic. The COVID risk register will be reviewed fortnightly by the Executive team

and the COVID incident managers. Risk on the corporate risk register which relate to the COVID incident are mirrored on the COVID Incident Risk Register to maintain overview by the responsible committees.

section	Item	Appendix
Section 2	Corporate Risk Register	Appendix 1 Audit Committee Risk Report Appendix 2 Corporate Risk Register - Significant Risks Appendix 3 Risk 38 Lack of clarity and visibility regarding STP and its governance
	Board Assurance Framework	Appendix 4 Board Assurance Framework 2020 – 2022 V1.3
	COVID Wave 2 Risk Register	Appendix 5 COVID Risk Register Wave 2 v6

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:

The Executives have responsibility for the risks identified on the Corporate Risk Register. Each committee of the Governing Body, following discussion with appropriate Executive(s), has approved any additions and / or closures to risk.

Key recommendations and actions requested:

1. Note that the risk is being managed appropriately through the Corporate Risk Register
2. Note current position of Board Assurance Framework
3. Note the addition of risks: 141, 142 and 143 to the corporate risk register
4. Note the content of the COVID wave 2 risk register
5. Note the update to risk 38 Lack of clarity and visibility regarding STP and its governance

Impact on Strategic Objectives

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

Reference to other documents or accompanying papers:

Corporate Risk Register
COVID-19 Risk Register
Board Assurance Framework
Risk 38 - Lack of clarity and visibility regarding STP and its governance

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

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

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.

Risk Assurance Report
Audit Committee
10 March 2021

1. Introduction

1.1 This paper provides the Audit Committee with relevant assurances regarding the risk process that is embedded within the CCG through the risk management framework policy. The data for this report was accessed on 23 February 2021.

2 Corporate Risk Register

2.1 At the time of writing the report there are 35 risks being monitored on the Corporate risk register.

2.2 There are seven risks on the Corporate Risk Register reporting to the Audit Committee, (appendix 1). In the reporting period three new risks (141, 142 and 143) have been added to the corporate risk register reporting to the Primary Care Commissioning and Quality Assurance Committee. These risks are summarised below and will be operationally managed to seek assurance that mitigating actions and controls are in place.

Risk Number	Risk Description	Executive	Committee	Risk Score
141	Due to the Covid 19 pandemic there is a risk that the Primary Care Nursing and Quality team, cannot fulfil all their functions in providing assurance on provider quality and safety. The reduction in team capacity is emphasised with members being redeployed to support high intensity workstreams such as PPE / IPC and Vaccination Program resulting in the equivalent of 2 Band 7 FTE posts vacant. The impact of this is; • The CCG are unable to gain appropriate levels of consistent quality and safety assurance to improve the quality of commissioned services for the population of Devon through Primary Care • Some areas of work will not be routinely managed • The inability to appropriately inform and support the Commissioning cycle across Primary Care and maintain positive relationships • Limited engagement/support with providers • Unable to proactively manage and support improvement work-streams • Business as usual workstreams such as clinical supervision, HCSW workforce programme and GPN workforce planning have been temporarily ceased, this may have long-term operational impacts • There is a considerable risk to the delivery of the CARE Programme • Remaining staff working within the team at risk of burn out • Maintaining staff retention due to reduced motivation/job satisfaction • Reduced resilience within the team should there be long term staff sickness/unplanned absences • Reduced number of staff with the right skills, competencies (Covid 40 Wave 2)	Darryn Allcorn	Primary Care Commissioning Committee	12 L = 4 I =3

142	Due to the Covid 19 pandemic there is a risk within the Patient Safety & Quality team and the likelihood of a further reduction in capacity, the team cannot fulfil all their functions in providing assurance on provider quality and safety as well as specialist support within the CCG. The reduction in team capacity is emphasised with members of the team being redeployed to support high intensity workstreams such as PPE / Restoration and Transformation along with staff that are leaving the organisation, resulting in the equivalent of 9 FTE posts being unavailable to do this work. The impact of this is; • The CCG are unable to gain appropriate levels of consistent quality and safety assurance to improve the quality of commissioned services for the population of Devon • Some areas of work will not be routinely managed • The inability to appropriately inform and support the Commissioning cycle across all services • Limited engagement/support with providers • Remaining staff working within the team at risk of burn out • Maintaining staff retention due to reduced motivation/job satisfaction • Reduced resilience within the team should there be long term staff sickness/unplanned absences • Reduced number of staff with the right skills, competencies • Limited capacity to ensure new staff receive the correct support and upskilling which will further impact on them functioning fully (COVID Risk wave 2 risk ID 41)	Darryn Allcorn	Quality Assurance Committee	12 L = 4 I + 3
143	There is a risk that safety for patients and the workforce is impacted upon by nosocomial (hospital-acquired) COVID-19 infection at Royal Devon & Exeter NHS Foundation Trust. The impact of this is: • That patient and staff safety is put at risk due to nosocomial C19 infection; lack of assurance in respect of commissioning safe services. • That staff absences (due to either acquiring COVID-19 or needing to self-isolate as a contact) will reduce Trust operational capacity, further impacting on safety. • Reputational risk to the CCG, in commissioning safe services. (Covid 43 Wave 2) **NB** the risk is being regularly reviewed as part of the COVID incident risk register and by the senior leadership team of Nursing and Quality Directorate, it is anticipated the risk score will be reduced.	Darryn Allcorn	Quality Assurance Committee	25 L = 5 I = 5

2.3 Five risks on the corporate risk register have seen movement to risk score during this reporting period:

2.4 The following two risks have an increased risk score

Risk 100 Call stacking on review 5 January 2021 has increased in score from 12 to 16 as call stacking is becoming more problematic across the footprint, including parts of Devon

Risk 118 - COVID- 19 - Primary Care Team The risk score has been increased from 12 to 16 on 6 January 2021 – The risk score increased as primary care team are now having to managing business as usual as well as Phase 3 recovery and extensive support for rapid PCN mobilisation of COVID vaccinations in line with new national expectations.

2.5 The following three risks have a reduced risk score

Risk 105 - Devon Doctors Call Stacking On review the risk score has been reduced from 12 to 6 DDOC are demonstrating ongoing improvement to both numbers of patients waiting in the queue and the safety support provided through comfort calling. Risk score reduced and a recommendation to close at Quality Assurance Committee 18 March 2021

Risk 123 - Fit testing – PPE/Covid Following review on 7 January 2921 the risk has a reduced score from 12 to 8 as In excess of 70 trained fit testers now in place in the system, the majority of which are in care homes and agencies. 5 CCG staff within the PPE cell are fit tested trained and 3-4 of them are acting as the Devon System fit testers and already out responding to requests that come in. Access to good stock of masks and other PPE. Many providers are self-sufficient.

Risk 124 - Delivery of Control Total Following review on 25 January 2021 the risk has a reduced score from 12 to 4 as the current forecast spend indicates that the possibility of breaching the control total based on the CCG allocation for the final 6 months of the year is unlikely.

2.6 At the time of writing this report the CCG has 12 risks scored significant summarised in the table below and detailed in appendix 2. To note new risk 143 is currently scored at 25 but it is expected that at the next review this will be reduced.

2.7 A review of each risk is undertaken by the risk owner and the risk co-ordinator on a schedule appropriate to each risk. Requests to close risks and add new risks are being approved by the named executive lead.

2.8 The following table summarised the status of risk held on the corporate risk register

** Risk is scored using a 5x5 matrix which does not produce the following risk scores 7, 11, 13 & 14.

Period of report - 31 December 2020 to 23 February 2021	
Total Risks on Corporate Risk Register	35
Low risks (scored 1-3)	0
Moderate/Medium risks (scored 4-6)	8
High risks (scored 8-12)	15
Significant/Very high risks (scored 15 to 25)	12
New Risks	
Risk score reduced since last report	3
Risk score increased since last report	2
Total Risks Closed (detail is within the committee minutes of the following committees)	
Quality Committee	*1*
Primary Care Committee	*0*
Finance & Performance Committee	*0*
Commissioning Committee	*0*

4 Board Assurance Framework

4.1 The Board Assurance Framework has been reviewed by the executives during February and is presented to this committee for assurance that risk within this framework are being reviewed and updated. Appendix 4.

5 COVID Incident Risk Register

5.1 This COVID risk register is being constantly reviewed and updated in response to the activities being taken to mitigate identified risk. Appendix 5

The COVID incident risk register is being presented to the incident managers weekly and reported to the Executives team meeting fortnightly.

Risk on the corporate risk register which relate to the COVID incident are mirrored on the COVID Incident Risk Register to maintain overview by the responsible committees.

6 Risk Management Training

5.1 The Governance team have produced a risk management presentation to give all staff an overview of risk management process within the CCG. The training presentation on teams can be found via this link and has been shared with al staff Risk Management Presentation

5.2 A Risk Coordinator's Teams site brings everything together in a shared workspace where the risk coordinators can discuss shared issues or horizon scan, hold meetings online, web conferencing and share files. This enables ongoing development, advice and support with oversight from the CCGs Risk and Governance Manager.

5.3 Regular bi-monthly Risk Co-Ordinator meetings have been established to offer support and ongoing training opportunities.

5.4 The Risk and Governance Manger and Head of Governance have been attending team meetings within directorates to give an overview of risk management within the CCG and to also explain the introduction of team risks registers.

7 Recommendations

The Audit Committee are requested to:

1. Note that the risk is being managed appropriately through the Corporate Risk Register
2. Note the addition of risks: 141, 142 and 143
3. Note the risk score movement as summarised in section 2.4 and 2.5
4. Note the Board Assurance Framework V1.3
5. Note the COVID wave 2 risk register V6

NHS Devon Clinical Commissioning Group

NHS DEVON CCG
Risk Report (Audit)

Date produced: 23-02-2021 - 11:58

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners
109	Improve service performance [Reporting Committee] Audit	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •There is reputational impact due to potential patient harm or perception of the CCG is impacted by patient outcomes. •Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (COVID Risk wave 2 risk ID 02) (HISTORIC ID: Na)	27/01/2021 The focus in phase 3 recovery has been recovery of service activity compared to 20/21 rather than the recovery of the constitutional standards. Under adapt and adopt the CCG has been working with system partners to implement the agreed actions under this programme. Elective recovery performance as detailed within adapt and adopt reporting was on plan until Mid December as a result of further waves of Covid. This reporting has been stood down by NHSE on 3.1.21 to be replaced by revised reporting as yet not stipulated. The CCG will fully comply when this reporting is available (AW) 27.01.21 The Devon system moving to surge with IS providers from 29th January gives us an opportunity to increase diagnostic cancer and elective capacity to support restoration (JF) For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group on a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. [Control Gaps] 01/10/20 Lack of involvement in provider access meetings. Impact of MyCare , dues to Covid System perf group has been stood down, need to reinstate that infrastructure 13/01/2020 - Opel 4 esculation at the start of January puts some risk into this delivery	20 [01/10/2020] ▲ 20 (L=5 x I=4) [22/10/2019] = 16 (L=4 x I=4) [31/07/2019] ▲ 16 (L=4 x I=4) [06/06/2019] 9 (L=3 x I=3)	Risk Opened: 06/06/2019 Reviewed: 28/01/2021	[05/11/2020] Reviewed by Executive Team 19 October 2020, [02/10/2020] 01/10/2020 Fortnightly NHSE/I elective care recovery meetings with system partners, consistent meeting to be established with providers under new Performance Team identity to assure against Phase 3 plan trajectories, [27/08/2019] System performance meeting monthly with providers,	Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. 13/01/2020 scrutiny at Dec SPG has provided assurance on these plans and elective board [Assurance Gaps] none identified	Executive Lead: Jayne Carroll Owner: John Finn

130	Lead the system's response to the coronavirus pandemic [Reporting Committee] Audit	There is a risk that the CCG does not respond effectively to the COVID-19 pandemic. The impact of this is that the CCG may delay or disrupt the pandemic response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and perception of the CCG. COVID Rik Register Wave 2 risk ID 14 (HISTORIC ID: Na)	18/02/2021 • Incident Management Team comprising of Incident Director, Incident Manager, admin support, Loggists and Cells to lead on specific workstreams, in place • Overview of the incident response maintained by Executive Team • Regular reviews of the Incident response structures and responsiveness are being undertaken • Regular co-ordination and update meetings scheduled, internally, across the system and with Region; these meetings are reviewed and the frequency adjusted to meet the needs of the response. 27/01/2021 CCG has a structured incident Reponses team in place, this is being managed and monitored daily to respond to daily issues or escalation as required by the Devon Health and Social Care community or requests from NHSE/I 12/11/2020 Risk reviewed no changes identified PC •Incident Management Team comprising of Incident Director, Incident Manager, admin support, Loggists and Cells to lead on specific workstreams, in place •Overview of the incident response maintained by Executive Team •Regular reviews of the Incident response structures and responsiveness are being undertaken •Regular co-ordination and update meetings scheduled, internally, across the system and with Region; these meetings are reviewed and the frequency adjusted to meet the needs of the response. Currently the System meetings are only held if an issue is identified. [Control Gaps] No Gaps Identified	12 [17/09/2020] 12 (L=3 x I=4)	Risk Opened: 17/09/2020 Reviewed: 18/02/2021	[13/10/2020] System Resilience Plan to be developed by 31/10/2020,	18/02/2021 CCG has a structured incident Reponses team in place, this is being managed and monitored daily to respond to daily issues or escalation as required by the Devon Health and Social Care community or requests from NHSE/I As part of a national requirement form NHSE/I the CCG has undertaken two mass vaccination exercises across Devon on 21/22 January 2021 No risk score change 27/01/2021 As part of a national requirement form NHSE/I the CCG has undertaken two mass vaccination exercises across Devon on 21/22 January 2021 Internal Interim Debriefing of the first wave completed and recommendations agreed by Executive Team •System Interim Debriefing of the incident response to the first wave drafted and awaiting submission to Executive Team. [Assurance Gaps] •Devon was not badly affected by the virus during the first wave and so the incident response structures and Provider capacities were not tested.	Executive Lead: Sonja Manton Owner: Phil Coutie
129	Improve service performance [Reporting Committee] Audit	There is a risk that a disruption to the availability of staff, IT and/ or telecoms, critical information, premises, supplies or suppliers/ contractors, may prevent the CCG from delivering its essential functions as set out in Directorate BCPs The impact of this is that CCG essential functions may be delayed or stopped with a knock on impact upon statutory functions, finance of CCG and Provider service delivery, and perception of the CCG is impacted by patient outcomes. (HISTORIC ID: Na)	16/02/2021 Reviewed by PC - Assurances updated 27/01/2021 Business Continuity Plans have been reviewed across the CCG Audit South West are undertaking an internal audit as part of the annual requirement on Business Continuity Plans arrangements in the CCG 12/11/2020 Risk reviewed no changes identified PC •Business Impact Analysis undertaken at least annually •Business continuity risks reviewed by Directorates at least annually •Business continuity audit undertaken annually •NHSEI EPRR assurance, incorporating business continuity, undertaken annually and reported upon to GB •Trained Directorate BC Leads in place •EPRR Lead now in place with responsibility to maintain oversight [Control Gaps] •Primary Care Business Continuity Plan (BCP) in development, not yet reviewed by EPRR or signed off.	9 [17/09/2020] 9 (L=3 x I=3)	Risk Opened: 17/09/2020 Reviewed: 16/02/2021	[13/10/2020] BC Audit to be completed by 31/12/2020., [13/10/2020] BC Framework and Plan to be revised by 30/11/2020., [13/10/2020] BC Review due to be complete by 12/10/2020 and outcome included in EPRR Assurance report to GB on 29/10/2020.,	16/02/2021 NHSEI EPRR Assurance undertaken annually, last completed in September/October 2020 EPRR policy reviewed and approved by Governing Body 19 November 2020 Business Continuity Audit undertaken annually, last completed in December 2019 - ongoing at this time 16/02/2021 NHSEI EPRR Assurance undertaken annually, last completed in October 2020 Business Continuity Exercise completed in March 2020 Review of Business Continuity plans undertaken in March/ April 2020 [Assurance Gaps] non identified	Executive Lead: Sonja Manton Owner: Phil Coutie
127	Achieve financial sustainability [Reporting Committee] Audit	There is a risk that Devon CCG may be subject to increased fraudulent activity during and following a pandemic or similar major incident The impact of this is potential , Financial loss to the CCG Phishing / Cyber attack Fraudulent staff absence / leave requests Information Governance Breaches Damage to CCGs integrity (HISTORIC ID: Na)	27/01/2021 The counter fraud officer monitors and oversees any fraudulent activities with support of specialist, reporting to Audit Committee or escalating any urgent matters to CFO and Board Secretary 16/12/2020 Risk reviewed by Head of Governance, update to assurances added Arrangements for invoice processing under continuous review by budget holders IT undertake regular phishing and spam email checks – clear process for staff to alert IT to any concerns which is logged and reviewed through both the CCGs IT provider and the NHS spam alert system. Counter Fraud Specialist in place as part of contract with internal audit provider Circulation of information to relevant staff on specific issues via Counter Fraud Specialist and other experts within the CCG raising issues in relation to fraudulent behaviours through team meetings and staff communications. [Control Gaps] Directorate managers across the CCG to review internal standard operating procedures for their areas of responsibility with support from the Governance team as necessarily to ensure relevant procedures are in place to monitor for fraudulent activity and address these with the CCGs counter fraud specialist	6 [03/09/2020] 6 (L=2 x I=3)	Risk Opened: 09/09/2020 Reviewed: 27/01/2021	[10/09/2020] On-going review of processes to mitigate fraudulent activity ,	Audit being undertaken by Counter Fraud service Policies in place which cover areas which may be impacted by fraudulent activity ie HR, Finance, commissioning, procurement 16/12/2020 Head of Governance contacted Counter Fraud to enquire of any guidance / documentation to assist with discussions at directorate level to embeded good practice around vigilance of fraudulant activity. [Assurance Gaps] Directorate managers across the CCG to review internal standard operating procedures for their areas of responsibility with support from the Governance team as necessarily to ensure relevant procedures are in place to monitor for fraudulent activity and address these with the CCGs counter fraud specialist	Executive Lead: John Dowell Owner: Clare Doble

128	Be an effective, well-led organisation with an empowered and inclusive workforce [Reporting Committee] Audit	There is a risk that CCG data will be compromised by unauthorised/accidental disclosure due to shared work areas with non-CCG organisations. This may be via data visible on desks and/or screens or telephone conversations. This also includes homeworking where area shared with other persons. The impact of this could be the CCG's ability to maintain patient, staff and/or corporate confidentiality. (HISTORIC ID: Na)	28/01/2021 Home working advice sent to all staff and staff advised to use headphones so conversations not overheard and papers and IT equipment shut down when in not in use. 16/12/2020 Risk Reviewed no changes identified MS 12/11/2020 Risk reviewed no changes identified MS 08/10/2020 'Homeworking' guidance created for all staff Screen lock (manual & timed) Clear desk Policy/Audit Secure lockers/cupboard Confidential waste bins/collections Secure printing via ID cards [Control Gaps] Lack of suitable private areas at home where calls may be overheard and screens viewed Secure storage for CCG equipment & work	6 [03/09/2020] 6 (L=3 x I=2)	Risk Opened: 10/09/2020 Reviewed: 18/02/2021		27/01/2021 Team directorate/team face to face meetings in progress Entry to buildings are via smartcard. Screens lock automatically after period of inactivity Clear desk policy and quarterly checks via the intranet and regular clear desk audit Personal & departmental lockers for secure storage of devices and documents Confidential waste bins are provided & appropriate disposal Printers activated by smartcard across all sites Isolated areas/rooms available for sensitive conversations Annual mandatory data security awareness training for all staff Data Security Awareness training for all staff and reviewed monthly and reported to the DPSG. [Assurance Gaps] Telephone calls, especially incoming, cannot always be taken away from the desk and to a separate area. Screens in view of shared office/living space whilst working from home during Covid-19	Executive Lead: Ginny Snaith Owner: Matt Spry
131	Improve service performance [Reporting Committee] Audit	There is a risk that the CCG will be unable to respond effectively in the event of an emergency or business continuity incident, through not meeting its statutory and policy obligations to be prepared to respond to emergencies and disruptive incidents. The impact of this is that the CCG may delay or disrupt an emergency response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and the perception of the CCG. COVID Rik Register Wave 2 risk ID 15 (HISTORIC ID: Na)	18/02/2021 • Maintenance of the ongoing COVID Incident response structures and process to be maintained • Reviews of emergency and business continuity plans to be continued as per EPRR work plan • Training of On-call and other key staff to be maintained as per the EPRR work plan • Participation in system and multi-agency emergency preparedness exercises to be maintained as per the EPRR work plan. 27/01/2021The CCG response to the current pandemic incident/EU Exit (D20) / winter and flu is monitored daily to identify any challenges and issue that may arise and managed in accordance with EPRR and framework and policy 12/11/2020 Risk reviewed no changes identified PC •EPRR Lead recruited to lead on preparedness workstream; •An EPRR workplan in place to ensure that preparedness is maintained and that new requirements are implemented in a timeous manner; •Suite of business continuity plans and emergency plans in place •On-call system in place, supported by trained on-call staff, available to initiate a response 24/7; •Trained Directorate Business Continuity Leads in place to maintain their business continuity plans •Regular training is undertaken by On-call staff and BC Leads to maintain knowledge and skill sets •Regular exercising of business continuity plans and participation in the exercising of multi-agency emergency plans is undertaken to ensure skills are maintained, plans are tested and the CCG is integrated into the multi-agency response to emergencies; •EPRR Lead is engaged with NHS and multi-agency (LRF) EPRR planning to ensure the CCG is integrated into these plans. •EPRR Lead will fulfil the CCG responsibility of undertaking an annual assurance of Providers preparedness in line with the NHSEI EPRR Core Standards and annual assurance process, and reporting upon this to the AEO & GB. [Control Gaps] •The incident response to COVID has placed most other EPRR work on hold, meaning that wider preparedness activities are not currently being undertaken.	6 [17/09/2020] 6 (L=2 x I=3)	Risk Opened: 17/09/2020 Reviewed: 18/02/2021	[13/10/2020] On-call Induction training to be provided to new On-call staff before participating in the rota., [13/10/2020] Refresher On-call training to be offered to On-call staff before 31/12/2020, [13/10/2020] Maintenance of On-call rotas, [13/10/2020] Ongoing refreshing of On-call pack and contact lists,	18/02/2021 The CCG response to the current pandemic incident/EU Exit (D20) / winter and flu is monitored daily to identify any challenges and issue that may arise and managed in accordance with EPRR policy. no risk score change •CCG and Provider emergency preparedness reviewed annually against NHS England EPRR Core Standards as part of a national NHSEI process; the 2019 assurance rated the CCG as Substantially compliant with work required on only 2 of 43 standards. •Business Continuity Plans audited in December 2019 with a Significantly assured outcome. [Assurance Gaps] •The 2020 NHS England EPRR Assurance process has been initiated, a lighter touch than normal, work is ongoing to prepare the CCG's Statement of Assurance and a letter has been sent to Provider AEOs requesting their Statements of Assurance by 12th October 2020.	Executive Lead: Sonja Manton Owner: Phil Coutie

38	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Audit	There is a risk that decisions will be made by the ICS which impact negatively on delivery of CCG functions As the ICS increasingly takes responsibility for decision making there is a risk that it will make decisions which a) have not had appropriate input/scrutiny from the CCG b) do not consider the CCG statutory functions c) are not supported by the CCG Governing Body These decisions may mean that the CCG may fail to adhere appropriately to one or more of its statutory duties or internal governance requirements, thus potentially failing in one or more of its legal duties. (HISTORIC ID: 319)	Dec 2020 Updated by GS/JD Governance arrangements for the ICS agreed by all partners setting out ongoing requirements for decision making of statutory bodies CCG AO and Chair on Partnership Board Appointment of joint System and CCG AO 11/11/2020 Discussed at Audit Committee. the committee agreed the risk is still pertinent and requested a review of wording to better express the risk. 12/10/2020 Risk to be presented to Audit Committee for discussion and review November 2020 [Control Gaps] Dec 2020 No NED representation at System or Locality level of ICS Potential for changed arrangements in line with NHSE consultation Arrangements for decision making during COVID pandemic may circumvent usual agreed mechanisms	4 [20/10/2020] ▼ 4 (L=2 x I=2) [23/06/2020] ▲ 9 (L=3 x I=3) [01/10/2019] = 6 (L=2 x I=3) [02/08/2018] ▼ 6 (L=2 x I=3) [23/05/2018] 12 (L=3 x I=4)	Risk Opened: 10/10/2016 Reviewed: 17/02/2021	[17/02/2021] A review of ICS governance underway in ine with new white paper Feb 2021, [05/11/2020] Reviewed by Executive Team 19 October 2020, [17/12/2019] Arrange workshop for system organisation Audit Chairs to review proposed system Risk Management arrangements GS,	Dec 2020 Updated by GS/JD CCG Risk Management Process reporting at all levels of organisation Regular updates to Governing Body through Chairs and AO report and specific items of relevance Internal Audit of ICS Governance arrangements NHSE ICS designation process [Assurance Gaps] No assurance Gaps identified	Executive Lead: Ginny Snaith Owner: Ginny Snaith

NHS DEVON CCG
Risk Report (High Risks Only)

Date produced: 23-02-2021 - 11:59

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners
143	Lead the system's response to the coronavirus pandemic [Reporting Committee] Quality Assurance	There is a risk that safety for patients and the workforce is impacted upon by nosocomial (hospital-acquired) COVID-19 infection at Royal Devon & Exeter NHS Foundation Trust. The impact of this is: •That patient and staff safety is put at risk due to nosocomial C19 infection; lack of assurance in respect of commissioning safe services. •That staff absences (due to either acquiring COVID-19 or needing to self-isolate as a contact) will reduce Trust operational capacity, further impacting on safety. •Reputational risk to the CCG, in commissioning safe services. (Covid 43 Wave 2) (HISTORIC ID: Na)	February 2021 - An unannounced CQC visit to the Trust took place in January and, when reported formally, an update will come to QAC, including the risk register. In addition the CCG IPC team undertook a supportive visit in January. The CCG continue to attend provider meetings, including Silver Command; these will continue to be the main mechanism for ensuring recent improvement is sustained, as well as monitoring incidents and other quality reporting. It is not proposed that the risk score changes currently, until a sustained improvement is seen (SW) January 2021 •Weekly RDEFT Silver Call, chaired by RDEFT director of infection prevention & control, with CCG, PHE and NHSE as members. •CCG weekly oversight of RDEFT Action Plan- open actions only- at Silver Call. •On-going CCG IPC and senior nursing support offer to RDEFT. •Weekly CCG/ System CNO and System DoNs meeting. •Daily IMT- executive oversight. •Monthly reporting and escalation through CCG QAC. •Regional IPC meetings, chaired by NHSE. •Devon and Regional Quality Surveillance Groups (QSG). •Nosocomial system monitoring report [Control Gaps] January 2021 - none identified	25 [19/01/2021] 25 (L=5 x I=5)	Risk Opened: 20/01/2021 Reviewed: 08/02/2021	[20/01/2021] February 2021 - The CCG are sufficiently assured that they are no longer attending the silver command meetings. The IPC visit contributed to this assurance level, however until evidence of sustained improvement over 2 months the risk score will not be changed January 2021 - Day planned with RDEFT IPC team (incl. DIPCs) to: oReview of team actions; critical friend role oSeek further assurance improvements being managed at pace required. oContinued communication at CNO and DON role- support and assurance. oContinued communication with PHE and NHSEI to confirm assurance levels and ensure Trust supported. , [20/01/2021] January 2021 •CCG attendance at meetings described within risk February 2021 - The CCG are sufficiently assured that they are no longer attending the silver command meetings however until evidence of sustained improvement over 2 months the risk score will not be changed,	February 2021 - The CCG continues to have confidence that the RDEFT have an improved position in relation to managing the Covid 19 pandemic (SW) January 2021 •RDEFT Bronze/ Silver/ Gold command strategy. •Daily IIMarch metrics of number of COVID-19 infections within all Devon trusts, broken down by nosocomial (hospital acquired) or new (community acquired). •RDEFT report progress to their Board. •RDEFT C19 Action Plan. •RDEFT IPC team, including DIPCs. [Assurance Gaps] January 2021 •CCG sight of COVID-19 mortality within the Trust, broken down by nosocomial and community acquired infection. •CCG sight of effective Trust COVID-19 incident reporting processes; no related/ linked serious incidents have been reported (as stipulated by the national CNO in June 2020). •Note: The CCG does not have sight of provider's internal lower level incidents (SEAs). •Appropriate processes for the investigation of and learning from COVID-19 deaths (as stipulated in National Medical Director letter, June 2020).	Executive Lead: Darryn Allcorn Owner: Sara Wright

109	Improve service performance [Reporting Committee] Audit	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •There is reputational impact due to potential patient harm or perception of the CCG is impacted by patient outcomes. •Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability. (COVID Risk wave 2 risk ID 02) (HISTORIC ID: Na)	27/01/2021 The focus in phase 3 recovery has been recovery of service activity compared to 20/21 rather than the recovery of the constitutional standards. Under adapt and adopt the CCG has been working with system partners to implement the agreed actions under this programme. Elective recovery performance as detailed within adapt and adopt reporting was on plan until Mid December as a result of further waves of Covid. This reporting has been stood down by NHSE on 3.1.21 to be replaced by revised reporting as yet not stipulated. The CCG will fully comply when this reporting is available (AW) 27.01.21 The Devon system moving to surge with IS providers from 29th January gives us an opportunity to increase diagnostic cancer and elective capacity to support restoration (JF) For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group on a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. [Control Gaps] 01/10/20 Lack of involvement in provider access meetings. Impact of MyCare , dues to Covid System perf group has been stood down, need to reinstate that infrastructure 13/01/2020 - Opel 4 esculation at the start of January puts some risk into this delivery	20 [01/10/2020] ▲ 20 (L=5 x I=4) [22/10/2019] = 16 (L=4 x I=4) [31/07/2019] ▲ 16 (L=4 x I=4) [06/06/2019] 9 (L=3 x I=3)	Risk Opened: 06/06/2019 Reviewed: 28/01/2021	[05/11/2020] Reviewed by Executive Team 19 October 2020, [02/10/2020] 01/10/2020 Fortnightly NHSE/I elective care recovery meetings with system partners, consistent meeting to be established with providers under new Performance Team identity to assure against Phase 3 plan trajectories, [27/08/2019] System performance meeting monthly with providers,	Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. 13/01/2020 scrutiny at Dec SPG has provided assurance on these plans and elective board [Assurance Gaps] none identified	Executive Lead: Jayne Carroll Owner: John Finn

137	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality Assurance	There is a risk that the impact of implementation of National Guidance during COVID- 19 may lead to patients who require planned care, including diagnostics, being delayed, deferred or choosing to self-defer, resulting in harm; both safety and experience could be affected. Note: This impact could be further exacerbated if changes in predictions of disease prevalence for the SW Peninsula result in a period of deferment in excess of that recommended by the national guidance. The impact to the CCG is commissioning impacted services that may result in: a) escalation requiring emergency admission and / or treatment for patients. b) early death, harm, including reduction of treatment options and poor experience for patients. c) reputational damage as a result of longer waiting times for patients across the County. (Covid 20 Wave 2) (HISTORIC ID: Na)	February 2021 - On-going planning to recover continues; the CCG will play a key leadership role as providers return to increased levels of planned care activity when able. With teams deployed internally and externally to their organisation to manage Covid 19 care, risk grows in other parts of the system including planned care. This has been captured in risk assessments the CCG has undertaken on behalf of the system (SW) January 2021 - A system risk assessment process, led and undertaken by the CCG has been implemented. Impact of reducing or ceasing planned care, as well as mitigation included. In addition, CCG and provider Comms continues to encourage patients to attend appointments/procedures if they are not cancelled (SW) December 2020 - Robust process in place to risk assess, manage/balance risk, escalate and maximising potential mutual support when required (SW) Holding providers to account for following national guidance for management of planned and elective care referrals and treatments. For example: cancer patients during the coronavirus outbreak (publications approval reference: 001559), assurance was sought that each patient has been clinically reviewed based on their individual clinical risk factors. For some, postponement of treatment has been assessed as clinically the safest thing to do. The Restoration & Transformation Cell has oversight of all service changes that fall outside of national guidance; step down and up. The process includes providers having to complete a QEIA and is reviewed by both commissioning and quality senior leads. The CCG is also informed by and seeks assurance through: •Provider Governance Committees to monitor provider processes for measuring impact of implementing national guidance. (assurance) •Provider led Clinical Reference Groups. (assurance) •Service line restoration groups, facilitated by the CCG, informing the R&T Cell workstream. (information and assurance) •Reporting of the CCG commissioned Population Needs workstream (information). [Control Gaps] January 2021 - With CCG prioritisation of work, as well as national guidance, increasing planned care delays are anticipated. On-going risk has potential to increase in light of wave 2 and reducing elective care. In addition, where planned care continues the public are being encouraged to attend appointments through CCG comms (SW)	20 [29/10/2020] 20 (L=4 x I=5)	Risk Opened: 02/11/2020 Reviewed: 08/02/2021		February 2021 - Positively, in January national steer about use of the Independent Sector (IS) was confirmed, with elective surge moving to independent providers. Providers have linked directly with the IS to manage patients, and the CCG is monitoring progress (SW) January 2021 - Continued system working and processes go some way to ensure safety across the system, this includes mutual aid (SW) December 2020 - Significant collaboration between CCG and providers across the system to ensure elective pathways remain where possible and patients are fully informed (SW) May 2020 - Head of Nursing & Quality embedded in restoration & transformation cell to support quality oversight & impact on all restoration work programmes (LW) [Assurance Gaps] February 2021 - There is a risk patients choose not to take up offers of either the IS option or other NHS providers elsewhere in Devon remains, but actions are in place to ensure patients make these decisions in an informed an supported way (SW)	Executive Lead: Darryn Allcorn Owner: Sara Wright

135	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality Assurance	There is a risk that some aspects of our core business of continuing healthcare will be exposed to additional risk as a result of the changes to the emergency framework period guidance and associated financial framework, particularly with the reset in relation to CHC assessments. a)There is a reputational risk that the CCG may be challenged through the undertaking of virtual assessments and the view that patients, their representatives and advocates may not see this process as robust enough to make a recommendation on levels of need; b)There is a risk that we are unable to take the same assurance with regard to the clinical safety and quality of care being provided to eligible individuals in the absence of face to face assessments; c)There is a financial risk associated with the increasing backlog of CHC assessments, and the cessation of emergency funding for new and enhanced CHC packages of care. The financial risk of approx. £3m is captured for 2020-21 and is managed as part of the CCGs overall financial risk assessment and delivery; These risks are to be recorded on the Corporate Risk Register and monitored and managed through the CCG's risk management processes. The current backlog has to be reduced by 31st March 2021 and therefore steps to mitigate the risks as a result. (HISTORIC ID: Na)	February 2021 - Risk score to remain the same. Weekly assurance calls with the provider holding the outsourced activity continue, as do meetings with the LAs to assure the CCG that CHC backlog is being address alongside Covid funded individuals requiring a Care Act assessment prior to exit of the pathway (JS) January 2021 - Risk score to remain the same. The CCG will continue to monitor the activity through regular data cleansing and fortnightly sitrep submissions to NHSE/I (JS) December 2020 - Risk score to remain the same. Fortnightly returns to NHSE so far have assured currently we are on target to meet our trajectory for clearance of the backlog however we anticipated this progress will not be sustained due to the Christmas period, slow mobilisation plans within the Western Locality and now significant vacancies within the core CHC teams who operationally deliver the process. Recruitment is underway to mitigate these risks however new starters will require induction therefore trajectory may be off target until end of February. Mitigation will be to increase the contract value of cases with the external company undertaking assessments on our behalf. A financial incentive has also now been offered to the care homes to support the process in terms of information gathering and sharing. Some face to face visits are now happening which are identifying early where quality issues may be apparent, some resulting in onwards referrals to safeguarding. (JS) [Control Gaps] February 2021 - NHSE/I have been very clear that there remains an expectation that the backlog of deferred assessments must be cleared by end of March 2021, and that should CCGs choose to redeploy CHC staff to fulfil other roles then there will be no financial support to follow (JS) January 2021 - The newly recruited staff now have induction dates beginning mid-Feb however these staff are also likely to be redeployed (JS) December 2020 - Fortnightly returns to NHSE so far have assured currently we are on target to meet our trajectory for clearance of the backlog, however we anticipated this progress will not be sustained due to the Christmas period, slow mobilisation plans within the Western Locality and now significant vacancies within the core CHC teams who operationally deliver the process. The virtual assessment process risk currently does not appear to be manifesting, although CHC Leads do report the end to end process is taking at least 1-2 weeks longer to complete (JS)	16 [29/10/2020] 16 (L=4 x I=4)	Risk Opened: 29/10/2020 Reviewed: 09/02/2021	[29/10/2020] Workplan being progressed. January 2021 - Workplan progressing well with agency staff now in place. Returner nurses beginning CHC shadow shifts next week and the outsourcing contract commencing February 2021 - Workplan progressing. Returner nurses have now been trained and are embedded within the CHC Hubs to support assessments. NHSE/I report that NHS Devon is an outstanding example in relation to hosting staff in this way (the CCG also have returner nurses delivering regular IPC interactive sessions online),	February 2021 - CHC processes have not been suspended as initially thought. Local challenges on CHC recovery plans remain however risks are mitigated through Exec support to not redeploy the staff. Returner nurses have now been trained and are embedded within the CHC Hubs to support assessments. NHSE/I report that NHS Devon is an outstanding example in relation to hosting staff in this way (we also have returner nurses delivering regular IPC interactive sessions online, see assurance gaps) (JS) January 2021 - Despite the Christmas slow down we are currently on target to meet the proposed trajectory for clearance of the backlog of CHC assessments (JS). October 2020 - Regular reporting to CHC Control Centre and performance oversight. Reporting the Executive team. Risk assessment tool in draft 02/10/20. Weekly meetings with Local Authority representatives to align assessment processes and agree priorities. Care Home and Home Care Cell cited on areas of risk relating to care delivery, separate risk logged for this (Jo Shill owner). Sitrep reporting every two weeks to NHS E. Communications with individuals will be undertaken prior to assessment scheduling. Weekly regional assurance calls in place with NHSE. Data feeds being developed to monitor progress on backlog of deferred assessments plus financial outturn. Local team performance management/supervision sessions in place. Use of ring fenced Covid funding to fund resources required to undertake the deferred assessment backlog (JS) [Assurance Gaps] February 2021 - The team are currently on target to meet the deadline for clearance of the backlog however an 'in year' waiting list is now emerging as the team's ability to respond to the increasing numbers of referrals generated through the new 6 week pathway is hampered through issues previously described. Clinical risks remain as we have to reduce 'footfall' into care homes to avoid community transmission of the virus. Mitigation undertaken as much as possible in a virtual way however we remain significantly concerned. We take assurance (or not) from staff behaviours when attending the group IPC sessions on line and will contact providers of concern individually where we are concerned about practices (JS) January 2021 - Wave 3 surge of Covid is very likely to see yet another 'pause' issued from central government. If this occurs, CHC staff will be redeployed into key areas to support patient flow and vaccination sites and therefore limited further activity will take place. The financial risk o a further pause is not yet understood as the Treasury announcement is awaited. Thus far, detailed communications to families and care homes has mitigated the identified risk of increased complaints and appeals, however there is a six month timescale for a family to appeal a decision therefore we are not able to assume the process is acceptable currently. The CCG remains concerned over the lack of scrutiny of packages of care and placements commissioned and the exposed clinical risks of this, and where possible continue to engage with provider forums on a county wide basis to enable high level escalation of concerns to be raised and then locally addressed (JS) October 2020 - To be Confirmed – plan to follow	Executive Lead: Darryn Allcorn Owner: Jo Shill

136	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Quality Assurance	There is a risk that care home placements and care at home could become compromised, due to Covid outbreak risks, lack of Personal Protective Equipment (PPE), staffing and pathway issues. The impact is that patients will be unable to be discharged from hospital in a timely manner to create acute capacity for new admissions. The safety & quality of an individual's care could be at risk due to: inadequate packages of care, staff capacity, equipment and training. (Covid 19 Wave 2) (HISTORIC ID: Na)	February 2021 - Risk score to remain the same. It is hoped now care home vaccinations have taken place that the outbreak status will reduce and flow will increase once more, thus reducing this risk score and that of 135 (JS) January 2021 - Risk score to remain the same. Previous controls remain in place with additional tactical support now being offered by the CCG particularly where there are issues with nursing capacity. A county wide discharge delay meeting has been instigated on a daily basis to enable cross county mutual aid to acute trusts needing to discharge individuals to care homes (JS) December 2020 - Risk score to remain the same. Risks continue to be escalated and addressed proactively via the Care Home and Home Care Cell x 3 per week Covid outbreaks have increased due to frequency of testing of both of residents and staff. Mitigations include tactical support via the LAs to homes in outbreak, financial support packages to support market sustainability. PPE Cell now in place and process for obtaining supplies in place. Risk remaining related to hospital discharge where patients continue to test Covid positive and cannot be discharged to a care home for 14 days or if remaining symptomatic. Actions taken to agree local interpretation and implementation over the four localities. Delays currently affecting 7 inpatients at present. (JS) [Control Gaps] January 2021 - Whilst the risk of lack of PPE has been addressed via formally established routes now, the impact of Covid outbreaks in local care homes is significant. The reduced capacity through home closure is beginning to impact on hospital discharges where now the CCG find there are occasions where available beds don't match the level of need of individual patients (JS). December 2020 - National guidance is conflicting (JS)	16 [29/10/2020] 16 (L=4 x I=4)	Risk Opened: 02/11/2020 Reviewed: 09/02/2021		February 2021 - It should be noted that there are areas within this risk that are now a reality (JS) November 2020 - Assurance on system support is gained from each locality x 3 per week during the Care Home and Home Care Cell meetings. Actions are documented and circulated prior to the next meeting. Issues related to outbreaks and any required support are discussed with each participating organisation requesting and receiving support as required. The notes and action log are updated frequently. Training on IPC/PPE has been relaunched. Designated bed offer being explored and implemented across the county. CCG is exploring a contract with NHSP to potentially provide an enhanced staffing resource to care homes where there are gaps in staffing rotas. [Assurance Gaps] February 2021 - Discharge delays are emerging where care home capacity is not available, specifically within the market caring for patients with complex dementia. We continue to host the daily 'tricky discharge' meeting to consider creative solutions to the problem, however Devon is very entrenched in a bed based model for supporting discharge therefore there are limitations to solving the issue. Additional 'live in' providers have been sourced to support care at home, we are negotiating with the hospice in Exeter to create additional end of life capacity and we continue to source appropriate placements, sometimes now further out of county into Somerset and Cornwall (JS)	Executive Lead: Darryn Allcorn Owner: Jo Shill
117	Improve service performance [Reporting Committee] Primary Care Commissioning	There is a risk that COVID-19 outbreak could adversely affect GP practices ability to deliver their core business as usual services. The impact of this is that the delivery of general practice is compromised and could impact all areas of the healthcare system. (COVID Risk wave 2 risk ID 06) (HISTORIC ID: Na)	3 Feb 2021 - reviewed with Deputy Director for Primary Care and Head of Primary Care (NEW) Jan 2021 - reviewed with Head of Primary Care (NEW) Dec 2020 - Review with Deputy Director for Primary Care Feb 2021 - most staff have received first vacs in line with JCVI guidance. Jan 2021 Some staff starting to receive vaccination in line with JCVI guidance Mar 2020 CCG Primary Care COVID lead identified Primary Care participation in CCG Daily COVID calls Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Regional NHS England and Public Health England updates Daily COVID updates from comms team to GP practices CCG providing resource to support implementation of e-Consult and implementing changes to online booking and triaging within practices. CCG purchased additional laptops to support practice business continuity plans to enable remote working [Control Gaps] None Identified	16 [02/12/2020] ▲ 16 (L=4 x I=4) [02/12/2020] = 16 (L=4 x I=4) [07/10/2020] ▲ 12 (L=3 x I=4) [10/08/2020] = 6 (L=2 x I=3) [08/07/2020] = 6 (L=2 x I=3) [06/07/2020] ▼ 6 (L=2 x I=3) [10/06/2020] ▼ 8 (L=2 x I=4) [12/03/2020] 12 (L=3 x I=4)	Risk Opened: 12/03/2020 Reviewed: 03/02/2021	[03/02/2021] Feb 2021 - plans in place for staff to receive 2nd dose. Need to understand ongoing capacity and workforce needs to ensure continued vacs delivery is sustainable. ,	COVID report due to monthly Primary Care Committee CCG gathering assurance from practices re business continuity plans. [Assurance Gaps] None Identified	Executive Lead: Jo Turl Owner: Rob Payne

118	Improve service performance [Reporting Committee] Primary Care Commissioning	There is a risk that COVID-19 outbreak could adversely affect the CCGs Primary Care Teams ability to deliver current workplan and business as usual tasks. The impact of this is that the delivery of general practice is compromised and could affect all areas of the healthcare system. (COVID Risk wave 2 risk ID 07) (HISTORIC ID: Na)	3 Feb 2021 - reviewed with Deputy Director for Primary Care and Head of Primary Care (NEW) Jan 2021 - reviewed with Head of Primary Care (NEW) Dec 2020 - Review with Deputy Director for Primary Care Feb 2021 - Primary Care prioritised work plan monitored on weekly basis. Mar 2020 Primary Care participation in CCG Daily COVID calls Mass vaccination cell in place with associated programme management Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Public Health England updates Team reviewing daily COVID updates from comms team Weekly review of workload plan and mitigating actions [Control Gaps] None Identified	16 [06/01/2021] ▲ 16 (L=4 x I=4) [02/12/2020] ▲ 12 (L=3 x I=4) [07/10/2020] ▲ 9 (L=3 x I=3) [09/07/2020] = 3 (L=1 x I=3) [08/07/2020] ▲ 9 (L=3 x I=3) [08/07/2020] ▼ 3 (L=1 x I=3) [10/06/2020] ▼ 6 (L=2 x I=3) [12/03/2020] 9 (L=3 x I=3)	Risk Opened: 12/03/2020 Reviewed: 03/02/2021	[03/02/2021] Feb 21 - need to conclude conversations to release proposed candidate through HR to replace additional capacity lost through maternity leave , [12/01/2021] 6 Jan 21 - Team to monitor Primary Care prioritised work plan on weekly basis. Actions being taken to second additional resource into team to support. ,	COVID report due to monthly Primary Care Committee Team business continuity plan Team whats app group enabled Working from home processes enabled Business as usual workload weekly review to assess risk. [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Rob Payne

121	Improve service performance [Reporting Committee] Commissioning Committee	There is a risk that the Mental Health Inappropriate Out of Area trajectory, agreed by MH providers (Devon Partnership Trust and Livewell Southwest), is not met. The impact of this for patients is poorer outcomes, poorer experience, increased cost and damage to the CCG's reputation due to not meeting the nationally derived target to eliminate OOA placements by 20/21. (COVID Wave 2 Risk 45) (HISTORIC ID: Na)	23/02/2021 - Providers agreed and submitted trajectories as part of Phase 3 planning which would achieve the elimination of out of area placements by Q2 2021/22. - Providers submitted action plans which describe the actions being taken to deliver the trajectories, however, as at 22/02/2021 the previous plans and trajectories are being reviewed and updated; due to the impact of Covid the position for LSW in regard to OOA numbers has worsened. - We are receiving weekly reporting of the position from both providers; however the route of receipt is not contractualised. - We are working with providers through the MHLDA Cell to monitor the impact of COVID on total bed based capacity and ongoing access to independent sector bed-based capacity - DPT and LSW are currently meeting daily to consider the system position and options for collaboration and support. - A joint plan is in place between the providers to enable a joint response to Covid within the providers inpatient estates - Levels of Covid positive staff and patients within the DPT and LSW mental health in patient provision have remained low throughout the pandemic and vaccination programmes are rolling out for inpatients in mental health wards across the STP. - DPT have activated the agreed surge plan in response to reduction in independent sector bed-based capacity as a result of Covid. This has resulted in 5 additional OPMH beds within the DPT estate and 8 adult acute beds in Exeter based Elysium estate becoming operational (c. w/c08/02/21). - Due to the recent increase in OOA patients and challenges in delivery (due to COVID outbreaks pan-system), in particular in relation to PICU, LSW and DPT are reviewing their OOA trajectory plans to ensure, where applicable, there is recovery at pace. Initial plans due by 01/03/21. [Control Gaps] Demand and capacity plans have been developed collaboratively to support planning, however, there is limited evidence nationally on which plans can draw an evidence base because all modelling in this context is predictive. At present the routine mechanisms for further challenge and assurance are not in place (i.e Contract Review Meetings) which limits potential for commissioners to seek further assurance against the plans if there should be deterioration. The second/ third wave of Covid has: -a direct impact upon adult acute mental health and OPMH bed-based provision, with wards closed to new admissions within the provider estate and within the sub-contracted estate. It should be noted that total ward closures resulting in relocation of individuals out of area- are not identified as 'inappropriate out of area placements' because they are clinical exceptions. However, wards being closed to new admissions limiting access to in area capacity is a direct impact, and one which is difficult to in a way which is difficult to predict as closure durations vary according to the nature of outbreak and the need for adheracne to strict IPC protocols. -An indirect impact as providers report (LSW) an increased acuity of need at the point of presentation Initial revised trajectory plans are to be submitted by providers by 01/03/21 to give assurance around the trajectory of OOA's for each provider.	16 [29/09/2020] = 16 (L=4 x I=4) [13/07/2020] 16 (L=4 x I=4)	Risk Opened: 13/07/2020 Reviewed: 23/02/2021		Trajectories were agreed which should have achieved elimination of inappropriate out of area placements by Q2 2021/22 and these were submitted as part of Phase 3 planning and submissions. Providers have action plans in place which describe the actions being taken to delivery. At present: -DPT are progressing with the planned OOA reduction -LSW number of OOA placements has increased from the original submission The providers have been asked to review their plans to ensure recovery (as applicable) and ensure that they achieve the intended impact. •Regular reporting from both MH providers (paused during COVID-19) available through the monthly performance book. •Weekly situation reports are in place whilst regular reporting and discussion mechanisms are suspended. •MHLDA Cell discusses position as part of provider updates. [Assurance Gaps] none identified at present	Executive Lead: Jo Turl Owner: Liz Cosford

108	Improve service performance [Reporting Committee] Primary Care Commissioning	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand and capacity) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system, including patient safety, could be affected. It is acknowledged that the risk will vary from locality to locality over time, with the need to focus resources where need is identified. This risk replaces risk 09 (SDT) and 68 (NEW Devon) (HISTORIC ID: Na)	Feb 2021 - Reviewed by Deputy Director for Primary care and Head of Primary Care Jan 2021 - reviewed with Head of Primary Care (NEW) Dec 2020 - Review with Deputy Director for Primary Care Feb 21 - new guidance re expansion of Additional Roles Reimbursement Scheme in for 2021/22 including paramedics and mental health practitioner. Oct 20 - CCG attending virtual BMJ job fayre - stand promoting SW region 6 Oct 20 - LMC GP alert system sent out on weekly basis highlights either localities or practices of concern. It is acknowledged that the risk will vary from locality to locality over time, with the need to focus resources where need is identified. 16.12.19 risk score not adjusted due to current list dispersals (from 2 practice closures) 14 Nov 19 - Risk score has been reviewed in light of CQC contract suspension of one practice within Western system, given (material) impact on 3 practices covering circa 25,000 patients. Score has not been adjusted as this was felt to be a manifestation of the risk rather than an escalation of it. 10 Oct 19 - BMJ Job Fayre in London on 4th & 5th October 19; stand promoting SW region - supported by CCG staff and Plymouth GP. 2 Sept 19 - Plymouth Prospectus circulated to Plymouth practices. Others were sent to practices in South Hams, West Devon and the rest of Devon to inform them of the prospectus and encourage them to send expressions of interest for when CCG launch our longer term transformation plans 7 Aug 19 - Reworked as Plymouth Prospectus; financial implications being reviewed; on track for 1 Sept 19 launch. Jul 19 - 100 day plan in design for Plymouth system 20 Jun 19 - risk reviewed at Primary care operational group. No further update Apr 19 - Work continues to support practices in working closer together and with wider parts of the system and also building on the skill mix development as outlined in the contract reform GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments March 2019 GP Strategy STP Workforce Group & Strategy Locality Workforce Groups GP Provider Collaborative Groups Regional Workforce Board 100 day plan in design for Plymouth system Regular review at Primary Care Operational Group Regular review at Primary Care commissioning committee Feb 19 - The GP framework associated with the long term plan, having been released, is being reviewed for opportunities to further mitigate this risk [Control Gaps] Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support In part a lack of evidenced change to new models	16 [02/12/2020] ▲ 16 (L=4 x I=4) [06/10/2020] ▼ 12 (L=3 x I=4) [29/05/2019] 20 (L=5 x I=4)	Risk Opened: 29/05/2019 Reviewed: 03/02/2021	[03/02/2021] Feb 21 - work underway to understand the new guidance re expansion of Additional Roles Reimbursement Scheme in for 2021/22 at system level to ensure that max benefit can be achieved from the scheme. , [06/01/2021] Reviewed by Executive Team 19 October 2020 2 Dec 20 - Work to increase investment in workforce and GP resilience programme. 6 Jan 21 - workforce and resilience remain prioritised work areas during COVID. , [06/10/2020] 10 Aug 20 - Proposal regarding reporting, claiming and payment methods for LES and DES payments beyond 31st July to be shared with Execs. 8 Sept 20 - Local income protection agreed at PCCC. 6 Oct 20 - income protection extended to 31st March 2021. ,	Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. practice resilience toolkit Heat map devised to identify vulnerable GP practices Regular resilience meetings with Devon LMC Work continues to develop Primary Care Networks and fill roles [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Rob Payne

134	Commission high-quality and safe services that reduce health inequalities and improve health outcomes [Reporting Committee] Commissioning Committee	There is a risk that Children and Family Health Devon do not recover the current position of increased waiting times and deteriorating RTT positions for CAMHS; Occupational Therapy; Speech and Language; Autism Assessment services. The impact of this is that children experience delay in accessing assessment, support and services for their physical, mental and communication development needs which may experience poorer quality and outcomes. CFHD are not yet achieving contracted service standards and NHS Devon cannot be confident that they will deliver the service improvements and transformation as set out in the contract agreed with NHS Devon CCG. There continues to be a lack of operational clarity in terms of service management and different service offer between Devon and Torbay, increasing wait times, regular queries and comments from families and schools, together with concerns regarding leadership and workforce capacity within the services that indicate CFHD are not yet achieving contracted service standards. The issues have been further intensified by the pause in a number of services as a result of COVID 19 and services are not currently being provided at the standard expected with increased wait times and reduced access to services(COVID Risk wave 2 risk ID 18) (HISTORIC ID: Na)	Increased contact between the CCG and the provider CFHD has been put in place to discuss and scrutinise the performance of services especially in light of the response and pressures of COVID. There are fortnightly meetings to monitor the ASD assessment wait list and recovery plan. Where concern is raised this is escalated to Associate Director and action taken in direct discussion with CFHD Directors. Associate Director of Commissioning (Community Services) formally wrote to CFHD on 20/11/20 requesting that a copy of their Integrated Performance Report and Integrated Governance Group Report are shared with the CCG by 27/11/20. Trajectories for the services which are behind agreed performance level have been requested and submitted. These will be monitored through the Liaison and Restoration meetings that are already established and recovery plans monitored on an individual service level with the appropriate service manager to ensure that the agreed actions are being implemented. [Control Gaps] Current formal contract management has been paused in line with National guidance during the COVID – 19 period. Issues with service delivery during this period are raised through the contracting email and through the Restoration / Liaison Meetings which have recently been instated. 20.01.2021: Exec to exec mtg used for escalation did not take place in January.	15 [27/10/2020] 15 (L=5 x I=3)	Risk Opened: 27/10/2020 Reviewed: 02/02/2021	[26/01/2021] 20/01/21- CCG summary report of concerns and recommendations. Decisions to be confirmed, [01/12/2020] Alliance Board Performance and Governance Reports requested to be submitted by 27.11.2020. Not received, escalated to Lorraine Webber. ,	•Performance and assurance meeting papers for meetings described above •Reports to Quality Assurance Committee (Quarterly) •Executive and Senior Manager escalation meetings with CFHD provider eg Safeguarding and CAMHS. •Presentations / reports for local authority scrutiny meetings eg. CAMHS and Autism presented to the Devon County Council Children Scrutiny Group on September 8th 2020 and Devon Children And Family Partnership meeting on October 13th. Group on September 8th 2020 and Devon Children And Family Partnership meeting on October 13th. 20.01.2021 Continuing concerns escalated to AD and Director [Assurance Gaps] Some assurances have been provided however there remains concerns relating to governance processes, monitoring of incidents, experience for long waiting patients and referral management process. These are being followed up directly with CFHD Quality lead. 20.01.2021 Continued concerns in timeliness of agreed reports being shared due to internal governance sign off arrangements, pace of progress in safeguarding action plan, lack of understanding of budget and investment made in Autism assessment service. Summary provided to AD & Executive within an SBAR report for escalation with recommendations for : •3 month action plan •monthly exec to exec escalation mtgs •attendance by CCG at internal CFHD mtgs – Quality Committee; •financial summary from April 1st 2019 be provided	Executive Lead: Jo Turl Owner: Siobhan Grady
100	Improve service performance [Reporting Committee] Quality Assurance	There is a risk that the population of Devon will not receive timely access to 999 emergency ambulance care when needed. The impact of this is upon patient experience and safety; public and professional confidence in the system and associated reputational impact. (HISTORIC ID: Na)	February 2021 - SWASFT continue to report call stacking across the footprint, including Devon. The CCG has not been made aware of any harm arising out of the call stack situation. Monitoring of ambulance handover delays continues and a national piece of work is underway to understand how best to monitor for and understand harm that might arise (SZ) January 2021 - Risk & score reviewed. Score increased from 12 to 15 (SZ) [Control Gaps] None identified	15 [05/01/2021] ▲ 15 (L=5 x I=3) [04/06/2020] ▼ 12 (L=4 x I=3) [02/08/2019] ▲ 20 (L=5 x I=4) [21/06/2019] ▼ 16 (L=4 x I=4) [21/01/2019] 20 (L=5 x I=4)	Risk Opened: 21/01/2019 Reviewed: 11/02/2021		February 2021 - Some data is now available to the CCG but it is not user-friendly - requesting BI support. The CCG has not been made aware of any harm arising out of the call stack situation (SZ) December 2020 - Risk score to remain at 12. Call stacking continues to be reported but no evidence of actual harm (SZ) November 2020 - Risk score to remain at 12. SWASFT continue to report call stacking, and handover delays within some EDs continue. No harm reported (SZ) [Assurance Gaps] January 2021 - Call stacking is becoming more problematic across the footprint, including parts of Devon. To date we have not been made aware of harm arising out of the call stack (SZ) December 2020 - Considerable challenges with delayed ED handovers at UHP being reviewed jointly by CCG, UHP and SWASFT staff (SZ)	Executive Lead: Darryn Allcorn Owner: Sarah Zanoni

102	Improve service performance [Reporting Committee] Quality Assurance	The CCG is not assured that DPT can appropriately demonstrate safe and effective services, due to leadership and governance processes, including risk management; the number of overdue RCA Serious Incident reports will impact on the trusts ability to embed learning, drive improvement, avoid patient harm and poor experience. The impact may also have implications on the wider health economy and partners, and CCG reputational damage. (HISTORIC ID: Na)	January 2021 - Safety Systems team continue to have weekly calls with DPT risk team to gain regular updates on timelines on specific investigations (IL) December 2020 - CCG/Provider meeting to discuss new SI framework took place as per previous update. Plans to support provider in place. NHSE/I IDM process to be implemented - first meeting planned for Jan 2021 (SW) [Control Gaps] November 2020 - The demonstration of sustained and trust wide improvement / learning through DPT following incident investigations is still not clearly evidenced, examples being in-patient incidents / improvement in care planning. This was also picked up by CQC and NHS E in recent inspections. The follow up meeting to the Single item quality surveillance group has not taken pace yet (IL)	15 [21/02/2019] ▼ 15 (L=5 x I=3) [25/01/2019] 20 (L=5 x I=4)	Risk Opened: 25/01/2019 Reviewed: 08/02/2021		February 2021 - DPT are progressing against their completed SI trajectory, due to outsourcing in the most part with a further 18 being confirmed this month. Whilst this does not demonstrate long term change in process, it has led to current open investigations being completed in a shorter timescale, increasing speed of potential learning as well as supporting those directly impacted by the incident. DPT are also planning their piloting of the new Patient Safety Incident Response Framework. They met with Kernow CCG in January to learn from their experience of being a pilot site; this evidences DPTs commitment to innovate and drive improvement. It is not proposed that the risk score changes currently, until a sustained improvement is seen (SW) January 2021 - Whilst overdue SI numbers have reduced and the use of external reviewers continues to be reviewed by the Trust this does not demonstrate a change in process or culture that would help reduce the risk score at present (IL) [Assurance Gaps] December 2020 - Quality of SI reports improved. On-going concern in relation to number of SI reports. CCG supporting provider to drive improvement which includes CCG CNO and CCG DON meetings (SW)	Executive Lead: Darryn Allcorn Owner: Sara Wright

NHS
Devon
Clinical Commissioning Group

Risk Summary: Lack of clarity and visibility regarding STP and its governance (ID:38)

Date produced: 18-02-2021 - 03:04

Produced by: theresa.farris@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Lack of clarity and visibility regarding STP and its governance	There is a risk that decisions will be made by the ICS which impact negatively on delivery of CCG functions As the ICS increasingly takes responsibility for decision making there is a risk that it will make decisions which a) have not had appropriate input/scrutiny from the CCG b) do not consider the CCG statutory functions c) are not supported by the CCG Governing Body These decisions may mean that the CCG may fail to adhere appropriately to one or more of its statutory duties or internal governance requirements, thus potentially failing in one or more of its legal duties.	Commission high-quality and safe services that reduce health inequalities and improve health outcomes	10/10/2016	10/10/2016	Audit

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
4	2	2	risk reviewed at Executive Team Meeting 20 Oct 2020 and score reduction agreed. GS	20/10/2020
9	3	3	STP/ICS arrangements under post-COVID review (GS)	23/06/2020
6	2	3	reviewed no change	01/10/2019
6	2	3	Governance arrangements and processes are in place. Tested major programmes of work in relation to YFC programmes and engaging in pieces of design work through future mandates which are being closely overseen by the Strategy (corporate governance) Directorate	02/08/2018
12	3	4	No Change	23/05/2018

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Ginny Snaith	Sonja Manton	Not Given	Ginny Snaith	Theresa Farris

Controls	Control Gaps
Dec 2020 Updated by GS/JD Governance arrangements for the ICS agreed by all partners setting out ongoing requirements for decision making of statutory bodies CCG AO and Chair on Partnership Board Appointment of joint System and CCG AO 11/11/2020 Discussed at Audit Committee. the committee agreed the risk is still pertinent and requested a review of wording to better express the risk. 12/10/2020 Risk to be presented to Audit Committee for discussion and review November 2020	Dec 2020 No NED representation at System or Locality level of ICS Potential for changed arrangements in line with NHSE consultation Arrangements for decision making during COVID pandemic may circumvent usual agreed mechanisms

Assurances	Assurance Gaps
Dec 2020 Updated by GS/JD CCG Risk Management Process reporting at all levels of organisation Regular updates to Governing Body through Chairs and AO report and specific items of relevance Internal Audit of ICS Governance arrangements NHSE ICS designation process	No assurance Gaps identified

Action	Date Added	Date Complete
A review of ICS governance underway in ine with new white paper Feb 2021	17/02/2021	
Reviewed by Executive Team 19 October 2020	05/11/2020	
Arrange workshop for system organisation Audit Chairs to review proposed system Risk Management arrangements GS	17/12/2019	
14/05/19 – Review of governance arrangements for STP to be undertaken GS	21/05/2019	01/12/2019
26/06/18 OD work commenced by Accountable Officer with Directors	27/06/2018	14/05/2019

Board Assurance Framework (BAF) 2021 to 2022 With sub objectives V1.3		last updated Feb 2021											
	CCG Objectives	Board Assurance Framework Risk Ref	Principle Risks *There is a risk that……*	Delivery Date	Corporate Risk Register mapping	Initial Risk Score	Updated score at last review	Risk Movement (Trend)	Risk Appetite /Target Score	Assurance Score	Lead Director	Date BAF Risk Reviewed	*Comments*
1	**Commission high-quality and safe services that reduce health inequalities and improve health outcomes**												
	We will ensure that we are clear about the outcomes we are commissioning from new and existing services and ensure that contracts are agreed to achieve these.	BAF 1a	We do not commission services based on the outcomes that they will achieve	Mar-22		9	9	⟷	6	8	Jo Turl John Finn	25/02/2021	
	We will work with our partners to reduce health inequalities and deliver on the 8 Urgent Actions outlined in Phase 3	BAF 1b	We do not deliver the CCG contribution to the Phase 3 Inequalities action plan	Sep-21		16	16	⟷	4	8	Ginny Snaith	25/02/2021	
	We will embed the commissioning cycle so that our decision making is based on a strategic evidence base and prioritisation framework	BAF 1c	We do not base our decision making on robust evidence of good practice and strategic intelligence	Mar-21		9	9	⟷	6	9	Kelvin Grabham	22/02/2021	
		BAF 1d	We do not implement a Population Health Management approach throughout the organisation	Jun-21		9	9	⟷	8	10	Jo Turl John Finn	25/02/2021	
	We will consider the use of new technology during the process of commissioning new services	BAF 1e	We do not make the most of opportunities to use digital technology	Dec-00		6	6	⟷	6	8	Jo Turl John Finn	25/02/2021	
	We will ensure that patient and public views are sought in everything we do	BAF 1f	Our plans do not reflect the views of patients and the public	Mar-22		6	4	↓	4	12	Andrew Millward	23/02/2021	
2	**Improve service performance**												
	We will ensure that we have robust mechanisms for monitoring progress on delivery of our plans	BAF 2a	The CCG does not meet its statutory requirements and objectives because it does not have effective mechanisms for monitoring progress	Dec-00		15	15	⟷	6	9	Jayne Carroll	26/02/2021	
		BAF 2b	The System and Locality Care Partnerships do not establish robust mechanisms for performance management	Dec-00		6	6	⟷	4	11	Jayne Carroll	25/02/2021	
	We will work with our partners to ensure delivery of the operational system plan	BAF 2c	We do not have full commitment from system partners to deliver operational system plan so change is not delivered	Dec-00		8	8	⟷	4	8	Jayne Carroll	25/02/2021	
	We will have robust processes in place for identifying and responding to emerging risks	BAF 2d	The system does not have robust mechanisms for identifying and responding to emerging risks	Dec-00		9	9	⟷	4	8	Ginny Snaith	17/02/2021	
	We will deliver the phase 3 restoration plan to maximise planned care during winter and corona virus	BAF 2e	We do not implement the phase 3 restoration plan including maximising planned care during winter and corona virus	Dec-00		15	15	⟷	4	8	Jayne Carroll	25/02/2021	
3	**Achieve financial sustainability**												
	We will ensure that the CCG delivers a break-even position for 20/21.	BAF 3a	We do not deliver a break-even position for the current financial year.	Mar-21	124	3	3	⟷	4	12	John Dowell	23/02/2021	
	We will agree a medium-term plan that will deliver against the financial ambition of the LTP	BAF 3b	We cannot agree a medium-term plan that will deliver against the financial ambition of the LTP	Mar-24	106	16	16	⟷	6	12	John Dowell	23/02/2021	
	We will deliver our agreed efficiency programme for 21/22	BAF 3c	We do not deliver our agreed efficiency programme for 21/22	Mar-22	144	9	9	⟷	6	10	John Dowell	23/02/2021	
		BAF 3d	We do not deliver efficiencies from CCG running costs which at least mitigate the cost of inflation and pay progression	Apr-21	144	4	6	↑	4	12	John Dowell	23/02/2021	
4	**Be an effective, well-led organisation with an empowered and inclusive workforce**												
	We will increase staff satisfaction by addressing the issues raised in the staff survey	BAF 4a	We do not address the issues raised in the staff survey	Mar-22		3	3	⟷	4	12	Andrew Millward/ Sam Tribble	25/02/2021	
	We will support staff through the ICS transitions process	BAF 4b	We do not manage the transition process for CCG to ICS well.	Dec-21		9	9	⟷	4	10	Andrew Millward / Katey Kerley	23/02/2021	
	We will achieve an improved NHSE assurance rating	BAF 4c	We do not improve our NHSE Assurance rating	Mar-22		8	8	⟷	6	8	John Dowell	23/02/2021	
	We will grow and develop our staff to meet their potential and the organisation's needs	BAF 4d	We do not grow and develop our staff to meet their potential and the organisation's needs	Mar-21		8	8	⟷	4	11	Andrew Millward/ Katey Kerley	23/02/2021	
	We wil increase the diversity of our staff to reflect that of the Devon population	BAF 4e	We do not increase the diversity of our staff to reflect that of the Devon population	Mar-22		9	9	⟷	4	12	Andrew Millward/ Sam Tribble	25/02/2021	
5	**Lead the system's response to the coronavirus pandemic**												
	We will support staff health, wellbeing and morale during the COVID pandemic	BAF 5a	There is a risk that staff will become tired and overworked so we do not have sufficient capacity	Sep-21		6	6	⟷	4	12	Andrew Millward/ Sam Tribble	25/02/2021	
	We will deliver our Primary Care strategy to increase capacity and capability in Primary Care	BAF 5b	There is insufficient capacity and capability in Primary Care to meet demand	Mar-22	**117, 118, 120, 132, 141**	12	12	⟷	8	8	Jo Turl	25/02/2021	
	We will maintain robust incident management arrangements	BAF 5c	We do not have robust incident management arrangements because we do not have robust incident management arrangements	Jan-21	**109**	9	6	↓	4	8	Sonja Manton	23/02/2021	

Risk Assessment Scoring Guidelines

Risk Assessment Scoring Guidelines - Using the management response guidance at the bottom of this page:

- If a risk falls into one of the boxes numbered **15-25** immediate action is required, so far as is reasonably practicable. (Risk score of 25 can only be approved by the Accountable Officer)
- If a risk falls into one of the boxes numbered **8-12** prompt action is required, so far as is reasonably practicable.
- If a risk falls into one of the boxes numbered **4-6**, risk reduction is required, so far as is reasonably practicable.
- If a risk falls into one of the boxes numbered **1-3** further risk reduction may not be feasible or cost effective.

Assessing the likelihood/probability of risk

Score	Description	Definition
5	Almost Certain	Very likely. The event is expected to occur in most circumstances as there is a history of regular occurrence at the CCG or within the NHS.
4	Likely	There is a strong possibility the event will occur as there is a history of frequent occurrence at the CCG or within the NHS.
3	Possible	The event may occur at some time as there is a history of ad-hoc occurrence at the CCG or within the NHS
2	Unlikely	Not expected but there is a slight possibility it may occur at some time.
1	Rare	Highly unlikely, but it may occur in exceptional circumstances. It could happen but probably never will.

Risk scoring matrix (5x5 scores for impact & likelihood/probability)

		Likelihood/probability of Risk Occurring				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Impact	1 low	1	2	3	4	5
	2 Minimal	2	4	6	8	10
	3 Moderate /Medium	3	6	9	12	15
	4 High	4	8	12	16	20
	5 Significant	5	10	15	20	25

Risk scoring categorisation	
1-3	Low risk
4-6	Medium/moderate risk
8-12	High risk
15-25	Significant risk

Overarching Risk Score and Management Response

Risk Ranking	Low	Medium/moderate	High	Significant
	1-3	4-6	8-12	15-25
Rectifying Action	Business as usual. Acceptable but continue to monitor.	Management responsibility must be specified and actions set out over time	Senior Management attention needed. Actions set out within defined timescale to address control weaknesses	Immediate action requir mitigate the risk and addre in control or arrange contin
Monitor	At operational / departmental level	At operational / departmental level	Senior management	Executive level
Escalation	Risk Register	Risk Register	Risk Register	Governing Body Risk Ass Framework
Acceptable Risk Score for Appetite	5	8	12	15

Summary of Risk Appetite and Acceptable Risk Score

Risk Category	Definition	Appetite/ tolerance	Residual / Acceptable Risk Score	Rationale
Public, Patient and staff Safety (people)	These concern insufficient staff resources (capacity and capability). These risks can have a significant impact on the performance and reputation of the CCG.	Low	4	Patient and staff safety is of the highest importance and the CCGs will not accept any risks that threaten this. The CCG will aim to commission quality services for our patients.
Provider Performance (quality / patient experience)	Risk events such as failure by a third party to deliver a service, breakdown in partnership with a third party, or failure to manage internal change etc.	Moderate	8	The CCG challenges provider performance so as to help improve the service to patients and the public,
Statutory and mandatory compliance and governance. National policy	These include health and safety, data protection, employment practices, employment legislation, the NHS Constitution, Freedom of Information Act, Civil Contingencies Act, Deprivation of Liberty and regulatory issues.	Low	4	The CCG complies with all applicable legislation and will not accept any risk which (if realised) would result in non-compliance.
Financial Statutory Duties	In line with Constitutional requirements and standing financial instructions.	Low	4	Achieving financial balance both within the CCGs and in the wider local health economy is both a strategic priority and a statutory duty. Therefore the CCG will not accept any risk that (if realised) will threaten this.
Fraud and negligent financial loss	This is in line with Anti-Fraud and bribery act and NHS Protect requirements.	Low	4	The CCG will not tolerate financial losses from fraud and negligent conduct as this represents corporate failure to safeguard public resources.
Commissioning	These relate to the day to day concerns the CCGs are confronted with when striving to deliver strategic objectives. They can be anything from loss of key staff to process failure.	Moderate	8	Innovative approaches for commissioning incorporate inherent risk, which can impact on the delivery of outcomes. These concern risks that programmes and projects do not deliver agreed benefits within agreed budget and/or introduce new or changed risks that are not effectively identified and managed.
Reputation	It is important that the reputations of both CCGs are protected through robust systems of communication with stakeholders. .	Low	4	The CCG will maintain high standards of conduct, to safeguard both the organisation and public and stakeholder confidence.
Strategic	Strategic risks can be defined as the uncertainties and untapped opportunities embedded in strategic intent and how well they are executed. As such, they can impinge on the whole organisation, rather than just an isolated department or locality.	High	12	Were the CCG to fail to deliver its strategic priorities, the reputation of the CCG would be compromised, jeopardising its ability to carry out its core purpose and/or meet its strategic objectives
Engagement	The processes of engaging with and involving stakeholders in commissioning decisions	Moderate	8	The CCG will work with its member practices and other organisations (including but not restricted to other CCGs and local authorities) to ensure the best outcome for patients and communities. We are willing to accept the risks associated with a collaborative approach.
Information and technology	These can be anything from loss of data to failure of a key IT system	Moderate	8	We manage our systems to minimise the threat of risk events such as a technological breakdown, loss of hard or soft copy data, failure by a third party to deliver a service, failure to manage internal change etc.
Innovation	Commissioning intentions and operating plan	High	12	We encourage a culture of innovation and are willing to accept risks associated with this approach where they do not threaten risk areas that the CCG are not prepared to accept (as defined above e.g. quality patient care / safety).

Adequacy of Assurance scoring

This score is used to inform the CCG of the degree of reliance they can place on an item of assurance.

1	Does this assurance provide evidence that the controls are achieving the desired outcome?	Yes - proceed to Section 2 No - Do not proceed with this assessment

2	**Timeliness**	**Score**
2a	If the information is older than 6 months then the adequacy score automatically becomes 0, otherwise proceed to question	
2b	How old is the most recent information on which the Assurance is based? Within the last month between 1 and 3 months between 4 and 6months	 **3** **2** **1**

3	**Scope of Positive Assurance**	**Score**
3a	Does it provide positive assurance on all aspects of the issue? For example, CCG is fully compliant / achieving the target.	**3**
3b	Does it provide partially positive assurances? For example, compliance in some areas.	**1**

4	**Sufficiency**	**Score**
4a	Is this a key/definitive source of assurance for this area? For example, CQC, formal reports, data.	**3**
4b	Is this one of a number of sources of assurances contributing to an overall picture?	**2**
4c	Is this an indicator of likely achievement of the outcome rather than evidence of actual achievement?	**1**

5	**Basis for Assurance**	**Score**
5a	What is the Assurance based on? Evidence - Audited externally Evidence - audited internally Self-assessment - externally validated Self-assessment - without audit or validation	 **4** **3** **2** **1**

Score 0	No assurance
Score 1 - 7	Weak assurance. Very limited reliance can be placed on this as an indicator.
Score 8 - 10	Moderate assurance. Limited reliance can be placed on this as evidence.
Score 11 - 13	Strong assurance. This evidence can be strongly relied upon.

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Jo Turl - Director Out of Hospital Commissioning John Finn - Director In Hospital Commissioning
Risk: BAF 1a – we do not commission services based on the outcomes that they will achieve				**Reviewer** **Jo Turl**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**25/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	Existing contracts which do not fully articulate the outcomes expected.
Risk score at last review	3	3	9	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date	Mar-22			
Controls: (What are we currently doing about this?)				**Assurances:**
A service review document which clearly articulates the outcomes required. Ensures that as commissioners we are clear about the outcomes we want to commissioning from a new or existing service. We are including training for commissioners on the use of the service review document Implemented the use of the commissioning proposal checklist which ensures commissioner s need to have considered Locality profiles identify needs				Commissioning Committee meets monthly which requires all commissioning reviews and decisions to follow the service review guidelines and checklist Identified contracts due to expire in next 18 months and identified lead to take forward process
Control Gaps				**Assurance Score:**
Existing contract which may not have the outcomes articulated Ensure that when we made a commissioning decision ensure we have been through the evaluation process				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
As we review services or contracts coming up for renewal we will follow the commissioning review guidance to ensure we embed the outcomes in future commissioning arrangements Currently described in the QIPP process we are set to undertake a review of the non statutory contracts in priority order For the 21/22 operating plan which will focus on recovery of elective backlogs, newly commissioned services in Ophthalmology, Orthopaedics and urology will be commisssioned to meet the GIRFT outcomes				Non identified
Narrative of anticipated timeline				Narrative update

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Commission outcomes-based services, for example the western integrated care partnership*	on track	Mar-21	
07/01/2021	Training for the Commissioning Team	on track	Mar-21	

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Ginny Snaith - Board Secretary
Risk: BAF 1b – we do not deliver the CCG contribution to the Phase 3 Inequalities action plan				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**25/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	4	4	16	Operational capacity of staff to consider health inequalities as part of commissioning process
Risk score at last review	4	4	16	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date	Sep-21			
Controls: (What are we currently doing about this?)				**Assurances:**
Inequalities workplan agreed by system Project team				E I exec leader ship group chaired by Chair of STP Phase 4 assurance meeting Reporting to partnership board
Control Gaps				**Assurance Score:**
Access to data - i.e. provider and BI capacity to analysis Operational capacity of staff to consider health inequalities as part of commissioning process The Health and inequalities Team have been redeployed and activity has ceased for most activities				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Dr Claire Hoooer presented a paper on commisson requirements post covid of which rquriemetn to reduce health inequalites is a core principle and actiosn will feed intot the operating plan for 21/22				QEIA process is not being routinely followed
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	ongoing monitoring and delivery of the Health inequalities workplan	In progress	Sep-21	

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Kelvin Grabham - Director of Strategic Intelligence
Risk: BAF 1c – we do not base our decision making on robust evidence of good practice and strategic intelligence				**Reviewer** **Kelvin Grabham**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**22/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	reflects current situation and work
Risk score at last review	3	3	9	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date	Mar-21			
Controls: (What are we currently doing about this?)				**Assurances:**
Developing the commissioning cycle to support the decision making which includes creation of a strategic evidence base and prioritisation framework Training for commissioners to access and use best available evidence				Strategic Intelligence in place Commissioning Committee provided with assurance that decision are based on evidence and best practice
Control Gaps				**Assurance Score:**
Evaluation of existing services due to lack of clarity of outcomes				9
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Building on the current process develop process to review existing services				no gaps identified
Narrative of anticipated timeline				In line with development of the commissioning cycle

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Deliver strategic commissioning cycle training for CCG staff	in progress	Mar-21	

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Jo Turl - Director Out of Hospital Commissioning John Finn - Director In Hospital Commissioning
Risk: BAF 1d – we do not implement a Population Health Management approach throughout the organisation				**Reviewer** **Jo Turl**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**25/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	
Risk score at last review	3	3	9	
Appetite:			8	**Rationale for risk appetite:**
Delivery Date	Jun-21			
Controls: (What are we currently doing about this?)				**Assurances:**
we have a population health management STP programme in place Commissioning checklist and service review document includes population health management (PHM) as a core part of the needs assessment? The CCG have identified BI resources to develop of PHM data Locality Directors will have the responsibility for ensuring the PHM data is used at place and PCN level				Commissioning committee will review all commissioning decisions are being made to ensure a full needs assessment undertaken PHM being led by the Chair of the CCG Intensive investment in development and learning
Control Gaps				**Assurance Score:**
There is a need for additional BI capacity Population health data not currently available at CCG/Place level Support for PCNs to engage in PHM				10
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Currently developing a business case for additional BI support Currently reviewing Primary Care team structure and locality teams to better support PCNs to utilise the PHM approach				
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Jo Turl - Director Out of Hospital Commissioning John Finn - Director In Hospital Commissioning
Risk: BAF 1e – we do not make the most of opportunities to use digital and modern technologies to commission services to meet best practice				Reviewer Jo Turl
Corporate risks				Date Last Reviewed:
Risk Scores				25/02/2021
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	2	6	
Risk score at last review	3	2	6	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
All commissioned services should be in accordance with national best practice as indicated in the commissioning checklist QEIA will identify areas of inequalities and actions will be taken to mitigate the lack of access to digital technologies				Commissioning Committee and forward planner for the committee
Control Gaps				**Assurance Score:**
Ensure there is a follow up to any areas of inequality identified Service policy is not fully aligned to the IMT policy Service policy not fully aligned to the HIP 2 strategy				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
As part of Phase 4 recovery and included as a guding principle in the 21/22 oeprating plan, the use of new tehchologies to support the delivery of outpatient care across a full spectrum of health services, eg acute, community and children, will be core to our CCG planning; taking into account all the learning form the Covid pandemic.				Alignment with the STP digital strategy
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 1f – our plans do not reflect the views of patients and the public				**Reviewer** **Andrew Millward**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**23/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	2	3	6	The rationale is that we have just been given a GREEN STAR rating (rated Outstanding) for our engagement by NHS England for the second year running
Risk score at last review	2	2	4	
Appetite:			4	**Rationale for risk appetite:**
				Risk level will fluctuate with time (e.g. when large or contentious consultation underway) so plan is to maintain risk at current level by actions outlined.
Delivery Date	Mar-22			
Controls: (What are we currently doing about this?)				**Assurances:**
We have a citizens panel - 1700 people from across Devon. This panel is totally representative of the Devon population and enables us to engage with them on a regular basis. 16/06/2020 Engagement strategy/Plan agreed CCG-wide communications strategy written and published. 16/06/2020				NHSE Annual Assurance on engagement NED for Patient and Public Engagement Engagement Panel with patient representatives
Control Gaps				**Assurance Score:**
non identified				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Continue to develop all staff within the CCG to increase capacity supporting engagement Continue to support and develop PPGs to deliver their practice role and to increase their involvement in wider engagement initiatives AM to take a paper on communication and engagement in preparation for the ICS in April to the partnership board				No gaps identified
Narrative of anticipated timeline				Business as usual
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Improve service performance				Director Lead: Jayne Carroll - Chief Operating Officer
Risk: BAF 2a – the CCG does not meet its statutory requirements and objectives because it does not have effective mechanisms for monitoring progress				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**26/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	5	3	15	the risk is scored 15, as the CCG will not meet its statutory targets in 20/21. However, this is not due to the lack of effective mechanisms, but to the COVID pandemic
Risk score at last review	5	3	15	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Performance Leads in post who are assigned to localities to monitor performance against constitutional standards and performance targets and also provide a lead on specific systemwide areas of focus R&T cell have been co-ordinating delivery of phase 3 plan and reports regularly to commissioning committee and executives on a weekly basis The CCG Patient Safety & Quality team has maintained regular dialogue with providers regarding the impact of failures to achieve statutory targets and, through provider quality committees, has ensured a focus on preventing harm.				Formal sub committee of Board - Finance & Performance committee Access to provider quality committees & CCG Quality Assurance Committee Quality surveillance group System performance group Exec to Exec provider meetings
Control Gaps				**Assurance Score:**
Vacancy for x1 Performance lead lack of capacity to support Regular performance review meetings agreed by system to stand down				9
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Recruited to vacancy above System performance group will be reconvened in Feb 2021 Performance framework being developed to set out how LCPs will approach performance and appropriate level of engagement/ check and challenge with providers Design and deliver an integrated performance reporting framework (includes dashboards) to address challenging performance and reduce inequalities Ensure 21/22 contracts set out clear expectations around performance improvement				SPG not meeting during COVID incident Exec to Exec provider meetings not in place for all contracts
Narrative of anticipated timeline				

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Feb-21	Recruitment of Performance Lead	complete	01-Apr-21	3rd Head of Performance appointed - comes into post on 5 April 2021.
Feb-21	SPG reconvened in Feb 21	in progress	18-Mar-21	SPG not convened in Feb 21 due to COVID response. Meeting set up for 18 March.
Feb-21	Performance Improvement Framework paper	in progress	mid-March 2021	Paper being presented to System CEOs on 5 March for consideration. Will then be finalised and shared more widely. Locality meetings that will facilitate performance improvement discussions are in place.
Feb-21	Integrated Performance Reporting	in progress		Core IPR being produced and shared with ICS Partnership Board. Community, children's and primary care indicators being considered for inclusion.
Feb-21	21/22 contracts	delayed	30-Jun-21	National planning & contracting guidance delayed

Corporate Objective: Improve service performance				Director Lead: Jayne Caroll - Chief Operating Officer
Risk: BAF 2b – the System and Locality Care Partnerships do not establish robust mechanisms for performance management				Reviewer
Corporate risks				Date Last Reviewed:
Risk Scores				25/02/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	2	3	6	it is unlikely that the LCPs will not establish robust mechanisms for performance management. The impact is moderate, as there are Heads of Performance in place and will be other governance structures within the ICS with a focus on performance.
Risk score at last review	2	3	6	
Appetite:			4	Rationale for risk appetite:
Delivery Date				
Controls: (What are we currently doing about this?)				Assurances:
Performance Leads in post who are assigned to localities to monitor performance against constitutional standards and performance targets Heads of Performance use provider board reports and provider internal performance forums to gather intelligence on issues and to track action plans				Through the ICS governance and NHSEI oversight
Control Gaps				Assurance Score:
NEW LCP West has recently been agreed and infrastructure to support is being developed LCPs are still under development and require infrastructure to ensure performance Regular performance review meetings agreed by system to stand down Vacant Head of Performance post in southern locality				11
Mitigating Actions: (What should we do?)				Gaps in Assurance: (What additional assurances should we seek?)
Recruited to vacancy above Performance framework being developed to set out how LCPs will approach performance and appropriate level of engagement/ check and challenge with providers Design and deliver an integrated performance reporting framework (includes dashboards) to address challenging performance and reduce inequalities Ensure 21/22 contracts set out clear expectations around performance improvement				
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update
Dec-20	Design and deliver an integrated performance reporting framework to address challenging performance and reduce inequalities (link to action in risk 2a)		Mar-21	Performance Improvement Approach paper being presented to System CEOs on 5 March for consideration. Will then be finalised and shared more widely. Locality meetings that will facilitate performance improvement discussions are in place.
Feb-21	Integrated Performance Reporting	in progress		Core IPR being produced, at LCP and System level. Community, children's and primary care indicators being considered for inclusion.
Feb-21	21/22 contracts	delayed	30-Jun-21	National planning & contracting guidance delayed

Corporate Objective: Improve service performance				Director Lead: Jayne Caroll - Chief Operating Officer
Risk: BAF 2c – we do not have full commitment from system partners to deliver operational system plan so change is not delivered				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**25/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	2	4	8	Likelihood of partners not committing to improve performance is very low. However, the potential impact if this did happen is significant.
Risk score at last review	2	4	8	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
LCPs are under development and all partners are contributing to this There is sign up by all system CEOs to a 21/22 operational planning process that uses system work streams and a				CEO oversight of the 21/22 planning process
Control Gaps				**Assurance Score:**
				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Feb-21	Operational Planning Process	in progress	Jun-21	National operational planning process delayed until early April, but System core group meeting on 26 February to set out expectations and timeline.

Corporate Objective: Improve service performance				Director Lead: Ginny Snaith - Board Secretary
Risk: BAF 2d – the system does not have robust mechanisms for identifying and responding to emerging risks				**Reviewer** Ginny Snaith
Corporate risks				**Date Last Reviewed:**
Risk Scores				17/02/2021
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	good controls in place but need to be tightened and maintained
Risk score at last review	3	3	9	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date				

Controls: (What are we currently doing about this?)	**Assurances:**
Regular reporting to committees Head of Governance and Risk Manager attendance at directorate team meetings Regular Risk Co-ordinators meetings and training Training available via teams Chairs reports template to identify risk escalation to GB Review of minutes by Governance team to escalate risk actions appropriately	Committee overview Audit Committee oversight of BAF/CRR/COVID Executive review of risk Governance forward planner for risk reporting in place and embedded Assurance scoring mechanism is available on web based register Directorate team meetings Internal audit review of risk annually
Control Gaps	**Assurance Score:**
Risk Management training at board level Lack of understanding between issues and risks	8
Mitigating Actions: (What should we do?)	**Gaps in Assurance: (What additional assurances should we seek?)**
regular reporting by SLT, and members of Exec and senior officers attending SLT can discuss and identify any emerging risks for consideration, action and escalation.	Directorate regular discussion to be considered monthly Actions are followed through to ensure emerging risks are recorded and actioned appropriately through the risk management framework policy. Assurance scoring on web based register currently not used
Narrative of anticipated timeline	Narrative update

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Improve service performance				Director Lead: Jayne Caroll - Chief Operating Officer
Risk: BAF 2e – We do not implement the phase 3 restoration plan including maximising planned care during winter and corona virus				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**25/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	5	3	15	
Risk score at last review	5	3	15	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
R&T cell co-ordinate delivery of phase 3 plan and reports regularly to commissioning committee and to executives on a weekly basis Delivery plan in place for Phase 3 - leads are held to account for progress against phase 3 actions, through regular meetings with the R&T cell On a weekly basis, the Devon system is held to account on elective restoration and its Adapt & Adopt plan. Meetings are attended by the System CEO and restoration lead.				Formal sub committee of Board - Finance & Performance committee Report through regional work streams - e.g.: Adapt & Adopt Elective & outpatient recovery - as of mid-December 2020, the system was on plan. However, it has significantly deteriorated since mid-Dec.
Control Gaps				**Assurance Score:**
				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Use of mutual aid through the Devon Mutual Aid group The System is planning to require surge in the Independent Sector provision, to meet gaps in urgent elective/cancer				As of 18 Jan 2021, the regional assurance process has been stood down, to start again in the second week of Feb 2021.
Narrative of anticipated timeline				
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Implement the phase 3 restoration plan, including maximising planned care during winter and during the coronavirus pandemic		Mar-21	
Feb-21	Deliver Devon's system winter plan and develop the 2021/22 system operating plan		Jun-21	Winter plan processes in place and delivering focused action in relation to escalation of both COVID and normal system pressure. Review of winter schemes to be undertaken in March, to assess impact and future requirements. National operational planning process delayed until early April, but System core group meeting on 26 February to set out expectations and timeline.
Feb-21	secure IS surge capacity			Additional IS surge capacity secured until 8th March 21 through national IS surge contractual arrangements. The return to the national framework will secure sufficient capacity for the remainder of March for RD&E and South Devon. We will need to put additional capacity through IS for UHP to be wroked through by 8th March. Discussions with CCG and UHP DoF has indicated that there is suffcient revenue to cover this.

Corporate Objective: Achieve Financial Sustainability				Director Lead: John Dowell - Chief finance officer
Risk: BAF 3a – we do not deliver a break-even position for the current financial year.				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**23/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	1	3	3	**all mitigations in place and year end forecast indicates we will deliver breakeven**
Risk score at last review	1	3	3	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date	Mar-21			
Controls: (What are we currently doing about this?)				**Assurances:**
Financial plan approved by Governing Body Budgetary control over expenditure Monthly review of financial risks and mitigation				Regular reporting to Finance Committee and Governing Body Internal audit of all financial control process Report to NHS England on risks and mitigations
Control Gaps				**Assurance Score:**
Non identified				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Narrative of anticipated timeline				31-Mar-21
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Deliver a break-even position for the current financial year	in progress	Apr-21	

Corporate Objective: Achieve Financial Sustainability				Director Lead: John Dowell - Chief finance officer
Risk: BAF 3b – we cannot agree a medium-term plan that will deliver against the financial ambition of the Long Term Plan				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**23/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	4	4	16	required recovery trajectory not yet issued by NHS England.
				Financial allocation not yet issued by NHS England Emergency financial regime confirmed to continue to end of Qtr. 1 2021/2022
Risk score at last review	4	4	16	Savings and efficiency plans require further development
Appetite:			6	**Rationale for risk appetite:**
Delivery Date	Mar-24			
Controls: (What are we currently doing about this?)				**Assurances:**
Medium Term Financial plan approved by Governing Body Budgetary control over expenditure Financial recovery trajectory agreed with NHS England Savings and efficiency plans approved by Governing Body and delivery responsibility assigned to executive team leads				Regular reporting to Finance Committee and Governing Body Internal audit of all financial control process Report to NHS England on risks and mitigations
Control Gaps				**Assurance Score:**
Further control required to achieve the shift in investment towards out of hospital services				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Narrative of anticipated timeline				
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Reset the medium-term plan to ensure that we deliver against the financial ambition of the Devon Long-Term Plan. This includes shifting the balance of investment towards out of hospital services by 2023/2024 and will mean financial sustainability with expenditure contained within allocated resources on an ongoing basis (living within our means)	In progress	Jun-21	

Corporate Objective: Achieve Financial Sustainability				Director Lead: John Dowell - Chief finance officer
Risk: BAF 3c – we do not deliver our agreed efficiency programme for 21/22				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**23/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	
Risk score at last review	3	3	9	
Appetite:			6	**Rationale for risk appetite:**

Delivery Date	Mar-22

Controls: (What are we currently doing about this?)	**Assurances:**
Efficiency programme based on realistic assessment of improvement opportunity Detailed delivery plans in place and regularly monitored	Regular review at Executive team and reporting to Finance committee Internal audit review of process
Control Gaps	**Assurance Score:**
Identify process to address any financial shortfall identified through the controls above	10
Mitigating Actions: (What should we do?)	**Gaps in Assurance: (What additional assurances should we seek?)**
Continuous process to identify pipeline of efficiency opportunity	

Narrative of anticipated timeline	

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Deliver agreed efficiency programmes in each financial year through to 2023/2024. These should be informed by ongoing assessment of value for money in our use of resources		Jun-21	

Corporate Objective: Achieve Financial Sustainability				Director Lead: John Dowell -Chief Finance Officer
Risk: BAF 3d – We do not deliver efficiencies from CCG running costs which at least mitigate the cost of inflation and pay progression				Reviewer John Dowell
Corporate risks				Date Last Reviewed:
Risk Scores				23/02/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	2	2	4	
Risk score at last review	3	2	6	Additional resource to deliver all programmes in long term plan currently being assessed. This MAY require additional efficiencies to be identified from elsewhere in the CCG running costs in order to remain within overall running costs ceiling.
Appetite:			4	Rationale for risk appetite:

Delivery Date	Apr-21

Controls: (What are we currently doing about this?)	Assurances:
Budget setting. Budgetary control over recruitment and non-pay expenditure	Reporting to Finance Committee and GB. Internal Audit of budgetary control processes
Control Gaps	**Assurance Score:**
Directorates funded establishment structure charts require updating for improved control	12
Mitigating Actions: (What should we do?)	**Gaps in Assurance: (What additional assurances should we seek?)**
	No gaps identified

Narrative of anticipated timeline	

	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update
Dec-20	Deliver efficiencies from CCG running costs which at least mitigate the cost of inflation and pay progression; and make best use of available resources		Apr-21	
Feb-21	Update of directorate structure charts/establishment	in progress	Apr-21	

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 4a – We do not address the issues raised in the staff survey				Reviewer Sam Tribble
Corporate risks				Date Last Reviewed:
Risk Scores				25/02/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	1	3	3	We have had the 2020 staff survey results and these show improvement again. Devon CCG was classed in the top quartile of improving CCG. There are still some areas requiring improvement and will be addressed during the year.
Risk score at last review	1	3	3	
Appetite:			4	Rationale for risk appetite:
				It is within the CCGs powers to address many of the issues raised in the staff survey and it is important to maintain key staff
Delivery Date	Mar-22			
Controls: (What are we currently doing about this?)				Assurances:
Each Directorate will review the results of their staff survey and agree actions We now have agreed new CCG objectives Increased staff engagement and listening events Well embedded organisational Vision and Values Celebrate You now an annual event				Remuneration and Strategic Workforce Committee HR Dashboard to SLT, Execs and Governing Body Monthly meeting of Staff Partnership Forum
Control Gaps				Assurance Score:
non identified				12
Mitigating Actions: (What should we do?)				Gaps in Assurance: (What additional assurances should we seek?)
Staff survey action plan will consist of three elements 1. Staff Partnership Forum has agreed to focus on two of the issues raised in the staff survey - How staff feel about communications between themselves and senior management and 2. We are revising the OD programme to focus on some key elements of the staff survey 3. We have asked each directorate to review the results and agree and action plan with their staff				non identified
Narrative of anticipated timeline				Business as usual
	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update
Dec-20	Directorates have been asked to review the 2020 staff survey and come up with an action plan for their teams by ??	in progress		
Dec-20	Implementation of talent management approach including talent conversations	in progress		
Dec-20	Implementation of Health and Wellbeing Strategy - launch of strategy and health and wellbeing champions	in progress		

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 4b – We do not manage the transition process for CCG to ICS well.				**Reviewer** **Katy Kerley**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**23/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	Waiting for national direction
Risk score at last review	3	3	9	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date	Dec-21			
Controls: (What are we currently doing about this?)				**Assurances:**
Executives have discussed this and once we have clear directions will agree an action plan Staff Partnership Forum Linked to priority 10 of the OD development plan 'Preparing our workforce for transition to an ICS' ICS white paper released February 2021 Learning from other local ICS organisations to inform our action planning				Workforce and Remuneration Committee Governing Body
Control Gaps				**Assurance Score:**
NHSE to issue detailed directions spring 2021				10
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
We are actively monitoring national changes so that we can act accordingly				No detail on national assurance requirements at February 2021
Narrative of anticipated timeline				Changes expected to take effect spring 2022
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Prepare staff and the organisation to work within an Integrated Care System (ICS)	in progress	Dec-21	

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: John Dowell - Chief finance officer
Risk: BAF 4c – We do not improve our NHSE Assurance rating				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**23/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	2	4	8	**there is a plan in place which will improve assessment against criteria**
Risk score at last review	2	4	8	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date	Mar-22			
Controls: (What are we currently doing about this?)				**Assurances:**
Review of current performance against 2019/2020 assessment criteria has been completed Action plan in response to 2019/2020 inadequate rating in place Executive team leadership responsibility assigned for delivery of action plan Corporate objectives support delivery of changes that will improve assessment outcome				Regular reporting to finance committee, Quality Committee and Governing Body
Control Gaps				**Assurance Score:**
2020/2021 and 2021/2022 criteria unknown				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
ongoing dialogue with NHSE to obtain the assessment criteria				
Narrative of anticipated timeline				
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 4d – we do not grow and develop our staff to meet their potential and the organisation's needs				Reviewer Katy Kerley
Corporate risks				Date Last Reviewed:
Risk Scores				23/02/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	2	4	8	Making good progress against the delivery of the CCG's people plan, however the impact of the pandemic on our workforce and therefore delivery of this priority maybe adversely impacted.
Risk score at last review	2	4	8	
Appetite:			4	Rationale for risk appetite:
				It is in the CCG's control to deliver against this objective based on feedback and learning from staff to continually improve processes.
Delivery Date	31/03/2021			
Controls: (What are we currently doing about this?)				Assurances:
Reviewing the results of staff survey, agreeing action plans and organisational learning Promoting health and well-being champions and delivery of an extended well-being programme for all staff Developing and implementing an apprenticeship strategy which supports the growth of new and existing talent Hosting and supporting graduates who are part of the Graduate Management Training Scheme Implementation and roll out of CCG Talent Management approach CCG Mentoring programme Staff training - Quality Improvement/Commissioning cycle & project management Measuring and supporting the development of a just and learning culture Governing Body and Executive Director team development programmes Preparing our workforce for transition to an ICS				Remuneration and Strategic Workforce Committee HR Dashboard to SLT, Execs and Governing Body Monthly meeting of Staff Partnership Forum Talent Management Panel Equality, Diversity and Inclusion Group (sub group of Staff Partnership Forum)
Control Gaps				Assurance Score:
No gaps identified				11
Mitigating Actions: (What should we do?)				Gaps in Assurance: (What additional assurances should we seek?)
Carry forward any work that has been delayed due to CCG vaccination/pandemic response into 21/22				No gaps identified
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update
Dec-20	Grow and develop staff to meet their potential and the organisation's needs: Implement an improved talent management process, linked to Appraisals; Develop and implement a graduate and apprenticeship strategy	Good progress has been made in all of the 10 priorities within the CCG's people plan	on-going	Due to the CCG's concentration on supporting Devon's vaccination programme and our system response to Covid it is likely that delivery of some of these priorities will be delayed.

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 4e – we do not increase the diversity of our staff to reflect that of the Devon population				**Reviewer** **Sam Tribble**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**25/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	**In 2020 there has been a real focus on improving EDI within the CCG and this work will continue into 2021 (as per "Controls" section below).**
Risk score at last review	3	3	9	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date	Mar-22			
Controls: (What are we currently doing about this?)				**Assurances:**
Embed the newly established Equality, Diversity and Inclusion Group (sub group of the Staff Partnership Forum) to focus our EDI agenda. NED representation within this group. Development and implementation of EDI action plan including actions from the WRES action plan, NHS People plan etc. Review findings of the commissioned STP wide review of the experience of BAME colleagues, through external				Strategic Workforce and remuneration Committee Equality, Diversity and Inclusion Group (sub group of Staff Partnership Forum) Executive Team Staff Survey Monitor achievement of EDI action plan completion Review of CCG workforce statistics
Control Gaps				**Assurance Score:**
non identified				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Continue with controls stated above.				Non identified
Narrative of anticipated timeline				Narrative update

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Jan-20	Drive to increase the current diversity of our staff (3.4%) to reflect that of the Devon population (6.9%)	ongoing	expected that good progress will be made toward this action in 2021/22.	
Jan-20	Develop and implement EDI action plan	ongoing	Mar-22	Action plan will be created by April 2021 for implementation within 21/22.

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 5a – that we do not have sufficient capacity as staff are tired and overworked				**Reviewer** **Sam Tribble**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**25/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	2	3	6	In 2020 there has been a focus on ensuring good health and wellbeing for our staff and this work has continued into 2021. Current impact of wave 2 will increase pressure on some staff therefore adjusting the score to reflect this, however assurances are in place to support staff.
Risk score at last review	3	3	9	
Appetite:			4	**Rationale for risk appetite:**
				It is within the CCG's power to ensure there is a robust wellbeing programme in place to support our staff.
Delivery Date	Sep-21			
Controls: (What are we currently doing about this?)				**Assurances:**
Ensured corporately that every member of staff had a formal wellbeing and home working assessment during wave 1. Wellbeing champions in the organisation - ongoing work including (alongside the HR team) holding wellbeing calls with every member of staff. More recently, Wellbeing Champions (alongside the HR team) are ensuring all staff have a further wellbeing call. Individuals concerns are dealt with and themes are fed back for CCG consideration. Focus of the Staff Partnership Forum All directorates are routinely checking in on staff as part of good management practice. Presently reviewing Staff Survey information and reviewing results and next steps.				Strategic Workforce and Remuneration Committee Staff Partnership Forum Executive Team Staff Survey Wellbeing Champions (through feedback from health and wellbeing conversations) Monitor of staff sickness levels Review of Employee Assistance and Occupational Health data
Control Gaps				**Assurance Score:**
Non identified				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Continue implementing the controls listed above, taking action as required.				Non identified
Narrative of anticipated timeline				Regular rolling programme
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Support staff health, wellbeing and morale	on going	on-going	
Dec-20	Be a learning organisation: Use COVID-19 learning to improve services and working practices Deliver quality improvement and commissioning cycle training Further develop the CCG's mentoring programme	on going	Sep-21	

Corporate Objective: Lead the systems response to the coronavirus pandemic				Director Lead: Jo Turl - Director Out of Hospital Commissioning
Risk: BAF 5b – there is insufficient capacity and capability in Primary Care to meet demand				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**25/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	4	12	
Risk score at last review	3	4	12	
Appetite:	2	4	8	**Rationale for risk appetite:**

Delivery Date	Mar-22

Controls: (What are we currently doing about this?)	**Assurances:**
CCG have agreed a framework for GPs to work within to allow them to prioritise urgent care to patients CCG primary care team are working with general practice to reduce bureaucratic burden on them Primary Care including MO actively supporting practices where there are resilience or capacity issues CCG have allowed the flexible use of funding to support the delivery of COVID vaccinations Undertake the PC webinar to allow feedback from PC relating to capacity issues which the PC team can respond to Increased funding and flexibility of funding to support vaccination work	Risk reports through to the PC committee, where we have GP members who can feedback areas of concern
Control Gaps	**Assurance Score:**
	8
Mitigating Actions: (What should we do?)	**Gaps in Assurance: (What additional assurances should we seek?)**
Provide support to GP to fully utilise the additional roles reimbursement scheme	

Narrative of anticipated timeline	Narrative update

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
25/02/2021	Vaccination cell looking at provision of vaccinations being delivered sustainably moving forward	in progress	Jun-21	

Corporate Objective: Lead the systems response to the coronavirus pandemic				Director Lead: Sonja Manton - Incident Director
Risk: BAF 5c – that we do not deliver our function as a system leader because we do not have robust incident management arrangements				**Reviewer** **Sonja Manton**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**23/02/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	Turnover is higher than expected, so controls have not reduced the like hood
Risk score at last review	2	3	6	
Appetite:			4	**Rationale for risk appetite:**
				all controls in place
Delivery Date	Jan-21			
Controls: (What are we currently doing about this?)				**Assurances:**
We have a robust incident structure and process in place designed by EPRR experts with appropriate cell structure to support Have in place a daily/weekly meeting rhythm to ensure appropriate information flows across the system Clear roles and responsibilities within the arrangements Staffed by deploying staff from across the CCG to provide resilience and share the experience across a wider cohort of				Wave one incident review and resulted in a action plan. The action plan is being regularly reviewed by the executive team Regular updates at Governing Body Part of the regional and national response structure which includes daily reporting Daily calls with regional operational centre were we are held to account for our response. Oct 2020 system exercise to test our COVID response and preparedness for wave 2
Control Gaps				**Assurance Score:**
				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Considered alternative support for EPRR Refreshed on call arrangements to improve resilience and improved incident response				No external review robustness of access to external EPRR in the event of in house absence of EPRR leads
Narrative of anticipated timeline				
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
05/01/2021	Increase the pool of admin and meeting support end of January	Complete	end February 2021	Increased the pool of admin staff to support the incident, likely to be trained in early February
05/01/2021	Broaden the pool of the incident management role	Complete	end February 2021	Identified further IMs and training currently underway
23/02/2021	Considered alternative support for EPRR	in progress	01-Mar-21	No additional capacity identified as yet and we are looking at a more resilient on call arrangements including incident response. Proposals to exec early March 2021

COVID Incident Risk Register - Wave 2

yellow highlight indicates risks requested to close

V6

updated 23/02/2020

Rag rating
Green - reviewed within last 2 weeks
Amber - Reviewed within one month
Red - review overdue - last review over one month

Risk Reference	Risk ID on CRR or TRR	Risk Title	There is a risk that.....	The Impact is	Mitigating Actions in Place	Exec Lead	Risk Owner	Further Action Required	Last Reviewed	Date Added	Likelihood/ve	Impact	Risk Score	Current Status/Updates
COVID 01 (Wave 2)	TRR	Providing a COVID response during Winter	there is insufficient capacity to manage the COVID emergency activity, as well as increased winter emergency demand and maintaining elective activity.	That elective activity will not be able to be provided and that waiting times will lengthen and patients may experience harm. Increase in delays in the management of emergency activity in ED departments, resulting in ambulance delays.	Additional capacity has been put in place, including Nightingale Hospital Exeter and winter schemes, as set out in the winter plan. Each provider has surge plans to respond to increased demand. Escalation framework sets out daily process to monitor pressure in the system and escalation actions, through the Operating Centre and Incident Director role, with supporting cell structure. DDMG established, overseeing a system wide stepwise escalation process to ensure a risk-assessed approach on escalation decisions, including a mutual aid process. Use of IS capacity to maintain urgent elective activity.	Jayne Carroll	Al Wilkinson		22/01/2021	21/01/2021	5	15	DDMG is reviewing the system operational position 3 times a week and making decisions to manage capacity to respond to COVID and non-COVID demand for Devon and supporting neighbouring systems.
COVID 02 (Wave 2)	(COVID Wave 1 risk 17)	Staff Capacity and Resilience	Staff will suffer an increase in mental health issues due to social isolation, lone working and reduced direction driven by home working	a)reduction in staff available to work due to health b)reduction in staff available to work due to personal relationship breakdown c) increase in self harm/suicidal tendencies	January 2021 - we are contacting all staff again about their well-being and are satisfied that this can remain the same score as 6 however I am expecting it to come down slightly as a result of the wellbeing calls that we are doing. Managers contacting staff on regular basis Video briefings from Simon Tapley Regular written communications Staff made aware of access to support services Use of Teams to provide video contact 05/06/2020 likelihood score reduced AM	Andrew Millward	Piers Tetley	Corporate risk to be articulated and approved by AM for addition to the corporate risk register	04/02/2021	23/12/2020	3	2	6	Risk being drafted to add to CRR by PT Risk score taken from wave 1 risk register
COVID 05 (Wave 2)	109	Underperformance Constitutional Standards Failure to delivery against planned recovery trajectories.	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level.	However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •There is reputational impact due to potential patient harm or perception of the CCG is impacted by patient outcomes. •Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability.	Fortnightly NHSEI elective care recovery meetings with system partners, consistent meeting to be established with providers under new Performance Team identity to assure against Phase 3 plan trajectories The focus in phase 3 recovery has been recovery of service activity compared to 20/21 rather than the recovery of the constitutional standards. Under adapt and adopt the CCG has been working with system partners to implement the agreed actions under this programme. Elective recovery performance as detailed within adapt and adopt reporting was on plan until Mid December as a result of further waves of Covid. This reporting has been stood down by NHSE on 3.1.21 to be replaced by revised reporting as yet not stipulated. The CCG will fully comply when this reporting is available (JF) 27.01 The Devon system moving to surge with IS providers from 29th January gives us an opportunity to increase diagnostic cancer and elective capacity to support restoration (JF)	Jayne Carroll	Al Wilkinson		28/01/2021	06/06/2019	5	4	20	See update in mitigating actions added 14.01.21 and revised risk title Updates provided by JF & AW
COVID 06 (Wave 2)	117	COVID-19 General Practice	There is a risk that COVID-19 outbreak could adversely affect GP practices ability to deliver their core business as usual services.	The impact of this is that the delivery of general practice is compromised and could impact all areas of the healthcare system.	Feb 2021 - most staff have received first vacs in line with JCVI guidance. CCG Primary Care COVID lead identified Primary Care participation in CCG Daily COVID calls Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Regional NHS England and Public Health England updates Daily COVID updates from comms team to GP practices CCG providing resource to support implementation of e-Consult and implementing changes to online booking and triaging within practices. CCG purchased additional laptops to support practice business continuity plans to enable remote working COVID report due to monthly Primary Care Committee CCG gathering assurance from practices re business continuity plans. PG 06 Jan 2021 some GP staff starting to receive vaccination in line with JCVI guidance. 6 Jan 21 - Awaiting further national guidance but we have commenced planning to identify further way to help GP with prioritisation of clinical work to ensure delivery of core services alongside full mobilisation of Mass vac programme.	Jo Turl	Rob Payne	Feb 2021 - plans in place for staff to receive 2nd dose. Need to understand ongoing capacity and workforce needs to ensure continued vacs delivery is sustainable.	03/02/2021	12/03/2020	4	4	16	
COVID 07 (Wave 2)	118	COVID- 19 - Primary Care Team	There is a risk that COVID-19 outbreak could adversely affect the primary care teams ability to deliver current workplan and business as usual tasks.	The impact of this is that the delivery of general practice is compromised and could affect all areas of the healthcare system.	Feb 2021 - Primary Care prioritised work plan monitored on weekly basis. CCG Primary Care COVID lead identified Primary Care participation in CCG Daily COVID calls Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Regional NHS England and Public Health England updates Team reviewing daily COVID updates from comms team COVID report due to monthly Primary Care Committee Team business continuity plan Team what's app group enabled Working from home processes enabled PG 06 Jan 2021 some GP staff starting to receive vaccination in line with JCVI guidance. 6 Jan 21 - prioritised work plan monitored weekly. Additional resource seconded into team to support.	Jo Turl	Rob Payne		03/02/2021	12/03/2020	3	4	16	
COVID 09 (Wave 2)	120	COVID-19 – Transference of work to Primary Care	There is a risk that COVID-19 outbreak may lead to the possible work transference from secondary care into General Practice, impacting on GP practices ability to undertake routine work	The impact of this is that the delivery of general practice is compromised and there may be funding implications if additional funding is sought.	CCG Primary Care COVID lead identified Regular COVID updates from comms team to GP practices. CCG providing resource to support implementation of e-Consult and implementing changes to online booking and triaging within practices. CCG purchased additional laptops to support practice business continuity plans to enable remote working. Gen Practice representation to key Restoration and Transformation (R&T) workstreams being developed. R and T matrix style review of interdependencies arranged. Work being undertaken by Mandy Seymour and John Finn to identify the work transfer and to ensure that this is achieved in a planned way. COVID report due to monthly Primary Care Committee LMC impact monitoring Dec 20 - Phlebotomy LES has now been put in place in order to mitigate some of the risk, as an interim arrangement ahead of system solution. Jan 21 - 97 out of 123 GP practices signed up to Phlebotomy LES. Uptake communicated to Jo Turl.	Jo Turl	Rob Payne	3 Feb 21 - 101 out of 123 GP practices signed up to Phlebotomy LES. LES extended an extra 6 months to 30 Sept 21.	03/02/2021	13/07/2020	3	3	9	

COVID 11 (Wave 2)	**123**	Fit testing – PPE/COVID	There is a risk that some carers may be exposed to COVID 19 because their FFP3 masks do not fit correctly. This would occur if the cared for individual were COVID positive and transmitting the virus when aerosol generating procedures were being undertaken. This risk has been identified as there are not enough fit testers available to manage the incoming demand for carer testing. Factors: likelihood will increase as carers have not been fit tested to ensure the face masks worn are sealed correctly around their faces which would prevent the virus being inhaled during the procedure.	The impact of this is significant to the CCG as this is an identified, known clinical risk and although there are plans in place to address the backlog of carers that require fit testing, there are significant delays in achieving this. There is a reputational impact due to potential harm or perception that the CCG is impacted by patient outcomes, as the lead organisation responsible for the oversight, organisation and implementation of fit-testing for PHB clients	February 2021 - The collaborative network with the local authorities is working well. There is to be another fit tester training course to be held in February, 8 more Devon carers are booked onto it (RC) PPE stocks include FFP3 masks are strong and readily available. The majority of PHB patients requiring fit testing to new masks are booked in. Any care home and agency that requests fit testing is booked in rapidly. There is no backlog and the team has capacity at present (RC) January 2021 - PHB carers are being contacted and booked in for fit testing. The GP procurement is coming to an end with just a final delivery of aprons to go. Staff still working on the inbox keeping on top of requests. There are now in excess of 70 trained fit testers in the system, the majority of which are in care homes and agencies. There are 5 CCG staff within the PPE cell and they are all fit tested trained, 3 - 4 of them are acting as the 'Devon System fit testers' and are already out responding to requests. Previous people supplied with FFP3 masks are being contacted and making sure they are fit tested to new masks. Mask supply is good, although we don't hold any stock, the 'Devon system collaboration' with the local authorities is working well. They have lots of stock and the processes for access are going well. The CCG are confident they can respond to requests to fit testing rapidly & have access to good stocks of masks and other PPE. Many providers are now self-sufficient (RC)	Darryn Allcorn	Vanessa Crossey	The CCG fit testing team is down to 3 staff with others redeployed to the vaccination programme. These 3 are the Devon System fit testers. They are on short term contracts due to finish at the end of March 2021. This is low numbers and whilst currently able to cope with the demand they have minimal resilience in cases of sickness or absences. RC who is currently running the PPE cell starts a new role in March 2021 and will be handing the management of the PPE cell over to another staff member (RC)	**16/02/2021**	04/08/2020	**2**	**4**	**8**	
COVID 12 (Wave 2)	**124**	Delivery of Control Total	There is a risk that the CCG will not be able to deliver its agreed control total of break even for the second 6 months of 2020-2021 as a result of the required savings to stay within the pre-COVID rate of expenditure on which the revised NHSE allocation is based. This total may also be affected by a lack of funding for non-COVID related overspends and increased costs of service provision due to ongoing of impact of COVID in some cases		25 Jan 2021 Current forecast spend indicates that the possibility of breaching the control total based on the CCG allocation for the final 6 months of the year is unlikely Review and reinstatement of CCG QIPP processes. Ongoing dialogue with NHSE and STP partners regarding the funding envelope for the second half of the financial year. No new recurrent expenditure commitments entered into in advance of knowledge of the revised allocation. Regular monthly reporting to the Finance Committee/Governing body on the inherent risk in the savings plan. Monthly finance working group meetings with system partners to discuss progress on delivery of the STP financial position against overall envelope	John Dowell	Kevin Wheller		**25/01/2021**	06/08/2020	**1**	**4**	**4**	
COVID 14 (Wave 2)	**130**	COVID-19 Incident Response	There is a risk that the CCG does not respond effectively to the COVID-19 pandemic.	The impact of this is that the CCG may delay or disrupt the pandemic response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and perception of the CCG.	18/02/2021 • Incident Management Team comprising of Incident Director, Incident Manager, admin support, Loggists and Cells to lead on specific workstreams, in place • Overview of the incident response maintained by Executive Team • Regular reviews of the Incident response structures and responsiveness are being undertaken • Regular co-ordination and update meetings scheduled, internally, across the system and with Region, these meetings are reviewed and the frequency adjusted to meet the needs of the response.	Sonja Manton	Phil Coutie		**18/02/2021**	17/09/2020	**3**	**4**	**12**	18/02/2021 CCG has a structured incident Reponses team in place, this is being managed and monitored daily to respond to daily issues or escalation as required by the Devon Health and Social Care community or requests from NHSE/I As part of a national requirement form NHSE/I the CCG has undertaken two mass vaccination exercises across Devon on 21/22 January 2021 No risk score change 27/01/2021 CCG has a structured incident Reponses team in place, this is being managed and monitored daily to respond to daily issues or escalation as required by the Devon Health and Social Care community or requests from NHSE/I As part of a national requirement form NHSE/I the CCG has undertaken two mass vaccination exercises across Devon on 21/22 January 2021
COVID 15 (Wave 2)	**131**	Emergency Preparedness	There is a risk that the CCG will be unable to respond effectively in the event of an emergency or business continuity incident, through not meeting its statutory and policy obligations to be prepared to respond to emergencies and disruptive incidents.	The impact of this is that the CCG may delay or disrupt an emergency response by providers, NHS England or multi-agency partners, with consequences for patients, provider or partner emergency response and the perception of the CCG.	16/02/2021 EPRR Lead in place to lead on preparedness workstream; EPRR Lead recruited to lead on preparedness workstream; •An EPRR workplan in place to ensure that preparedness is maintained and that new requirements are implemented in a timeous manner; •Suite of business continuity plans and emergency plans in place and updated in March and August 2020 respectively. Internal Business continuity (BC) audit ongoing at this time •On-call system in place, supported by trained on-call staff, available to initiate a response 24/7; •Trained Directorate Business Continuity Leads in place to maintain their business continuity plans •Regular training is undertaken by On-call staff and BC Leads to maintain knowledge and skill sets •Regular exercising of business continuity plans and participation in the exercising of multi-agency emergency plans is undertaken to ensure skills are maintained, plans are tested and the CCG is integrated into the multi-agency response to emergencies; •EPRR Lead is engaged with NHS and multi-agency (LRF) EPRR planning to ensure the CCG is integrated into these plans. •EPRR Lead will fulfil the CCG responsibility of undertaking an annual assurance of Providers preparedness in line with the NHSEI EPRR Core Standards and annual assurance process, and reporting upon this to the AEO & GB.	Sonja Manton	Phil Coutie	18/02/2021 • Maintenance of the ongoing COVID Incident response structures and process to be maintained • Reviews of emergency and business continuity plans to be continued as per EPRR work plan • Training of On-call and other key staff to be maintained as per the EPRR work plan • Participation in system and multi-agency emergency preparedness exercises to be maintained as per the EPRR work plan.	**18/02/2021**	17/09/2020	**2**	**3**	**6**	18/02/2021 The CCG response to the current pandemic incident/EU Exit (D20) / winter and flu is monitored daily to identify any challenges and issue that may arise and managed in accordance with EPRR policy. no risk score change 27/01/2021 The CCG response to the current pandemic incident/EU Exit (D20) / winter and flu is monitored daily to identify any challenges and issue that may arise and managed in accordance with EPRR and framework and policy
COVID 16 (Wave 2)	**132**	Robust incident reporting processes not in place across primary care	There is a risk that until robust reporting processes are embedded in general practice that there will be reduced assurance to fully understand how the learning from incidents will be shared and actions implemented. Additionally, there is an associated risk that until comprehensive and robust systems are in place to monitor quality and patient safety that only limited surveillance will be able to be implemented.	The impact of this is that a failure to recognise the need for reporting incidents, completing a robust report in a timely manner and learning from incidents will be lost and the incident may therefore reoccur. That until the learning is embedded in practice the risk of the same incident reoccurring is not reduced and could occur repeatedly.	October 2020 - A report and live demo on the Early Warning System is to be presented at the PCCC on 1st October and at the QAC in November (VC) September 2020 - Incident reporting processes are in place: The agreed process currently in place is to monitor safety incidents through a variety of systems, SEA, SI, Yellow card/PITCH. Each month the incidents are required to have a clinical lead to review and follow-up: •Potential SI reported and currently in decision making process •SI review process in place •SI review shared with NHSE Performance Advisory Group •SEA themes are regularly identified and learning shared. •PITCH themes analysed and learning shared We have access to 2 x Band 7 Primary Care Nurses who can support the work with the Safety Systems team to identify if the actions within both SEA's & SI's are completed & the learning embedded in practice. All primary care SI's will have 2 reviewers due to the lack of confidence in primary care governance processes (VC)	Jo Turl	Rob Payne	Feb 21 - Deputy Director for Primary care confirmed issue needs to go on primary care work plan for rapid progression.	**03/02/2021**	16/09/2020	**4**	**3**	**12**	
COVID 17 (Wave 2)	**133 (COVID Wave 1 risk 07)**	Changes to services commissioned by the CCG	There is a risk that decisions to make changes to services commissioned by the CCG through providers are done so without full cognoscente, clinical oversight and agreement whilst responding to the COVID 19 outbreak and management of capacity and resource.	The impact: a) decisions made in isolation may impact on other services or capacity in system b) inequitable access for patients to services	February 2021 - The CCG and system processes remain in place to ensure sight of service changes and appropriate escalation if required, including to the Dynamic Decision Making Group (DDMG). No change in risk score. (SW) January 2021 - System risk assessment process, led and undertaken by the CCG commenced to risk assess the stepping down of services and / or deployment of workforce to other areas to support Covid-19 response (SW) January 2021 - Weekly R&T cell calls and other CCG and whole system processes, including DDMG, continue to mitigate against the risk of lack of oversight of changing services (SW) December 2020 - R and T cell process (twice weekly call meeting has oversight). Locality/CCG/Provider meetings with trigger forms to R and T, DDMG, COOs, etc, (SW)	Darryn Allcorn	Sara Wright		**08/02/2021**	21/10/2020	**2**	**5**	**10**	

COVID 18 (Wave 2)	**134**	Operational delivery by Child and Family Health Devon	There is a risk that Children and Family Health Devon do not recover the current position of increased waiting times and deteriorating RTT positions for CAMHS; Occupational Therapy; Speech and Language; Autism Assessment services. The impact of this is that children experience delay in accessing assessment, support and services for their physical, mental and communication development needs which may experience poorer quality and outcomes. CFHD are not yet achieving contracted service standards and NHS Devon cannot be confident that they will deliver the service improvements and transformation as set out in the contract agreed with NHS Devon CCG.	There continues to be a lack of operational clarity in terms of service management and different service offer between Devon and Torbay, increasing wait times, regular queries and comments from families and schools, together with concerns regarding leadership and workforce capacity within the services that indicate CFHD are not yet achieving contracted service standards. The issues have been further intensified by the pause in a number of services as a result of COVID 19 and services are not currently being provided at the standard expected with increased wait times and reduced access to services	20.01.2021: Exec to exec mtg used for escalation did not take place in January. Continuing concerns escalated to AD and Director Increased contact between the CCG and the provider CFHD has been put in place to discuss and scrutinise the performance of services especially in light of the response and pressures of COVID. There are fortnightly meetings to monitor the ASD assessment wait list and recovery plan. Where concern is raised this is escalated to Associate Director and action taken in direct discussion with CFHD Directors. Associate Director of Commissioning (Community Services) formally wrote to CFHD on 20/11/20 requesting that a copy of their Integrated Performance Report and Integrated Governance Group Report are shared with the CCG by 27/11/20. Trajectories for the services which are behind agreed performance level have been requested and submitted. These will be monitored through the Liaison and Restoration meetings that are already established and recovery plans monitored on an individual service level with the appropriate service manager to ensure that the agreed actions are being implemented.	Jo Turl	Siobhan Grady	20.01.2021 Continued concerns in timeliness of agreed reports being shared due to internal governance sign off arrangements, pace of progress in safeguarding action plan, lack of understanding of budget and investment made in Autism assessment service. Summary provided to AD & Executive within an SBAR report for escalation with recommendations for : •3 month action plan •monthly exec to exec escalation mtgs •attendance by CCG at internal CFHD mtgs – Quality Committee; •financial summary from April 1st 2019 be provided 20/01/21- CCG summary report of concerns and recommendations. Decisions to be confirmed	**02/02/2021**	27/10/2020	**5**	**3**	**15**	Update 29.12.20 LW Improvement trajectories for wait lists received and also a copy of the CFHD Internal Integrated Governance report. Review of trajectories & further discussion held at QAC on 17.12.20 and update requested in 3 months. NHSE have advised of additional funding allocated to CCG's for 20/21 to support children's services – plan for use of resource in draft.
COVID 19 (Wave 2)	**136**	Care Home & Care at Home	There is a risk that care home placements and care at home could become compromised, due to COVID outbreak risks, lack of Personal Protective Equipment (PPE), staffing and pathway issues. The impact is that patients will be unable to be discharged from hospital in a timely manner to create acute capacity for new admissions. The safety & quality of an individual's care could be at risk due to: inadequate packages of care, staff capacity, equipment and training. (COVID risk 09)	The impact is that patients will be unable to be discharged from hospital in a timely manner to create acute capacity for new admissions. The safety & quality of an individual's care could be at risk due to: inadequate packages of care, staff capacity, equipment and training.	February 2021 - Risk score to remain the same. It is hoped now care home vaccinations have taken place that the outbreak status will reduce and flow will increase once more, thus reducing this risk score and that of 135 (JS) January 2021 - Risk score to remain the same. Previous controls remain in place with additional tactical support now being offered by the CCG particularly where there are issues with nursing capacity. A county wide discharge delay meeting has been instigated on a daily basis to enable cross county mutual aid to acute trusts needing to discharge individuals to care homes (JS)	Darryn Allcorn	Jo Shill	February 2021 - Discharge delays are emerging where care home capacity is not available, specifically within the market caring for patients with complex dementia. We continue to host the daily 'tricky discharge' meeting to consider creative solutions to the problem, however Devon is very entrenched in a bed based model for supporting discharge therefore there are limitations to solving the issue. Additional 'live in' providers have been sourced to support care at home, we are negotiating with the hospice in Exeter to create additional end of life capacity and we continue to source appropriate placements, sometimes now further out of county into Somerset and Cornwall (JS) January 2021 - Whilst the risk of lack of PPE has been addressed via formally established routes now, the impact of Covid outbreaks in local care homes is significant. The reduced capacity through home closure is beginning to impact on hospital discharges where now the CCG find there are occasions where available beds don't match the level of need of individual patients (JS).	**09/02/2021**	29/10/2020	**4**	**4**	**16**	
COVID 20 (Wave 2)	**137 (COVID Wave 1 risk 29)**	Impact of implementation of National Guidance	There is a risk that the impact of implementation of National Guidance during COVID- 19 may lead to patients who require planned care, including diagnostics, being delayed, deferred or choosing to self-defer, resulting in harm; both safety and experience could be affected. Note: This impact could be further exacerbated if changes in predictions of disease prevalence for the SW Peninsula result in a period of deferment in excess of that recommended by the national guidance.	The impact to the CCG is commissioning impacted services that may result in: a) escalation requiring emergency admission and / or treatment for patients. b) early death, harm, including reduction of treatment options and poor experience for patients. c) reputational damage as a result of longer waiting times for patients across the County.	February 2021 - On-going planning to recover continues; the CCG will play a key leadership role as providers return to increased levels of planned care activity when able. With teams deployed internally and externally to their organisation to manage Covid 19 care, risk grows in other parts of the system including planned care. This has been captured in risk assessments the CCG has undertaken on behalf of the system (SW) Positively, in January national steer about use of the Independent Sector (IS) was confirmed, with elective surge moving to independent providers. Providers have linked directly with the IS to manage patients, and the CCG is monitoring progress (SW) January 2021 - A system risk assessment process, led and undertaken by the CCG has been implemented. Impact of reducing or ceasing planned care, as well as mitigation included. In addition, CCG and provider Comms continues to encourage patients to attend appointments/procedures if they are not cancelled (SW) January 2021 - Continued system working and processes go some way to ensure safety across the system, this includes mutual aid (SW)	Darryn Allcorn	Sara Wright		**08/02/2021**	29/10/2020	**4**	**5**	**20**	January 2021 - With CCG prioritisation of work, as well as national guidance, increasing planned care delays are anticipated. On-going risk has potential to increase in light of wave 2 and reducing elective care. In addition, where planned care continues the public are being encouraged to attend appointments through CCG comms
COVID 21 (Wave 2)	2- 20201026	Implications of Covid	The implications of Covid-19 will fall across all of the CCG not just this directorate. The risks are set out within the impact.	Already experienced in terms of staff redeployment and or sickness and potentially likely to be experienced again if there is a resurrection of internal cells. The need for staff in other locations will result in BAU and other contractual obligations being stood down or showing a status of incomplete due to demand and capacity. This includes the standing down of Contract Review Meetings and JTWGs etc due to capacity. This also includes the standing down of contractual paperwork including National variations to contract, local variation orders and has created a backlog of work for the team to respond to. This reduces the ability the CCG has to be assured of safe, effective and accessible services being delivered for the population of Devon. The team will not be able to contract monitor in a way that ensures safely due to, no longer having full sight of any contract finance / activity. There is a risk that some procurements might have been delayed or higher risk strategies such as increase in direct award have been taken and this is likely to continue with ongoing implications of Covid-19. There have been delays to the Contracting Governance processes experienced to date and again these are likely to be impacted going forward.	Prioritisation of resource within the team to respond to the most at risk areas of work. The Contracting Team have weekly and monthly Team Meetings and the individual System and Central Teams each have monthly Team Meetings. There are also 1-2-1's as usual. This structure ensures consistency and that all staff are up to date with developments and workload capacities. This is especially important given the possibility of silo working that results from the team working remotely. The impact of Covid-19 on services is being managed through the teams involvement in monitoring all changes in delivery of services and the ongoing restoration of services once impact has reduced.	John Dowell	Barbara Jones	Prioritisation of resource may be affected by future waves of Covid-19 if staff are once again redeployed. The Head of Contracting to continue to inform Senior Management of the potential risks and escalate where appropriate. The Contracting Team to continue to mitigate risk through use of current controls.	**05/02/2021**	26/10/2020	**2**	**3**	**6**	
COVID 23 (Wave 2)	GOV 016	Communicable Disease Pandemic Incorporating National & LRF Risks of • Pandemic Influenza • Emerging infectious disease pandemic (e.g. Covid-19, Suspect.)	• A serious epidemic of much greater severity than seasonal flu, involving a novel virus. • Weekly GP consultations for new episodes of related illness likely to exceed 400 per 100,000 of population at the peak (compared with a peak of around 200 per 100,000 population per week in an average year)."	• Significant increase in pressure across the Devon System requiring system incident management structures to be put in place by the CCG • Increased impact upon system processes and capacities depending upon infection prevention and control guidance • Likely to require heavy investment of the CCG's Senior Leadership time, other staff resources and financial support to the system • likely to impact upon delivery of CCG Strategic Plans"	18/02/2021 System exercise completed on 6th October 2020, with significant learning for participants. System Resilience Plan in development at this time, completion expected in October 2020." • Significant increase in pressure across the Devon System requiring system incident management structures to be put in place by the CCG • Increased impact upon system processes and capacities depending upon infection prevention and control guidance • Likely to require heavy investment of the CCG's Senior Leadership time, other staff resources and financial support to the system • likely to impact upon delivery of CCG Strategic Plans"	Ginny Snaith	Phil Coutie	Debrief recommendations include: • develop System Resilience Plan • hold a System exercise of the second wave coinciding with flu, winter pressures and increased staff sickness"	**18/02/2021**	12/12/2020	**4**	**4**	**16**	• System exercise undertaken on 08 October 2021, learning from the exercise was incorporated into winter plans. • The system resilience plan has been delayed and a draft is expected to be completed by 31 March 2021. no change to risk score, the numbers on this risk won't change going forward - it's the highest national risk.
COVID 24 (Wave 2)	MO 9	MO workforce pressures related to COVID-19	MO workplan will be delayed due to the fact that team is required to dedicate workforce (mainly pharmacy workforce) to respond to COVID -19 pressures	Not delivering QIPP and MO Workplan	Update 25th January 2021 Covid vaccination: Pharmacy cell reports to Programme Board and routes of escalation in place TORs written and submitted to Programme Board SitRep reports daily Risk reported to SVOC updated weekly Essential activities have been identified as part of CCG priorities and resource is being allocated to these MO Covid vaccination team established MO Working Group meets daily MO Covid Vaccination inbox in operation for resilience Covid-19 response - resource in place to respond and utilisation of MOCC/Advice and Guidance mechanism to ensure resilience - capacity and workload is currently manageable Essential activities have been identified as part of CCG priorities and resource is being allocated to these - work ongoing to ensure we review capacity within team	Jo Turl	Leanna Brown		**25/01/2021**		**4**	**3**	**12**	

COVID 26 (Wave 2)	**N&Q0005**	Impact on not accessing services in a timely way	There is a risk that that patients across the age spectrum, who require urgent or ongoing care will not access care in a timely way due to fears or uncertainty about attending or contacting hospital services.	The impact of this: a) escalation requiring emergency admission and / or treatment b) early death or harm, including reduction of treatment options c) future capacity unable to cope with backlog or sudden increase in referrals as lockdown is lifted.	05/02/21 Senior Patient Experience & Safety Systems Manager met with Comms and are continuing to monitor contact into the CCG via both the Comms and patient experience and safety routes. There is still no patient safety or experience evidence that the CCG holds to demonstrate this being an issue. As the CCG deal with the immediacy of contact in relation to the vaccination roll out there isn't capacity to do any targeted work in relation to this area and being congnisant of the pressure on general practice. The CCG plan is to do look back reviews and targeted work when the immediate pressure has passed. Primary Care team have also advised no issues around access has been raised with them. The team will continue to monitor the situation. January 2021 - Safety Systems and Patient Experience do not hold any evidence to show that people do not want or aren't accessing General Practice. Patient Experience contacts have been received in relation to the vaccination programme and via General Practice, however these are general enquiries rather than specific around access. Although practices are now offering econsult & telephone triage the CCG are mindful of equity of	Darryn Allcorn	Sara Zanoni	January 2021 - SH to highlight at January QAC the concerns and lack of evidence from complaints and equity of access to general practice	**05/02/2021**		3	2	6	26/01/2021 we continue to monitor patient experience information for evidence of concerns raised in relation to attending health appointments. 03/12/20 Preventative work aimed at reducing the incidence of gram negative blood stream infections is a key objective of the community infection management service. The response to Covid 19 is compromising the ability to progress with this at present. Assessment – risk level remains appropriate. Further monitoring required until resource can be better deployed for reduction strategies (JP)
COVID 27 (Wave 2)	**Localities (COVID Wave 1 risk 33)**	Seven day discharge Delayed Discharges	the combination of a second wave pandemic during the winter months will require rapid discharge arrangements which may be compromised by insufficient capacity within the community, such as car home availability, dom care provision, due to outbreaks and the availability of staffing		Scheme 2 Hospital discharge implemented from 1st September 2020 to support timely discharges. additional capacity has been brought in for dom care and care homes, through winter plan, including patient hotels established as required each locality has discharge forums daily to review all discharges and system wide disch cell is in place for escalation and oversight daily care home mutual aid group	Chief Operating Officer	Al Wilkinson		**27/01/2021**		3	4	12	29/12/2020 LW Scheme 2 Hospital discharge implemented from 1st September 2020 to support timely discharges.
COVID 30 (Wave 2)		Voluntary sector - recruitment	That the voluntary sector will be unable to recruit volunteers and have reduced capacity due to the number of volunteers shielding and/or concerned about the impact of Covid	There has been a slight reduction in volunteers from older age groups but this has been backfilled by younger volunteers (possibly those people on furlough). This may not be sustainable.	Feb 2021 We are working with VCSE organisations to advise us if the reduction of volunteers become significant and affects service delivery. At the moment, it is not an issue but it is being monitored.	Darin Halifax	Darin Halifax		**04/02/2021**		3	3	9	Currently not a significant issue but it could emerge if the current restrictions of the pandemic continue.
COVID 38 (Wave 2)	**138**	COVID-19 Vaccination programme	There is a risk that NHSE/I and NHS Devon CCG will be unable to deliver the mass COVID-19 vaccination programme. NHSE/I and CCGs are responsible for the planning and resources of a phased programme of vaccination. The programme may be affected by several factors, including: •The recruitment programme not being as effective and the impact on BAU for health and social care •PPE requirements for healthcare workers delivering the vaccination clinics will be high, increasing the risk of a PPE shortage •Location, choice of venues and accessibility •Wastage of vaccine due to limitations in timeliness of distribution and safe storage •Impact should the uptake reduce for the second vaccine, following any side effects, increasing vulnerability both individual and system wide •Impact on the booking system should there be technical failure of IT systems •Likelihood of additional costs associated with delivering the vaccinations in different ways and to additional cohorts, resulting in cost pressures for the CCG if the dedicated funding support runs out •Potential legal challenge under the Equality Act if equal access to the vaccination programme is not provided •Reputational impact due to potential harm or perception that the CCG is impacted by patient outcomes, as one of the lead organisations responsible for delivery of this vaccination programme	The impact of this is if NHSE/I and the CCG fail to deliver a phased programme of vaccination addressing delivery via vaccine hubs, primary care and any large scale vaccination sites it could result in a reduced safe and effective vaccine, adequate vaccinator capacity, cold chain management and public safety issues.	February 2021 - Close monitoring vaccination numbers; Covid vaccination cell is co-ordinating vaccination sites and monitoring uptake (JP) Over 200,000 people received their first vaccine dose as of 31 January, including 92% of those aged 80+ (JP) January 2021 - The Covid vaccination cell is coordinating and monitoring Covid vaccination update (AH/JP) December 2020 - UHP have begun vaccinating, as have mass immunisation sites and PCN sites (JP) December 2020 •NHSE/I have been undertaking planning with dedicated capacity for several months. A system programme board exists chaired by CCG Chief Nursing Officer (with PH representation) to oversee planning and delivery. •QEIA completed on delivery programme •Communication plan to manage attitudes for vaccination take up	Darryn Allcorn	Jonathan Plumb	February 2021 - potential limiting factor is vaccine availability (JP) January 2021 - Mass immunisations continue, and immunisation of staff and residents in larger care homes is under way. Immunisation of frontline health care workers in acute trusts is progressing. (AH/JP) December 2020 •Change of plan announced on 09.11.20 for Primary care to deliver vaccination programme but plan may still involve mass vaccination sites. •Impact on BAU if CCG staff recruited to deliver vaccines Variations in guidance and detail updated from national on a daily basis means there is complexity in monitoring consistent gaps.	**11/02/2021**	18/12/2020	3	3	9	
COVID 39 (Wave 2)	**139**	Infection control team capacity	There is a risk that there is insufficient capacity within the CCG infection control workforce to meet both the duties of the COVID-19 pandemic and those of normal Infection Prevention & Control (IPC) business. * COVID-19 business; potential to fail to gain assurance on COVID-19 outbreaks, programmes of work and overall status within the Devon footprint and potential to not provide operational advice in a timely fashion when requested	The impact of this is on: * Normal business; reduced focus on prevention & monitoring functions, including rates of notifiable hospital-acquired infections, reduced ability to attend and gain assurance from provider infection control meetings, change in focus of IPC sub teams due to COVID-19 support and reduction in capacity to monitor and support the Devon flu vaccination programme	February 2021 - Two local authority IPC staff have commenced in post. The focus of their work is advice on prevention in non-health and social care settings such as schools and workplaces. This does not therefore affect the risk rating. Monthly reporting to QAC and quarterly reporting to Devon Health Protection Committee. Risk score to remain at 12 (AH/JP January 2021 - Two new local authority staff members joining the IPC team in February 2121, after successful recruitment process (AH/JP) December 2020 December 2020 •Improvements to structure of IPC team to improve resilience, including the short-term reallocation of staff members to the team to cover specific workstreams •Improved definition of community infection management service roles, both in an out of a pandemic scenario •Work with local authority partners to recruit additional staff •Move to generic IPC email address •Quarterly IPC report to Quality Assurance Committee •Section in monthly quality report to Quality Assurance Committee	Darryn Allcorn	Jonathan Plumb	December 2020 •Delay to new staff recruitment through local authority •Unanticipated and unpredictable pandemic workload •Additional unanticipated workstreams- for example, avian flu Team email address and action log only recently set up and not fully integrated into process	**11/02/2021**	21/12/2020	4	3	12	
COVID 40 (Wave 2)	**141**	Primary Care Quality Team Capacity	Due to the Covid 19 pandemic there is a risk that the Primary Care Nursing and Quality team, cannot fulfil all their functions in providing assurance on provider quality and safety. The reduction in team capacity is emphasised with members being redeployed to support high intensity workstreams such as PPE / IPC and Vaccination Program resulting in the equivalent of 2 Band 7 FTE posts vacant.	The impact of this is; •The CCG are unable to gain appropriate levels of consistent quality and safety assurance to improve the quality of commissioned services for the population of Devon through Primary Care •Some areas of work will not be routinely managed •The inability to appropriately inform and support the Commissioning cycle across Primary Care and maintain positive relationships •Limited engagement/support with providers •Unable to proactively manage and support improvement work-streams •Business as usual workstreams such as clinical supervision, HCSW workforce programme and GPN workforce planning have been temporarily ceased, this may have long-term operational impacts •There is a considerable risk to the delivery of the CARE Programme •Remaining staff working within the team at risk of burn out •Maintaining staff retention due to reduced motivation/job satisfaction •Reduced resilience within the team should there be long term staff sickness/unplanned absences •Reduced number of staff with the right skills, competencies	January 2021 •Prioritisation of Primary Care work being more reactive than proactive •Additional supervision / support to staff to ensure appropriate prioritisation of work / delegations / communication of staff changes •Seeking support from wider Directorate and CCG ensuring input is continued at meetings •Recruitment process underway for a further member of staff to join the primary care safeguarding nurse team •Review/reduce amount of internal meetings •Primary Care Safeguarding nurses improving element of quality •Health & Wellbeing - Clear / regular contact with team through 121's, coffee and chat, weekly meetings and huddles with wider Directorate, SLT daily meetings •Ensure offer of Occ Health support continues to be highlighted •Monitor sickness rates •Monthly Quality Assurance Report taken to Quality Assurance Committee	Darryn Allcorn	Vanessa Crossey	January 2021 •Prioritisation of Primary Care work being more reactive than proactive •Additional supervision / support to staff to ensure appropriate prioritisation of work / delegations / communication of staff changes •Seeking support from wider Directorate and CCG ensuring input is continued at meetings •Recruitment process underway for a further member of staff to join the primary care safeguarding nurse team •Review/reduce amount of internal meetings •Primary Care Safeguarding nurses improving element of quality •Health & Wellbeing - Clear / regular contact with team through 121's, coffee and chat, weekly meetings and huddles with wider Directorate, SLT daily meetings •Ensure offer of Occ Health support continues to be highlighted •Monitor sickness rates •Monthly Quality Assurance Report taken to Quality Assurance Committee	**11/01/2021**	11/01/2021	4	3	12	
COVID 41 (Wave 2)	**142**	Patient Safety and Quality Team Capacity	Due to the Covid 19 pandemic there is a risk within the Patient Safety & Quality team and the likelihood of a further reduction in capacity, the team cannot fulfil all their functions in providing assurance on provider quality and safety as well as specialist support within the CCG. The reduction in team capacity is emphasised with members of the team being redeployed to support high intensity workstreams such as PPE / Restoration and Transformation along with staff that are leaving the organisation, resulting in the equivalent of 9 FTE posts being unavailable to do this work.	The impact of this is; •The CCG are unable to gain appropriate levels of consistent quality and safety assurance to improve the quality of commissioned services for the population of Devon •Some areas of work will not be routinely managed •The inability to appropriately inform and support the Commissioning cycle across all services •Limited engagement/support with providers •Remaining staff working within the team at risk of burn out •Maintaining staff retention due to reduced motivation/job satisfaction •Reduced resilience within the team should there be long term staff sickness/unplanned absences •Reduced number of staff with the right skills, competencies •Limited capacity to ensure new staff receive the correct support and upskilling which will further impact on them functioning fully	January 2021 •Active recruitment to vacant posts with secondments •Prioritisation of PSQ work being more reactive than proactive •Additional supervision / support to staff that remain to ensure appropriate prioritisation of work / delegations / communication of staff changes •Review/reduce number of internal meetings, where appropriate •Seeking support from wider Directorate and CCG ensuring input is continued at meetings •Access to Employee Assistance Programme, Occupational Health, local mental health support and various health & wellbeing tips & advice on the CCG intranet •Training and upskilling of new members of staff will be prioritised January 2021 •Recruitment to backfill / fill job roles •Health & Wellbeing - Clear / regular contact with team through 121's, coffee and chat, PSQ weekly meetings and huddles with wider Directorate, SLT daily meetings •Access to Employee Assistance Programme, Occupational Health, local mental health support and various health & wellbeing support tips & advice on the CCG intranet •Monitor sickness rates •Monthly Quality Assurance Report taken to Quality Assurance Committee	Darryn Allcorn	Vanessa Crossey	February 2021 - Whilst one post (Band 7 PSQ - 22hrs) has been temporarily filled we now have a new gap with a member of staff taking up a new post in the CCG. There will be a gap whilst this post is advertised (VC) January 2021 •Ongoing development and training, including mandatory – of the substantive team members may be affected and will have to be de-prioritised •Induction processes reduced due to capacity within the team to support & develop new members of staff •Induction processes reduced due to capacity within the team to support & develop new members of staff	**16/02/2021**	13/01/2021	4	3	12	

COVID 42 (wave2) added 20/01/21	**COVID RR**	IUCS service capacity	The issue of staff within the Devon Doctors IUCS service testing positive for Covid and/or being told to self isolate for 10 days by the Track and Trace App. significantly reduces the level of staffing in the IUCS service for a prolonged period of time.	Devon Doctors are unable to fill their rotas with sufficient staffing to maintain the levels of call answering performance required to ensure that 111 and the CAS fully support the Devon system in ensuring that patients are appropriately directed towards the right source of care and away from 999 and ED.	Implement increased rates of pay for HA/SA 150% Revisions to the distribution of incoming calls Increased rostering of and use of clinical assessment of initial call outcomes Review of Offline Time Allocated Real Time Manager on shift Regular Touchpoint Calls Real Time Data in use for planning Ongoing communication with the CCG	Jo Turl	Helen Bailey	CCG to consider alternative cover for or step down of some services provided by Devon Doctors to allow redeployment of staff into the IUCS service.	**22/02/2021**	**16/01/2021**	**1**	**2**	**2**	Close monitoring of the worfforce situation, care rota planning, good will from staff not off sick and use of national contingency during weekends has ensured that the provider has been able to maintain performance that, whilst not fully in line with national averages, has been better than expected. Covid related sickness has improved over recent weeks. Latest figures (as at 22nd Feb) suggest the following Covid related sickness absence •1 member of staff has tested positive in the last 10 days •2 are awaiting results •3 isolating as a result of Track &Trace notifications Significant work undertaken by the CCG with Devon Doctors to improve infection protection and control. PROPOSE CLOSE COVID RISK. NB. There are still outstanding sickness issues within Devon Doctors, however these are no longer Covid related.
COVID 43 (wave2) added 20/01/21	**143**	RDEFT COVID-19: Nosocomial COVID-19 infection	There is a risk that safety for patients and the workforce is impacted upon by nosocomial (hospital-acquired) COVID-19 infection at Royal Devon & Exeter NHS Foundation Trust.	The impact of this is: •That patient and staff safety is put at risk due to nosocomial C19 infection; lack of assurance in respect of commissioning safe services. •That staff absences (due to either acquiring COVID-19 or needing to self-isolate as a contact) will reduce Trust operational capacity, further impacting on safety. •Reputational risk to the CCG, in commissioning safe services.	February 2021 - An unannounced CQC visit to the Trust took place in January and, when reported formally, an update will come to QAC, including the risk register. In addition the CCG IPC team undertook a supportive visit in January. The CCG continue to attend provider meetings, including Silver Command; these will continue to be the main mechanism for ensuring recent improvement is sustained, as well as monitoring incidents and other quality reporting. It is not proposed that the risk score changes currently, until a sustained improvement is seen (SW) The CCG continues to have confidence that the RDEFT have an improved position in relation to managing the Covid 19 pandemic (SW) January 2021 •Weekly RDEFT Silver Call, chaired by RDEFT director of infection prevention & control, with CCG, PHE and NHSE as members. •CCG weekly oversight of RDEFT Action Plan- open actions only- at Silver Call. •On-going CCG IPC and senior nursing support offer to RDEFT. •Weekly CCG/ System CNO and System DoNs meeting. •Daily IMT- executive oversight. •Monthly reporting and escalation through CCG QAC. •Regional IPC meetings, chaired by NHSE. •Devon and Regional Quality Surveillance Groups (QSG). •Nosocomial system monitoring report RDEFT Bronze/ Silver/ Gold command strategy. •Daily IMarch metrics of number of COVID-19 infections within all Devon trusts, broken down by nosocomial (hospital acquired) or new (community acquired). •RDEFT report progress to their Board. •RDEFT C19 Action Plan. •RDEFT IPC team, including DIPCs.	Darryn Allcorn	Sara Wright	February 2021 - The CCG are sufficiently assured that they are no longer attending the silver command meetings. The IPC visit contributed to this assurance level, however until evidence of sustained improvement over 2 months the risk score will not be changed January 2021 •CCG sight of COVID-19 mortality within the Trust, broken down by nosocomial and community acquired infection. •CCG sight of effective Trust COVID-19 incident reporting processes; no related/ linked serious incidents have been reported (as stipulated by the national CNO in June 2020). •Note: The CCG does not have sight of provider's internal lower level incidents (SEAs). •Appropriate processes for the investigation of and learning from COVID-19 deaths (as stipulated in National Medical Director letter, June 2020).	**08/02/2021**	19/01/2021	**5**	**5**	**25**	•CCG sight of COVID-19 mortality within the Trust, broken down by nosocomial and community acquired infection. •CCG sight of effective Trust COVID-19 incident reporting processes; no related/ linked serious incidents have been reported (as stipulated by the national CNO in June 2020). •Note: The CCG does not have sight of provider's internal lower level incidents (SEAs). •Appropriate processes for the investigation of and learning from COVID-19 deaths (as stipulated in National Medical Director letter, June 2020).
COVID 44 (wave2) 20/01/2021 added 20/01/21	**COVID RR**	Critical care surge planning	There is a risk that the requirement on providers to expand critical care capacity to meet surge in demand impacts on our ability to provide P1&P2 elective surgery for our residents .	The impact of this is would be to reduce significantly the urgent and emergency care capacity available to be provided to our residents and will increase waiting lists ,lead to some inequality in access to care and potentially some patients could come to harm.	23/02/2021 All units offered aid in line with process and formal outcome report shared with providers. Mutual aid no longer being offered on regular basis and all units decompressing into baseline footprint (PH) The critical care activation response team is overseeing the process at regional level and DDMG monitors impact three items a week. There is a system wide risk assessed mutual aid process to enable transfer of patients and or services in place and ethical framework to ensure decision making which across with CCG principles and values The risk sits in provider and regional operations risk registers albeit the impact is differential. There is a system of mutual aid operated across the sub region (Peninsula) and Region (South west) to decompress any units moving into amber surge and to enable P1&P2 operations to be supported where possible. The CCG is represented in the Activation Response Team responsible for making recommendations about mutual aid to ensure that this mutual aid takes account of local demands and pressures. Mutual aid decisions are signed off by relevant provider and confirmed with regional and National teams as appropriate	Penny Harris	Penny Harris	The impact of decisions has been risk assessed in advance and enacting the mitigations needs to be agreed through DDMG. Whilst there is no gap in assurance there is a risk that under pressure processes are not followed by individual providers or clinical teams Reporting of decisions made is through Regional operations centre and ICC	**23/02/2021**	20/01/2021	**2**	**4**	**8**	
COVID 45 (wave2) added 23/02/2021	**121**	Mental Health Inappropriate Out of Area bed trajectory	There is a risk that the Mental Health Inappropriate Out of Area trajectory, agreed by MH providers (Devon Partnership Trust and Livewell Southwest), is not met.	The impact of this for patients is poorer outcomes, poorer experience, increased cost and damage to the CCG's reputation due to not meeting the nationally derived target to eliminate OOA placements by 20/21.	23/02/2021 - Providers agreed and submitted trajectories as part of Phase 3 planning which would achieve the elimination of out of area placements by Q2 2021/22. - Providers submitted action plans which describe the actions being taken to deliver the trajectories, however, as at 22/02/2021 the previous plans and trajectories are being reviewed and updated; due to the impact of Covid the position for LSW in regard to OOA numbers has worsened. - We are receiving weekly reporting of the position from both providers; however the route of receipt is not contractualised. - We are working with providers through the MHLDA Cell to monitor the impact of COVID on total bed based capacity and ongoing access to independent sector bed-based capacity - DPT and LSW are currently meeting daily to consider the system position and options for collaboration and support. - A joint plan is in place between the providers to enable a joint response to Covid within the providers inpatient estates - Levels of Covid positive staff and patients within the DPT and LSW mental health in patient provision have remained low throughout the pandemic and vaccination programmes are rolling out for inpatients in mental health wards across the STP. - DPT have activated the agreed surge plan in response to reduction in independent sector bed-based capacity as a result of Covid. This has resulted in 5 additional OPMH beds within the DPT estate and 8 adult acute beds in Exeter based Elysium estate becoming operational (c. w/c08/02/21). - Due to the recent increase in OOA patients and challenges in delivery (due to COVID outbreaks pan-system), in particular in relation to PICU, LSW and DPT are reviewing their OOA trajectory plans to ensure, where applicable, there is recovery at pace. Initial plans due by 01/03/21.	Jo Turl	Louise Arrow	Demand and capacity plans have been developed collaboratively to support planning, however, there is limited evidence nationally on which plans can draw an evidence base because all modelling in this context is predictive. At present the routine mechanisms for further challenge and assurance are not in place (i.e Contract Review Meetings) which limits potential for commissioners to seek further assurance against the plans if there should be deterioration. The second/ third wave of Covid has: -a direct impact upon adult acute mental health and OPMH bed-based provision, with wards closed to new admissions within the provider estate and within the sub-contracted estate. It should be noted that total ward closures resulting in relocation of individuals out of area- are not identified as 'inappropriate out of area placements' because they are clinical exceptions. However, wards being closed to new admissions limiting access to in area capacity is a direct impact, and one which is difficult to in a way which is difficult to predict as closure durations vary according to the nature of outbreak and the need for adheracne to strict IPC protocols. -An indirect impact as providers report (LSW) an increased acuity of need at the point of presentation Initial revised trajectory plans are to be submitted by providers by 01/03/21 to give assurance around the trajectory of OOA's for each provider.	**23/02/2021**	13/07/2020	**4**	**4**	**16**	

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 25 March 2021

Dates of Committees covered in this report 18 March 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.
- **Quality & Performance Report** – the Committee received information on key quality and performance indicators for the period 1 April to 31 January 2021, 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 again from 77% to 70.5%. Performance against the main two-week wait standard continues to be below target, and has fallen from 75.9% in December to 72% in January. All providers are below target, with NDHT falling from 85.8% to 73%, RDEFT improving slightly to 62.5%, TSDFT falling slightly from 78.9% to 77% and UHP falling from 88.4% to 77.2%. The Committee noted with concern that breast symptomatic performance had fallen to its lowest position in two years; performance fell in January from 61.2% to 32%. All providers have seen a worsening position, with TSDFT falling from 94% to 75%, NDHT from 66% to 13%, UHP from 48% to 24% and RDEFT remaining at just under 3% and affecting 72 patients.
    - 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) has played a key role in delivering urgent planned care and the CCG and providers will seek to continue this, despite the national contract coming to an end.
    - Referral to treatment times – January data shows a steady position for RTT 18-week performance, falling slightly from 60.3% to 59% at an STP level, compared to the target of 92% and national performance of 66.7%. However, long wait patients continued to increase, with over 52 week waits rising quickly at all providers in January.
    - Diagnostic waiting times have been significantly affected by the Covid-19

pandemic. Performance has worsened slightly again this month, with the STP position of 60.5% remaining well below the 99% target and below the England position of 66.7%. The Nightingale Hospital is set to resume as a diagnostics facility.

- A&E waiting times - February saw a slight improvement in performance against the 95% national four-hour standard – at 82.4% for all types and 76.3% for type 1 attendances, following a reduction in the number of A&E attendances.
- UHP recorded 1,078 ambulance handover delays (that is handover times of more than 15 mins) in February (1,050 in January). This led to a lost resource time of 483 hours. By comparison, NDHT had 135 delays and lost 14 resource hours, RDE had 391 delays and lost 38 resource hours and TSD had 371 delays and lost 73 resource hours. SWASFT has participated in national work looking at the harm impact of handover delays on patients; it is anticipated that this will be reported in due course. The Western Locality is putting in place a Locality Urgent Care Recovery Programme which will tackle these challenges and enable movement towards improvements in services, processes and patient experience.
- 111 performance remained below trajectory in January due to significant sickness as a result of Covid abstractions (sickness and self-isolation). Performance has drifted from national average to the extent that exception reports have been provided for the previous seven weeks. Attrition rates for call handling staff remain high and this is seen as an area of risk. The Committee noted the recent CQC report and "inadequate' rating.
- The Committee was pleased to note the development of a system of future reporting of outcomes, quality, performance finance and workforce information for the ICS, and recognised that this work in progress.

Reports received and noted

- **Devon CCG Monthly Finance Report** - the report once 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.
- 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 10, due to 2020/21 untaken staff holidays within Trusts, the system forecast outturn moved to a £18.9m deficit for the year ended 31st March 2021. It is currently anticipated that both these drivers of the forecast overspend will be funded nationally.
- **STP Monthly Finance Report** – the paper was presented for information to the Committee, outlining the position at Month 9.

    - As noted above, 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 are being 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 9 the Devon system had a £13m YTD favourable variance (M8 £6.3m).
    - The forecast outturn at M9 showed a £14.5m adverse variance to plan. (M8 £2.5)
        - The movement on University Hospitals Trust, Royal Devon and Exeter Foundation Trust, Northern Devon Healthcare NHS Trust and Torbay and South Devon Foundation Trust forecast relates to an annual leave accrual previously recorded as a risk, and as referred to above this will be funded nationally.
        - The movement on Devon Partnership Trust's forecast relates to a gain on disposal of an asset
    - As at M9, there has been £103.3m of COVID related spend (M8 £92.2), with an additional £26.9m spent on Nightingale (M8 £26m) and £3.4m spent on virus testing (M8 £2.2m).
    - The spend on substantive staff is underspent by £9.8m as at M9 (M8 £8.2m) and forecast to be overspent by £20.8m at the year end. (M8 underspend £1.8m)
        - £17.5m of the forecast overspend relates to the annual leave accruals issue.
    - M9 year to date overspend on bank of £4.1m (M8 £2.7m), forecast overspend on bank is £4.6m (M8 £3.7m).
    - YTD overspend on agency £2.4m (M8 £1.5m), forecast overspend on agency £5.1m (M8 £3.1).
    - System capital spend is £14.6m under plan as at M9. (M8 £4.7m), forecast system CDEL is £3.6m under plan (M8 £0).
    - Total national CDEL capital spend is £6.4m over plan as at M9 (M8 £0.6m), forecast national CDEL is currently over plan by £66.4m, (M8 £63m) but this is expected to be balanced by the year end as retrospective allocations are received.
    - As at M9 total risks to the system are £15.9m (M8 £32m) with mitigations of £15.9m (M8 £29.3) leaving a net risk of £0m. (M8 £2.5m).
- The Committee received a further update on the action plan produced in response to the National Intensive Support Team Report and noted that much is still on hold pending resumption of 2021/22 operational planning. It was noted that system governance had been strengthened by the formation of the System Transformation and Efficiency Committee.
- The Committee received an update on 2021/22 operational planning, which indicated that the temporary financial framework would be extended for a further period into the next financial year and that guidance was expected around the end of March.

Risk Register Review (changes and areas of concern)

- There have been no risks recommended for closure, and no risk score movement.
- A new risk (144), agreed by the Committee in January, has been added to the corporate risk register shortly, to cover concern regarding 2021/2022 financial delivery - with the operational planning process delayed for 2020-21 and uncertainty regarding allocation and the required recovery trajectory for 2021/22, there is a risk that this will result in the CCG not being able to contain expenditure within required limits.

- The impact of this is that the CCG could fail one of its key financial duties resulting in reputational damage, adverse assurance rating and a need to cut expenditure in an unplanned way, jeopardising other key deliverables in its corporate objectives.

Committee Decisions

- The Committee received a report on the Mental Health Provider Collaborative, which explained that there is an intention to delegate, in shadow form, the commissioning of adult and children and young people's mental health and learning disability services to the lead provider for the Mental Health Provider Collaborative from April 2021. The Committee noted the suggestion that this gave the best opportunity to achieve the aims set out in the technical guidance, which are:
    - higher quality and more sustainable services;
    - reduction of unwarranted variation in clinical practice, outcomes and efficiency;
    - reduction of health inequalities, with fair and equal access to services;
    - better workforce planning;
    - more effective use of resources, including clinical support and corporate services;
    - enhancing productivity by reducing duplication and enhancing consolidation.
- The Committee suggested that formal approval of the proposed arrangements would require consideration by the Finance and Performance Committee and Quality Assurance Committee prior to Governing Body approval in due course.
- The Committee suggested that the following areas of assurance would need to be addressed prior to formal approval:
    - Governance arrangements
    - Clarification of the services to be included in the arrangement to ensure there are no gaps in the provision of essential services
    - The resources to be included in the arrangement
    - The resources to be retained by the CCG/ICS
    - Any potential risk share arrangements
    - Assurance around quality of the services
    - Consideration of a more regional approach, potentially including Cornwall/Somerset
    - Assurance that the most appropriate leadership arrangements are in place

Recommendations for Governing Body

- The Committee received a report on the work undertaken by Devon County Council and the CCG to amend and refine the necessary financial arrangements that underpin the Better Care Fund (BCF) for 2020/21, with effect from 1 April 2020. This includes, who holds the pooled funds, the risk sharing arrangements in relation to the fund and the governance arrangements surrounding the operation of the pool.
- The preparation for signing of the agreement has been delayed until now due to the NHS England NHSE) and the Ministry of Housing, Communities and Local Government (MHCLG) guidelines and assurance process being delayed this year. NHSE Guidance requires the s75 agreement to be signed before 31st March 2021.
- The construction of the pool is similar to the arrangements in 19/20 The main changes in the make up of the BCF for 19/20 are as follows:
    - Annual increase to the disabilities facilities grant.
    - Increased health resources to support social care as mandated by NHSE of £1.1m
    - Carry forward of general BCF underspend of £731k by DCC for application in 19/20.
    - Carry forward of £1.0m of 19/20 unspent improved better care fund grant to

support slippage in schemes.

- The CCG's contributions are the minimum required under the BCF guidance.
- The scheme of delegation requires such agreements to be approved by the Governing Body, and the Committee, having reviewed the report and agreement, recommends that it is signed and sealed by the CCG. A copy of the document and a report to Governing Body is attached to this report

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.

GOVERNING BODY

Report title: Devon County Council Better Care Fund S75 Agreement 2020/21				
Date of committee: 25th March 2021 **Date report produced: 11th March 2021**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern) **Contact Details:** kevin.wheller@nhs.net		**Supporting Executive:** **Name and Title:** John Dowell **Contact Details:** john.dowell@nhs.net **Report Approved by:** **Name and Title: John Dowell** **Date** 11th March 2021		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

Devon County Council (DCC) and NHS Devon CCG (CCG) have worked together to amend and refine the necessary financial arrangements that underpin the Better Care Fund (BCF) associated with the Devon County Council footprint for 2020/21. This includes, who holds the pooled funds, the risk sharing arrangements in relation to the fund and the governance arrangements surrounding the operation of the pool

The purpose of the report is to present the s75 agreement to the Governing Body following recommendation from the Finance Committee that the CCG signs the agreement. The scheme of delegation requires such agreements to be approved by the Governing Body

Management of Conflict of interests:

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

Committees that have previously discussed/agreed the report and outcomes:
Finance Committee
Key recommendations and actions requested:
The Governing Body are asked to review the contents of this report and the accompanying s75 agreement and if satisfied with the agreement formally approve that it can be signed and sealed.
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 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	BCF is designed to improve the quality of healthcare particularly in relation to hospital discharge	
Health Inequalities	BCF ambitions include addressing health inequalities	
Equality (staff or public)		√
Resource and Finance	BCF represents a £101m joint health and social care	
Legal	S75 agreement is a legal agreement	
Engagement and Consultation	Through the Health and Well Being Board	
Risk	Low financial risk of the Better Care Fund overspending in	

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

Devon County Council Better Care Fund
S75 Agreement 2019/20

1. Executive Summary

Devon County Council (DCC) and NHS Devon CCG (CCG) have worked together to amend and refine the necessary financial arrangements that underpin the Better Care Fund (BCF) associated with the Devon County Council footprint for 2020/21. This includes, who holds the pooled funds, the risk sharing arrangements in relation to the fund and the governance arrangements surrounding the operation of the pool.

The arrangements are set out in a section 75 Agreement[1] between DCC and the CCG with effect from 1st April 2020. The preparation for signing of the agreement has been delayed until now due to the NHS England NHSE) and the Ministry of Housing, Communities and Local Government (MHCLG) guidelines and assurance process being delayed this year.

The purpose of the report is to present the s75 agreement to the Governing Body following recommendation from the Finance Committee that the CCG signs the agreement. The scheme of delegation requires such agreements to be approved by the Governing Body

The full s75 agreement is attached to this report. This report sets out the main elements of the agreement.

2. Construction of the Pool

The construction of the pool is similar to the arrangements in 19/20

The main changes in the make up of the BCF for 19/20 are as follows:

- Annual increase to the disabilities facilities grant.
- Increased health resources to support social care as mandated by NHSE of £1.1m
- Carry forward of general BCF underspend of £731k by DCC for application in 19/20.
- Carry forward of £1.0m of 19/20 unspent improved better care fund grant to support slippage in schemes.

The CCG's contributions are the minimum required under the BCF guidance.

Application of the funds to individual schemes and investments is set out in schedule 5 of the s75 agreement. The budget for the BCF is fully supported in the current CCG's 20/21 Financial Plan.

[1] Section 75 of the NHS Act 2006

There is no mandatory requirement in 20/21 to operate a performance fund linked to the objectives of the fund and no performance fund arrangements have been proposed.

3. Pooled Fund Manager

As in previous years DCC will continue to manage the pooled fund through its books and account for the pool with the County Treasurer assuming the role of 'Pooled Fund Manager'

4. Risk Sharing Arrangements

The proposed risk sharing arrangement for 20/21 are the same as 19/20 and are as follows.

Devon County Council	50%
NEW Devon CCG	50%

The proposal for 20/21 recognises 3 pools, the risk sharing arrangements being

Capital Pool £8.2m

Spend is based on fixed allocations and will not overspend. Any underspend will be carried forward into the following financial year

Revenue Pool £63.0m

- Overspends and underspends will be shared on the percentage shares set out above.
- Overspends will require each party to contribute additional funds to the pool
- Underspends will be returned to the partner organisations

iBCF Pool £29.3m

The iBCF pool includes the local authority winter pressure grant in 20/21.The iBCF Pool is not expected to overspend. Underspends will be returned to the partner organisations

5. Governance

Management of the pooled fund will be governed by the terms of the s75 agreement between the partners. The decision making authority will lie with the members of the Joint Commissioning and Co-ordinating Group (JCCG). The authority to act within this group will be determined by the delegated authority of the members of the group based on their delegated authority within their respective organisations.

The JCCG reports to the Health & Well Being Board.

7. Timeline for Sign Off

NHSE Guidance requires the s75 agreement will need to be signed before 31st March 2021. Provided the Governing Body are satisfied the s75 can be signed and sealed by the Chief Finance Officer and witnessed by two members of the Governing Body.

8. Summary and Recommendations

The Governing Body are asked to review the contents of this report and the accompanying s75 agreement and if satisfied with the agreement formally approve that it can be signed and sealed.

Dated February 2021

DEVON COUNTY COUNCIL

and

NHS DEVON CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES

BETTER CARE FUND

X

Contents

Individual Scheme Specifications form an Appendix to this Agreement.

THIS AGREEMENT is made on day of 2021

PARTIES

Devon County Council of County Hall, Topsham Road, Exeter EX2 4QD (the **"Council"**)

NHS Devon Clinical Commissioning Group of County Hall, Topsham Road, Exeter EX2 4QD (the **"CCG"**)

Each a **"Partner"** and together the **"Partners"**

BACKGROUND

The Council has responsibility for commissioning and/or providing social care services on behalf of the population of Devon excluding Plymouth and Torbay.

The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the region of Devon including Plymouth and Torbay.

The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. The Partners wish to extend the use of pooled funds to include funding streams from outside the Better Care Fund.

Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also the means by which the Partners will pool funds and align budgets as agreed between the Partners.

The aims and benefits of the Partners in entering into this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives; and

c) make more effective use of resources through the establishment and maintenance of a pooled fund for expenditure on the Services.

The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

DEFINED TERMS AND INTERPRETATION

In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Accident & Emergency Board (A&E Board) refers to five NHS-led planning groups (one county-wide and four boards covering the local health economies of Northern Devon, Eastern Devon, Western Devon and Southern Devon) with a particular emphasis on addressing waiting lists, delays in transfers of care for people who no longer need to be in hospital and winter pressures. These Boards bring together local providers, commissioners and social care organizations.

Accountable officer means an officer of any local authority, CCG, NHS provider or community interest company given delegated authority to make decisions on the detailed allocation of a specific part of the Better Care Fund. Accountabilities are normally assigned at the individual scheme level.

Affected Partner means, in the context of Clause 0, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreed Purposes: the performance of obligations under this Agreement; the delegation and fulfilment of Functions; achieving Integrated Commissioning, Joint (Aligned) Commissioning, and Lead Commissioning Arrangements; the delivery of Services; and the delivery of Individual Schemes.

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price.

Authorised Officer means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

CCG means NHS Devon Clinical Commissioning Group

CCG Statutory Duties means the duties of the CCG pursuant to sections 14P to 14Z2 of the 2006 Act

Capital Expenditure is an amount spent to acquire or improve an asset, including buildings, vehicles, equipment and ICT, that generates economic value beyond a 12 month period.

Capital Pool is that part of the Better Care Fund ring-fenced for capital expenditure. The Disabled Facilities Grant can only be used within this Pool.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1 April 2020.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

which comprises Personal Data or which relates to any patient or his treatment or medical history;

the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

which is a trade secret.

Contract Price means any sum payable to a Provider under a Service and / or goods Contract as consideration for the provision of Services and / or goods and which, for the avoidance of doubt, does not include any Default Liability.

Controller, processor, data subject, personal data, personal data breach, processing and appropriate technical and organisational measures: as set out in the UK Data Protection Legislation in force at the time.

Data Discloser: a party that discloses Shared Personal Data to the other party.

Data Protection Legislation: the UK Data Protection Legislation and any other European Union legislation relating to personal data and all other legislation and regulatory requirements in force from time to time which apply to a party relating to the use of Personal Data (including, without limitation, the privacy of electronic communications).

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

Disabled Facilities Grant may refer either to (i) capital grant paid to a local authority via the Better Care Fund that may be used only for the purposes that a capital receipt may be used for in accordance with regulations made under section 11 of the Local Government Act 2003, or (ii) capital grant paid by a local authority to an individual in support of the local authority's duty to offer assistance under the Housing Grants, Construction & Regeneration Act 1996 or its discretionary powers under the Regulatory Reform (Housing Assistance) (England & Wales) Order 2002. Technical guidance related to the Better Care Fund requires the first kind of DFG to be used as a source of funding for the second kind of DFG. Use of this grant is subject to conditions set by the MHCLG in grant determinations 31/5037 and 31/5267, which must be observed when determining the allocation of this funding.

Emergency Hospital Admissions means all non-elective hospital admissions (rates given are per 100,000 of the population)

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event;

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means the Partner that will host the Pooled Fund and shall be the Council unless the Partners agree otherwise in writing.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Improved Better Care Fund Grant (iBCF) means the grant allocated by the Ministry of Housing, Communities & Local Government (MHCLG) to Devon County Council. Use of this grant is subject to conditions set by the MHCLG in grant determination 31/5019, which must be observed when determining the allocation of this funding. Additional external reporting requirements also apply.

Improved BCF Pool means the pool used to fund activities from the improved Better Care Fund Grant.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Project means a sub-set of activities and expenditure within an Individual Scheme – see more detailed definition below.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification. Schemes may be sub-divided into projects, which do not have separate specifications, but which feature in the more detailed reporting of expenditure from within the Better Care Fund required by NHS England or the Department for Communities and Local Government.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

JCCG means the joint coordinating commissioning group responsible for review of performance and oversight of this Agreement as set out in Schedule 2

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

any statute or proclamation or any delegated or subordinate legislation;

any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner(s) in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Locality budget means a sub-set of either the Improved Better Care Fund Grant Pool or the Revenue Pool assigned to one of four localities within Devon North, East, West & South), which is used for reporting and budgetary control purposes. Financial controls (e.g. those governing virements) apply to the individual schemes within the locality budget, rather than the locality budget as a whole.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

Overspend means any expenditure from a pool within the Pooled Budget in a Financial Year that which exceeds the Financial Contributions to that pool for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure is expenditure on the following:

…the Contract Price;

…where the Council is to be the Provider, the Permitted Budget;

…Third Party Costs;

…Approved Expenditure

…management costs (if agreed by the JCCG)

…management costs (where the management provided by a Partner is above the level provided prior to the Commencement Date)

Permitted Recipients: the parties to this agreement, the employees of each party, and any third parties engaged to perform obligations in connection with this agreement.

Pool means the grouping of Individual Schemes used to determine the risk sharing arrangements as set out in Schedule 3

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

Pooled Fund Manager means the s151 officer of the Council who is the Host Partner for the Pooled Fund unless the Partners specify otherwise in writing.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations mean the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Revenue Pool means the pool used to fund activities not funded by the Disabled Facilities Grant or improved Better Care Fund Grant.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Section means a sub-set of schemes within a budget Pool that are grouped together for budget management purposes. See locality budget.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services and/or equipment entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individuals for whom the Partners have a responsibility to commission the Services.

Shared Personal Data: the personal data to be shared between the parties under clause 27.1 of this agreement. Shared Personal Data shall be confined to the following categories of information relevant to the following categories of data subject:

a. Key items of information which could be used to establish a person's identity:

- Name

- Address including postcode

- Date of Birth

- Other Dates (i.e. death, diagnosis)

- Sex

- Ethnic Group

- NHS Number

- Local Identifier (i.e. hospital or GP Practice Number or personal identification number (Social Care)

- National Insurance Number

- Diagnosis/treatment

- Physical and mental health

b. Sensitive personal data, including:

- the racial or ethnic origin of the data subject,
- his political opinions,
- his religious beliefs or other beliefs of a similar nature,
- whether he is a member of a trade union
- his physical or mental health or condition,
- his sexual life,

the commission or alleged commission by him of any offence, or proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in

the proper performance of its obligations under this Agreement and as agreed by the JCCG.

Underspend means any Financial Contributions made to a pool within the Pooled Budget in any Financial Year which exceeds the expenditure of that pool for that Financial Year.

UK Data Protection Legislation: all applicable data protection and privacy legislation in force from time to time in the UK including the General Data Protection Regulation ((EU) 2016/679); the Data Protection Act 2018; the Privacy and Electronic Communications Directive 2002/58/EC (as updated by Directive 2009/136/EC) and the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended.

VAT Guidance: means the guidance contained in Pooled Budgets: A Practical Guide for Local Authorities and the National Health Service (Third Edition) (CIPFA, 2017).

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971. In the event that a different definition applies in individual scheme specifications, this will be noted in the specification itself.

In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

Any reference to the Partners shall include their respective statutory successors, employees and agents.

In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

In this Agreement, words importing the singular only shall include the plural and vice versa.

In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency

at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

TERM

This Agreement shall come into force on the Commencement Date.

This Agreement shall continue for one (1) year, unless it is terminated earlier in accordance with Clause 21.

The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

GENERAL PRINCIPLES

Nothing in this Agreement shall affect:

…the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

…any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

The Partners agree to:

…treat each other with respect and an equality of esteem;

…be open with information about the performance and financial status of each; and

…provide early information and notice about relevant problems.

For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

PARTNERSHIP FLEXIBILITIES

This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

…Lead Commissioning Arrangements;

…the establishment of the Pooled Fund

in relation to Individual Schemes (the “Flexibilities”):

The Council delegates to the CCG and the CCG agrees to exercise, on the Council’s behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

The CCG delegates to the Council and the Council agrees to exercise on the CCG’s behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme

Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

FUNCTIONS

The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

This Agreement shall include such functions as shall be agreed from time to time by the Partners.

Where the Partners add a new Individual Scheme to this Agreement an outline Scheme Specification for each Individual Scheme in the form set out in Schedule 1 shall be completed and agreed between the Partners in writing.

Scheme Specifications shall be updated in accordance with clause 29 (Variation) following:

… … any change in Lead Commissioner or Provider;

… any Service Contract re-tendering exercise (even where there has been no change in provider); and or;

…the issue of any variation order pertaining to a Service Contract.

The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

The introduction of any Individual Scheme will be subject to business case approval by the JCCG., or in the case of iBCF Grant schemes, by the named accountable officers

Copies of Scheme Specifications shall be provided to both parties to this agreement, and a master list of all Scheme Specifications shall be held by the Pooled Fund Manager. Scheme Specifications as at the start of the financial year are contained in Appendix 1, which is contained in a separate file in electronic versions of this document.

COMMISSIONING ARRANGEMENTS

Integrated Commissioning

Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, the Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

The Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

The Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partner's Financial Contribution in respect of that particular Service in each Financial Year.

The Partners shall comply with the arrangements in respect of any Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

Each Partner shall keep the other Partners and the JCCG regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund.

The JCCG will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner

Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

…exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

…endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

…commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

…contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

…comply with all relevant legal duties and guidance of the Partners in relation to the Services being commissioned;

…where Services are commissioned using the NHS National Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

…undertake performance management and contract monitoring of all Service Contracts;

…make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

…keep the other Partners and the JCCG regularly informed of the effectiveness of the arrangements including any Overspend or Underspend.

…provide the other Partners with electronic copies of all Service Contracts and any other contracts that are entered into pursuant this agreement and individual reports on each Service commissioned by the Lead Commissioner.

Each Lead Commissioner shall designate an accountable officer for each Individual Scheme, with responsibility for ensuring its delivery and with delegated authority to make decisions in respect of the budget allocated to that Scheme, subject to any written instructions that the JCCG may issue. For Schemes within the iBCF Pool, two accountable officers may be nominated to make joint decisions regarding detailed budget allocations. All such decisions must be reported in writing to the Pooled Fund Manager, who may seek additional information regarding planned expenditure and the timing of that expenditure in order to assist with the overall financial management of the Fund.

ESTABLISHMENT OF A POOLED FUND

In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such a Pooled Fund for expenditure as set out in Schedule 3 and to spend the funds in that Pooled Fund on the Scheme Specifications as set out in Schedule 5.

The Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by both Partners.

The Host Partner shall be the Partner responsible for:

…holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

…providing the financial administrative systems for the Pooled Fund; and

…appointing the Pooled Fund Manager;

…ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

POOLED FUND MANAGEMENT

The Pooled Fund Manager shall have the following duties and responsibilities:

…the day to day operation and management of the Pooled Fund;

…ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

…maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

…ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

…ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

…preparing and submitting to the JCCG (by email if there is no meeting scheduled) Quarterly reports (or more frequent reports if required by the JCCG) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the JCCG to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

…preparing and submitting reports to the Health and Wellbeing Board as required by it.

In carrying out their responsibilities as provided under Clause 8.1, the Pooled Fund Manager shall have regard to the recommendations of the JCCG and shall be accountable to the Partners.

FINANCIAL CONTRIBUTIONS

The Financial Contribution of the CCG and the Council to the Pooled Fund for the Financial Years of operation shall be as set out in Schedule 3.

Financial Contributions for subsequent financial years will be determined by the JCCG with the endorsement of the Health and Wellbeing Board, subject to any approvals required by each Partner under its internal rules and regulations. A separate agreement document shall be produced for each Financial Year not covered by the current Agreement.

No provision of this Agreement shall preclude the Partners from making additional contributions to the Pooled Fund from time to time by mutual agreement. Any such additional contributions shall be explicitly recorded in JCCG minutes, including whether they are non-recurrent or not and recorded in the budget statement as a separate item.

The funds in the Pooled Fund shall be spent on the Services as set out in Schedule 5.

NON FINANCIAL CONTRIBUTIONS

The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

The partners have agreed risk share arrangements as set out in Schedule 3, which provide for financial risks arising within the commissioning of services from the Pooled Fund.

Overspends in the Pooled Fund

The Lead Commissioner for each Scheme shall manage expenditure on that Scheme from the Pooled Fund, making reasonable efforts to ensure expenditure does not exceed the funds allocated from the Pooled Fund that funds the Scheme (as detailed in Schedule 5)

The Lead Commissioner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the JCCG in accordance with Clause 11.4.

In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the JCCG is informed as soon as reasonably possible and the provisions of Schedule 3 shall apply.

Underspends in the Pooled Fund

Underspends shall be treated as set out in Schedule 3. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

CAPITAL EXPENDITURE

12.1 The spending of funds on capital expenditure must be agreed by the Partners.

VAT

Where the Council is appointed as Host Partner, the Partners agree to adopt the principal arrangements whereby the lead body's VAT regime applies (previously known as "Partnership Structure (a)) as described in the VAT Guidance through which the Council purchases goods and services for the Partnership and the Council recovers any VAT which may be incurred under its VAT regime. Where the CCG is appointed as Host Partner the Partners agree that the Host Partner acts as agent for the other Partners

(previously known as “Partnership Structure (b)) as described in the VAT Guidance through which the Host Partner will either arrange for invoices for goods and services to be sent directly to the other Partners or will purchase goods and services then invoice the other Partners.

AUDIT AND RIGHT OF ACCESS

Both Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund in accordance with its statutory requirements.

All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

LIABILITIES AND INSURANCE AND INDEMNITY

Subject to Clause 0, and 0, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

Clause 0 shall apply only to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the JCCG.

If any third party makes a claim or intimates an intention to make a claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 0, the Partner that may claim against the other indemnifying Partner will:

…as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

…not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

…give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority or self-insure) in respect of all potential liabilities arising from this Agreement.

Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

STANDARDS OF CONDUCT AND SERVICE

The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners' respective Standing Orders and Standing Financial Instructions).

The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Fund are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

CONFLICTS OF INTEREST

17.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 7.

GOVERNANCE

Overall strategic oversight of partnership working between the Partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

The Partners have established a JCCG to carry out the functions set out in Schedule 2.

The JCCG is based on a joint working group structure. Each member of the JCCG shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the JCCG to carry out its objects, roles, duties and functions as set out in this Clause 18 and Schedule 2.

The terms of reference of the JCCG shall be as set out in Schedule 2.

Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

The JCCG shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the JCCG and Health and Wellbeing Board.

REVIEW

Save where the JCCG agrees alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and the provision of the Services no later than 3 Months before the end of each Financial Year.

Subject to any variations to this process required by the JCCG, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2. Annual Reviews will be conducted to ensure the deployment of resources fully supports improvements in performance against the BCF metrics and delivery of the national conditions.

The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause. A copy of this report shall be provided to the JCCG. Adjustments as a result of the reviews will be made to the financial schedule and S75 agreement as required with the aim of achieving benefit in savings or redistribution of resources in 2019/20.

In the event that the Partners fail to meet the requirements of the Better Care Fund Plan the Partners shall provide full co-operation with NHS England to agree a recovery plan.

COMPLAINTS

20.1 The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

TERMINATION & DEFAULT

This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

If any Partner ("Failing Partner") fails to meet any of its obligations under this Agreement, the other Relevant Partner(s) (if more than one acting jointly) may by notice require the Failing Partner to take such reasonable action within a reasonable timescale as the other Relevant Partner(s) may specify to rectify such failure. Should the Failing Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 22.

Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 13,14,15,21,22,23,25,27,31,32 and 38.

In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

Upon termination of this Agreement for any reason whatsoever the following shall apply:

…the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

…where any of the Partners has entered into a Service Contract, which continues after the termination of this Agreement, that Partner shall continue to fulfil its obligations under the Service Contract and both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination of this Agreement and will enter into all appropriate legal documentation required in respect of this;

…the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partners requests the same in writing provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

…where a Service Contract held by a Lead Commissioner relates in full or partially to services which relate to the other Partner's(s') Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

…the JCCG shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

…termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner(s) already accrued, prior to the date upon which such termination takes effect.

In the event of termination in relation to an Individual Scheme the provisions of Clause 21.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

DISPUTE RESOLUTION

In the event of a dispute between the Partners arising out of this Agreement, any Partner may serve written notice of the dispute on any other Partner, setting out full details of the dispute.

The Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 0, at a meeting convened for the purpose of resolving the dispute.

If the dispute remains after the meeting detailed in Clause 0 has taken place, the Partners' respective chief executives or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

If the dispute remains after the meeting detailed in Clause 0 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate mediation, any Partner may give notice in writing (a **"Mediation Notice"**) to the other Partners requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. No Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

Nothing in the procedure set out in this Clause 22 shall in any way affect any Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

FORCE MAJEURE

No Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by any other Partner or incur any liability to any other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs, and it is prevented from carrying out its obligations under this agreement by that Force Majeure Event.

On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner(s) as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

As soon as practicable, following notification as detailed in Clause 0, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 0, facilitate the continued performance of the Agreement.

If the Force Majeure Event continues for a period of more than sixty (60) days, any Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partners. For the avoidance of doubt, no compensation shall be payable by any Partner(s) as a direct consequence of this Agreement being terminated in accordance with this Clause.

CONFIDENTIALITY

In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

…the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

…the provisions of this Clause 24 shall not apply to any Confidential Information which:

is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

is obtained by a third party who is lawfully authorised to disclose such information.

Nothing in this Clause 24 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

Each Partner:

…may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

…will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

…shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 0 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

OMBUDSMEN

26.1 The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

DATA PROTECTION AND INFORMATION SHARING

Shared Personal Data. This clause sets out the framework for the sharing of personal data between the parties as controllers. Each party acknowledges that one party (referred to in this clause as the **Data Discloser**) will regularly disclose to the other party Shared Personal Data collected by the Data Discloser for the Agreed Purposes.

Effect of non-compliance with UK Data Protection Legislation. Each party shall comply with all the obligations imposed on a controller under the UK Data Protection Legislation, and any material breach of the UK Data Protection Legislation by one party shall, if not remedied within 30 days of written notice from the other party, give grounds to the other party to terminate this agreement with immediate effect.

Particular obligations relating to data sharing. Each party shall:

ensure that it has all necessary notices and consents in place to enable lawful transfer of the Shared Personal Data to the Permitted Recipients for the Agreed Purposes;

provide information as required under article 13 and article 14 of the General Data Protection Regulation to any data subject whose personal data may be processed under this agreement. This includes giving notice that, on the termination of this agreement, personal data relating to them may be retained by or, as the case may be, transferred to one or more of the Permitted Recipients, their successors and assignees;

process the Shared Personal Data only for the Agreed Purposes;

not disclose or allow access to the Shared Personal Data to anyone other than the Permitted Recipients;

ensure that all Permitted Recipients are subject to written contractual obligations concerning the Shared Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this agreement;

ensure that it has in place appropriate technical and organisational measures, reviewed and approved by the other party, to protect against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data and shall provide written notice to the other if it becomes aware of a Personal Data Breach involving Shared Personal Data.

not transfer any personal data received from the Data Discloser outside the European Union unless the transferor:

complies with the provisions of Articles 26 of the GDPR (in the event the third party is a joint controller); and

ensures that (i) the transfer is to a country approved by the European Commission as providing adequate protection pursuant to Article 45 of the GDPR; or (ii) there are appropriate safeguards in place pursuant to Article 46 GDPR; or (iii) Binding corporate rules are in place or (iv) one of the derogations for specific situations in Article 49 GDPR applies to the transfer.

Mutual assistance. Each party shall assist the other in complying with all applicable requirements of the UK Data Protection Legislation. In particular, each party shall:

consult with the other party about any notices given to data subjects in relation to the Shared Personal Data;

promptly inform the other party about the receipt of any data subject access request;

provide the other party with reasonable assistance in complying with any data subject access request;

not disclose or release any Shared Personal Data in response to a data subject access request without first consulting the other party wherever possible;

assist the other party, at the cost of the other party, in responding to any request from a data subject and in ensuring compliance with its obligations under the UK Data Protection Legislation with respect to security, personal data breach notifications, data protection impact assessments and consultations with supervisory authorities or regulators;

notify the other party without undue delay on becoming aware of any breach of the UK Data Protection Legislation;

at the written direction of the Data Discloser, delete or return Shared Personal Data and copies thereof to the Data Discloser on termination of this agreement unless required by law to store the personal data;

use compatible technology for the processing of Shared Personal Data to ensure that there is no lack of accuracy resulting from personal data transfers;

maintain complete and accurate records and information to demonstrate its compliance with this clause 27 and allow for audits by the other party or the other party's designated auditor; and

provide the other party with contact details of at least one employee as point of contact and responsible manager for all issues arising out of the UK Data Protection Legislation, including the joint training of relevant staff, the procedures to be followed in the event of a data security breach, and the regular review of the parties' compliance with the UK Data Protection Legislation.

Indemnity. Each party shall indemnify the other against all liabilities, costs, expenses, damages and losses (including but not limited to any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and legal costs (calculated on a full indemnity basis) and all other reasonable professional costs and expenses) suffered or incurred by the indemnified party arising out of or in connection with the breach of the UK Data Protection Legislation by the indemnifying party, its employees or agents, provided that the indemnified party gives to the indemnifier prompt notice of such claim, full information about the circumstances giving rise to it, reasonable assistance in dealing with the claim and sole authority to manage, defend and/or settle it.

Information Sharing Protocol. The Partners will follow the Information Sharing Protocol set out in Schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law.

NOTICES

Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 28.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

…personally delivered, at the time of delivery;

…sent by facsimile, at the time of transmission;

…posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

…if sent by electronic mail, at the time of transmission a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

The address for service of notices as referred to in Clause 0 shall be as follows unless otherwise notified to the other Partners in writing:

…if to the Council, addressed to the Chief Officer for Adult Care and Health, County Hall, Room G38, Topsham Road, Exeter, Devon, EX2 4QD, Tel: 01392 383299, Fax: 0345 155 1003 email: jennie.stephens@devon.gov.uk

…if to the CCG, addressed to Director of Commissioning, NHS Devon Clinical Commissioning Group, The Annexe, County Hall, Topsham Road, Exeter EX2 4QD.

VARIATION

29.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

CHANGE IN LAW

The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 22 (Dispute Resolution) shall apply.

WAIVER

31.1 No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

SEVERANCE

32.1 If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

ASSIGNMENT AND SUB CONTRACTING

33.1 The Partners shall not subcontract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

EXCLUSION OF PARTNERSHIP AND AGENCY

Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

…act as an agent of the other;

…make any representations or give any warranties to third parties on behalf of or in respect of the other; or

…bind the other in any way.

THIRD PARTY RIGHTS

35.1 Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

ENTIRE AGREEMENT

The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

COUNTERPARTS

37.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by both Partners shall constitute a full original of this Agreement for all purposes.

GOVERNING LAW AND JURISDICTION

This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

Subject to Clause 22 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **DEVON COUNTY COUNCIL**)
)
was hereunto affixed in the presence of:)

Signed for on behalf of **NHS DEVON CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

– SCHEME SPECIFICATION TEMPLATE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

Insert details including:

(a) Name of the Individual Scheme
(b) Relevant context and background information
I Whether there are Pooled Funds:

The Host Partner for Pooled Fund X is [ ] and the Pooled Fund Manager, being an officer of the Host Partner is [ ]

2 AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme

3 THE ARRANGEMENTS

Set out which of the following applies in relation to the Individual Scheme:

Lead Commissioning;

Integrated Commissioning;

Joint (Aligned) Commissioning;

the establishment of one or more Pooled Funds as may be required.

4 FUNCTIONS

Set out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

Consider whether there are any exclusions from the standard functions included (see definition of NHS Functions and Council Health Related Functions)

SERVICES

What Services are going to be provided within this Scheme. Are there contracts already in place?
Are there any plans or agreed actions to change the Services?
Who are the beneficiaries of the Services? [2]

COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Set out what arrangements will be in place in relation to Lead Commissioning/Joint (Aligned) commissioning. How will these arrangements work?

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[2] This may be limited by service line –i.e. individuals with a diagnosis of dementia. There is also a significant issue around individuals who are the responsibility of the local authority but not the CCG and Vice versa

Contracting Arrangements
Insert the following information about the Individual Scheme:

relevant contracts

arrangements for contracting. Will terms be agreed by both partners or will the Lead Commissioner have authority to agree terms

what contract management arrangements have been agreed?
What happens if the Agreement terminates? Can the partner terminate the Contract in full/part?
Can the Contract be assigned in full/part to the other Partner?

Access
Set out details of the Service Users to whom the Individual Scheme relates. How will individuals be assessed as eligible

FINANCIAL CONTRIBUTIONS

Financial Year 201…./201

Revenue	
Capital	

Financial resources in subsequent years will be determined in accordance with the Agreements for those years.

FINANCIAL GOVERNANCE ARRANGEMENTS

(1) *[(1) As in the Agreement with the following changes) Management of the Pooled Fund*

Are any amendments required to the Agreement in relation to the management of Pooled Fund
Has the budget been agreed?
How will changes to the budget level be implemented?
Have eligibility criteria been established?
What are the rules about access to the pooled budget?
Does the scheme's budget manager require training?
Have the scheme managers' delegated powers been determined?

(1) *Is there a protocol for disputes3)Audit Arrangements*

What Audit arrangements are needed?
Has an internal auditor been appointed?
Who will liaise with/manage the auditors?

(1) *Whose external audit regime will apply4)Financial Management*

Which financial systems will be used?
What monitoring arrangements are in place?
Who will produce monitoring reports?
What is the frequency of monitoring reports?
What are the rules for managing overspends?
Do budget managers have delegated powers to overspend?
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?
How will overspends and underspends be treated at year end?

Will there be a facility to carry forward funds?
How will pay and non pay inflation be financed?
Will a contingency reserve be maintained, and if so by whom?
How will efficiency savings be managed?
How will revenue and capital investment be managed?
Who is responsible for means testing?
Who will own capital assets?
How will capital investments be financed?
What management costs can legitimately be charged to pool?
What re the arrangement for overheads?
What will happen to the existing capital programme?
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?
Has the calculation methodology for recharges been defined?
What closure of accounts arrangement need to be applied?][3]

VAT

Set out details of the treatment of VAT in respect of the Individual Service consider the following:

Which partner's VAT regime will apply?
Is one partner acting as 'agent' for another?
Have partners confirmed the format of documentation, reporting and accounting to be used?

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

Will there be a relevant Committee/Board/Group that reviews this Individual Scheme?
Who does that group report to?
Who will report to that Group?

Pending arrangements agreed in the Partnership Agreement, including the role of the Health & Wellbeing Board, Partners to confirm any bespoke management arrangements for the Individual Scheme

[3] Although some of the information overlaps with the information that is included in the main body of Agreement, each Scheme needs to be considered in order to determine whether the overarching arrangements should apply and to seek authorisation from the JCCG if this is not the case.

NON FINANCIAL RESOURCES (IF ANY)

Council contribution

	Details	Charging arrangements[4]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

CCG Contribution

	Details	Charging arrangements[5]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

STAFF

Consider:

Who will employ the staff in the partnership?
Is a TUPE transfer secondment required?
How will staff increments be managed?
Have pension arrangements been considered?

Council staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the CCG.

If the staff are being seconded to the CCG this should be made clear

CCG staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the Council.

If the staff are being seconded to the Council this should be made clear.

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[4] Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

[5] Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

ASSURANCE AND MONITORING

Set out the assurance framework in relation to the Individual Scheme. What are the arrangements for the management of performance? Will this be through the agreed performance measures in relation to the Individual Scheme.
In relation to the Better Care Fund you will need to include the relevant performance outcomes.
Consider the following:

What is the overarching assurance framework in relation to the Individual Scheme?
Has a risk management strategy been drawn up?
Have performance measures been set up?
Who will monitor performance?
Have the form and frequency of monitoring information been agreed?
Who will provide the monitoring information? Who will receive it?

LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Devon County Council					
CCG					

There will be some schemes where lead officers are only drawn from one or two of the partners.

INTERNAL APPROVALS

Consider the levels of authority from the Council's Constitution and the CCG's standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme;
Consider the scope of authority of the Pool Manager and the Lead Officers
Has an agreement been approved by cabinet bodies and signed?

RISK AND BENEFIT SHARE ARRANGEMENTS

Has a risk management strategy been drawn up?
Set out arrangements, if any, for the sharing of risk and benefit in relation to the Individual Scheme.

REGULATORY REQUIREMENTS

Are there any regulatory requirements that should be noted in respect of this particular Individual Scheme?

INFORMATION SHARING AND COMMUNICATION

What are the information/data sharing arrangements?
How will charges be managed (which should be referred to in Part 2 above)
What data systems will be used?

Consultation – staff, people supported by the Partners, unions, providers, public, other agency
Printed stationery

DURATION AND EXIT STRATEGY

What are the arrangements for the variation or termination of the Individual Scheme.
Can part/all of the Individual Scheme be terminated on notice by a party? Can part/all of the Individual Scheme be terminated as a result of breach by either Partner?
What is the duration of these arrangements?

(1) *Set out what arrangements will apply upon termination of the Individual Service, including without limitation the following matters addressed in the main body of the Agreemen1) maintaining continuity of Services) allocation and/or disposal of any equipment relating to the Individual Scheme) responsibility for debts and on-going contracts) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements)) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.*

Consider also arrangements for dealing with premises, records, information sharing (and the connection with staffing provisions set out in the Agreement.

OTHER PROVISIONS

Consider, for example:

Any variations to the provisions of the Agreement
Bespoke arrangements for the treatment of records
Safeguarding arrangements

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Signed by		
Date		
On behalf of	NHS Devon Clinical Commissioning Group	Devon County Council

–JCCG TERMS OF REFERENCE

The JCCG Leadership Group referred to in this Schedule has no active role in the governance of the Partnership Agreement. However, references to this Group remain in this Schedule in order to replicate the agreed Terms of Reference for the JCCG

A. Document control

Version	Date	Author	Change Ref	Sections Affected
Draft V0.01	15/05/15	JB	Initial draft	All
Draft V0.02	15/05/15	AG	Initial draft review	All
Draft V0.03	18/05/15	JB	2nd draft review	All
Draft V0.04	27/05/15	AG	3rd draft review	All
Draft V0.05	03/06/2015	AG	4th draft review	All
Final v1.0	02/07/2015	AG	Final version	All
Revised	12/02/2016	KDD	Revised version JCCG Leadership	1.2, 3.4, 4.2, 5.2, 6.2
Revised	05/05/2016	PL	Revised terms of reference for finance representatives and financial reporting	3.2, 5.1.5
Final v1.1	26/9/2016	JL	New Attendee added	2
Refresh V2	22/03/2017	SS	Refresh	All
Refresh V3	21/11/2017	SS	Refresh for 2017/18	All
Refresh V4.0	7/10/19	NP	Refresh for 2019/20 (approved March 2019)	All
Refresh V5.0	5/10/20	NP	Refresh for 2020/21 (approved October 2020)	2,3, 4(b),5

Joint Coordinating Commissioning Group (JCCG)
Terms of Reference (rev. Oct.2020)
Agreed JCCG 5/10/20

1. Purpose
   The Joint Coordinating Commissioning Group provides system leadership and oversight of all joint commissioning arrangements including the Better Care Fund, between Devon County Council and NHS Devon CCG (for the area covered by DCC). The members have delegated authority from their organisation to make decisions on joint commissioning issues.

2. Membership and attendance at meetings

   a. Joint Associate Director of Commissioning or deputy
   b. DCC County Treasurer or deputy
   c. NHS Devon CCG Chief Finance Officer or deputy
   d. Associate Directors of Commissioning

   Regular attendee without membership:
   - Deputy Head of Service – Adult Commissioning and Health (DCC)
   - Head of Integrated Care Model- Northern and Eastern Locality (CCG)

- Head Accountant – Health (DCC)

The group may invite other appropriate officers as required to support reporting on progress and inform key decisions.

The Joint Associate Director of Commissioning (or deputy) will chair the meetings.

3. Quorum
   - Joint Associate Director of Commissioning or a deputy agreed by all members
   - At least one commissioning representative from both DCC and the CCG.
   - At least one finance representative from both DCC and the CCG

   Decisions of the JCCG shall be made unanimously. Where unanimity is not reached then the item in question will be referred to the next meeting of the JCCG. If no unanimity is reached on the second occasion, then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the s.75 Agreement.

   Where a partner is not present a matter may be discussed, and those present may make and record a conditional decision pending written agreement from the absent partner.

4. Purpose and responsibilities
   a. Ensure that direction and strategies are in line with the priorities identified in the STP
   b. Setting direction, agreeing priorities and providing oversight and assurance of all joint commissioning including the BCF pooled fund
   c. The commitment or redeployment of resources associated with related programmes within limits delegated by statutory partners to the individual officers
   d. Coordinate and provide information to committees of the partner statutory organisations and to the Health and Wellbeing Board as required

5. Frequency
   Meetings will usually be held monthly for the first quarter, then quarterly from June (or as required). For 2020/21 meetings will be monthly. Decisions may be made by email correspondence if a face to face meeting is unable to be convened.

6. Accountability, authority and reporting
   The JCCG is accountable to partner organisations and reports progress to the Health and Wellbeing Board.

The JCCG is not a formal committee of any of the statutory partners; authority is exercised by the individual officers on behalf of the organisations to whom they are accountable and within their delegated limits. Within these parameters, decisions can be made at the meeting.

Each Member is accountable for ensuring all appropriate internal decision-making bodies are appropriately engaged. They are also accountable for dissemination of information from JCCG back to their respective organisations.

7. Post-termination
   The JCCG shall continue to operate in accordance with this Schedule following any termination of this Agreement to fulfil the duties required under this schedule but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

8. Review
   The JCCG will review these terms of reference annually or more frequently if BCF guidance or STP governance arrangements necessitates it.

SCHEDULE 3 – CONTRIBUTIONS TO THE POOLED FUND, RISK SHARE AND OVERSPENDS

1. **Structure of the Pooled Budget**

1.1 The overall budget will be sub-divided into three pools: a Capital Pool, an Improved BCF Pool and a Revenue Pool. This division exists solely to recognise the restrictions placed on the use of grants from central government. Revenue expenditure can be incurred in the Improved BCF Pool and the Revenue Pool.

1.2 The amounts allocated to each Pool at the start of the financial year shall be as follows:

Table 1

2020-21

Contributions	Carry-forward	20-21 sources	**Revenue**	Carry-forward	20-21 sources	**Capital**	**Total**
	£	£	**£**	£	£	**£**	**£**
Devon County Council	1,740,376	4,154,000	**5,894,376**			**0**	**5,894,376**
Devon County Council - ringfenced grants		28,270,473	**28,270,473**	0	8,245,371	**8,245,371**	**36,515,844**
NHS Devon CCG		58,091,132	**58,091,132**			**0**	**58,091,132**
	1,740,376	**90,515,605**	**92,255,982**	**-**	**8,245,371**	**8,245,371**	**100,501,352**

Application	Carry-forward	20-21 sources	**Revenue**	Carry-forward	20-21 sources	**Capital**	**Total**
	£	£	**£**	£	£	**£**	**£**
Capital - Central			**0**	0	8,245,371	**8,245,371**	**8,245,371**
iBCF	1,009,617	28,270,473	**29,280,090**				**29,280,090**
Revenue - Central	730,759	51,803,132	**52,533,892**				**52,533,892**
Revenue - Localities		10,442,000	**10,442,000**				**10,442,000**
	1,740,376	**90,515,605**	**92,255,982**	**-**	**8,245,371**	**8,245,371**	**100,501,352**

1.3 The detailed allocation between localities and to individual schemes is set out in Schedule 5 to this agreement.

2 **Virements**

2.1 Virements are permitted within each Pool, subject to agreement by the JCCG, or in the case of the Improved BCF Pool, by the named accountable officers.

2.2 In reaching decisions on any virement between schemes within each Pool, including decisions on where to invest any uncommitted funds, the JCCG or accountable officers will take into account:

2.2.1 …geographical boundaries and effect on overall spending of the fund in relation to contributions to it; and

2.2.2 …the objectives of the Better Care Fund

2.3 If a virement is made under this paragraph 2 of Schedule 3, then the JCCG or accountable officers will make any corresponding amendments needed to Table 1 of Schedule 3 and Schedule 5 to ensure any virement does not cause an Overspend or Underspend.

3 **Overspends**

3.1 If there is an Overspend in the Revenue Pool, the Partners will meet the percentage of the Overspend amount for that Pool set out in Table 2

Table 2

Devon CCG	50%
Devon CC	50%
Total	100%

3.2 The Capital Pool will be used solely to make fixed contributions to specified projects: as a result, the issue of overspending should not arise. Allocations to projects must fall within the total amount available in the Capital Pool.

4 **Underspends**

4.1 All parties agree that the money should be used for the benefit of the health and wellbeing of the people within the administrative area of Devon County Council

4.2 If there is an Underspend in either the Revenue Pool or the Improved BCF Pool the percentage of the Underspend amount set out in Table 2 for that Pool will be returned to the Partners. The Relevant Partners can agree to then carry forward any Underspend to the next Financial Year if they wish to do so.
Decisions on the specific use of a carry forward from these pools will be subject to the agreement by the JCCG.

4.3 The Capital Pool is funded by central government grants for capital purposes. If there is an Underspend in the Capital Pool that relates to the use of these grants, that funding can only be used for capital purposes in a future financial year or returned to central government. Therefore, any unspent capital grant will be carried forward to the following financial year, subject to permission from the relevant Government Department to do so.

5 **Additional contribution managed via the BCF governance arrangements**

5.1 One of the contracts included in the Fund is a dementia support contract. The scope of this contract has been extended to cover the Torbay area. In recognition of that wider scope, Devon CCG will contribute an additional £110,000. Although not strictly part of the Fund itself because Torbay lies outside the Fund's boundaries, the additional contribution will be managed in the same way as the Fund itself and is subject to the same governance and risk-share arrangements.

SCHEDULE 4 – JOINT WORKING OBLIGATIONS

– LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS National Form Contract save where this Agreement or the context requires otherwise.

The Lead Commissioner shall notify the other Partners if it receives or serves:

a Change in Control Notice;

a Notice of a Event of Force Majeure;

a Contract Query;

Exception Reports

and provide copies of the same.

The Lead Commissioner shall provide the other Partners with copies of any and all:

CQUIN Performance Reports;

Monthly Activity Reports;

Review Records; and

Remedial Action Plans;

JI Reports;

Service Quality Performance Report

Service Contracts entered into (electronic only);

The Lead Commissioner shall consult with the other Partners before attending:

an Activity Management Meeting;

Contract Management Meeting;

Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

The Lead Commissioner shall not:

permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

vary any Provider Plans (excluding Remedial Action Plans);

agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

give any approvals under the Service Contract;

agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

suspend all or part of the Services;

serve any notice to terminate the Service Contract (in whole or in part);

serve any notice;

agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners (acting through the JCCG) such approval not to be unreasonably withheld or delayed.

The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports)

– OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS National Form Contract save where this Agreement or the context requires otherwise.

Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

resolve disputes pursuant to a Service Contract;

comply with its obligations pursuant to a Service Contract and this Agreement;

ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the Service Contract;

No Partner shall unreasonably withhold, or delay consent requested by the Lead Commissioner.

Each Partner (other than the Lead Commissioner) shall:

comply with the requirements imposed on the Lead Commissioner pursuant to the Service Contract in relation to any information disclosed to the other Partners;

notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 - INDIVIDUAL SCHEME VALUES

2020-21

	Total	Locality				
		Central	East	North	West	South
	£	£	£	£	£	£
Capital	**8,245,371**	**8,245,371**	**0**	**0**	**0**	**0**
Disabled Facilities Grant						
Disabled Facilities Grant	8,245,371	8,245,371				
Winter Pressures	**3,575,532**	**3,575,532**				
Winter Pressures (part of iBCF grant)	3,575,532	3,575,532				
Revenue	**62,975,892**	**52,533,892**	**5,159,000**	**2,226,000**	**1,274,000**	**1,783,000**
Care Act duties (non carer)						
Care Act duties (non carer)	172,000	172,000				
Dementia Diagnosis						
Dementia Alzheimer's Contract	572,000	572,000				
Dementia Café	32,000	32,000				
Dementia Capable Communities	0	0				
Dementia Partnership	6,000	6,000				
Enabler						
CCT Co-ordination for the virtual ward	413,000		191,000		145,000	77,000
Community Support Contracts	216,000	216,000				
Devon Doctors	72,000		72,000			
Exeter Acute Community Team	671,000		671,000			
Finance and Project Support for Better Care Fund	58,000	58,000				
Joint Agency Business Support and programme management costs	19,000			19,000		
LD Review Team	146,000	146,000				
LD Specialist Team	262,000	262,000				
MH Out of area placements	1,000,000	1,000,000				

Revenue continued	Total	Locality				
		Central	East	North	West	South
	£	£	£	£	£	£
Enabler infrastructure - Hospital Discharge services						
Discharge Support Devon Partnership Trust	34,000		34,000			
Hospital discharge facilitation	347,000				97,000	250,000
ND4 Com Hosp Discharge Co-ord	125,000			125,000		
ND7 Pathfinder	118,000			118,000		
Onward Care	299,000		299,000			
Order Communication System CHC posts	44,000		44,000			
Enhanced Carers offer						
Action for Children Family Based Respite Care	0	0				
Carers	3,886,000	3,886,000				
Enhanced Community Equipment Service						
Adult Equipment Store	6,366,000	6,366,000				
Additional one-off funding	730,759	730,759				
Children Equipment Store	678,000	678,000				
Frailty and Community Care						
Care Home Team Roll Out	70,000		70,000			
Community Services for NHS Devon CCG	22,928,897	22,928,897				
Connected Communities and Supported Volunteering	41,000	41,000				
District Nurse Support to residential homes	195,000			195,000		

Revenue continued	Total	Locality				
		Central	East	North	West	South
	£	£	£	£	£	£
DTOC	0	0				
Rapid Response Domiciliary Care						
Rapid Response Domiciliary Care	3,303,000		1,909,000	615,000	330,000	449,000
Single Point of Co-ordination						
Community Hub	30,000			30,000		
Single Point of Co-ordination	414,000			110,000	145,000	159,000
Social Care Reablement						
Social Care Reablement	600,000		371,000	111,000	48,000	70,000
Step Up Step Down Care						
ED2 Home Based Reable WEB H@Home	324,000		324,000			
ED3 Home Based Reable Wakeley	443,000		443,000			
ED5 Home Based Reable Mid Devon	471,000		471,000			
Exeter Step Up Step Down Beds	40,000		40,000			
Home based Intermediate Care	1,287,000				509,000	778,000
Mid Step Up Step Down Beds	84,000		84,000			
ND1 Personal care inc Dom	150,000			150,000		
ND2 Home Based Intensive Rehab	653,000			653,000		
ND8 Recuperative Placements	100,000			100,000		
Recuperative Care	0				0	0
Stroke Early Supported Discharge	100,000		100,000			
Wakeley Step Up Step Down Beds	6,000		6,000			
WEB Step Up Step Down Beds	30,000		30,000			

Revenue continued	Total £	Locality Central £	East £	North £	West £	South £
Support to social care						
Support to social care	15,248,235	15,248,235				
Additional support to social care	0	0				
SWAS FT Right Care, Right Place						
SW Ambulance FS Trust Right Care	191,000	191,000				
Revenue - iBCF grant	**25,704,558**	**24,843,941**	**391,729**	**195,283**	**124,122**	**149,483**
Support to social care	19,650,187	19,650,187				
Market sufficiency - personal care	500,000	500,000				
Technology Enabled Care and Support	0	-				
Prevention	214,000	214,000				
Mental Health Services	1,206,000	1,206,000				
Disability Services	47,500	47,500				
Older People - North	500,000	500,000				
Older People - East	1,230,000	1,230,000				
Older People - West	280,000	280,000				
Older People - South	500,000	500,000				
Strategic Market Development	567,254	567,254				
Short Term Services	1,009,617	149,000	391,729	195,283	124,122	149,483
Grand Total	**100,501,352**	**89,198,735**	**5,550,729**	**2,421,283**	**1,398,122**	**1,932,483**

SCHEDULE 6 – BETTER CARE FUND

BETTER CARE FUND PLAN **in** **http://www.devonhealthandwellbeing.org.uk/jsna/bcf/**

SCHEDULE 7 – POLICY FOR THE STANDARDS OF BUSINESS CONDUCT AND MANAGEMENT OF CONFLCITS OF INTEREST

1. **Better Care Fund**

1.1 This policy is in addition to the standards of business conduct and managing conflicts of interest set out in the CCG's constitution and Devon County Council's Constitution.

1.2 Engagement of providers is vital to ensure the success of the Better Care Fund. Some service providers can attend sub groups established by the JCCG, such as the iBCF Governance Group. This results in a situation whereby they are present when decisions regarding services they perform are made or recommendations are agreed to be put forward to the Joint Coordinating Commissioning Group.

1.3 To mitigate this conflict of interest the parties must recognise that:

Any sub groups established by the JCCG will not be a decision making group unless delegated by the JCCG. In that context, the authority of sub-groups is derived from the individuals present. Although such groups will help to ensure that the voices of interested parties are listened to and considered, the decision or recommendation rests with the commissioning parties.

2. **Standards of Business Conduct**

2.1 Employees, Members, Committee and Sub-committee members of the parties should uphold the utmost standard of business conduct in all their dealings with and pertaining to this section 75 agreement. They should act in good faith and in the interests of the population of Devon and should follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles).

2.2 They must comply with their own party's policy on business conduct, including the requirements set out in the policy for managing conflicts of interest.

2.3 Individuals contracted to work on behalf of the parties or otherwise providing services or facilities to the parties will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

3. Conflicts of Interest

3.1 As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, and the Localism Act 2011, the parties will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the parties will be taken and seen to be taken without any possibility of the influence of external or private interest.

3.2 Where an individual, i.e. an employee, Member, Governing Body Member, or a member of a Committee or a Sub-Committee of the parties or its Governing Body or its Council has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the parties considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this policy.

3.3 A conflict of interest will include:

3.4 Disclosable pecuniary interests including:

a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

an indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

3.5 Interests other than disclosable pecuniary interests:

(i) a non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

(ii) a non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

(iii) where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

3.6 If in doubt, the individual concerned should assume that a potential conflict of interest exists.

4. Declaring and Registering Interests

4.1 The parties will maintain their own registers of the interests which will be made available to the JCCG.

4.2 Copies of the register are available from individual parties' websites.

4.3 Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the group, in writing to the governing body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

4.4 Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

5. Managing Conflicts of Interest: general

5.1 Individual members of the group, the governing body, committees or sub-committees, the committees or sub-committees of its governing body and employees will comply with the arrangements determined by the group for managing conflicts or potential conflicts of interest.

5.2 The Chair of the Joint Coordinating Commissioning Group (JCCG) will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the group's decision making processes.

5.3 Arrangements for the management of conflicts of interest include the following:

(i) when an individual should withdraw from a specified activity, on a temporary or permanent basis;

(ii) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

5.4 Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Chair of the JCCG.

5.5 Where an individual member, employee or person providing services to the group is aware of an interest which:

(i) has not been declared, either in the register or orally, they will declare this at the start of the meeting;

(ii) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests.

5.6 The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

5.7 Where the chair of any meeting of the group, including committees, sub-committees, or the governing body and the governing body's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

5.8 Any declarations of interests, and arrangements agreed in any meeting will be recorded in the minutes.

5.9 Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.

5.10 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of

interest or potential conflicts of interests, the chair of the meeting shall consult with each parties' Governance Lead on the action to be taken.

5.11 This may include:

(i) requiring another of the group's committees or sub-committees, the group's governing body or the governing body's committees or sub-committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible,

(ii) inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the governing body or committee / sub-committee in question) so that the group can progress the item of business:

5.12 These arrangements must be recorded in the minutes.

6. Managing Conflicts of Interest: contractors and people who provide services to the group

6.1 Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the clinical commissioning group in relation to the potential provision of services or facilities to the group, will be required to make a declaration of any relevant conflict / potential conflict of interest.

6.2 Anyone contracted to provide services or facilities directly to the parties of this agreement will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

7. Transparency in Procuring Services

7.1 The parties recognise the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The parties will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

SCHEDULE 8 – INFORMATION SHARING PROTOCOL

The Information Sharing Protocol can be found at:

https://devoncc.sharepoint.com/:w:/s/InformationGovernance/ETdKg4W4T6lOoZFHtgnIi8wB1SivCAwlu7LEpYfo9OMUdQ?e=afmB2j

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 25th March 2021

Date of Committee covered in this report: 4th March 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

Finance Report

- The primary care position is forecast as a small annual underspend (on premises changes) with break-even forecast across the wider CCG
- Finance support for delegated primary care has become fully CCG owned
- Budget setting for next year – expectation of continuation of current arrangements for at least 1st Quarter of next year after which return to business as usual is anticipated.

Deputy Director's Report – with updates on

1. Personal Medical Services Premium Funding
2. Committee Forward Planner
3. Honiton Surgery
4. Barton Learning
5. Special Allocation Service

Summary of Deferred Activity due to COVID

The Primary Care team, with clinical input, reviewed the LES and DES services and agreed the services which could be suspended, or paused subject to clinician discretion, during this period

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

NHS
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GOVERNING BODY

Report title: Committee Chair Report – Commissioning Committee

Date of Governing Body: Thursday 25th March 2021

Dates of Committees covered in this report: Thursday 11th March 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
- Note the transfer of risk 11 to the Urgent Care Team risk register
- Note risk score increase Risk 134, Operational delivery by Child and Family Health Devon. Score reviewed and increased due to continued lag in providing information and financial decision making (in relation to autism wait list).

Committee Decisions

Options for Establishing and Implementing Diagnostic Imaging Networks in the South West Peninsula

The Committee approved in principle the recommendations made within the options for establishing and implementing diagnostic imaging networks in the South West Peninsula paper, as outlined below:

- Imaging diagnostics has been a service where collaboration throughout the Peninsula has become a fundamental part of its normal operations. Examples of this are the development of the Peninsula Radiology on Call service and the collaborative work to create a single incidence of Picture Archiving and Communication System and Radiology Information System.

- The decisions made by the joint Peninsula leadership to support the recommendations for imaging diagnostics from the Peninsula Clinical Services Strategy workstream has confirmed and reinforced the appetite throughout the Peninsula to continue to work in a collaborative way to realise the strategic aspirations of the Peninsula leadership. The Collaboration model is the best fit in aligning and supporting the existing culture, strategy, and aspirations of the Peninsula.
- Development of an imaging network is significant strategic change that has the potential to disrupt the service. The model that would support the continuation of the ongoing Peninsula Clinical Services Strategy work and minimise disruption is the Collaboration model.
- The authors of this document would recommend to the Commissioning Committee approval of development of the governance structures to support the Collaboration model of operational governance as the first step in the formal development of the Peninsula Imaging Network.
- Approval of the recommended operational governance model will trigger the process to design and develop the appropriate governance structures for approval. The model as described below mirrors the guidance from NHS England.

Newborn Hearing Screening Programme

The Committee approved the 9 recommendations made within the Newborn Hearing Screening Programme, as outlined below:

- **Recommendation 1:** The committee are invited to note the risk and impact from Newborn Hearing Screening Programme National IT system (provided under contract with Public Health England by Northgate Public Services) changes and the impact and potential risk this has on our planning and decisions. This has brought forward the start date for the new arrangements to 1st December 2021, (from 1st April 2022).
- **Recommendation 2:** Based on the planning and to mitigate risks it is proposed that there is a phased approach to our commissioning arrangements for Newborn Hearing Screening Programme; Proposed phased approach.
    - **Phase 1:** new service in North and East Devon changes from a community to hospital model/targets, and Torbay and Plymouth screen babies currently screened by Devon County Council Public Health Nurses providing a solution for South Devon, South Hams and West Devon areas
    - **Phase 2:** (from April 2022) review Torbay and Plymouth services and models, in partnership with NHS Kernow CCG, NHS England/Improvement and Public Health England.
- **Recommendation 3:** The commissioning committee are invited to consider the proposed key milestone's (the milestones are indicative and subject to further planning).
- **Recommendation 4:** New Newborn Hearing Screening Programme service for North and East Devon commencing on 1st December 2021 delivering a hospital model. Either Royal Devon & Exeter Foundation Trust or North Devon Healthcare Trust be lead provider and host Newborn Hearing Screening Programme service.
- **Recommendation 5**: Indicative costs have currently been identified but will require further negotiation. In terms of both non recurrent and recurrent funding. The current estimates are that in 2021/22 £147k and in 2022/23 £82k is required.
- **Recommendation 6:** It is proposed that commissioners and providers for the Devon County Council Public Health nurses and the new North and East Devon service, Torbay and Plymouth review current equipment resources and considerations about surplus and new devices are part of the further planning discussions about budgets and on-costs are anticipated.
- **Recommendation 7:** To ensure there is the capacity and a competent workforce the new arrangements require pump-priming of new screening staff and non-recurrent funding in 2021/22. Recruitment should commence by providers, including by the Devon County Council Newborn Hearing Screening Programme

Team Leader/Local Manager aiming to get staff into post by July 2021 at the latest, this mitigates risks for insufficient staffing capacity for new arrangements.

- **Recommendation 8**: It is proposed that following the decision by the commissioning committee, contracting and commissioners work with providers to progress planning discussions and negotiations aiming for final decision by 31st March 2021.
- **Recommendation 9:** The commissioning committee are invited to consider the restructure and transfer guidance, to assure a safe transfer the planning will need a dedicated CCG resources (commissioning, contracting and finance) to lead and support the process from April – December 2021.

ADHD & Autism Review

The Committee approved the recommendations made within the ADHD & Autism Review Papers, as outlined below:

- Approve the adoption of the following criteria for commissioning of services for ADHD and adult social care, that provide the best patient outcomes for patients and within finite budgets available:
    - Services must provide for the full patient pathway and episode of care including advice and guidance, assessment, treatment (including physical health checks) and ongoing prescribing and monitoring via follow up including through shared care arrangements where clinically appropriate in agreement with GP practices
    - The costs of service will be provided at the local tariff rate
    - The service will not lead to inequity of access or exacerbate inequalities
- Note that referral pathways, 'best practice' guidance and referral templates have been developed with clinical leads.
- Note that Shared Care arrangements are being developed and will be discussed at the Formulae Interface Group on 28th April and after at Local Medical Committee
- Note interim communications are being developed to reflect the agreed approach
- Note trajectories on reducing waiting times are being finalised for agreement within contracts for 2021/22
- Acknowledge that further financial work is required to understand the overall budgetary pressures in the next financial year.

Suicide Postvention

The Committee approved the recommendations made within the Suicide Postvention paper, as outlined below:

- It is recommended that the contract is awarded to the provider detailed in the Contract Award Recommendation Report with agreed assurances and actions contractualised with a clear timeline for delivery against.
- 3.2 Decision is requested in relation to awarding a contract knowing that the financial envelope and potential cost incurred are not aligned. To note the assurance provided from the preferred provider in relation to the financial risk would be incorporated into contract award.

Items of concern to be escalated to the Governing Body

ADHD & Autism Review

The Committee noted that the ADHD & Autism item should be escalated to Governing Body Members. The Committee members were made aware that the CCG may be open to legal challenge by a current provider who are only providing parts of the pathway and not the full pathway for both ADHD and Autism services.
Recommendations for Governing Body
None.
Recommendations for other Committees
None.
Terms of Reference or other committee effectiveness issues
None.

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NHS
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Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 25 March 2021

Dates of Committees covered in this report: 18 March 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, long waits and follow up backlogs. The low number and lateness in the day of discharges is causing a backlog of patients on a daily basis. This results in patients in Emergency Department being unable to be admitted to wards. This has been inherent for a number of years and despite best efforts with regards to significant programmes of work to improve early discharge. With the Emergency Department full, delays have been incurred by ambulance crews when trying to handover.
- **Elective care and planned care:** Waiting lists are growing and the system risk increases. The system response includes providers working closely together. The Independent Sector (IS) has played a key role in delivering urgent planned care during the pandemic, but this national approach/ contract will be coming to a phased end in March. The CCG and NHS providers will continue to work closely with the Independent Sector. Moving forward, NHS providers will be stepping up the planned care services for all patients.

Childrens and Family Health Devon Improvement Plan:
Intensive work continues to improve waiting times where performance is below required RTT.
Key areas of focus

- Data cleansing continues and data transfer onto a standard electronic record system
- Improvement plans and trajectories for all pathways – internal efficiencies created through pathway re-design, standardising productivity and utilisation of clinical resources, improved clinical triage and streaming, increasing digital offers for self-management and brief interventions.
- Demand and capacity work – the service has engaged with NHSEI to work with clinical leads to strengthen management of demand and capacity using the D&C tool for complex pathways.
- Augmented performance management of waiting times and trajectories is on-going.
- Ofsted and CQC inspectors return to Devon on 19th March 2021 for a SEND monitoring visit at which we will be expected to present a firm plan to address the number of CYP waiting and duration of waits.

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 4 March 2021 of which it informs the Committee of any changes since the last Quality Assurance Committee (QAC) on the 18 February 2021. Fourteen risks report to QAC. The Committee • **Noted** that three risks have moved in score. • **Agreed:** risk 143 - RDEFT COVID-19: Nosocomial COVID-19 infection. • **Risk 105** to remain at the same score - Devon Doctors Call Stacking – The Committee agreed the risk score would remain**.** Darryn Allcorn highlighted that the risk in its current form does not give the CCG true assurance around the actual risks, in light of the CQC report. It was agreed that this risk be reviewed and to remain open until new risk/s are added to the Risk Register around the GP Out of Hours service, 111 service and contingency. The CCG also need to consider incorporating risk 126**.**
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
None

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