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

MS Teams joining details contained within formal invitation

26 November 2020 13:30 - 26 November 2020 16:30

AGENDA

#	Description	Owner	Time
1	Patient Experience Speaker	Non-Exec Lay Member Public and Patient Involvement	13:30
2	Welcome and Apologies Verbal	Chair	13:50
2.10	Questions from the public Verbal	Chair	
3	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 202011... 6	Chair	14:00
4	Minutes of last meeting and action log Paper 1 Draft PUBLIC GB minutes 271020 v1 nc_198174... 11 Master Action Log - PUBLIC v2 nc.xlsx 23	Chair	14:05
5	Chair's Report Paper 1 cover sheet chair's report.docx 24 2 Chairs Report November 2020.docx 26	Chair	14:10
6	Accountable Officer's Report Paper GB 26 November 2020 - Accountable Officer (AO) r... 28	Accountable Officer	14:20
7	PROGRAMMES OF WORK		14:30

#	Description	Owner	Time
7.10	Winter Plan Paper 1 winter plan GB cover sheet_840114806.docx 33 2 Devon system winter plan 202021 PUBLIC_8401... 35	Chief Operating Officer	
7.20	BREAK		15:00
8	FINANCE, PERFORMANCE AND QUALITY		15:15
8.10	Month 7 Finance Report Paper FPCReportFPCMonth 7Final202021 GB Cover_84... 80 FPCReportFPCMonth 7Final202021 GB Version_8... 83	Finance Director	
8.20	Performance and Quality Report Paper GB Public 261120 Nov Performance Quality report... 102	Chief Operating Officer/ Chief Nurse	
9	GOVERNANCE		15:45
9.10	Emergency Preparedeness Resilience Response (EPRR) Framework Paper 1 GB report EPRR cover sheet 202011_84011480... 126 2 Devon CCG EPRR Policy v1.1 2020-11-16.docx 129	Board Secretary	
10	COMMITTEE CHAIR'S REPORTS		15:55

#	Description		Owner	Time
10.10	Audit Committee Chair's Report Paper		Audit Committee Chair	
	1 Audit Committee Chair Report 111120cd_198174...	140		
	2 4a Audit Commitee Risk Report 11 November 20...	142		
	4a Appendix 1 Audit Committee Risk Report 27 Oc...	149		
	4a Appendix 2 Significant Risks on Corporate Risk_...	152		
	4a Appendix 3 Risk 113 EPRR Core Standards_19...	156		
	4a Appendix 4 Risk 127 Increased fraudulent activ_...	158		
	4a Appendix 5 Risk 128 Shared working area confi...	159		
	4a Appendix 6 Risk 129 Business Continuity_19817...	160		
	4a Appendix 7 Risk 130 COVID19 Incident Respon...	161		
	4a Appendix 8 Risk 131 Emergency Preparedness...	162		
10.20	Quality Assurance Committee Paper		Chair of Quality Assurance Committee	
	1 QAC Part 1 Chair Report November 2020 V4.doc...	163		
	2 Quality Assurance Committee terms of reference...	167		
10.30	Commissioning Committee Paper		Secondary Care Doctor	
	November GB Commissioning Committee Report 1...	174		
10.40	Finance Committee Paper		Chair of Finance Committee	
	Finance Committee Chair Report 19 November 20...	176		
10.50	Primary Care Commissioning Committee Paper		Chair of Primary Care Commissioning Committee	
	Nov + JH Committee Chair Report - Public PCC - N...	179		
11	LOCALITY UPDATES			16:20

#	Description		Owner	Time
11.10	Northern, Eastern, Southern and Western Paper		Locality Triumvirate	
	[P] 0 Locality Updates Cover Sheet_1981745755 REVI...	182		
	[P] 1 Northern Locality Report November 2020 V2_198...	184		
	[P] 2 Locality Update Report Eastern November 2020_...	187		
	[P] 3 South Locality Update Report November 2020_19...	189		
	[P] 4 WL Update Report November 2020 Agreed_198...	193		

Declaration of Interests Register - Governing Body

Register updated and generated by the Governance Team - 13 November 2020

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Allcorn	Darryn	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
	Ball	Nick	Vice Chair/Non Executive Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geographical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 , Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		10/05/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Blackford	Derek	Associate Director of Finance	Attendee of Audit Committee (Deputy for CFO) Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Member of Vacancy Control Panel	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Non Executive Lay Member - Patient and Public Involvement Geographical remit - Northern	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Member Primary Care Commissioning Committee (PCCC)	Self-Employment business consultant from September 2019 Associate for Research In Practice Feb 2020 Associate for Research In Practice Supplier/Associate for SWAHSN (Feb 2020) Within my role as SWAHSN associate will be part of their project team which is supporting the Think 111 project Associate for Devon Communities Together		04/04/2019		04/08/2020	Financial/Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Carroll	Jayne	Interim Chief Operating Officer	Member Governing Body Member of Senior Leadership Team (SLT) Commissioning Committee (CC DOI) Member of Finance and Performance Committee Devon Urgent Care Board	Independent member of Fostering Panel for Pathway Care.		08/08/2020		08/08/2020	Professional	Indirect		NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt School Governor for Tavistock Primary and Nursery School	Partner is employed by Livewell Southwest in position of influence	26/09/2017		17/09/2020	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

	Coles	Anna	Locality Director - Plymouth	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning) Strategic Commissioning Partnership Meeting	No interests declared		12/03/2019	22/10/2020				Plymouth City Council
	Davis	Alison	Associate Non-Executive Director	Attendee Governing Body	Plymouth City Council – Foster panel Chair Torbay Council- Foster panel Chair Pathway Care Fostering- Ashburton- Independent Reviewing Officer University of Exeter – student mentor Somerset County Council- casual employee		19/10/2019	20/10/2020	Personal, Professional & Financial	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015	20/10/2020			Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Doble	Clare	Head of Governance Deputy Senior Information Risk Owner (SIRO)	Attendee of Audit Committee Quality Assurance Committee Primary Care Commissioning Committee (PCCC) Governing Body (ad hoc) Health and Safety Group Chair Staff Partnership Forum Data Protection Steering Group	Member of Taunton & Somerset NHS Foundation Trust Godmother to member of governance team's daughter	Partner on secondment to CCG Business Intelligence Team	22/08/2017	21/08/2020	Non-Financial Personal Interest	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)	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
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 Geograhical remit - Southern	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) (Chair) Member of Remuneration and Workforce Committee		Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	10/03/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Harrell	Ruth	Director of Public Health, Plymouth City Council	Devon STP Clinical & Professional cabinet NHS Devon CCG Governing Body Member of Devon JCEG	Director of Public Health for Local Authority		26/10/2016	18/08/2020	General	Direct		Plymouth City Council
	Harris	Penny	Interim Executive Director of Commissioning - In Hospital	Attendee of Governing Body CCG Execs and Clinical Chairs Senior Leadership Team (SLT) Strategic Commissioning Partnership Meeting CCG Executive Team Meeting Finance and Perfomance 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		26/09/2017	14/08/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Attendee of Audit Committee Member Strategic Commissioning Programme Board Commissioning Committee (CC DOI)	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Lees	Sarah	Representative of Director of Public Health for Plymouth City Council	Member of Governing Body (Deputy) Member of Primary Care Commissioning Committee (PCCC) Population Core Group	School Governor, College Road Primary School, Plymouth	Husband is an employee of Livewell Southwest	10/11/2017		Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Manton	Sonja	Executive Director SRO for Integrated Care Partnership (Western Devon)	Member of Governing Body CCG Executive Team Meeting Joint Staff Partnership Forum Senior Leadership Team (SLT) Attendee Audit Committee Chair of Integrated Care Partnership Executive Group	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit	03/04/2017	25/09/2020	Professional & personal	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Lead Clinical Representative (Western) – CCG Governing Body Strategic Clinical lead - Maternity Clinical Lead - Western Locality	Member of Governing Body Member of Quality Assurance Committee Member of QEIA Panel Member of Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) Member of Individual Packages of Care Panel (IPOC) Member of Local Maternity System (LMS) Board and Operational Committee	Elected member (and Deputy Chair from September 2019), South West Regional Council of BMA GP Appraiser (NHS England) Shareholder GlaxoSmithKline Working at Church View Surgery as self-employed sessional GP Elected to the Medical managers Committee of the BMA from September 2019	Partner is: Medical Secretary and Board member of Devon LMC GP Partner, Church View Surgery, Plymstock Clinical Director of Mewstone Primary Care Network(PCN)	26/09/2017	20/10/2020	Financial, Professional & Personal Interests	Direct & Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Chief Communications, IT and People Officer, NHS Devon CCG	Member of Governing Body CCG Executive Team Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	04/03/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Pearson	Virginia	Chief Officer for Communities, Public Health, Environment and Prosperity/Director of Public Health, Devon County Council System Director of Population Health and Wellbeing, Devon STP	Co-opted Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Member of Strategic Commissioning Partnership Meeting Strategic Commissioning Programme Board	Member, STP Directors Group Member, STP Programme Delivery Executive Group Member, Devon Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Association of Directors of Public Health Member, British Medical Association Honorary Clinical Professor, University of Exeter College of Medicine and Health		02/02/2017	22/04/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council
	Quartermaine	Jade	Senior Administrator	Administrative support to: CCG Senior Leadership Team (SLT) Exec Team Meeting Governing Body	No interests declared		01/08/2016	20/08/2020				NHS Devon CCG

	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee of Quality Assurance Committee Attendee of Finance and Performance Committee Attendee of Audit Committee Attendee of Remuneration and Workforce Committee Attendee of Commissioning Committee (CC DOI) Attendee of Primary Care Commissioning Commitee (PCCC) CCG Executive Team Meeting Senior Leadership Team (SLT) Working with Industry and Sponsorship Group System Restoration and Transformation Group Member of Strategic Commissioning Partnership Meeting	No interests declared		22/03/2019	10/08/2020				NHS Devon CCG
	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Strategic Commissioning Partnership CCG Executive Team Senior Leadership Team (SLT) Attendee Audit and Assurance Committee (Audit Committee) Finance and Performance Committee	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	21/10/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	Associate Director of HR and OD	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel CCG R&T Project Team meeting	No interests declared		16/10/2018	19/10/2020				NHS Devon CCG
	Turl	Jo	Executive Director of Commissioning - Out-Of-Hospital	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Strategic Commissioning Partnership Meeting Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Quality Assurance Committee	No interests declared		13/08/2015	19/10/2020	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee (Chair)	Co-opted Councillor on Budleigh Salterton Town Council (Independent Member – non-political)	Son employed by Care Quality Commission as an Information Analyst	16/10/2019	26/11/2019	Indirect interest		Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Wheller	Kevin	Associate Director of Finance	Attendee of Audit Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Northern and Eastern Preparatory Group Working with Industry and Sponsorship Group CCG R&T Project Team meeting		Spouse is employed as a finance manager at Castle Place Surgery in Tiverton. The Surgery is operated by the Royal Devon & Exeter NHS FT	22/10/2015	25/01/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (Non exec rem)	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: 29 October 2020 Time: 14:00 – 16:30 Location: Via Microsoft Teams

Item	Discussion	*Action*
	PJ opened the meeting and noted although the meeting was not live it would be available on our website for view but hoped that if any members of the public watching would find it a valuable experience. **Patient Story** CB introduced today's patient story which was in the form of a video that was produced by the Royal Devon and Exeter NHS Foundation Trust (RDE). The video explained how the Patient and Liaison Service at the RDE supported a family, who's relative was admitted to hospital after suffering a stroke and how they supported the family to communicate with their loved one whilst we were responding to the coronavirus. On reflection the Governing Body agreed that during our response to phase one of the pandemic it was in the interests of the safety of the population to adhere to infection control measures with limiting visitors to the hospital, but in doing this there still was a communication route through to loved ones particularly for those at the end of life. CB wondered as to whether this communication resource could be replicated in social care provider sector. PJ mentioned that on the care home webinars regular reference was made to the novel approaches to maintaining links with families and that it would be good to take that learning and work with local authorities to reinforce the messages out to our care home providers. AD indicated that some care homes offer a booking system for facetime or skype calls and suggested a check in with care homes as to whether this could become normal practice rather than by exception. The chair felt this was a good and positive way to start today's meeting in demonstrating that people are working on practical solutions to overcome social boundaries.	
1	**Welcome and Apologies** The chair welcomed everyone to the meeting. Apologies noted from: Sonja Manton Gaynor Appleby Glynis Atherton Virginia Pearson	

	Caroline Dimond Ruth Harrell	
	Questions from the Public PJ referred to a question that had been submitted in advance of this meeting. *''As you will be aware, the CCG spent £13.8million last year on stoma and urology appliances, which is one of the largest spends in England. Many CCGs are advancing plans to centralise services with the aims of improving patient experience, increasing formulary compliance and containing costs. Do you have any plans to look into this area? And if so, who will be leading on this?''* Dr Paul Johnson read out NHS Devon CCGs response, which would be formally responded to following this meeting. A planned review of the provision of stoma and urology appliances is being considered for next year. The provision of such appliances is a complex area, we are aware that some CCG's are making proposals for service change and any learning would be captured as part of any future review of local services. As with many of the services the CCG delivers our spend is comparatively higher than other CCGs this is a result of our size, being the 5th largest CCG in the country. Any future review will be undertaken by the Medicines Optimisation Team within the CCG in partnership with our providers. There were no other questions submitted or raised.	
2	**Register of Interest (ROI)** PJ referred to the ROI included in the pack and no new or amended declarations made. There were no conflicts of interests declared pertaining to the agenda items scheduled for this meeting. **The Governing Body received and noted the ROI and the additional declarations made.**	
3	**Minutes of the last meeting** PJ led a page by page review of the minutes of the last meeting held on 24 September 2020. These were approved as a true and accurate record of the meeting. **The action log was reviewed and updated as follows:** 1. HR are working with line managers regarding the importance of making sure that outstanding GP wellbeing risk assessments are completed as soon as possible. AM assured the Governing Body and gave a commitment that all outstanding assessments would be completed by the next Governing Body. It was agreed for this action to be formally closed. 2. Action completed and this was formally agreed to be closed. 3. Action completed and this was formally agreed to be closed. 4. Action completed and this was formally agreed to be closed. 5. Action completed and this was formally agreed to be closed.	

4	**Chairs Report** PJ did not propose to go into the Chair's report in details but drew attention to the following. The recruitment process for the ICS CEO Lead/ CCG Accountable Officer is progressing and the long listing of candidates has taken place. The long list of candidates has been refined following conversations with Gatenby Sanderson, recruitment consultants and the interview panel will be reviewing the shortlist on Monday 02 November 2020. Stakeholder focus groups are being arranged for the 17 November 2020, with the formal interviews taking place on 18 November 2020. PJ was encouraged by applications received and was confident there would be candidates identified to move through to the interview stage. To date the process has been positive and will also include psychometric assessments and feedback from the stakeholder groups. There will also be an opportunity for MPs, councilors and members of the public to also be involved in wider stakeholder focus groups and this wider engagement which is a priority for the CCG makes this a robust process. There was a query as to the number of referees and Gatenby Sanderson suggest at least two referees along with background checks and extended conversations with clients. JH felt it would be of benefit asking for a reference from an individual who has directly worked with the candidate and how they have worked at a senior level managing up as well as managing down and it was proposed this could form part of the discussions with the wider stakeholders and public. SMc highlighted that this could pose a risk as the candidate could nominate a reference from an individual who possibly would be stepping into their role they vacate, however the Governing Body felt that there was enough leadership experience to be able to read between the lines of references. PJ confirmed that the CCG was not fixed on the number of referees and there would be no problem with increasing the numbers if the Governing Body requested this. **The Governing Body received and noted the contents of the Chair's Report.**	
5	**Accountable Officer's Report** ST presented this report and highlighted the following: There have been 1,110 written responses from the public with regards to the Teignmouth and Dawlish consultations. ST expressed his thanks to Dr David Greenwell, Dr Paul Johnson and Jo Turl for their contribution as panel members for the engagement events. He was slightly disappointed that the numbers of people attending the engagement meetings were not as many as the CCG would have liked, however the engagement that has taken place has been very good. An engagement video has been produced and is available on our website, and we are monitoring the views. A report is being developed by Healthwatch which will be presented to the consultation team and the Governing thereafter in December. GT congratulated JT, AM and the wider consultation team for the fantastic level of engagement and consultation that had taken place during our response to COVID-19 with this being done on-line, through the telephone and engaging with hard to reach groups remotely, this has set a high level standard and he wanted to thank them properly.	

	PJ echoed the approach taken by the team who screened questions if they were personal and the panel did face strong concerns and tough questions from the public meetings emotion and they were answered consistently which gave the best chance of working over virtual environment. CB proposed for a reflective learning session to support and inform engagement more broadly and this should be recognised for the willingness to improve things and she looked forward to seeing the insights coming out of the interim report. 244 nominations have been received for the staff awards and ST was pleased with the engagement from the workforce as it has been a difficult year and he acknowledged that staff were tired but took the time to nominate colleagues. The staff awards ceremony will take place virtually on the 11 November 2020 and ST requested for members to let him know if they had not received the invitation into their calendars. SMc drew attention to the 'Think 111' section of the Accountable Officer's report and felt that this project did not provide clarity and that we need to be clearer in our communication when going out to public and GP practices. JT responded that it would be the expectation that if members of the public contact GP practices the process would be the same as before, there would be no change to in hours routes for contacting general practice. The 'Think 111' project is to support urgent care out of hours, in hours and out of hours have different pathways. SMc felt there had been a missed opportunity to remind the public of alternative ways for support and to not use general practice inappropriately. It was confirmed that communications are being developed to support 'Think 111' to inform the public they can be seen in another setting as an alternative to the emergency department. The Governing Body were reminded that the 'Think 111' was in the early stages of this project and alternative pathways for the public is being developed through a phased approach. It was agreed that we will need to consider the language used in how we will communicate this to the public. SK wondered if there were enough services or projects for black, Asian, minority, ethnic (BAME) communities in Devon. AM confirmed that Dame Suzi Leather was leading on this project and that we are gathering feedback from the population as to what support is out there, what is needed and what we need to do differently. A report will be developed including recommendations that will be presented to Trust boards within the integrated care system (ICS). AM disclosed that the early findings have identified that we are not doing enough for staff, patients and the community and that we are also lacking data intelligence. **The Governing Body received and noted the contents of the Accountable Officer's Report.**	
6	**Outcomes Framework** ST introduced this item and informed the members that work had been developed on the framework over the past twelve months which has been progressed by public health and Devon CCG. The outcomes framework was recently presented to the ICS shadow partnership board in October. ST handed over to VP to provide the members with an update in more detail.	

VP referred to the paper in the pack which outlined the parameters of discussion and how the outcome framework is a useful tool which has been divided into two sections health and locality authority. The outcomes framework broadly relates to health and links directly to outcomes selected by the three Health and Wellbeing Boards (Plymouth, Devon and Torbay) who have responsibility for health improvement.

The second section is the Integrated Care System direct link to the joint health and wellbeing strategies life course approach with a selection of indicators that fit together. VP explained that this is innovative work builds on what was done previously and unpicks health inequalities to make sure analysis is built into the outcomes framework.

VP described how the framework will link to a set of performance indicators drawn from national available data and will be used to supplement local data.

She highlighted the landscape pages 36 and 37 and noted it will look differently and this was an indication of the background that will be used to pull information on trends data, sources and footprints to benchmark.

VP signaled the members to pages 38 and 39 and drew attention to the life course health of population and overarching indicators, integrated care system and outcomes chosen from system working.

VP noted the framework was not set in stone, but that NHS, Public Health and Social Care representatives will work on this which will develop and continuously be improved.

Comments from the board included:

- Acknowledged that the data will be useful if used and when developing strategies this would be a useful data source
- Noted the outcomes framework will be monitored against constitutional standards and will be part of a continuous development tool
- Agreed we must not just rely just on the health and social care community to plan the implementation it involves building understanding with our partners and communities in what we are doing to contribute, and this is everyone's responsibility to deliver
- Outcomes framework wider appeal – in public domain
- JWo fantastic start – wondered about housing and is this a move to include this. It will be reviewed as not part of 3 outcomes frameworks, and this will need to be done at a lower level of population with a direct link to the web tool to show a deeper level of detail
- Agreement this will be a basis to engage with the public to support and help them take responsibility for their health and wellbeing

PJ saw the outcomes framework as a benefit for influencing local plans and shaping where we are as a system and at place level to deliver desirable outcomes.

The Governing Body

- **Noted progress on the framework and its further development was supported, including the inclusion of additional information on interventions and priorities from ICS workstreams and the identification of system leads**

7	**Phase 3 Restoration and Transformation** JC informed the members that Phase 3 Restoration and Transformation plan was submitted to NHS England/ Improvement on 05 October 2020 and reflects plans and trajectories for getting services back online and recovery in terms of activity levels. JC thanked her colleagues who had contributed to this work and the CCG is awaiting further feedback for final sign off for the working plans to moves us into delivery. We continue to report through the performance and quality assurance committee on a monthly basis on progress to understand challenges and exceptions and we are taking remedial action as necessary. SK asked if we are aspiring to deliver more activity than before. JC replied that system targets are nationally set to specific levels which is a challenge in being able to maximise capacity in the context of responding to COVID-19 and our plans are predicated on the independent sector. JH felt it was important to register the challenges that remain in the system and understood our phase 3 aspiration to achieve delivery but would be tough due to the increase in COVID-19 cases. Uncertainty remains in a complex landscape we are facing this winter and we are committed to doing our best in the system to maximise wherever possible to deliver our requirements. It was Important for everyone to work together as a system through mutual support and aid to deliver maximum capacity all the time. **The Governing Body received and noted the Phase 3 Restoration and Transformation verbal update.**	
8	**Month 6 Finance Report** JD asked the members to take the report as read. He noted that the CCG was currently operating under the emergency financial framework which has put in place costs to support our response to COVD-19. This is an interim allocation for the first half of the financial year and processes have been put in place for retrospective reimbursement. JD directed the Governing Body to the table in section 3 of the report which details the spend on a range of health services we commission, and £33.5m was attributed to direct costs in dealing and driven by the pandemic. He indicated there were more details set out in section 4 of the report and he mentions the faster hospital discharge and other range of supporting services. The £7.5m in deficit represents the amount of reimbursement we are waiting to receive and JD assured the Governing Body there was no reason to believe the CCG would not receive this funding and was confident at the half year point we would achieve a break even position. For the second half of the year we would receive a fixed allocation. PJ asked if the extra funding that had been received was in comparison to other CCGs across the country. JD confirmed that it was similar, and that the financial framework is different to where we have been previously. The allocation share for the NHS is deemed right for the population to deal with the level of expenditure for services. DG enquired as to what the underlying deficit figure would be when we move into the next financial year so we could understand what the costs savings would be. JD responded to confirm we are working through our operational planning looking at we would need to deliver £20m savings and efficiencies. It was important to note pandemic	

	has impacted on services such as infection control measures and we won't have made progress as we have had to divert to deal with the pandemic. The financial position would worsen if there was no change to our allocation for population and at this present time, we are not sure what are allocation will be. There is a need for an assessment of costs for providing services which had increased, and JD noted caution around the £43m deficit which was very likely still to be the position for the CCG and across the wider system. JW queried why there seemed to be an increase in running costs given the CCG would have seen a benefit of savings associated with travel and expenses. JD clarified that running costs have not increased year on year there is some variation on plan, and we have seen a slight reduction linked to reduced travel costs. He also reported that the CCG is looking at other savings and running costs and the impact of home working and office accommodation and this is being worked through for 21/22 **The Governing Body:** • **Considered, reviewed and discussed the month 6 year to date performance including the current risks.**	
9	**Performance and Quality Report** This report covered the constitutional standards for performance and quality for the period of August and September 2020. The following areas were highlighted the following areas: • Cancer waits have held their position for the 62-day target. There has been slippage against the two weeks wait target which has seen a rise in the demand, which is seen as a positive showing a confidence in the public in seeking assessment • Elective surgery in understand our response to the first wave of the pandemic this has created a challenge and back log of long waiters and JC referred to page 5 of the report. This showed a breakdown and identified a rise in 52 week waits which has increased month on month. We continue to focus on this area and review specialties comparing contracts and work with clinicians to maximise capacity • Good validation process is in place and there is a major national push on waiting list validation to minimise risk. A system wide patient treatment list (PTL) is being used for a consistent approach which has been adopted across system piloted specialties • Diagnostics remains a challenged area with a focus in place for CT and endoscopy. The adapt and adopt programme is being used against scrutiny and good progress is being made in some areas • There is a focus on enhanced capacity and improved productivity • Urgent care remains below the national average for the four-hour target and there is a range of different positions across our providers. There have been 12 breaches and this have been reviewed end to end and no harm has been identified, however we are waiting on a report on medium/ long term harm and getting it right first time (GIRFT) and we are continuing to work with colleagues around deep dive triangulation and any impact • Ambulance handovers showed an improvement in August, lost hours in ambulance delays and handovers reflects the challenges in system	

	• DA drew the Governing Body's attention to the challenges with regards to 111 and out of hours. We continue to support Devon Doctors and we are now seeing early signs of improvement following an increase in the workforce. • A continuing healthcare position report has been presented to the executive directors which detailed a reduction in claims and financially we are ahead of trajectory. • Serious incidents (SI) are seeing improvements and we continue review the yellow card process to add value, previous delays have improved, and we are confident that trajectories will be met in early November • We continue to focus and support Infection Protection Control site visits to ensure areas remain COVID-19 secure seeing, however it was noted outbreaks have been seen in the system • Flu vaccine uptake is higher for this year. There has been supply issues with vaccines, however we are now able to draw from national stockpiles • Noted progress in relation trajectory for Children with Learning Disability and Autism in patient care and we recognised achievements of the team and the importance that children are supported in a home setting. • RDE performance has dipped against the 4 hours wait for Emergency Department (ED) due to delayed transfers of care (DTOC) and Diagnostics, are surviving • Northern Devon Healthcare Trust (NDHCT) are challenged and struggling to maintain performance, and this was similar for all Trusts due to the COVID-19 environment we are working especially with patient flows and pathways. • My Care is a new patient administration system (PAS) which has been implemented at the RDE and this has curtailed activity which was planned for JC confirmed that from next month that there will be deep dives into performance areas with a focus on areas for improved position considering the environment we are in, in responding to the pandemic. JWo voiced concern with 111 performance and call abandonment. He asked if there was attempts to phone callers back and whether any harm had been done. DA reassured the Governing Body that we are working on weekly indicators and improvement plans for staff and surveying call abandonment. Issues will be reported through the quality assurance committee to review unintended consequences and will be reported to the Governing Body through the Quality Assurance Chair's report. SMc highlighted that improving access to psychological therapies (IAPT) recovery rates had deteriorated and were variable for Livewell Southwest during COVID whereas Devon Partnership Trust (DPT) remained stable. JT was not able to explain why this was and agreed to take this action away. **ACTION 1** **JT to investigate the reasons why that improving access to psychological therapies (IAPT) recovery rates had deteriorated and were variable for Livewell Southwest during COVID**.	
10	**Health and Safety Policy** GS presented the refreshed policy which has been updated to accommodate our response to health and safety requirements in line with our statutory obligations. This year has been a bigger task as we have incorporated measures put in place with regards to our response to the pandemic.	

	The workplace COVID-19 secure measures are not included in detail in the policy but are underpinned in guidance and protocols for staff and have also been included into arrangements for working at home safely and lone working. The CCG has also revised its incident reporting procedures GS drew attention to the changes which were highlighted in red in the document. SMc enquired as to how many staff were working in the office. GS responded that the figures were low, with most staff working from home except for Devon Referral Support Service staff who were mainly working office based. JWo referred to section 15.1 and queried the wording used with regards to the use of handheld mobiles whilst driving. GS agreed to take this away and check. **ACTION 2** **GS agreed to check the wording in section 15.1 of the Health and Safety Policy that has been used with regards to the use of handheld mobiles whilst driving.** **The Governing Body** • **Accepted the track changes, subject to the check on the wording for section 15.1 and formally approved the amendments to the CCG's Health and Safety Policy to ensure that the CCG meets its statutory obligations and duty of care under the Health and Safety at Work Act 1974.**	
11	**Statement of EPRR Assurance for NHS Devon CCG and its Commissioned Providers** GS referred to the report in the pack and noted that this is a yearly assurance process and this year was a lighter touch for the CCG and NHS commissioned provider services due to our response to the pandemic. We have received a statement from each of the accountable officers of each organisation detailing their compliant standards. GS assured the Governing Body around compliancy for the standards as the EPRR leads are working much more closely on a day to day basis than they have done before. GS also stated and recognised that we have significantly tested our response to COVID-19 and have undertaken additional exercise processes for robustness to ensure we are able to respond to a much higher level of incident. NK questioned the compliancy for organisations against a self-assessment and the CCG taking this on trust, GS responded that further documentary evidence can be requested if needed and testing is in place on an on-going basis. VP confirmed that we were subject to a regional exercise in September and gave confidence that as a system we would be able to respond to more than one threat at a time. **The Governing Body:** • **Received and approved this Statement of Assurance of the CCG and its Providers state of emergency preparedness.** • **Received the self-assessed assurance ratings of our provider organisations, as assessed by their Accountable Emergency Officers, which will be presented to their Boards.**	

12	**Quality Assurance Committee (QAC) Chair's Report** DA presented this report in the absence of the QAC chair and referred to the Devon Partnership NHS Trust Quality Surveillance Group and that the CCG will continue to work with them through and executive to executive meeting on a monthly basis. DA noted at the last meeting the QAC members received a presentation on Autism Spectrum Disorders and this highlighted potential gaps in this service and this will be discussed further at the commissioning committee. **The Governing Body received and noted the contents of the Quality Assurance Committee Chair's Report.**	
13	**Commissioning Committee Chair's Report** NK presented this report and highlighted the following as an escalation recommendation from the meeting held on 23 September. The Commissioning Committee noted that the additional funding in education settings for children with additional health needs, required escalation to Governing Body due to seeking a legal opinion. A further update following legal opinion prior to approving any recommendations made within the paper will be presented back to Commissioning Committee in November. PJ confirmed that the Commissioning Committee executive director members had delegated powers however if there was a need for a decision that was deemed beyond those powers or there were significant implications for the wider system this would be escalated through to the Governing Body, and this process demonstrates how we operate our decision making process.	
14	**Finance Committee Chair's Report** GT did not propose to go through the report in detail but did bring the Governing Body's attention that the revised Terms of Reference (ToR) that were appended to last months report were not formally approved by the Governing following recommendation from the Finance Committee. The changes were that the membership had increased to include the Chief Operating Officer and a change from two to three Non-Executive Directors. There were no objections to the changes to the ToRs for the Finance Committee and therefore these were **approved.** GT also highlighted three decisions the Finance Committee agreed: 1. A call for system restart process for a credible financial plan that had been paused due to our response to the pandemic 2. Clear leadership role in the CCG 3. Reflection not just financial recovery but an integrated action plan **The Governing Body received and noted the contents of the Finance Committee Chair's report**	
15	**Primary Care Commissioning Committee Chair's Report** There was nothing further to add to this report, however JH drew attention to a presentation that the Primary Care Commissioning Committee received on a quality assurance early warning system when a practice is closed. Both Primary Care and the quality team are working hard to develop a system to enable alerts if a practice needs support.	

	The Governing Body received and noted the contents of the Primary Care Commissioning Committee Chair's Report.	
16	**Locality Updates** Northern There was nothing further to add to this report, but JWo signposted the members to the risk summary relating to winter pressures and COVID-19 challenge. Eastern SK drew attention to the diagram in the Eastern Report and Local Care Partnership architecture and that the Eastern Locality delivery group will bring together clinicians to discuss issues and they also received a presentation from the prevention lead. Reestablishing links with the Eastern Locality forum is underway and will be further report at next months meeting and there are plans to re-engage with GP practices and reestablish the leg ulcer service. Southern DG noted at the Southern Locality were behind with Local Care Partnership development but reassured the Governing Body that time is being taking in building the model of care and he highlighted groups that are supporting the elements of this work. Western SMc highlighted the Integrated Care Partnership procurement and that due diligence is continuing and she also mentioned fair shares whereby proposals are being worked up SK noted that there was a problem in the Eastern Locality and indeed was a national problem in the ability to recruit to Primary Care Networks, and this is being further explored through the Primary Care Commissioning Committee as part of the HR workforce element of the Primary Care Strategy. The Eastern Locality are meeting with Clinical Directors and working with providers looking at rotational roles and how this would work, and this report will go through the Primary Care Commissioning Committee. **The Governing Body received and noted the contents for the four locality update reports.**	
17	**Any other business** The chair thanked everyone for their contribution and concentration and encouraged the members to find a wellbeing space to relax following these discussions. As this was the last Governing Body that VP would attend as she was retiring, PJ, on behalf of the members thanked VP for her leadership for Public Health in particular in the challenging environment were are in, and that she was held in very high regard, and wished her all the very best for her next adventure. **The meeting closed at 16.47pm**	

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) **		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) A		Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) A		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 Womersley – Dr (JWo) **		Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **		Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **		Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF) A (in absence of DG)		Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **		Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **		Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) Chair **		Clinical Chair, Devon CCG
Penny Harris – (PH) **		Director, Devon CCG
Ruth Harrell - Dr (RH) A		Director of Public Health, Plymouth City Council
Simon Kerr – Dr (SK) **		Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc)**		Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST)**		Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) A		Executive Director and SRO for Integrated Care Partnership (Western Devon), Devon CCG
Virginia Pearson – Dr (VP) **		Director of Public Health, Devon County Council
In Attendance		
Nikki Coombes (NC) ** **Minute Taker**		Executive Assistant, Devon CCG
Jean Almond (JA)** ***Patient Story only***		Joint Commissioning Engagement Manager, Devon CCG and Devon County Council
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**	**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		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	29-Oct-20	JT to investigate the reasons why that improving access to psychological therapies (IAPT) recovery rates had deteriorated and were variable for Livewell Southwest during COVID.	26-Nov-20	Jo Turl	16.11.2020 The mental health team provided a rationale as to the variable recovery rates and the team are going to monitor closely to ensure this does not happen again.				**FOR CLOSURE**
2	29-Oct-20	GS agreed to check the wording in section 15.1 of the Health and Safety Policy that has been used with regards to the use of handheld mobiles whilst driving.	26-Nov-20	Ginny Snaith	16.11.2020 Governance has been reviewed and confirmed this is the latest guidance from the Health and Safety Executive (HSE). The Heath and Safety Policy has now been published.				**FOR CLOSURE**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Chair's Report				
Date of committee: 26 November 2020 **Date report produced: 18 November 2020**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive: N/A** **Name and Title:** **N/A** **Contact Details: N/A** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date:** 18 November 2020		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

- Introduction
-

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

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

N/A

Key recommendations and actions requested:
This report is for information and the Governing Body are asked to note the contents.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
Does this report have implications in any of the areas highlighted below?

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

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

NHS
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GOVERNING BODY – CHAIRS REPORT

1. Introduction

At the time of writing this report, the NHS has moved to OPEL Level 4, the highest state of alert with warnings that hospitals will continue to fill up with COVID-19 patients whilst still expected to manage non-covid winter emergencies and urgent elective care. And yet there are signs of the first shoots of a return to normality. The promise of an effective vaccine now feels more real with at least two options nearing the end of their final trials and our GPs, with support from the CCG and wider system, making plans for what will be a huge task of mass population vaccination.

And so we have one eye on the present – on supporting our hospitals, community services and primary care to care for the increasing numbers of Covid patients and minimise delays and potential harm to other patients, planning enough bed capacity and safe staffing levels. And one eye on the future – our journey to becoming an Integrated Care System, our need to address the longer term financial and performance challenges and to cement the benefits of system working we have seen during the last 6 months.

2. System Lead Executive and CCG Accountable Officer Recruitment

Verbal Update

3. Integrated Care System (ICS) Partnership Board

The Shadow ICS Partnership Board was held on 4 November. Key decisions include:

- Agreement that our system should be organized around five Local Care Partnerships – North Devon, East Devon, South Devon and Torbay, West Devon and Plymouth. A paper considering the options was presented and discussed, representatives of the Western Primary Care Collaborative Board were present and able to contribute to the discussion.

- Agreement to changes of ICS Governance Framework. The recommendations made by the CCG Governing Body were considered by the Partnership Board and agreed to:
    - The terms of reference are explicit in the expectation of System Chairs to fulfil the Non-Executive function of the Board.
    - The responsibilities of the Partnership Board should include holding itself to account on equality and diversity, and on equity of access and outcomes.
    - The frequency of Whole System Engagement should be increased.

4. Regional CCG Chairs Network

I have established a South West Regional CCG Chairs Network, currently meeting virtually fortnightly with a plan to continue less frequently once we return more to business as usual. This provides a very useful forum to share ideas, concerns and examples of good practice. We have been able to make sure there is consistency in approach on a number of issues including Covid vaccination planning. As part of this network we have agreed to attend neighbouring Governing Body meetings. On 19 November I attended Bath, North East Somerset, Swindon and Wiltshire CCG Governing Body chaired by Dr Andrew Girdher and am looking forward to welcoming him join us in January. There is much to be learnt from our neighbours and I will be only too pleased to share that learning with you.

5. Director of Public Health, Devon County Council

On 13 November, Dr Virginia Pearson who has been leading the Public Health team in Devon County Council since it transferred to local councils in 2013, retired. Virginia has provided a wealth of experience and leadership in this role, not least during the last few months. I wish Virginia all the best for her next adventure and warmly welcome Steve Brown as the incoming Director and look forward to working with him.
On behalf of the Governing Body, I sent an e-card to Virginia which can be found at the following link: https://www.groupgreeting.com/sign/bbfcb61990df4a7

we

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GOVERNING BODY

Report title: Accountable officer's report				
Date of committee: 26 November 2020 **Date report produced:** 18 November 2020				
Author (s) Name and Title: Simon Tapley, accountable officer Sam Cush, internal communications manager **Contact Details:** sam.cush@nhs.net 01392 675 367		**Supporting Executive:** **Name and Title:** Simon Tapley, accountable officer **Contact Details:** **Report Approved by:** **Name and Title:** Simon Tapley, accountable officer **Date:** 18 November 2020		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

1. National lockdown
2. Devon's COVID-19 response and winter planning
3. Integrated Care System planning
4. Deputy chief nurse interviews
5. Staff awards
6. Supporting staff wellbeing

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

	If Yes, please give details	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. National lockdown

The Prime Minister announced a new lockdown across England from Thursday 5 November until Wednesday 2 December.

People should not leave their home except for specific purposes including education, shopping for basic needs and medical appointments. Full guidance is published on the GOV.UK website.

We are working with our partners to provide local communities with important updates and advice, and we are continuing to encourage our staff to work from home where possible.

The NHS has also returned to incident level 4, meaning incident management is coordinated nationally.

To support this, we stepped up our operations centre (previously known as our incident management team) in October to help us coordinate efforts across the system.

It oversees COVID-19, winter pressures (such as flu), non-COVID-19 services (such as planned care) and the potential impact of the EU Exit.

2. Devon's COVID-19 response and winter planning

Our chief executives from across the system and I recently met with NHS England regional directors to discuss demand and capacity throughout COVID-19 and winter.

Feedback from the November meeting with Elizabeth O'Mahony (south west regional director) and Martin Wilkinson (director of performance and improvement) from NHS England was constructive.

Organisations within the Devon system continue to work together, showing commitment and flexibility in working to deliver the best for our local population.

By sharing resources and expertise, we will be best placed to manage the impact of the coronavirus pandemic, prepare for winter and keep essential services running.

We want to continue to provide as much as we can as locally as possible, but by doing some things differently, we have a chance at reducing the long-term effects COVID-19 has on our health system.

Some of the things we're doing include:

- Devon's four **acute hospitals** will work closely as a network to manage resources in the most effective way to deliver a range of services as safely as possible
- Continuing to **reduce waiting lists**, as well as treating **COVID-19 patients** and handling **emergency admissions**
- Contacting patients directly if an **appointment is postponed**
- Encouraging people to continue to **attend medical appointments** and seek treatment when they are unwell
- Reducing **hospital visiting arrangements** but implementing new schemes so patients and relatives can stay in touch.

3. Integrated Care System planning

Plans for Devon to become an Integrated Care System (ICS) are well underway, with a draft submission to be submitted to NHS England in December.

We are aiming to become an ICS in 2021, building on the collaborative work we have been doing over the past couple of years.

The approach will see health and social care organisations in Devon working together to plan and deliver the right services for our population.

We held a planning session in November to discuss strategic commissioning, what support we will need, and how the system will be structured.

4. Deputy chief nurse interviews

I took part in a recruitment process for our new deputy chief nurse on Monday 16 October.

We had several high-calibre candidates who presented at stakeholder sessions, followed by formal interviews.

The deputy chief nurse is a key role within our senior leadership team. They will work under our chief nurse, Darryn Allcorn, to lead and support our nursing and quality team.

Outcomes from the process will be shared in the coming weeks, with the successful candidate likely to take up the role in March 2021.

5. Staff awards

Dedication, compassion and collaboration were common themes among our Celebrating You Award winners.

Some 33 individuals, teams and projects received awards at the ceremony in mid-November – congratulations to those who were recognised.

Hundreds of staff joined the online event as we celebrated the fantastic achievements of our staff, teams and projects over the past 12-months.

My co-host, Dr Paul Johnson, and I found the whole event hugely uplifting, and judging by the 3,000 likes, shares and comments we received, so did many staff.

I am also grateful to the inspirational Michael Caines MBE who joined us to thank staff for their incredible dedication and speak movingly about how the NHS has helped him personally.

It was the first time we have held it online, so I would like to thank our communications team who planned and ran the event professionally, as well as those who attended the ceremony.

6. Supporting staff wellbeing

Supporting our staff to stay well remains a key focus.

We are continuing to engage with them through a range of tools and channels to support their wellbeing:

- My executive colleagues and I have been meeting staff across the organisation to have **informal chats** about how they are feeling. We've had a great response from staff who appreciated the opportunity to discuss their thoughts and make suggestions for how they could be better supported
- Our **staff webinars** continue to be attended by many staff. More than 300 people join every two-weeks to hear the latest updates from Paul, executive colleagues and me. We also invite a member of staff to talk about work they are involved in, with a particular focus on personal wellbeing
- Our **staff bulletins and intranet** regularly feature wellbeing advice including exercise, diet and mindfulness tips
- Our **quality team** have held virtual 'coffee and chat' sessions where staff can pop in to chat to colleagues. The team has received good feedback, and we are encouraging others to set up similar schemes.

I would like to thank our staff for their incredible work throughout the pandemic. The way they have come together to support the system, local communities, and each other has been fantastic.

NHS Devon Clinical Commissioning Group

NHS DEVON CCG GOVERNING BODY (PUBLIC)

Report title: Devon System Winter Plan				
Date of committee: 26 November 2020 **Date report produced: 19 November 2020**				
Author (s) Name and Title: **Caroline Stead – Head of Performance** **Lauren Benham - Senior Commissioning Manager – Community Services** **Alison Wilkinson – Deputy Chief Operating Officer**		**Supporting Executive:** **Name and Title:** **Jayne Carroll – Interim Chief Operating Officer** **Report Approved by:** **Name and Title:** **Jayne Carroll – Interim Chief Operating Officer** **Date: 19 November 2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The attached winter plan describes how we will maintain essential NHS services and the predicted increase in numbers of admissions of patients with COVID-19 to our hospitals over the coming months.

The clinical and operational leadership teams of all providers in Devon are actively contributing to this approach. This plan sets out how our providers will work together in the months ahead, including liaising with colleagues and providers in Cornwall.

The Plan will be refined as required in response to changing circumstances and will be monitored during winter 2020/21, with escalation to the Devon Urgent Care Programme Board (UCPB) where necessary.

This plan:

- Reflects a system approach to planning for winter
- Builds upon the learning from the previous winter and learning from the system response to the COVID-19 pandemic
- Ensures that the additional pressure on services experienced throughout winter and a second surge of COVID-19 does not compromise the safe and effective delivery of services for Devon patients
- Reflects operational actions taken at both a locality and a system level to ensure effective delivery of the plan
- Establishes the system escalation arrangements, which build upon the arrangements in individual organisations
- Identifies the key risks and mitigating actions, in the relevant sections and summarised at the end of the plan

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:

Members of Governing Body are asked to approve the Winter Plan.

Impact on Strategic Objectives

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

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

	If Yes, please give details	No
Quality of Services	A lack of adequate planning for winter would have implications for the quality of care provided to the population of Devon.	
Health Inequalities		√
Equality (staff or public)		√
Resource and Finance		√
Legal		√
Engagement and Consultation		√
Risk	Reputational risk to the CCG of not ensuring adequate winter planning.	

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

Together for Devon

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

Devon system winter plan

2020-21

FINAL DRAFT to be signed off at CCG Governing Body 26 November 2020

Contents

Version Control

First draft locality plans received	1 September 2020
Second draft locality plans received	8 September 2020
First draft system winter plan to Devon UCPB	17 September 2020
Stress testing of locality plans	16-18 September 2020
Plan updated following comments received from: Members of UCPB NHS England	30 September 2020
Third draft locality plans received	30 September 2020
Plan reviewed by Devon UCPB	15 October 2020
Reviewed by Devon System Leadership Executive	20 October 2020
Word version of the winter plan submitted to NHSEI	6 November 2020
Urgent Care Programme Board for sign off	19 November 2020
CCG Governing Body for approval	26 November 2020

1. Purpose

1.1. The purpose of this plan is to bring together all relevant activities across Devon's health and social care system which relate to planning, delivery and resilience for winter 2020/21 and to provide a single system approach to maintaining the delivery of safe and effective services during winter.

1.2. This winter is likely to be different than any other we have experienced, and we do not underestimate the challenge of managing winter pressures combined with the consequences of the COVID-19 pandemic.

1.3. All of our staff have responded magnificently to the challenges of the first wave of the COVID-19 pandemic and continue to do so as we manage winter pressures and the second wave of the pandemic.

1.4. This winter plan includes how we will maintain essential NHS services and the predicted increase in numbers of admissions of patients with COVID-19 to our hospitals over the coming months.

1.5. The clinical and operational leadership teams of all providers in Devon are actively contributing to this approach. This plan set out how our providers will work together in the months ahead, including liaising with colleagues and providers in Cornwall.

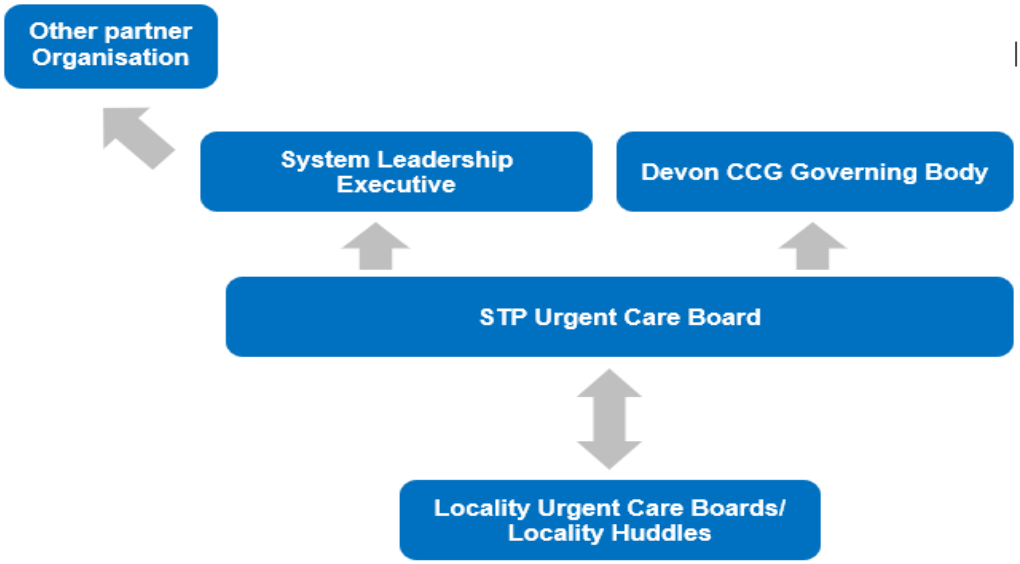
1.6. This year the winter plan forms an integral part of the phase 3 restoration plan, which was submitted to our regulators on 5 October 2020. This plan will be refined as required in response to changing circumstances and will be monitored during winter 2020/21, with escalation to the Devon Urgent Care Programme Board (UCPB) where necessary.

1.7. This plan**:**

- Reflects a system approach to planning for winter
- Builds upon the learning from the previous winter and learning from the system response to the COVID-19 pandemic
- Ensures that the additional pressure on services experienced throughout winter and a second surge of COVID-19 does not compromise the safe and effective delivery of services for Devon patients
- Reflects operational actions taken at both a locality and a system level to ensure effective delivery of the plan
- Establishes the system escalation arrangements, which build upon the arrangements in individual organisations
- Identifies the key risks and mitigating actions, in the relevant sections and summarised at the end of the plan

2. A Joint Approach

2.1. All partners in the Devon system have contributed to the development and delivery of this plan, overseen by the UCPB. The plan has also been aligned with the Phase 3 restoration plan. The Governance arrangements are shown in the diagram below.



Local authority winter plans

2.2. The Adult Social Care (ASC) winter plan was launched on the 18 September and local plans were finalised at the end of October. We have worked with local authority colleagues across Devon, Torbay and Plymouth to ensure our plans not only align, but actively support one another's delivery.

2.3. The commitments of our Local Authorities are-

- to maintain oversight of Infection Control Fund, using this to improve Infection Prevention and Control (IPC) across Devon and ensuring that providers are regularly updating their Capacity Tracker. More detail can be found in our IPC section;
- the development and communication of relevant guidance through provider fora eg: Provider Engagement Network;
- to promote regular testing, use of the capacity tracker tool and flu vaccination;
- to undertake dynamic risk assessment of care home visits through the public health teams;
- to reopen safely day and respite services;
- to update business continuity plans for a winter with COVID-19, focusing on workforce;
- to follow all national and local guidance and advice, including regarding care home visits;
- to ensure regular testing and flu vaccination of staff and residents;
- to use the Clipper Portal and Local Authority/Local Resilience Forum (LRF) arrangements to ensure sufficient supplies of PPE;
- to support safe discharge from NHS settings;

- to support shielding and people who are clinically extremely vulnerable, market management and provider sustainability.

Lessons learned

2.4. A review of both winter 2019/20 and the COVID-19 outbreak period has highlighted a number of key factors that helped maintain system capacity and flow which are reflected in this year's winter plan as follows.

What we learned	Our response
Enhanced and accelerated use of digital technology, including for virtual outpatient consultations, staff training and meetings	Continued use of technology to support non-face to face attendances is a core element of the phase 3 plan
Improvements to weekend discharges, including through support of the voluntary sector	Investment in additional capacity in key roles over the weekend (senior nurses, community capacity)
Additional local MH inpatient and step-down bed capacity	Plan includes a joint approach to bed management across the county and additional bed capacity
Urgent MH assessment hubs	Investment in pre-psychiatric liaison triage
Improved triage of patients away from ED	Think 111 First initiative
Pro-active support to care homes, reducing admissions	GP visiting scheme and care home LES in place
The 24/7 mental health crisis response telephone line	Urgent and crisis response investment included in MH plan
Provision of dedicated wellbeing support to staff across the system	Our workforce plans for wellbeing
The CCG co-ordination role and cell structure employed during the COVID-19 incident response	'Winter room' approach Discharge, critical care and Care home and home care cells will be retained/reinstated as part of escalation

2.5. Additionally, areas where our response could be improved have also been identified, notably:

- Increasing the alternatives to attendance at emergency departments (ED) – this is a key workstream within the Think 111 First initiative;
- Improved joint working with the Cornwall system – Representatives from the Cornwall system took part in the winter plan review meeting in September, to clarify joint working arrangements to maintain flow;
- Improving mechanisms for reporting on progress with implementation and delivery of schemes – this will include oversight on a monthly basis by the Devon UCPB.

3. Response to COVID-19

3.1. This section sets out the Devon's system approach to meeting the requirements in direct response to the COVID-19 pandemic, as set out by NHS England on 31 July 2020 in the document 'Third Phase of NHS Response to COVID-19'.

3.2. It describes how we will continue to follow good COVID-related practice to enable patients to access services safely and protect staff, including -

- our approach to COVID-19 testing;
- applying Infection Prevention and Control (IPC) guidance;
- ensuring staff and patients have access to appropriate personal protective equipment (PPE);
- following Public Health England (PHE) guidance on outbreak management;
- plans to utilise the Nightingale Hospital Exeter (NHE).

Testing

3.3. We continue to follow all PHE/Department of Health and Social Care (DHSC) policies on testing in both acute and community settings.

3.4. There is weekly COVID-19 testing for health and care staff visiting care homes. A set of system-wide principles for health and care professionals required to visit care homes are in place and in line with national requirements. Testing capacity is prioritised for pre-discharge testing of all patients transferring to care home settings and this is now well established as routine across the Devon system.

3.5. We have also developed a joint Testing Strategy for the Peninsula with our partners in Cornwall. A daily report of laboratory capacity and the number of tests undertaken per day is received to ensure real-time information on capacity and utility of testing resource. As a system we are confident that required laboratory capacity is available should there be a need for an accelerated number of routine staff tests.

3.6. Prompt confirmatory testing for influenza and COVID-19 will be essential to guide outbreak management and guide antiviral provision. We plan to ensure a large platform of testing capacity is available, but also retain the ability to provide local rapid testing.

3.7. We are working on plans for pillar 1 (NHS swab testing) to support pillar 2, commercial swab testing. This includes utilising local laboratory testing capacity for individuals unable to book a local test through the national portal.

Infection Prevention and Control (IPC)

3.8. Infection Prevention and Control support for community health and care services and primary care medical services is in place through the recently implemented Community Infection Management Service.

3.9. This service is integrated within the four acute providers where specialist teams, including additional microbiology support, ensure responsive, specialist advice for all out of hospital services. A system infection prevention and control lead has been recruited within the CCG. This additional resource enabled through the STP's Prevention programme, has initially been focussed on supporting the response to COVID-19. The service will provide additional support in the winter months when there are the additional winter pressures of influenza and viral gastroenteritis.

3.10. On behalf of the STP, the CCG maintains awareness oversight of IPC arrangements of providers, through membership of infection prevention committees. The providers are also members of the Devon IPC forum, hosted and chaired by the CCG.

Out of hours arrangements

3.11. Out of hours arrangements vary according to provider. They are well tested and additional provision has been available during the response to the pandemic. The SW PHE health protection team additionally provides an out of hours service for infection prevention advice to non-NHS settings.

Screening venues

3.12. Mobile and community screening programmes are delivered in a variety of venues with unique IPC challenges, and have all restarted after full IPC sign off.

3.13. Additional resource has been expended to adapt these settings, this has included inserting screens and handwashing facilities, implementing one-way systems and changes to furniture to enable enhanced cleaning.

3.14. All restart plans have been signed off by the relevant Trust's IPC lead and all settings which undertake screening follow IPC guidance.

IPC in adult social care settings

3.15. The Department for Health and Social Care (DHSC) has distributed IPC funding as part of its support package for care homes. The funding has been paid directly to local authorities with 75% paid directly to Care Homes *"to support adult social care providers to reduce the rate of transmission in and between care homes and support wider workforce resilience"*, and with the remaining 25% to be determined by each local authority.

Local Authority	Total allocation	Priority areas for 25% of spend
Devon	£10.500m	• Supporting the market with PPE • IPC for supported living providers
Plymouth	£3.125m	• Supporting all providers with PPE and infection control measures
Torbay	£2.700m	• Uplifted rate for domiciliary care providers • Supporting care homes with PPE • IPC for supported living, day services and outreach providers

3.16. Local Authorities have plans in place in to support particularly 'at risk' areas, such as supported living and day services where the IPC risk is greater due to the social nature of the service.

Personal Protective Equipment (PPE)

3.17. Provision of adequate PPE for all services across the health and care system to protect staff and support workforce resilience and capacity throughout winter is critical.

PPE coordination across the system

3.18. Clinical assessment and data analysis of current PPE usages in services and predicted winter requirements has been undertaken and a central system function is being established to aid procurement, storage and supply logistics.

3.19. An assessment of the additional PPE requirements to support extended vaccination programmes has been undertaken and the system is confident that PPE supply is sufficient to cover this.

3.20. A periodic review of the data availability regarding PPE levels across the system ensures a regular checkpoint and highlights whether data collection and oversight can be improved.

3.21. The CCGs PPE cell was operational until 1 September 2020, but can be quickly re-established in the event of:

- insufficient PPE availability which risks patient safety or service delivery;
- inability of provider supply chains and mutual aid to meet the needs of service providers across the system;
- sufficient demand for PPE advice from the system.

3.22. This cell will be tasked to access emergency PPE stocks, mutual aid and ensure ongoing supply. Additional contingency supplies of PPE are held in stores by the Local Resilience Forum (LRF), local authorities and acute hospitals for use if required.

Provider PPE arrangements (including Primary Care)

3.23. The CCG's PPE cell has procured masks, gloves, aprons and visors for Primary Care and Devon Doctors out of hours service for the next three months, to ensure sufficient provision. During this period, Primary Care providers will secure their own long-term solution for supply of PPE.

3.24. Acute trusts order and receive PPE delivery through the Palantir system. The CCG, if required, will maintain monitoring of PPE stocktake through the system. This mechanism will also facilitate mutual aid requests between acute providers. National Supply Disruption Response (NSDR) will be used if supply becomes low.

3.25. Fit testing arrangements for staff conducting aerosol generating procedures (AGP) in all health and care settings are in place; Continuing Health Care (CHC) nurses have been specially trained to undertake fit testing. Hospital discharge planning includes consideration of any PPE training or fit test training required for onward care setting, family or carers. There is an adequate supply of initial 28-day PPE requirement on discharge. Trained specialist IPC nurses are working with acute providers in discharge planning.

3.26. Additionally, we have ensured that carers of Personal Health Budget clients are being fit tested (if they require AGPs) and are supplied with reusable gowns and FFP3 masks.

3.27. Regarding PPE for screening staff, we would expect that fluid-resistant masks, gloves, aprons and eye protection would be donned regardless of screening type and venue. This is based on the assumption that they are not AGPs. If a service not commissioned directly by the CCG sought support, they would be redirected to the NHS portal PPE website (for all who are CQC registered) or Palantir (for NHS organisations).

Outbreak Management

3.28. Devon's acute providers have robust outbreak plans and infection control policies in place for prevention and management of any infection outbreaks within the hospital setting.

3.29. In Devon there are two Local Outbreak Management Plans (LOMPs):

- Devon and Torbay
- Plymouth

3.30. These provide clear plans on how local government works with the new NHS Test and Trace service, ensuring a whole system approach to prevent, contain and manage local outbreaks. They describe each organisation's role in the prevention and management of outbreaks in each possible setting.

3.31. Local Outbreak Engagement Boards provide political and strategic oversight, whilst the newly formed Health Protection Boards oversee the operational delivery of the LOMPs.

3.32. The community infection management service is providing specialist infection prevention advice as required to the technical cells supporting these boards. There are plans to recruit two further infection prevention specialists to assist with infection prevention and outbreak management in the wider community, in addition to the community infection management service providing this for primary care, and community health and social care.

3.33. Information exchange mechanisms with the local health protection teams and local authority public health teams are robust, facilitating effective outbreak management.

Acute COVID-19 surge capacity – Nightingale Hospital Exeter

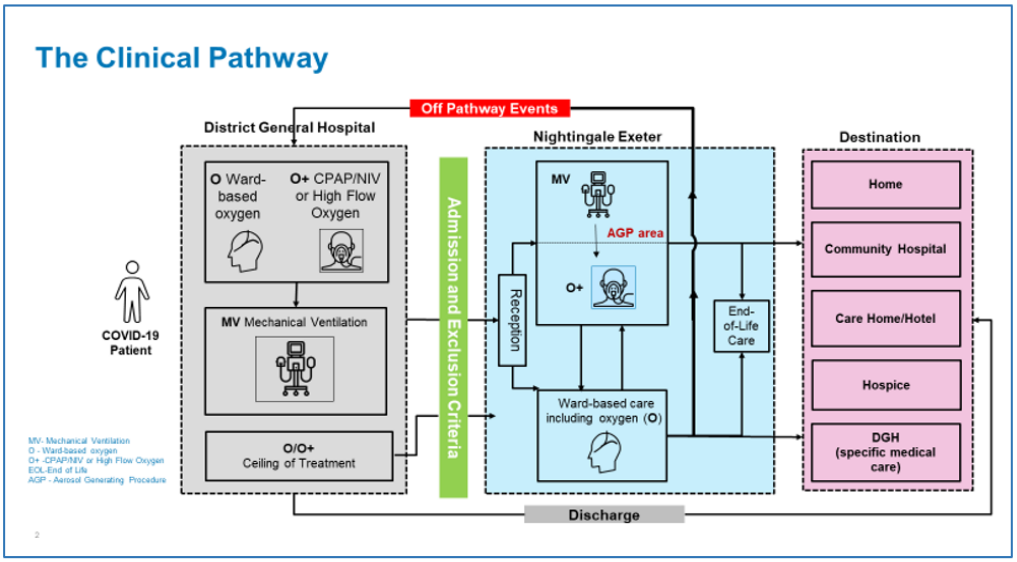
3.34. From 6 July the South West Peninsula has had access to the Nightingale Hospital Exeter (NHE). This is ready to accept patients with a positive diagnosis of COVID-19, but is currently in stand-by mode, ready to take one ward of patients within 72 hours. It has the capacity to care for 116 patients, with every bed capable of providing mechanical ventilation, and two of the five wards designated for intensive care.

3.35. The clinical model, based on learning from other Nightingale hospitals is unique, in that it primarily offers general ward-based care for patients with COVID-19, with the capability for more intensive care if required. Patients may be transferred from a District General Hospitals (DGH), returning there should any unexpected or 'off-pathway' events occur, and more specialist care is required. Patients would be discharged directly from the NHE to an onward setting of care, or to their place of residence with therapeutic support at NHE to enable this. This will alleviate further pressure on our DGHs.

The NHE workforce

3.36. NHE is staffed through a reservist model. Processes are set to ensure that the workforce could be mobilised within a 14-day planned period, but within 72 hours if required. Trusts have already agreed the proportion of staff they will provide to the NHE and targeted recruitment is ongoing for staff with specific skills. 'Returners' are being secured to provide backfill at the Trusts.

3.37. Workforce innovation will be key, as the existing workforce will be spread across all clinical settings. Weekly readiness sitreps are monitored looking at workforce and the skill-mix available.



3.38. Whilst in stand-by mode, the NHE has been used as a site to for additional diagnostic capacity (eg: Echocardiograms, Ultrasound, MRI) and vaccine trials. It is anticipated that this will continue when the NHE is also used to care for inpatients with a positive COVID diagnosis, with the diagnostic testing facilities being based outside of the main hospital building. Section 5.8 describes the triggers for opening of NHE

4. System-wide plans and initiatives

4.1. This section of the winter plan sets out the Devon's system winter approach across system-wide initiatives and service areas. This includes:

- expanding the 111 First offer;
- delivering an expanded flu vaccination programme for priority groups and NHS staff;
- delivering an Expanded Flu Vaccination Programme;
- the system priorities to support Primary Care services;
- increasing capacity and managing demand for Mental Health services
- integrated Urgent Care Services;
- the focus of our ambulance services, including the Hear and Treat, See and Treat programme;
- working with the Voluntary sector.

Expanding the Think 111 First offer

4.2. A programme of work commenced at the end of July, to implement the 111 First programme in Devon. A programme board meets weekly, with representation from all key organisations within the STP, to oversee the work of workstream groups as follows:

- Clinical pathways;
- Demand and capacity;
- Digital (including DOS profiles);
- Human resources (HR);

- Estates;
- Communications;
- Evaluation.

4.3. Implementation of 111 First: The programme is progressing as expected, to go live on 30th November; the STP national assurance checkpoint meeting is on 9th November. All five elements that are necessary to go live are rated green or green/amber (ready to go live) - these are: 111 clinical capacity, communications, evaluation, direct booking and alternative pathways.

4.4. The ambition is that by 1st December a minimum of 20% of ED attendances will move to be "heralded" via NHS 111, increasing to 50% by 1 April 2021.

4.5. More patients accessing services through 111 will receive clinical advice and support as an alternative to being seen and if they do need to be seen there will be acute and community alternatives to ED.

4.6. The ambition is for 70% of ED outcomes and 90% of ambulance outcomes to be validated by December 2020, rising to 90% and 95% respectively by April 2021. As of end of October, 83% of ED outcomes are being validated and nearly 90% of ambulance outcomes.

4.7. The CCG has agreed to invest in the 111 service, to increase non-clinical and clinical staff capacity to the levels indicated as being required in the NHS England modelling for 20% heralded attendances.

4.8. This increases non-clinical capacity significantly (an additional 36 whole time equivalents (WTE)), and the CCG and STP are supporting Devon Doctors to rapidly increase capacity including alternative estates options and Proud to Care recruitment campaigns. As of 23rd October, 83 WTE call advisors were recruited, in line with the trajectory which will see 104 WTEs in post mid-December.

4.9. Based on modelling, 25 WTE clinical staff will be required as part of this programme. As additional non-clinical capacity increases, additional capacity for clinical validation of emergency outcomes will become available. As of 23rd October, 12.3 WTE clinicians were recruited, although recruitment to 111 clinicians is problematic and at present the required staffing levels are achieved with a significant proportion of agency staff.

4.10. All attempts are being made to recruit permanent staff; however, it is likely that going forward agency clinicians will still form a significant part of the 111 clinical workforce which will bring additional cost pressures to the system. Further clinical resource will be necessary to achieve higher rates of validation and downgrade, and a proposal is currently in development based on the Cornwall IUCS operating model to strengthen the CAS. A business case for validation resource should be ready by 11th November for first review.

Delivering an Expanded Influenza (Flu) Vaccination Programme

4.11. Devon STP recognises the challenges of successfully delivering an extended influenza (flu) programme in 2020, during a global pandemic. Predictive modelling has identified an additional workforce of 312 vaccinators will be required across Devon to deliver an anticipated increase of 630,619 vaccines across all eligible groups compared to the last years programme.

4.12. Preliminary data suggests there is sufficient capacity in the number of vaccinators to enable successful delivery of the “extended flu programme” to all eligible groups. NHSE/I have centrally procured adequate stocks of vaccine and arrangements for obtaining these have been published for general practice, community pharmacy and secondary care. Timeliness of supply will be important to ensure planning of clinics and appointments

4.13. System-wide working, honed during the COVID-19 response, is focused on ensuring good uptake of immunisations in the extended eligible groups. A multi-agency Devon-wide flu planning and oversight group, and a CCG-led flu planning and support group have been established.

4.14. The groups are monitoring vaccine uptake rates and outbreaks in the system and providing prompt support or resolution to challenges as they arise throughout the flu programme.

4.15. Our flu immunisation plan sets out the specific activities that will:

- Deliver vaccinations for an extended cohort;
- Improve uptake among risk groups to reduce inequalities;
- Ensure there is an offer to 100% of frontline health and care workers;
- Maximise uptake for housebound patients, residents of care homes, shielded patients and their household contacts

4.16. Co-circulation of flu and COVID-19: Seasonal influenza increases the demand on health and social care and adversely affects staff availability annually. This could be exacerbated with co-circulation of COVID-19.

4.17. The high uptake of a vaccination, as outlined in the flu plan, will be crucial to mitigate this risk in winter. Prompt confirmatory testing for flu and COVID-19 will be essential to guide outbreak management and guide antiviral provision. The Devon 2020/21 communications and engagement strategy includes action to increase vaccination through various approaches.

Supporting primary care

4.18. A key aim of phase 3 and winter planning is to secure the resilience of our primary care providers, enabling them to maintain a level of access to their patients that can meet urgent primary care need and minimises risk of escalation to other parts of the system.

4.19. Primary Care Networks (PCNs) have strengthened their business continuity plans and updated them to reflect the acceleration in digital models of

delivery, eg: ability for clinicians to work remotely and learning around prioritisation of essential workload.

4.20. The main priorities for primary care winter planning for the system are:

- Maximising opportunities through digital acceleration – remote working, eConsults and video consultations;
- Enhanced Support to Care homes – working with MDT's as part of the PCN requirements;
- Extended Access – maximising uptake of extended access in primary care and embedding 111 direct referrals into primary care workflows;
- Supporting primary care delivery of the flu vaccine (eg: support for at scale delivery);
- Enhancing primary care data collection as part of system situation reports and early warning systems;
- Ensuring primary care engagement in locality forums and winter plans
- PCN development;
- Estates development prioritisation;
- Strengthening our Primary Care workforce.

4.21. The COVID response is described in four levels of escalation, which is set out in more detail within the escalation framework:

Level 1	Practices managing within their own practice or with a buddy practice
Level 2	Demand managed as a Primary Care Network
Level 3	Response at a locality level, with designated hot and cold sites
Level 4	A pan-Devon response

4.22. The CCG is engaging with the Local Pharmaceutical Committee (LPC) and community pharmacies around medicines optimisation activities during the winter, specifically where changes to prescribing behaviour are anticipated.

Mental Health services

4.23. Mental health services have sustained a good level of bed occupancy over the period of the COVID-19 pandemic and have decreased the level of delayed transfers of care (DToCs).

4.24. Initiatives have been started for surge capacity to include winter in the form of crisis prevention; additional beds (both inpatient and step down in the community); initiatives to prevent mental health pressure on other parts of the system. The mental health winter plan includes demand and capacity modelling, summarised below.

Devon Partnership Trust (DPT)	Livewell Southwest (LSW)
There will be: • An increase in need of 12% for adult mental health services (18-64) • an increase of 26% in need for people over 65 • An increase of 110% in need for children and young people	There will be: • An increase in demand of 14% for adult mental health services (18-64) • an increase of 47% in referrals for people over 65 • An increase of 77% in need for children and young people

4.25. Additional winter funding of £411,000 has been allocated to the Devon system, which has been prioritised to schemes that support patient flow, improve resilience and expand crisis care, including:

- A pool of staff who can work flexibly to support both inpatient and community teams;
- A nurse within Livewell Southwest to support more timely discharge;
- Expansion of the crisis care service for older people.

4.26. Bed management: Livewell and DPT are working together to enable resources to be used across the system, to support COVID positive patients and protect other bed capacity.

- Green and blue hospital sites have been agreed and capacity has been allowed for cohorting of COVID-positive patients at "blue" trust site (Cedars site, Exeter);
- Resources are managed effectively so that people who are COVID positive and in need of acute mental health care have timely access to it;
- People will be supported in the community whenever safe and appropriate to do so with the support of community-based services;
- Decision re implementation of this protocol will be via Silver/Gold command within the Incident Management Team.

4.27. In addition, a plan has been developed to introduce additional MH inpatient beds and increase the utilisation of ‘step down’ beds within non-NHS community providers.

4.28. Urgent and Crisis Response: There are good crisis response services across both DPT and LSW and wider partnerships, providing services for all ages, including Children and Young People, which include:

- The joint response unit manned by the Police and Mental Health Professional (pilot in Exeter and Torbay, substantive in Plymouth);
- The First Response crisis lines in Devon and Plymouth;
- The Crisis House in Exeter;
- Crisis Cafes across Devon;
- Support provided in conjunction with voluntary sector partners.

4.29. LSW Psychiatric Liaison: From September, two pre-psychiatric liaison triage shifts per week have been re-established. This enables triage to take place prior to a full Psychiatric Liaison assessment which can support someone to access appropriate alternative offers and reduce the demand on Psychiatric Liaison services.

4.30. LSW Primary Care Mental Health: LSW have completed a pilot with Pathfields PCN which was in place for 18 months. This pilot will continue and be rolled out over the coming months. During the winter period this model will be in place within three PCNs in Plymouth.

4.31. DPT Social Navigators: This initiative will reduce the use of secondary services by enabling more effective management of people on the Community Mental Health Team (CMHT) waiting list and ensuring access to appropriate services for social needs.

4.32. DPT Social Workers on Wards: Throughout the winter period DPT are hosting Social Workers in clinical settings, resourced through the Better Care Fund, to provide input to MDT decision making. This improves patient flow and provides increased quality and support for people of no fixed abode on mental health acute inpatient units.

Addressing Mental Health demand and capacity gaps – key actions undertaken

4.33. Impact on beds, community mental health teams and Improved Access to Psychological Therapies (IAPT) has been modelled and gaps identified as part of phase 3 demand and capacity plan.

4.34. The CCG market management team and local authorities are working together to develop the market of care homes who can accept people with complex needs due to dementia.

4.35. The development of supported living for adult mental health continues as an alternative to residential care.

Integrated Urgent Care Service (IUCS)

4.36. Devon Doctors provide Devon's out-of-hours GP service and 111/IUCS service. The GP out-of-hours service is available 6pm to 8am on weekdays, and 24 hours over weekends and bank holidays. They are a critical system partner in managing demand for urgent care services during the winter period, especially over Christmas.

4.37. The key drivers of demand this winter are:

- Prevalence of flu;
- Prevalence of COVID-19;
- Closure of Primary Care over bank holidays;
- Increased winter-related illness;
- Adverse weather.

Lower acuity validations from 111 and the IUCS

4.38. From 1 October, the key objective is to achieve lower acuity validations from 111 and the IUCS. We aim for up to 15% more clinical validation in 111/IUCS on category 3 and 4 outcomes.

4.39. This will be achieved through use of the Clinical Assessment service (CAS). We expect to see an increase of validations by 70%, with 50% downgrade expected. This is currently a work in progress through one of the 111 First sub-groups, which will look at rates of validation, downgrades and skill mix.

Ambulance services

4.40. Following reflections on their experience over the COVID-19 pandemic Period South West Ambulance Service Foundation Trust (SWASFT) have revised their approach to winter planning which will see the development of an Annual Resilience and Capacity Plan. This plan will be refreshed on a 6 weekly basis to reflect actual activity

4.41. Going into winter 2020/21 SWASFT's focus will be on:

- Protecting call 999 answering and ambulance dispatch;
- Increasing clinician presence in 999 calls through increased "hear and treat" Increasing front line capability;
- Protecting business critical services;
- Increasing wider system support across planning, delivery and recovery.

4.42. Planning has already been undertaken to ensure sufficient fleet and vehicle capacity.

4.43. SWASFT have refreshed their escalation and surge arrangements to include business as usual and COVID-19 surge plans. Internal surge planning arrangements have been developed in order to enable actions to be undertaken prior Resource Escalation Action Plan (REAP) arrangements being activated. Work has also been undertaken with Exeter University and

the Met Office to develop a comprehensive forecasting model which has been shown to be accurate in predicting demand.

4.44. SWASFT clinicians are supported to make appropriate non-conveyance decisions. SWASFT staff have access to local guidelines that support staff over and above those set by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), mainly focussed at supporting appropriate non-conveyance.

4.45. SWASFT continues to work with systems at a local level through its Clinical Leads and County Commanders in the identification and use of alternative conveyance routes. Information is available through the DoS, and the Clinical Leads share updates and information about new pathways available in each area.

4.46. SWASFT is working with the south and west Devon systems to implement the ECIST ""care co-ordination scheme"" whereby paramedics are trusted assessors and can refer to the community SPOA as an alternative to ED.

4.47. SWASFT is fully engaged with implementation of 111 first and alternative pathways (in-hospital and community)."

4.48. Schemes for winter include:

- Increased remote triage using paramedics and specialist practitioner who will have access to the control room to help manage 999 calls;
- Exploring the possibility of continuing to use fire fighters, who once given additional training, can support paramedic crews (this has already been tested through the COVID-19 response);
- Introducing a substantive Winter Manager role, available 24/7 to act as a single point of contact and to report management activity, demand pressures and handover delays;
- Using regional funding to introduce more Hospital Ambulance Liaison Officers (HALOs), into acute trusts over winter to help manage hand over delays.

4.49. SWASFT have identified handover delays as one of the biggest challenges over winter, as social distancing arrangements have meant it is no longer possible to cohort patients which means the potential for more ambulances queuing at acute hospitals. Whilst some actions have been identified above to help manage ambulance handover delays it is recognised that this is something that needs a system wide approach. Acute hospitals have named leads for ambulance handover and are working to align systems with ECIST best practice to reduce delays.

Specific actions Trusts are taking include:

- Development of space available for emergency care;
- Offsite minor injuries/illness;
- Arrival and initial assessment units/changes;
- Triage of patients to allow for streaming and redirection away from ED;
- Workforce reviews;

- Prioritising bed availability on assessment units;
- Refresh of escalation plans in response to crowding.

Hear and Treat and See and Treat

Schemes to maximise use of Hear and Treat and See and Treat include:

Lower acuity validations from 111/IUCS	Commissioners will support 999 to increase clinical validation through our active collaborative commissioner arrangement for SWASFT. Under the Think 111 First programme a series of Directory of Service (DoS) profile reviews will be undertaken for groups of services which provide in-hospital alternatives such as assessment facilities; community urgent care and mental health services as a minimum. The emphasis will be on changes to DoS profiles to reduce ED attendance and 999 activation. Additionally, a wide range of services will receive referrals from the 999 clinical hub and expect that the ambulance service will look to increase the number of clinicians based in the 999 hubs over the winter, reducing the need for ambulance despatch.
Same day Patient Transport Service (PTS)	This has been operational since April 2020 and provides responsive non-emergency transport for patients to ensure maximum capacity to meet Hear and Treat and See and Treat arrangements without involvement of ambulance transport.
Think 111 First	See section 4.2

System support to the ambulance service

4.50. Commissioners are committed to the 2020-22 ambulance strategy and transformation plan, which includes the requirement for 999 to increase the clinical review of category 3 & 4 incidents.

4.51. The Devon IUCS operates a paramedic advice line 24/7 giving access to GP advice for crews on scene and most EDs run a paramedic advice line. The Think 111 First programme includes an aspiration for in-hospital alternatives to ED to be available remotely with specialist clinicians by Q4.

4.52. The Devon DoS team have a rolling programme of DoS review and validation with a high level of accuracy on services currently profiled. Across Devon, 999 have access to Same Day Emergency Care (SDEC), frailty services and community step-up services.

Working with the voluntary sector

4.53. The voluntary sector is a vital part of the Devon system which has contributed significantly to the COVID-19 response through local groups and initiatives.

NHS Volunteer Responders Scheme

4.54. It is estimated that approximately 20,000 volunteers across the county responded to the pandemic in their local communities, some came from the NHS Responders Scheme, but the majority have been self-organised mutual aid groups operating on a very local level.

4.55. Local authorities have played an essential role in promoting this local offer and it is anticipated that, should the need arise, groups of volunteers would respond again to meet local need.

4.56. Partnership with large organisations, such as British Red Cross and Age UK, has been key to the support of smaller, local partners to ensure that the individual needs of people have been met, whilst at the same time avoiding duplication. It is anticipated that these relationships will continue to provide a holistic offer to local communities.

5. Acute and Out of Hospital Winter Plans

Locality acute demand and capacity

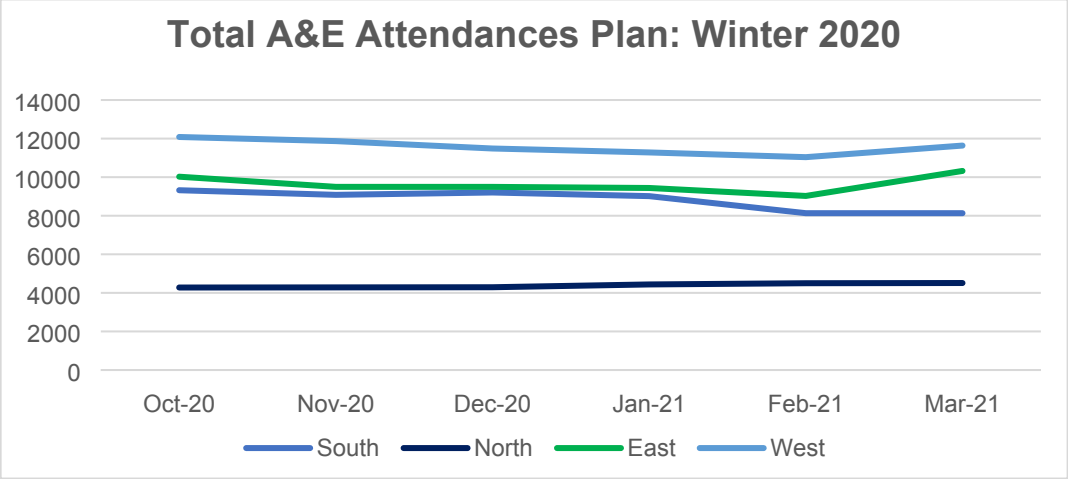
5.1. As part of the phase 3 submission, Northern Devon Healthcare NHS Trust (NDHT), Royal Devon and Exeter NHS Foundation Trust (RDE), Torbay and South Devon NHS Foundation Trust (TSD) and University Hospital Plymouth NHS Trust (UHP) have modelled their demand for Emergency Department (ED) attendances, emergency admissions and trajectories for elective activity. Subsequently, bed capacity has been planned to manage occupancy to withstand fluctuations in urgent care demand.

5.2. The challenge is to also protect elective capacity, crucial to address the lengthening waiting lists. Key to this are the initiatives to avoid unnecessary attendance/admission to hospital and effective management of patient flow through the system; these are described in more detail in the locality winter plans.

5.3. As described earlier, the Nightingale Hospital Exeter (NHE) provides additional bed and critical care capacity to the Devon system and wider peninsula.

5.4. The following graphs show the modelled levels of urgent care demand and the assumptions used as a part of the phase three submission.

Emergency department demand plans and assumptions



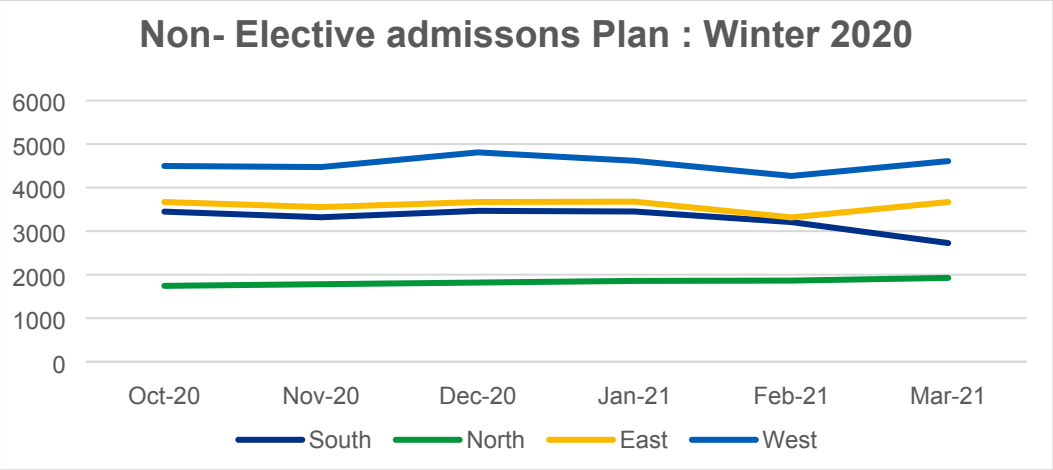
5.5. All providers will see demand rise to previous year's volumes with NDHT and RDE seeing 6% and 2% growth on previous year's volumes as planning pre-COVID indicated.

- **UHP:** Plan for a return to 100% of previous year's activity across all types.
- **NDHT:** Assuming 6% growth against pre-COVID, as per previous years, as attendances are already close to 100% of last year. Ability to be flexible with use of MIUs (Type 3) to relieve pressure on main ED, dependent on demand and safe staffing levels, to deliver safe treatment whilst maintaining blue and green pathways.

- **TSDFT:** Plan sees a return to 100% emergency demand. With the opening of the surgical and medical receiving unit with pathways of direct admission to these assessment areas the overall number of ED attendances may reduce by up to 50 per day. The plan does not currently reflect these changes in setting of care.

- **RDE:** 100% attendances from August for both Wonford ED and Honiton.

Emergency admissions demand plans and assumptions



5.6. The system is planning on marginal growth on previous year's volumes aligned to ED assumptions.

- **UHP:** Plans for a return to 100% of previous year's activity. Due to March 2019 activity being affected by COVID, an assumption has been made based on the average of previous months of 2019/20. There is a risk that there could be growth above this level, or further increases in patient complexity. Previous plans identified an increase in demand from the elderly and a more complex case mix in 2019/20, which impacts on length of stay and additional bed occupancy pressure.

- **NDHT:** Assuming 6% growth against pre-COVID, in line with A&E growth, conversion rates are expected to reduce back to pre-COVID levels. Planning for Devon NHS 111 First and Urgent & Emergency Care Centres will reduce ED attendances.

- **TSDFT:** Forecast unscheduled care activity to 100% of pre-COVID levels. Plans to redirect patients to medical and surgical referral units are designed to remove crowding pressure on the ED department and preserve front door COVID response. The full impact in terms of coding and counting of these changes has not been developed. Managing the flow through ED and assessment areas for rapid senior specialist review is critical to admissions avoidance and easing pressure on ED and historical capacity challenges.

- **RDE:** The Trust has experienced a return to near pre-COVID levels of admissions and has forecast return to normal levels of non-elective admissions

Acute hospitals bed capacity

5.7. Providers have modelled to keep occupancy rates low, in order to:

- Protect elective capacity as far as possible
- Provide capacity to cope with the uncertainty around levels of COVID demand

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Occupancy	Available beds	2,138	2,138	2,138	2,152	2,228	2,228	2,228
	Beds required	1,823	1,881	1,893	1,918	2,050	1,999	1,986
	% occupancy	**85.3%**	**88.0%**	**88.5%**	**89.1%**	**92.0%**	**89.7%**	**89.1%**

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Activity Split	Elective IP/DC (excl IS)	49.6%	49.9%	50.9%	47.5%	50.8%	52.0%	54.8%
	Non-elective	50.4%	50.1%	49.1%	52.5%	49.2%	48.0%	45.2%

Acute COVID-19 bed capacity

5.8. All acute hospitals have amber beds/areas for COVID assessment.

5.9. The NHS Nightingale Hospital Exeter (NHE) is one part of a two-phased system approach to limit the impact of COVID-19 on our acute hospitals.

5.10. **Phase 1** - RDE is designated as the hub site to transfer suitable COVID ward-level care patients from TSD and NDHT, in order to reduce the total number of wards required for inpatient COVID care across North, East, South (NES) Devon. UHP will provide for both COVID and non-COVID pathways together with tertiary services and will work with Royal Cornwall Hospitals Trust (RCHT) to manage COVID demand.

5.11. **Phase 2** – activity triggers have been agreed for the activation of the NHE. RDE have designated 50 ward beds for this cohorting of patients and at 75% capacity will escalate for a system decision to open ward level beds at Nightingale Exeter. UHP have designated 64 ward level beds for COVID escalation and at 75% occupancy (including any flow from RCHT) will escalate for a system decision to open ward level beds at Nightingale Exeter.

5.12. These triggers have been sensitised to reflect wider hospital pressures, for example: number of medical outliers and patients awaiting community packages of care.

5.13. Approval of NHSEI is required for the opening of NHE.

Critical Care Capacity

5.14. At low numbers of COVID patients, 10 ICU beds across the three hospitals in the North East and South (NES) are designated to COVID as a ‘pool’ (RDE 5, TSD 3, NDHT 2), with patients transferred between the 3 hospitals via the Critical Care Retrieval service (from 2 November) in order to maintain maximum ICU function and efficiency across NES Devon.

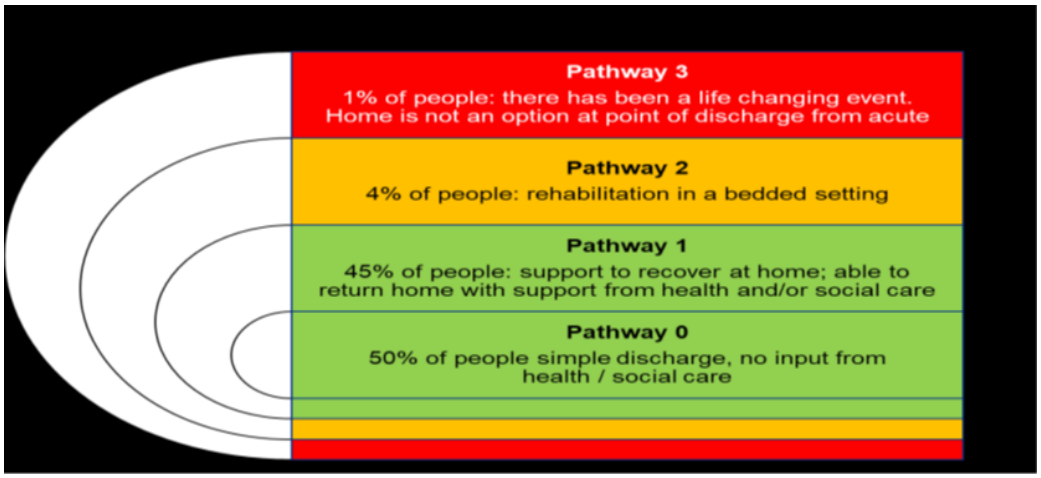
5.15. This would be managed at a clinical and operational level by communication between the ICU teams at the 3 trusts, with the aim to maintain a vacant ICU bed on each site for COVID escalation. UHP & RCHT are working together as sub-regional critical network to manage COVID capacity between the two providers.

5.16. The table below shows the number of core critical care beds across the four acute hospital sites, the additional "green surge" capacity that can be provided, including using additional capital investment already agreed for the system, and the maximum ICU capacity that could be provided, in addition to any NHE capacity, but that would impact on other services ("amber surge"). A peninsula critical care escalation management plan has been developed

Trust	Core critical care beds	Green surge capacity	Amber Surge Beds	Total Beds	Additional Notes
NDHT	10	4	12	26	
RDEFT	13	10	38	61	2 ITU unfunded beds within Green Surge
TSDFT	10	4	33	47	
UHPT	28	18	71	117	

Out-of-hospital demand and capacity

5.17. In March 2020, NHS England and Improvement published hospital discharge service requirements stating very clearly that unless a patient requires to be in hospital, they must not remain in an NHS bed. The Discharge to Assess (DTA) model, based on four clear pathways, was introduced and is illustrated below.



5.18. The DTA model is now embedded for all acute and community hospital discharges. Systems are in place to ensure support pathways also in place for step-up services to offer health and care support to avoid hospital admission.

5.19. Existing DTA arrangements were augmented during the initial COVID-19 response and have been enhanced in line with new discharge guidance and policy. Processes are in place ensuring care and support arrangements are fully funded for the six-week period.

5.20. As part of the DTA pathway, a detailed care & health assessment will take place in the post discharge period for all individuals on Pathways 1 and 2 with a rehabilitation focus supporting therapy goals. For individuals identified as having a long-term care need (primarily those under pathway 3) long term funding assessment processes have been instigated through development of pathways across health and social care to ensure this is completed in a timely way and considers longer term assessed needs.

5.21. Each Locality has a plan which reviews demand and capacity for out of hospital care. The plans focus on demand and capacity required for patient discharges in line with pathways 1-3 in the DTA model. Initiatives to address capacity gaps are identified in the locality winter plans.

5.22. The out-of-hospital demand and capacity plans across Devon show that, whilst there was an increase during the COVID-19 pandemic period, the number of Pathway 1 discharges is still below the nationally expected levels and capacity for pathway 1 discharge is below the level needed in the event of a COVID-19 surge.

5.23. This means that there is a need to be able to source more short-term packages of care, often of a more complex nature and which can be more

difficult to source. The locality plans identify a range of actions to address this and include: increasing 'home first' capacity; reviewing the short term services across the Devon County Council footprint; development of support to the market to deliver flexible capacity and exploring the role of the voluntary sector in providing non personal care.

5.24. Overall, the locality demand and capacity plans indicate that the availability of community hospital and care home capacity is sufficient across Devon. However, there are some particular challenges relating to sourcing specialist placements for particular cohorts of patients, including those requiring short term intermediate care, complex dementia patients, bariatric patients and those requiring specialist nursing care.

5.25. Locality plans identify the need for a market management approach to provide greater levels of support for care homes with these particular cohorts of patients and the need to address an imbalance between nursing and residential provision. The plans also refer to the potential use of hotel capacity and the identification of community hospital surge capacity in the event of a COVID-19 surge.

5.26. The importance of primary care capacity to support out of hospital care is recognised but has been difficult to quantify. Several schemes already exist to support out of hospital care eg: GP visiting schemes and Care Home Local Enhanced Service (LES). However, primary care faces challenges in some areas, particularly Western Devon

.

5.27. As part of the three local authority winter plans, designated beds have been identified in each locality, to enable discharge of COVID positive patients into the community.

Continuing healthcare assessments

5.28. NHS Continuing Healthcare assessments have resumed across the CCG from 1 September, with redeployed assessment staff now returning to business as usual (BAU) assessment activity. There is prioritisation of six-week funded DTA individuals and new referrals to ensure adherence of the 28-day framework requirements. Managing competing demands from addressing the deferred assessment list whilst undertaking new assessments has been identified and escalated.

5.29. A range of innovative approaches to assessment processes (including trusted assessor model) are being considered in partnership with local authorities and providers to support the delivery of 28-day verification requirements.

Community services

5.30. Plans have been developed at a place-based level to support the restoration and resilience of community services throughout the winter period. There are some challenges posed by accommodation limitations due to ensuring environments are 'COVID-safe' and a significant impact on group-based activities which are unable to operate as usual due to social distancing requirements.

5.31. Priorities for community services:

- Focus on supporting digital delivery where this is appropriate;
- Regular review of waiting lists at a locality level with prioritisation of those who are clinically vulnerable or were part of the shielding cohort;
- Capitalising on learning through pandemic response to embed 'one team approach' and through re-deployment of staff to more urgent areas of need to support community services, primarily Urgent Crisis Response (UCR).

Crisis response

5.32. Across Devon there is an existing UCR/Rapid Reablement (UCR/RR) service with a clear focus on crisis response and supporting rehabilitation. Locality UCR/RR demand and capacity forms a key component of winter planning to ensure resource to cope with modelled demand. Additional investment (utilising iBCF monies) is targeted on areas where additional capacity is required to support individuals and ensure system flow in the short term.

Vulnerable/shielding patients

5.33. Across Devon services have been stepped up to ensure all individuals who require a home visit have one. At a locality level, caseloads are regularly reviewed to ensure prioritisation and support for vulnerable/shielding patients. Where gaps are identified work has been undertaken to transform community services to respond to current and predicted need.

End-of-life

5.34. A sudden increase in the number of patients requiring palliative and/or end of life care (EOLC) and after death care within the community could adversely impact the health and care system. In order to prepare for this each locality has submitted an EOLC surge plan which has been reviewed against key potential risk areas:

- Workforce – Current capacity and ability of community, primary care and specialist care providers to increase capacity for provision of EOL care.
- Workforce – Required numbers of staff with skills and competence in all areas of end of life care, including medicines administration.
- Equipment – access to increased stock of syringe pumps and associated consumables.
- Advanced Care Planning – ability of care providers to maintain good practice standards in the provision of end of life care for patients and families/carers including ensuring that Treatment Escalation Plans (TEP's) are in place.
- Medicines – access to increased supply of medicines required to support symptom management in end of life care.
- Hospital discharges – ability of community and primary care services to receive increased numbers of rapid discharges for end of life patients.
- After death care – capacity to manage increased verification of death requirements and management of the deceased.

- Bereavement services – ability to support an increase in referrals for bereavement care and support for families/carers.
- Hospice capacity to receive rapid transfer/hospital discharges & flexibility of admission criteria.
- Specialist palliative care services current commissioned model – whether this enables monitoring of utilisation and responsiveness across the system.

5.35. No areas have been identified as high risk or red rated however there are areas which with an overall amber rating, requiring further consideration and potentially further mitigating actions. The Devon EOL Group will be undertaking further review and monitoring of these areas. The detail is included here.

6. Locality winter plans

6.1. Each of the four localities in Devon have produced local winter plans which are summarised in this section.

6.2. To develop these plans each system has worked collaboratively and plans reflect the unique funding situation and key initiatives in each area.

6.3. Locality winter plans were stress tested during September and the outcomes have informed the further development of the plans, with a particular focus on clarifying bed capacity, escalation arrangements and plans for delivery of schemes in each locality.

6.4. It should be noted that different arrangements and prioritisation processes are in place across the localities in terms of funding for schemes. In some cases, organisations have identified funding from within their existing resources.

6.5. In the Northern and Eastern Localities, a key source of funding for identified schemes is the Better Care Fund held by Devon County Council. In the Southern and Western Localities, the position is different as this funding has been included in acute trust baseline allocations. At the present time, no additional money has been identified for winter schemes.

6.6. A key aim of the winter plans for each locality are ensuring that actions are in place to keep occupancy below 92%, this is being balanced against the need to ensure elective recovery.

6.7. In order that occupancy is at or below 92% localities have put a number of schemes in place to optimise length of stay and to support patient discharge in line with the standards set in the National Hospital Discharge Policy and Operating Model.

Northern locality

6.8. Northern Devon Hospital Trust (NDHT) is the provider of both acute and community health services in the northern locality. Mental health services provided by Devon Partnership Trust, social care services are provided by Devon County Council and children's community services are provided by an alliance of local NHS providers

6.9. A single point of access (SPOA) manages discharges across pathways 1-3.

6.10. To support Pathway 1 discharges, services are delivered through social care reablement and urgent care reablement operations.

6.11. NDHT are assuming 6% growth against pre-COVID, in line with A&E growth and conversion rates expected to reduce back to pre-COVID levels.

Northern locality winter plan

6.12. The Northern Locality winter plan is supported by an Out of Hospital Demand and Capacity Plan and detailed provider plan. The Northern Locality winter

plan identifies the following key challenges along with schemes to address them:

- Ensuing the enough capacity for elective admissions. This is impacted by social distancing, limited outsourcing options, bed and estate constraints;
- Ensuring enough community hospital capacity - plans are in place for an additional 8 beds at South Molton Hospital;
- Ensuring enough short-term capacity to support Pathway 1 discharges. Services are delivered through social care reablement and urgent care reablement operations. A piece of work is currently underway across Devon to review the social care reablement (SCR) and urgent care reablement (UCR) operations and to develop these short-term services to maximise efficiency and patient care quality;
- Ensuring provision of short-term residential placements for bedded rehabilitation (pathway 2)

6.13. The Northern Delivery Group has oversight of the winter plan including the prioritisation of schemes for funding and ongoing monitoring.

Eastern Locality

6.14. Royal Devon and Exeter Foundation Trust is the provider of both acute and community health services in the eastern locality. Mental health services are provided by Devon Partnership Trust, social care services are provided by Devon County Council and children's community services are provided by an alliance of local NHS providers.

6.15. A single point of access (SPOA) manages discharges across pathways 1-3. To support Pathway 1 discharges, services are delivered through Social Care Reablement and Urgent Care Reablement operations.

6.16. The Trust has experienced a return to 100% of pre-COVID levels of ED attendances and has forecast return to normal levels of non-elective admissions.

Eastern locality winter plan

6.17. The Eastern Locality winter plan is supported by an Out of Hospital Demand and Capacity Plan and detailed provider plan. The Eastern Locality winter plan identifies the following key challenges along with schemes to address them:

- Ensuring enough elective capacity to meet the targets for elective, outpatients and day cases;
- Ensuring bed occupancy stays below the 92% maximum. Modelling has suggested that this level will be reached in January 2021;
- Ensuring enough short-term services capacity to support Pathway 1 discharges. Services are delivered through social care reablement and urgent care reablement operations. A piece of work is currently underway across Devon to review the social care reablement (SCR) and urgent care reablement (UCR) operations and to develop these short-term services to maximise efficiency and patient care quality;

- Ensuring provision of short-term residential placements for bedded rehabilitation (pathway 2). Modelling suggests up to 20 additional beds are required to provide targeted rehabilitation

6.18. Oversight of the winter plan in the Eastern Locality is via the Eastern Delivery Group which includes representatives of health and social care. In mid-September this group considered recommendations for the allocation of Better Care Fund monies to support the winter schemes. Bids were invited from all partners and were reviewed and prioritised by a task and finish group. The delivery group will monitor the implementation of the winter schemes.

Western locality

6.19. Acute health services are delivered by University Hospital Plymouth, whilst community services are delivered by Livewell Southwest who also provide mental health and social care services in Plymouth and children's community services across the western footprint. For South Hams and West Devon mental health services are provided by Devon Partnership Trust and social care is provided by Devon County Council.

6.20. A single team manages discharges on pathways 1-3, to support pathway 1 discharges services are provided via the Home First service.

6.21. Plans for a return to 100% of previous year's activity. Due to March 2019 activity being affected by COVID an assumption has been made based on the average of previous months of 2019/20. There is a risk that there could be growth above this level, or further increases in patient complexity.

6.22. Previous planning has identified an increase elderly and more complex case mix in 2019/20, which impacts on length of stay and additional bed occupancy pressure.

Western locality winter plan

6.23. The Western Locality winter plan is supported by an Out of Hospital Demand and Capacity plan and detailed provider plan. The Western Locality winter plan identifies key challenges and schemes to address these over winter.

6.24. Challenges include:

- Ensuring enough acute trust capacity to manage emergency and elective demand. Key areas of focus include hospital front door (particularly ambulance handover delays and use of same care emergency care) retaining low length of stay and low levels of delays to discharge;
- Maintaining discharge over a seven-day period. To support this increased home first and domiciliary capacity will be commissioned to support pathway 1 discharges. To support pathway 2 discharges there is a plan in place for the lease of a 24 bedded care home to provide intermediate care capacity, this will support pathway 2 discharges. It is recognised that there are some particular pressures in relation to discharges to Cornwall which have been escalated.

- Increasing the provision of community based urgent care, to reduce the demand on the Emergency Department;
- Enabling primary care to deal with increasing levels of demand. Primary care resilience is a critical issue in the Western Locality. To support practices over winter 'hot hub' capacity will be built on to provide a hot visiting service, co-ordinated flu support and increased capacity, especially for children;
- Ability to react to changes in the care home and domiciliary care market. Capacity is seen as fragile and there is the potential to be impacted by further COVID peaks.

6.25. The available funding for winter plan schemes has been allocated by the local system to specific schemes/actions taking into account several factors such as impact of the scheme, cost, state of readiness of the scheme and experience of system partners in winter planning.

6.26. Prioritisation for currently non-funded schemes has followed a similar process, with organisations using their own funding and making the final decision having considered system partners' views and the overall plan

Southern locality

6.27. Torbay and South Devon Foundation Trust is an integrated care organisation (ICO), providing acute and community health services and adult social care. Mental health services are provided by Devon Partnership Trust and children's community services are provided by an alliance of local NHS Providers.

6.28. The Discharge Hub manages discharges across pathways 1-3. To support pathway 1 discharges, services are delivered through social care reablement and urgent care reablement operations.

6.29. Predicted emergency admissions over winter are set to be 100% of pre-COVID levels.

Southern locality winter plan

6.30. The Southern Locality winter plan is supported by an Out of Hospital Demand and Capacity Plan and detailed provider plan. The Southern Locality Winter Plan identifies key challenges and schemes to address these over winter. Challenges include:

- Ensuring enough Acute Trust capacity to manage emergency demand. Key areas of focus include admission avoidance, hospital front door, bed management;
- Maintaining the role of the discharge hub over 7 days. This is essential for ensuring the flow of discharges of pathways 1-3. The service has experienced workforce challenges due to sickness annual leave and vacancies;
- Ensuring enough capacity within short term services to increase the number of people discharged on pathway 1 and to avoid patients being delayed within both acute and community beds. Short term services have

faced work force challenges due to sickness, annual leave and vacancies;

- Enabling patients to be discharged without delay on pathways 2 and 3. While Care Home capacity appears to be enough, there is a lack of specialist provision particularly for patients with complex dementia;
- Ensuring end of life patients receive the care they need on discharge, currently this is fulfilled via additional capacity from the independent sector;
- Enabling primary care to deal with increasing levels of demand. Increased numbers are already presenting with mental health issues and there is a concern about the potential for an increase in demand relating to respiratory tract infections indistinguishable from COVID-19 which may necessitate the need for patients to be seen in 'hot' clinics;
- Ensuring there is capacity in the voluntary sector to support patients in accessing healthcare and to stay well in their own homes. Support to carers and community delivered transport are key challenges

6.31. A local winter planning task and finish group is in place and will continue to monitor the impact of the winter plan

7. Escalation and governance

System escalation arrangements

7.1. Escalation arrangements utilising the OPEL framework are in place in each locality and at system level. The Devon system escalation framework in use during the winter of 2019/20 has been further developed since thresholds have changed and additional triggers are required to reflect escalation due to COVID-19, including availability of critical care capacity, cohorting of COVID positive patients at 'blue' hospital sites and opening of the Nightingale Hospital Exeter (NHE).

7.2. In addition, building on the learning from the management of the COVID incident and recognising the risks associated with this winter, a Devon Operations Centre has been in place from the 19th October aligned to the Regional Operations Centre approach and providing system coordination of:

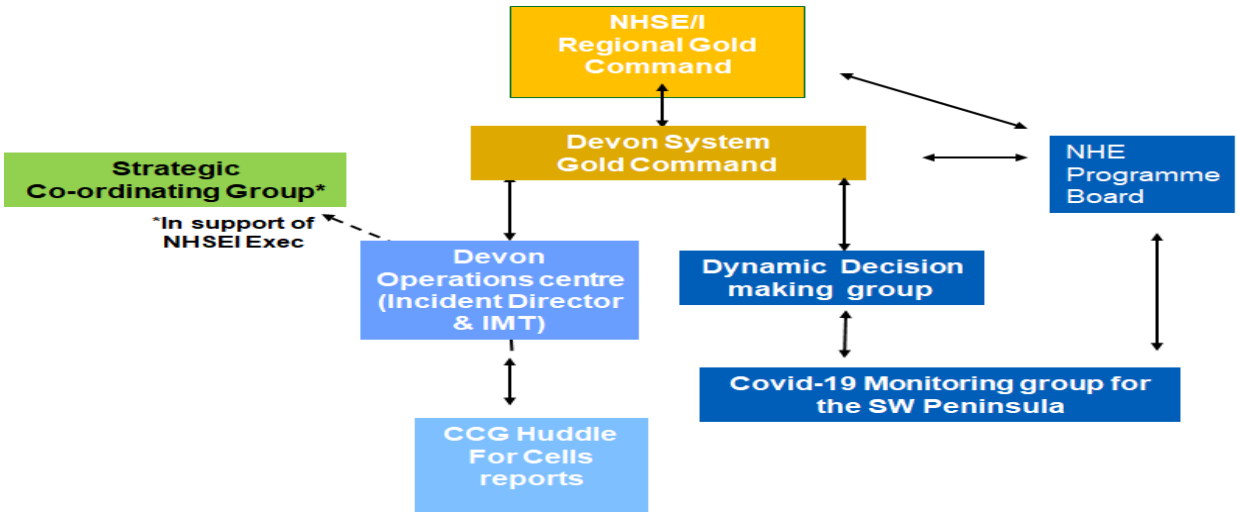
- Winter requirements & system escalation;
- COVID incident surges;
- Issues arising from the UKs exit from the European Union (D20);
- Recovery

7.3. The Operations Centre will run until 12 April 2021 and will operate daily through dedicated staff and through on-call arrangements out of hours.

7.4. The operations centre director will lead the response, supported by an enhanced Incident Management Team, and will be underpinned by 'cells' which will deliver the resource and expertise to respond quickly and impactfully as issues arise.

7.5. A Dynamic Decision-Making Group (DDMG) has been established, meeting three times per week and chaired by the STP medical director, which ensures rapid operational actions are put in place, to keep the system safe. This group will use a System Decision Framework for stepwise escalation of Covid and Non-Covid activity across Devon and the sub region.

7.6. The diagram below sets out the system reporting arrangements of these groups.



Emergency preparedness, resilience and response (EPRR)

Emergency response & escalation

7.7. The CCG's emergency preparedness is linked to Devon system providers and NHS England. Plans are in place covering escalation, severe weather and other potential emergencies. Internally, the CCG has business continuity plans in place to enable a response to an internal service disruption.

7.8. The CCG's response to emergencies and out-of-hours escalations are led by our directors on-call. These executive and associate directors have all received training in the plans and processes, to enable an effective response to be initiated with our providers and multi-agency partners.

Mortuary capacity

7.9. All mortuaries in Devon are operated by the NHS and are part of acute trusts. These mortuaries are also, by contract, the local authority public mortuaries. Each mortuary has an escalation plan in place and is also incorporated into the Devon, Cornwall and Isles of Scilly (DCIoS) Local Resilience Forum Excess Deaths Plan, to be used in the event of an emergency incident resulting in large numbers of deaths. The COVID-19 pandemic meets the criteria for the activation of this plan and Devon local authorities have put plans in place to support the acute trust mortuaries should this be required.

Severe weather

7.10. Those staff who would normally attend an office base to work, but are prevented from doing so by severe weather, will be expected to use remote working tools and work from home.

7.11. A protocol to govern the activation and use of the Devon and Cornwall 4x4 Reserve volunteers by NHS organisations in Devon and Cornwall is in place and may be activated via EPRR in hours and the Director on-call out-of-hours. This protocol is subsidiary to the DCIoS LRF 4x4 Cell Tactical Framework.

Cold weather plan for England

7.12. The national *Cold Weather Plan for England* is published on the Gov.uk website. The CCG and all commissioned providers are required to implement its guidance.

December 2020 (D20) – end of transition out of the EU

7.13. National planning for the D20 transition will require the CCG and providers to put in place similar structures and processes to those which were in place in the run up to EU Exit in late 2019 and January 2020. While this process has not yet started, the CCG has a D20 Lead and Senior Responsible Officer (SRO) in place.

7.14. The risks that the Devon system face in the event of no deal being agreed with the EU will be similar to those being mitigated nationally in the run to EU Exit, but with an added risk to our COVID-19 response should the PPE supply chain be affected by border crossing or EU transit delays.

8. Enablers

Workforce

8.1. We have developed **our response** to the NHS People plan, which describes our key challenges and sets out action to support transformation across the Devon system across four priorities:

1. Looking after our people
2. Belonging in the NHS
3. New ways of working and delivering care
4. Growing for the future

8.2. Winter 2020/21 will bring unique and additional challenge in terms of workforce resilience due to the impact of the COVID-19 pandemic. However, there have been a number of opportunities that have arisen as a result of COVID-19 to accelerate our broader ambitions. For example, we already know that Devon's economy is the fourth hardest hit by redundancies from COVID-19 in the UK up to June 2020, and that health and social care will form a key sector in our county's economic recovery. The health and social care sector has seen positive growth as a result of COVID-19, with the workforce being recognised and valued by society as a whole.

8.3. There are a number of winter-specific considerations to ensuring workforce resilience this year:

Supporting health and wellbeing

8.4. We understand the impact to staff of working through the COVID-19 pandemic peak, and thus a key feature of our approach to winter is the wellbeing of our staff. Actions include:

- Regular promotion of the national health and wellbeing offer;
- Extensive and regular system and organisational communications provided to staff, including those across primary care and social care coordinated through the CCG/STP Communications team with advice and guidance;
- Regular webinars for staff in social care and primary care hosted by the CCG;
- Devon Partnership Trust (DPT) Talkworks service, a priority pathway for those people working in the NHS, social care and the police. Provided by high intensity therapists, delivering psychological first aid based on the World Health Organisation guidelines. Where further intervention was required DPT prioritise individuals into the usual NICE interventions for

common mental health difficulties. 120 staff have accessed this service since March;
- Online support also offered via DPT website and enables access to Silvercloud;
- All staff able to access Occupational Health and Employee Assistance Programmes. CCG extended EAP contract for all Primary Care (including pharmacy) workforce to access;
- Free staff parking offered across all NHS sites remains in place for the time being;
- Rest and recuperation offer to staff in all NHS organisations with clear guidance. Regular communications to staff to encourage taking time off and taking leave in particular before winter pressures;
- Bi-weekly whole system Partnership Forum meetings with unions with staff wellbeing focus;
- All NHS staff receiving a consistent system agreed risk assessment.

Flu vaccination

8.5. We will ensure there is an offer to 100% of frontline health and care workers and have a communications strategy in place to ensure maximum uptake. This is described in our flu response. All Devon NHS providers have a flu plan in place for front-line health and care workers, and this includes the innovative use of COVID-19 testing centres to provide staff flu vaccination.

8.6. Social care and hospice workers employed by registered residential or domiciliary care providers are also eligible to receive a free flu vaccine via their general practice or a community pharmacist. Eligible groups have been expanded this year to include those health and social care workers, such as personal assistants, employed through Direct Payment and/or Personal Health Budgets to deliver domiciliary care to patients and service users.

PPE and IPC

8.7. Provision of adequate PPE for all services across the health & care system to protect staff and support workforce resilience and capacity throughout winter is critical. A central system function is planned to aid procurement, storage and supply logistics.

High risk groups

8.8. Health inequalities amongst our staff, has been brought to the forefront as a result of COVID-19 with greater awareness of our vulnerable workforce. All BAME staff and staff at higher risk must have a risk assessment in their role to ensure appropriate measures are in place to keep them safe. In June 2020 we established a BAME staff network to improve local support and strengthen the voice of our BAME staff.

8.9. Workforce growth predictions have been developed by NHS organisations until the end of March 2021 (see right), taking account of Adapt and Adopt and the growth required due to COVID-19 recovery:

- RD&E increased their workforce from 7,914 to 8,031 in months 4-6;
- Torbay anticipate requiring minimal additional staff to deliver activity and have included growth in bank rather than substantive staff due to recruitment challenges;
- Plymouth have the greatest increase in nursing workforce with recruitment checks completed or underway for 116 preceptees. 28 International nurses will join their organisation October to November.

8.10. PCNs have already submitted recruitment plans for 2020/21 to NHSE/I via the CCG.

September 2020 to March 2021 growth prediction by staff group	
	Change
Bank and agency	13 ↑
Medical	28 ↑
Non medical clinical	291 ↑
Non medical non clinical	12 ↑

Quality and patient safety

8.11. Quality and equality impacts are an integral component of each work programme within the recovery, restoration and transformation of services within the Devon system. With quality at the heart of this decision process, key areas assessed include infection prevention standards and impact on individuals, families, carers and our workforce.

8.12. As services resume for patients after the COVID-19 peak, in line with national guidance, the Devon system is capturing and developing innovation that has emerged during the pandemic to keep patients safe.

8.13. Supporting the principle of high quality, safe and effective care through system collaboration and sharing best practice. Standardisation of evidence based key care pathways across the system promotes good outcomes and utilises resources more effectively.

8.14. Consistency in triage, assessment and review of patients who may be delayed enables potential adverse impacts of waits to be minimised. A system waiting list is being derived at an individual patient level, with a view to being able to equalise waits across the system wherever this is feasible to do.

Hospital-based services

8.15. Plans to restore planned care and elective procedures have included ensuring enhanced COVID-19 precautions are in place for all those requiring treatment. PPE requirements, social distancing and in some settings reductions in available beds have needed to be considered in these plans, particularly in the context of increased unplanned care attendances associated with winter pressures. NICE guidance has been published detailing pre-admission precautions for planned care to reduce COVID-19

related risks. These are risk-based, dependent on individual risk factors and the planned procedure. It includes advice on testing and self-isolation prior to admission

8.16. The CCG led service change process continues; providers are required to comply with national guidance, including COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services when restoring elective services. Additionally, providers are required to evidence their impact assessment when restoring and/ or adapting the way a service is provided, using a CCG designed standard Quality and Equality Impact Assessments (QEIA) template.

8.17. Timely planning for continuing health care arrangements as part of hospital discharge planning are in place to support safe and effective transitions of care.

Community services

8.18. As key partners in the system a range of methods has been used to support independent community care and care homes providers winter planning arrangements. System wide COVID-19 prevention principles for health and care professionals required to visit care homes have been agreed via the CCG care home and home care cell and has been widely distributed.

8.19. Forums and provider engagement networks have enabled early discussions on discharge pathways including those that need to be expedited such as individuals within the end of life phase of care. A regular interactive care sector webinar supports themed topics and promotes information sharing and discussions between independent and statutory organisations and regulators. This gives a clear route for emerging issues to be identified and sharing of resources, experience and innovative practice across the system. A key feature of the live webinar is an interactive Q&A section with a core panel of providers, CCG Senior Managers, Local Authorities and any field experts.

Urgent and emergency care

8.20. Several measures are in place to ensure oversight of the quality of services in the emergency departments, the 999 service, 111 service and out of hours GP services. All services provide metrics including 12-hour breaches, ambulance handover delays, ambulance response times, call answering times, abandonment rates and time to clinical assessment (in 111 / OOH) for example. Where any metric is unexpected and unexplained, or causes concern, key lines of enquiry request further detail / deep dive into the specific area. CCG staff attend quality and governance meetings for 111 / OOH (monthly) and 999 services (quarterly) where detailed analysis of information provided is undertaken.

8.21. COVID-19 prevents CCG clinical staff from undertaking usual routine visits to emergency departments, or into the clinical assessment services of 111 / OOH. These visits have previously generated rich information about experience of staff and patients. This year we will therefore be more reliant on information provided which will be used alongside other intelligence such

as serious incident management and patient experience information. Performance and quality monitoring is combined in localities and across the system to give early indications and enable trigger of supportive interventions and actions.

Patient feedback

8.22. There are many routes and touch points by which patients and citizens can give their feedback we would continue encourage patients to use these routes as usual during the winter period.

8.23. All providers in Devon have robust processes via patient experience, PALS and complaints teams by which patients can feedback. Feedback can be provided directly to the CCG's own patient experience team, and to Healthwatch as an independent consumer champion that can support patients. Providers also continue to use patient opinion websites.

8.24. In primary care, patients are encouraged to raise their experience directly with the practice in the first instance, but if they feel unable to do so or don't want to, there is a process in place to take concerns through the NHS England national contact centre.

8.25. We continue to encourage people wherever possible to speak directly to the service in the first instance. If people feel unable to do this, they can contact the CCG or Healthwatch.

Communication and public messaging

8.26. This is the fourth year we have taken a system approach to winter communications planning and it builds on our previous award-winning work. We are working as a Devon system to ensure one consistent approach to winter communication so it's targeted and timely.

8.27. The campaign involves uplifting the national Help Us Help You campaign, and features themed weeks as outlined in the full communications and marketing strategy, focussing on key areas of the campaign and at-risk groups, for all partners to align messages and activity for maximum impact.

8.28. The CCG works closely with regional team at NHS England to ensure public messages are in line with national statements. The Devon communications strategy has been signed off by NHS England and will be presented to partners at the Devon A&E Delivery Board.

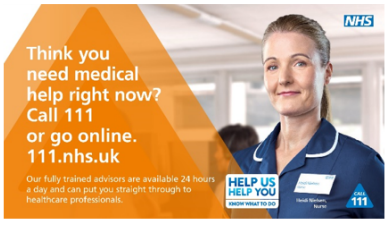
8.29. The messages are based on encouraging flu vaccination uptake, staying healthy and knowing which service you need, with a focus on helping to keep the elderly or those with long-term health conditions out of hospital.

8.30. The aim of this plan is to help keep people safe and well this winter whilst reducing pressures on NHS organisations in the regions during the winter months. In addition, this plan supports the flu season ambition to improve the uptake rate among the specified cohorts, at risk groups including pregnant

women, children, adults and some specific groups at higher risk of severe disease.

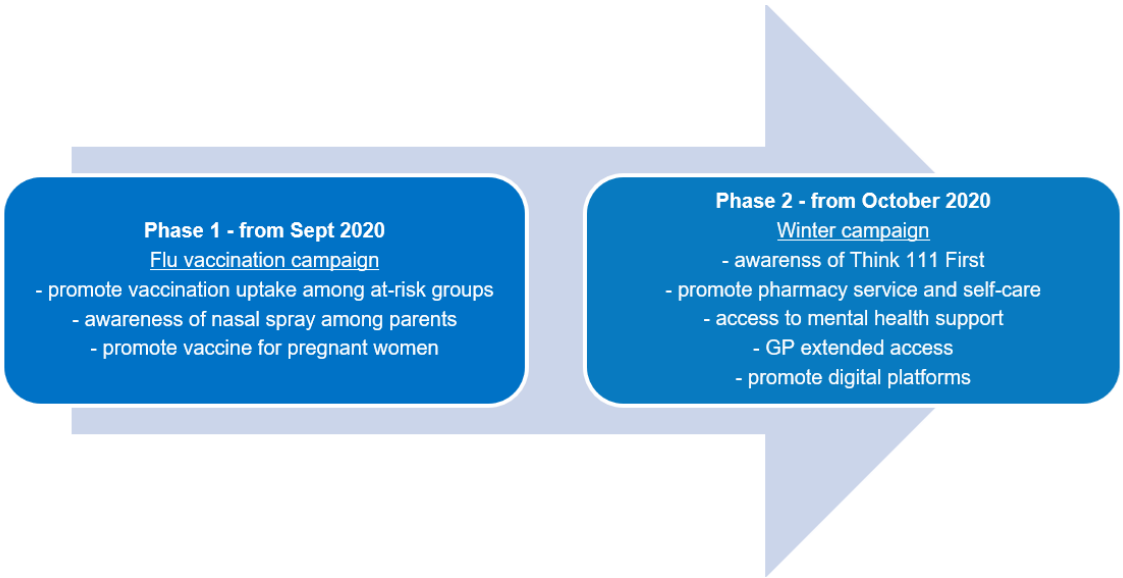
8.31. PHE research suggests the at-risk group might be more interested this year because of COVID-19 and there are plans for a national call and recall system that should help improve the flu immunisation uptake. As such, our communications planning will factor in the increased numbers required.

8.32. The CCG communications team work with provider communications leads and locality-based teams to deal with routine issues and keep NHS England informed of issues that may be of major significance, including reporting any incidents, actions or escalation issues.



Key areas of focus for 2020/21 communications campaign:

- **Think 111 First** – behaviour change campaign to encourage contacting 111 before attending ED;
- **Digital offer** – eConsult, video consultations, NHS app;
- **Flu** – all groups (with new expanded groups for 20/21) and added messaging on measure in place to keep people safe, limit exposure, etc;
- **Paediatrics** – continue success from last year with work on face-to-face and social media engagement on HANDi app;
- **Mental health** - support available for people, especially as we approach Christmas and New Year, and launch of 24/7 crisis lines, as well as crisis cafes.



9. Risk and Monitoring Delivery

The following tables set out a summary of the key risks that have been highlighted in preparation of the winter plan and the mitigations either in place or under consideration to manage these risks. Key areas of risk include:

- Management of peaks in demand for both COVID and non-COVID activity;
- Ability to deliver elective activity in line with Phase 3 restoration trajectories;
- Availability of workforce.

Oversight of delivery of this Plan and risk register will be through the Devon Urgent Care Programme Board (UCPB) on a monthly basis and through locality urgent care forums.

Together for Devon

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

Area	System Risk	System Mitigation
Demand and capacity	Peaks in COVID-19 demand are higher than planned and exceed available bed capacity	COVID escalation triggers are in place, linked to opening of Nightingale capacity
		Designated COVID capacity in place in the community
	Elective activity is cancelled because Covid-19 demand is not offset by reduction in other emergency demand	Clear reporting of capacity across all parts of system
		A system approach to manage this risk will be overseen by the Dynamic Decision Making Group, to agree system actions, including mutual aid arrangements
		Planned options for extra capacity, including use of Independent sector
	Increased demand to ED, leading to over-crowding and ambulance handover delays	Primary Care "hot hubs" established
		Utilisation of admission avoidance pathways
		Think 111 First implementation
		Maximising flow across the system to ensure timely discharge
		Public communications plan on alternative pathways
	Insufficient critical care capacity to respond to the modelled surge/increase of COVID positive patients in Devon	Agreed peninsula critical care network protocol, including mutual aid
		Additional Nightingale hospital capacity
		Dedicated critical care transport service (Retrieve) established
	Vulnerability in domiciliary care provision and availability of care home bed capacity could lead to delays in discharge with beds becoming blocked impacting on the ability to admit and/or treat other patients	Community services; intermediate care, rapid response, reablement, providing support to minimise any shortfall in provision
		Discharge to Assess resilience and agility
		Market Management – commissioning additional care home beds and personal support through use of agency arrangements
		Working with the voluntary sector to support domiciliary care work
Infection Prevention and Control	Loss of capacity due to outbreaks within hospitals and out of hospital (eg: care homes)	Infection control team providing; proactive management and support to Care Home market
		Social distancing and IPC guidance adherence
		Outbreak management plans in place
	PPE levels run low	Maintain strong communications regarding management of Covid-19 pathways, PPE usage and guidance around self-isolation and protection of staff, patients and public
	Environments become high Covid-19 infection zones with nosocomial transmission of Covid-19 from asymptomatic staff to patients and vice versa	Adopt consistent IPC practice across system in line with national guidance
		The IPC team are providing proactive management and support to all parts of the system, including care homes

Flu	Seasonal flu impacts further on demand	Comprehensive Flu Campaign and Infection Control management
		Strong focus on isolation & point of care testing
		Good uptake of vaccines within the health and social care system - aiming for 100% of frontline staff
Mental health services	Increased demand for all age mental health services, due to the psychological impact of Covid-19	An improvement programme to include older person's mental health is underway
		Psychological liaison services and crisis response are in place
		Primary care initiatives will help to prevent pressure on mental health providers
	Insufficiency of beds could result in out of area placements	Additional beds have been identified
	Insufficiency of high-end dementia care home placements	Market development in progress
Workforce	Availability and wellbeing of the workforce is reduced through increased sickness and social isolation requirements	High uptake of vaccination programme and good testing capacity including package of care testing for flu and Covid-19
		Robust rota management to ensure safe staffing levels
		Staff swabbing now offered from day one of symptoms
		Wellbeing programme of work
		Ensure all organisations following optimal Occupational Health recommendations and IPC guidelines
	A shortage of testing kits may result in increased absence and impact on workforce levels	System wide management of testing kits for Devon
	Inability to recruit will impact on delivery of winter schemes	Trusts are reviewing opportunity to release existing staff and back fill as well as recruiting early to maximise opportunities

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 26th November 2020 **Date report produced: 19th November 2020**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date:** 19th November 2020		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

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

The report details the financial position for the period ending 31st October 2020, as well as the forecast outturn (FOT) for year ending 31st March 2021. The report includes reference to the impact of the COVID19 pandemic and the financial consequences for the CCG during 2020/21.

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

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

In May NHS England (NHSE) put in place a temporary financial regime covering the period 1st April to 30th September, resulting in NHSE re-setting the CCG Allocation for a six-month period. The allocation is based on the CCG's forecast outturn expenditure for 19/20 uplifted for NHSE derived growth and inflation assumptions and adjusted for changes made to the NHS and Independent sector funding arrangements during the COVID19 emergency period (The NHSE Model).

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 now includes system top-up and COVID19 allocations, previously paid directly to our system's NHS providers. In addition to this CCG's will continue to be reimbursed for eligible costs in relation to the Hospital Discharge Programme.

Based on the updated financial framework, the CCG will receive a total allocation of £2,198.9m, including a £7.6m month 6 retrospective top-up allocation that we are expecting. NHSE are reviewing organisations month 6 positions and once satisfied the top-up funding will be confirmed.

Assuming the CCG is reimbursed the month 6 top-up allocation and 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.

NHSE expectation is that providers and CCGs must achieve financial balance within the system funding envelopes. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions.

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

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

None.

Key recommendations and actions requested:

The Governing Body is requested to:

Consider, review and discuss the month 7 year to date performance including the current risks.

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
N/A

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

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

NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 7 – 2020/21

Contents

Appendices

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Detail of the CCG budget and expenditure is set out in Appendix 3.

Financial Position

The following detailed report reflects the budget set by the NHSE model compared with our expectations of commitments against that budget for the period to 31st October and year ending 31st March 2021.

	Budget £'000	Actual £'000	Variance £'000	Additional HDP Allocation £000	Revised Variance £'000
Year to date position	1,244,031	1,249,126	5,095	5,095	0
Year end forecast	2,198,875	2,228,047	29,172	29,172	0

Overall, subject to the CCG receiving the expected reimbursement from NHSE for the Hospital Discharge Programme (HDP), the CCG is forecast to balance for the year ended 31st March 2021.

Within the year to date (YTD) and forecast balanced position there are a number of variances that are detailed in the sections below with the significant variances being a product of the Hospital Discharge Programme, other primary care and running costs being greater than budget, offset by underspends relating to prescribing and continuing healthcare.

The costs linked to the COVID19 pandemic are detailed in section 4.

Savings Plan

The CCG's original plan included a saving requirement of £22.6m. The full year budget based on the revised financial framework is based on 19/20 forecast expenditure and by inference does not include an implicit savings target. The CCG will be reviewing its original planning assumptions and actions to deliver savings as we move into the next stage of the financial framework post 30th September 2020.

Risk

There is a risk that the CCG does not meet NHSE's assurance process for the month 6 retrospective top-up allocation of £7.584m. Should the top up fall short of the excess costs experienced we will seek to understand the reasoning and address appropriate mitigating actions to meet the NHSE objectives of a breakeven position.

In addition, the updated financial regime exposes the CCG to an estimated £6.0m risk in regard to Plymouth Orthopaedic Partnership (POP) and the nationally contacted independent sector activity that is being passed back to CCGs. We are awaiting further guidance and clarification.

STP Plan

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 short fall relates entirely to lost private and commercial income.

The plan is currently under review by NHSE and as such has still to be agreed. Whilst this is outstanding contract envelopes agreed between the system partners to deliver the submitted plan are being transacted.

Providers and CCGs must achieve financial balance within the funding envelopes. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions.

2. Financial Assurance Dashboard

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

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

- Financial plan
- In Year Financial performance

The detailed areas of assessment that feed into these top-level indicators are shown in tables below and are based on the plan submitted in October 2020.

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date position (including the expected reimbursement of Hospital Discharge Programme funding)	0.0	0.0	0.0%	GREEN
3	Forecast Outturn (Including the expected reimbursement of Hospital Discharge Programme funding)	0.0	0.0	0.0%	GREEN
4	Running Costs	19.9	21.6	108.6%	RED
5	Risk adjustment to deficit (% of allocation)	0.0	0.0	0.0%	GREEN
6	Cash Position (% drawn down)	58.3%	62.1%	106.5%	RED
7	BPPC (% paid - value)	95.0%	99.1%	104.3%	GREEN

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

3. Detailed Financial Performance

The financial position to the 31st October 2020 by main service heading is as follows.

2020/21 FINANCE BOARD REPORT PERIOD FROM 1 APR to 31 OCT 2020 Month 07 October	DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES										
Acute Services	547,165	547,110	-	547,110	-55	1,015,526	1,015,526	-	1,015,526	-0
Mental Health Services	128,908	128,272	261	128,534	-375	229,511	229,033	261	229,294	-216
Community Health Services	182,842	161,814	25,387	187,201	4,358	296,552	275,587	48,524	324,110	27,559
Placements	75,747	73,023	2,184	75,207	-540	128,881	126,434	2,184	128,618	-263
All Other Healthcare	32,393	23,858	7,586	31,444	-948	46,636	38,652	9,973	48,624	1,989
Primary Care Services										
Prescribing	127,611	123,153	2,761	125,914	-1,696	216,483	211,066	3,376	214,442	-2,040
Delegated Commissioning	4,254	4,137	-	4,137	-117	7,094	7,094	-	7,094	-
Other Primary Care	130,504	125,350	6,121	131,471	967	216,609	210,976	8,644	219,620	3,011
Primary Care Subtotal	262,369	252,640	8,882	261,523	-846	440,185	429,136	12,020	441,156	971
Commissioned Services Subtotal	1,229,424	1,186,718	44,301	1,231,018	1,595	2,157,290	2,114,367	72,962	2,187,328	30,039
CORPORATE										
Running Costs	10,990	11,985	590	12,575	1,586	19,882	20,967	629	21,596	1,713
RESERVES AND CONTINGENCIES										
Contingency	-	-	-	-	-	-	-	-	-	-
Other Reserves	3,617	5,532	-	5,532	1,915	21,703	19,123	-	19,123	-2,580
Reserves Subtotal										
TOTAL COMMISSIONED SERVICES	1,244,031	1,204,235	44,891	1,249,126	5,095	2,198,875	2,154,456	73,591	2,228,047	29,172

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

3.1 Acute Services

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

For the majority of NHS Acute Services, the contract payments to providers for the period to 30th September 2020 has been determined by NHSE through a methodology linked to a projection of their underlying expenditure.

Under the new finance framework, from month 7, the CCG and system providers have agreed a set of block contract payments that also include top-up payments, growth funding and COVID19 allocations, previously paid directly to providers from NHSE. The CCG's budget under these financial arrangements has been set to match the payments.

Up until October 2020 contracts with the main independent sector providers have been negotiated and paid for nationally. After this date, it is expected that local commissioning for all acute independent sector services will resume. Funding the CCG received is based on historic levels and could therefore result in a potential financial risk.

At month 7 acute services has a small underspend of £0.1m YTD and is forecast to balance at the end of the year.

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

3.2 Mental Health Services

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

In 2020/21 the CCG had planned to invest £11.9m (5.63% increase) in Mental Health Services. Increases in mental health spend to 30th September and projected spend within the system agreement for the remaining year currently meet the requirements of the Mental Health Investment Standard to invest the planned £11.9m.

At month 7 there is a YTD underspend of £0.4m and FOT underspend of £0.2m for all mental health services.

The underspend is driven by lower commitments in relation to mental health and learning disability individual patient placements being lower than expected.

3.3 Community Health Services

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

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

The overspend of reported relates almost entirely to the cost of the Hospital Discharge Programme for which the CCG is expecting to receive national funding for following a regional reporting and assurance process of the spend incurred.

3.4 Placements

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

The Month 7 forecast position is to underspend by £0.3m. This is largely as a result of exceptional costs during the current pandemic (uplifts to market rates), variance between NHSE/I budget setting model verses local plan and non-delivery of QIPP but offset by client number reductions and additional budget received from NHSE/I for COVID costs & 19/20 FNC uplift. The table below summarises the key variances.

Placements FOT Variance	
Variance Type	**£m**
Additional Covid related costs e.g. fee uplifts	2.1
Additional Budget for Covid costs M1-6 & M5 variance top up	0.7
Budget variances (NHSE/I model vs local plan) & profiling	3.0
Non delivery of QIPP savings plan	4.6
Cost reduction due to client number movements (partly Covid related)	-11.3
FNC Uplift over and above plan assumption	1.4
Additional Budget for 1920 FNC Uplift	-0.8
Total	- 0.3

The COVID emergency is having a number of specific effects on costs and on the focus of the service which will impact on how the financial position unfolds during 2020/21.

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

The reported forecast outturn position is an estimate regarded as the likely scenario, but it is recognised that a range of factors exist which could potentially result in significant financial risk/benefit to that estimate.

Some examples include:

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

The Phase 3 planning guidance includes provision that CHC assessments should be re-commenced for new placements from the 1st September with reviews of those placements made between 19th March and 31st August to be undertaken. The operational team are mobilising internal & external resources to complete these assessments by 31st March 2021.

3.5 All Other Healthcare

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

At month 7 there is a YTD underspend of £0.9m and an expected FOT overspend of £1.7m, due mainly to the expected additional costs relating to COVID19. The larger elements of the COVID costs relate to discharge arrangements in the Western Locality and should be covered by a future allocation under the Hospital Discharge Programme.

3.6 Primary Care Services

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

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

Prescribing

Based on August's Prescribing Monitoring Document (PMD) prescribing is underspent by £1.7m year to date and is forecast to underspend by £2.0m by the year end.

Category M risk is no longer included as the guidance has now changed. The No Cheaper Stock Obtainable (NCSO) spend has also decreased, meaning no further

risk to us outside of the forecast at present. We have included some further risks we are aware of based, for example Freestyle Libre increases.

Delegated Commissioning

The month 7 delegated commissioning figure is reported as a YTD £0.1m underspend and a balanced forecast position.

Other Primary Care

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

3.7 Running Costs

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

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

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

The CCG's allocation for 2020-21 was set to reduce from £25.4m last year to £22.4m for this financial year but as part of the new framework has been revised to £20.4m. The CCG is reporting YTD spend at month 7 as £12.6m and forecast to spend £21.6m, of which £0.6m are specific short-term costs in relation to COVID19.

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

3.8 Resource Allocation

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

Planned revenue resources	£'000
Allocation after place based pace of change	1,759,720
Primary care commissioning	170,193
Running costs allocation	22,411
Recurrent adjustments	-1,768
Non recurrent adjustments	143,279
Non recurrent allocation System COVID19	57,238
Non recurrent allocation COVID19 (to month 5)	26,801
Non recurrent retrospective top-up (to month 5)	13,416
Total revenue resources confirmed	**2,191,290**
Anticipated month 6 top-up allocation	7,584
Expected revenue resources	**2,198,874**

The resources include a non recurrent COVID19 allocation totalling £84.0m, £26.8m of which the CCG was reimbursed for the period ended 31st August and £57.2m of which is to support total system costs.

The revenue resources confirmed excludes the assumed month 6 top-up allocation to cover the overspend position reported.

The high level parameters under which the allocation was set are as follows:

The calculation methodology for adjusted CCG allocations is consistent with the approach for M1-M6, except for several amendments including:

- Adjustments to block contract values for material service changes, material errors identified in the M1-M6 block contracts and specialised block contracts have been updated to remove funding for CDF and Hep C medicines.
- The expenditure baseline for CCG delegated primary care expenditure and CCG running costs has been updated from 2019/20 M11 to 2019/20 M12;
- The growth rate applied to generate the running cost expenditure expectation has been updated to be the lower of; 2019/20 year end position excluding spend with NHS providers uplifted by 3%; and the 2020/21 published running cost allocation excluding spend within NHS providers.
- The expenditure expectation for CCG-commissioned acute Independent Sector services has been updated to reflect M1-M4 2020/21 average run-rate.
- The system top-up, growth funding and COVID-19 funding now sit within the CCG's allocation.

4. COVID19 Specific Costs

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

The CCG has incurred costs of £44.9m to date, as detailed below.

COVID 19 Commitment Analysis	YTD £m
Nightingale Hospital	2.16
CHC Market Enhancements	2.34
Prescribing	2.76
Primary Care	5.64
PPE Staffing and other costs	5.71
	18.62
Hospital Discharge	
Devon CCG	2.42
Devon County Council	17.72
Plymouth City Council	3.62
Torbay & Southern Devon FT	0.80
Livewell South West (Social Care)	1.72
	26.28
Total	44.90

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

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

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

In addition to these measures a national initiative to speed up discharge from Hospital and reduce the burden of assessment on decisions supporting discharge NHSE and Local Authority's regulators agreed a hospital discharge programme supported by £1.9bn of NHSE funding. It allows Local Authorities to reclaim the cost of discharge packages and enhanced costs of care to prevent hospital admissions to be reclaimed via the CCG. We continue to work without Local Authorities on the developing strategies for the market management of the care home sector and responding to the Phase 3 guidance in relation to the Hospital Discharge Programme

as well as recommencement of CHC assessments from the 1st September and reviews of those placements made between 19th March and 31st August.

Hospital discharge costs in relation to Torbay Council are incurred by Torbay and Southern Devon NHS FT. For the period to 30th September 2020 these costs were reclaimed by them directly from NHSE. For the period from 1st October 2020 these costs are included within the CCG's claim.

5. Risks

There is a risk that the CCG does not meet NHSE's assurance process for the month 6 retrospective top-up allocation of £7.584m. Should the top up fall short of the excess costs experienced we will seek to understand the reasoning and address appropriate mitigating actions to meet the NHSE objectives of a breakeven position.

In addition, the updated financial regime exposes the CCG to an estimated £6.0m risk in regard to the Plymouth Orthopaedic Partnership (POP) and the nationally contacted independent sector activity that is being passed back to CCGs. We are awaiting further guidance and clarification.

6. Other Financial Information

6.1 Statement of Financial Position

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

The CCG's position at 31st October 2020 is shown in appendix 1.

6.2 Capital

NHS England has approved capital of £0.1m for business as usual laptop replacements, as well as a £0.2m capital grant contribution to Delt infrastructure.

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non NHS Creditors - % of bills paid within target	99.33%	97.59%
NHS Creditors - % of bills paid within target	95.11%	99.67%

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

6.4 Cash

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

7 Recommendations

The Governing Body is requested to:

Consider, review and discuss the month 7 year to date including the current risks.

Appendices

Appendix 1: Statement of Financial Position

AS AT 31 OCTOBER 2020	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	1,665
Intangible Assets	2
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	1,668
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	132,285
Trade & Other Receivables - Non NHS	26,292
Other Current Assets	-
Cash & Cash Equivalents	15,750
Non-current Assets held for Sale	-
Total Current Assets	174,726
Total Assets	176,394
CURRENT LIABILITIES	
Trade & Other Payables - NHS	- 12,158
Trade & Other Payables - Non NHS	- 168,998
Other Liabilities	- 1,232
Borrowings / Cash in Transit	- 3,809
Provisions	-
Total Current Liabilities	- 186,197
Total Assets less Current Liabilities	- 9,804
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 89
Total Non Current Liaibilities	-
Total Assets Employed	- 9,892
FINANCED BY TAXPAYERS EQUITY	
General Fund	9,892
Total Taxpayers' Equity	9,892

Appendix 2: Cash

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

Measure	Month 7
CCGs must operate within their expected annual cash drawdown requirement. *The expected annual cash drawdown requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £2,188.625m for Devon CCG the year.*	62.1% of the MCD has been utilised as at month 7 (58.33% is expected based on a straight-line trajectory at month 7). Over utilisation is due to the requirement by NHS England to pay Providers one month's block payment in advance.
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £8,523 for October.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has not met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

Appendix 3: Operating Expenditure

2020/21 FINANCE BOARD REPORT PERIOD FROM 1 APR to 31 OCT 2020 Month 07 October	DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
ACUTE CARE										
NHS Royal Devon & Exeter Foundation Trust	165,278	165,279	-	165,279	1	300,889	300,889	-	300,889	-
NHS University Hospitals Plymouth NHS Trust	140,060	140,060	-	140,060	0	269,410	269,410	-	269,410	-0
NHS Northern Devon Healthcare Trust	73,010	73,010	-	73,010	0	135,857	135,857	-	135,857	-0
NHS South Devon Healthcare Foundation Trust	122,712	122,712	-	122,712	0	230,632	230,632	-	230,632	-
NHS Taunton and Somerset	5,631	5,631	-	5,631	0	9,653	9,653	-	9,653	0
NHS South Western Ambulance Trust	29,488	29,488	-	29,488	-0	50,685	50,685	-	50,685	-
Independent Sector	848	848	-	848	-0	1,564	1,564	-	1,564	-
Other Acute	10,138	10,081	-	10,081	-57	16,837	16,836	-	16,836	-0
Subtotal	547,165	547,110	-	547,110	-55	1,015,526	1,015,526	-	1,015,526	-0
PLACEMENTS										
Continuing Healthcare	66,800	64,838	1,696	66,534	-266	114,233	112,403	1,696	114,099	-135
Funded Nursing Care	8,460	7,741	488	8,229	-231	13,800	13,271	488	13,759	-41
Individual Patient Placements	486	443	-	443	-43	847	760	-	760	-87
Subtotal	75,747	73,023	2,184	75,207	-540	128,881	126,434	2,184	128,618	-263
COMMUNITY & NON ACUTE										
Livewell Southwest	31,469	28,412	3,251	31,663	194	50,921	47,865	4,323	52,189	1,268
Royal Devon and Exeter Community	34,262	34,262	-	34,262	-0	58,735	58,735	-	58,735	-
Northern Devon Healthcare Community	17,857	17,866	-	17,866	9	30,612	30,612	-	30,612	-
South Devon Healthcare Community	41,131	41,131	797	41,928	797	70,510	70,510	4,046	74,556	4,046
Children and Families Health Devon	6,560	6,560	-	6,560	-0	11,246	11,246	-	11,246	-
MIU Contracts	472	460	-	460	-12	818	818	-	818	-
Plymouth Integrated Fund	8,287	5,208	3,624	8,832	545	10,934	7,855	6,349	14,204	3,270
Better Care Fund_Devon CC	33,339	18,473	17,715	36,188	2,849	46,534	31,668	33,805	65,474	18,939
Better Care Fund Torbay	1,922	1,922	-	1,922	-	3,294	3,294	0	3,294	0
Other Community Services	7,544	7,521	-	7,521	-23	12,948	12,983	-	12,983	35
Subtotal	182,842	161,814	25,387	187,201	4,358	296,552	275,587	48,524	324,110	27,559
MENTAL HEALTH SERVICES										
Devon Partnership NHS Trust	79,801	79,801	-	79,801	-	145,885	145,885	-	145,885	0
Livewell MH Services	22,611	22,612	-	22,612	1	38,761	38,761	-	38,761	-
Children and Families Health Devon	6,476	6,476	-	6,476	0	11,101	11,101	-	11,101	-
Individual Patient Placements	16,423	16,154	161	16,315	-108	28,070	27,693	161	27,854	-216
Other Mental Health	3,599	3,230	101	3,331	-268	5,693	5,593	101	5,693	-0
Subtotal	128,908	128,272	261	128,534	-375	229,511	229,033	261	229,294	-216

2020/21 FINANCE BOARD REPORT PERIOD FROM 1 APR to 31 OCT 2020 Month 07 October	DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance Adv / (Fav)	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance Adv / (Fav)
OTHER COMMISSIONED SERVICES										
NHS 111	2,125	2,110	-	2,110	-15	3,567	3,500	-	3,500	-67
Integrated Urgent Care Service	297	67	-	67	-230	116	116	-	116	-
Hospices	5,017	4,936	66	5,002	-15	8,373	8,362	116	8,478	105
Patient Transport Services	4,995	4,839	207	5,046	51	8,660	8,567	302	8,869	209
All Other Commisionned Services	19,959	11,906	7,313	19,219	-740	25,920	18,107	9,555	27,662	1,742
Subtotal	32,393	23,858	7,586	31,444	-948	46,636	38,652	9,973	48,624	1,989
PRIMARY CARE										
Prescribing	127,611	123,153	2,761	125,914	-1,696	216,483	211,066	3,376	214,442	-2,040
Enhanced Services	50,507	50,507	-	50,507	-0	86,584	86,584	-	86,584	-
Delegated Commissioning	4,254	4,137	-	4,137	-117	7,094	7,094	-	7,094	-
GP Out Of Hours	8,609	7,921	663	8,584	-25	14,009	13,412	989	14,401	392
Other Primary Care	71,387	66,921	5,459	72,380	993	116,016	110,980	7,655	118,635	2,619
Subtotal	262,369	252,640	8,882	261,523	-846	440,185	429,136	12,020	441,156	971
TECHNICAL										
Coding Errors	-	-	-	-	-	-	-	-	-	-
Suspense	-	-	-	-	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-	-	-	-	-
TOTAL COMMISSIONED SERVICES	1,229,424	1,186,718	44,301	1,231,018	1,595	2,157,290	2,114,367	72,962	2,187,328	30,039
RUNNING COSTS										
Pay	8,325	9,463	393	9,857	1,532	15,317	16,471	430	16,901	1,584
Non Pay	2,716	2,582	197	2,779	63	4,631	4,570	199	4,769	138
Income	-51	-60	-	-60	-9	-65	-74	-	-74	-9
Subtotal	10,990	11,985	590	12,575	1,586	19,882	20,967	629	21,596	1,713
EARMARKED RESERVES AND CONTINGENCIES										
Earmarked Reserves										
Contingency										
Other Reserves	3,617	5,532	-	5,532	1,915	21,703	19,123	-	19,123	-2,580
Subtotal	3,617	5,532	-	5,532	1,915	21,703	19,123	-	19,123	-2,580
NET TOTAL OPERATING COSTS	1,244,031	1,204,235	44,891	1,249,126	5,095	2,198,875	2,154,456	73,591	2,228,047	29,172
CCG Control Total	-1,244,031	-1,204,235	-44,891	-1,249,126	-5,095	-2,198,875	-2,154,456	-73,591	-2,228,047	-29,172
2020/21 Surplus/Deficit	-	-	-	-	0	-	-	-	-	- 0

NHS Devon Clinical Commissioning Group

NHS DEVON CCG GOVERNING BODY – PUBLIC

Report title: Performance and Quality Report				
Date of committee: 26 November 2020 **Date report produced: 12 November 2020**				
Author (s) Name and Title: **Sara Wright – Head of Nursing & Quality** **Sian Jones – Business Intelligence Manager** **Alison Wilkinson – Deputy Chief Operating Officer**		**Supporting Executive:** **Name and Title:** **Jayne Carroll – Interim Chief Operating Officer** **Report Approved by:** **Name and Title:** **Jayne Carroll – Interim Chief Operating Officer** **Darryn Allcorn – Chief Nursing Officer** **Date: 12 November 2020**		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The purpose of the paper is:

- To present the 1 April 2020 to 30 September 2020 (month 6) performance against Constitutional and routine performance standards;
- To present the quality, nursing and safety performance position for the period 1 April to 31 October 2020;
- To provide an update on performance against the Devon System Phase 3 trajectories, as submitted to NHS England on 5 October 2020.

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 and Performance Committee

Key recommendations and actions requested:

Members of the Governing Body are asked:

- To present the 1 April 2020 to 30 September 2020 (month 6) performance against Constitutional and routine performance standards;
- To present the quality, nursing and safety performance position for the period 1 April to 31 October 2020;
- To note the update on performance against the Devon System Phase 3 trajectories, as submitted to NHS England on 5 October 2020.

Impact on Strategic Objectives

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

Appendix 1 - Performance report

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

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

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

NHS Devon CCG
GOVERNING BODY - PUBLIC
26 November 2020

Performance and Quality Report

1. Introduction

This paper builds on the last performance paper presented to the Governing Body on 29 October 2020. The purpose of the paper is three-fold:

- To present the 1 April 2020 to 30 September 2020 (month 6) performance against Constitutional and routine performance standards**;**
- To present the quality**,** nursing and safety performance position for the period 1 April to 31 October 2020.
- To provide an update on performance against the Devon System Phase 3 trajectories, as submitted to NHS England on 5 October 2020.

2. Constitutional Standards Performance from 1 April to 30 September 2020

This section of the report summarises the latest available performance information using a combination of nationally validated monthly data as at 30 September 2020 or, where available, 31 October 2020, plus some unvalidated weekly data.

It should be noted that validated national data is periodically refreshed and subject to change. Providers are continuing to improve validation processes for weekly data so there may be an element of data quality issues which adversely affect performance. There is also an impact of the MyCare EPR implementation at the Royal Devon and Exeter NHS Foundation Trust (RDEFT).

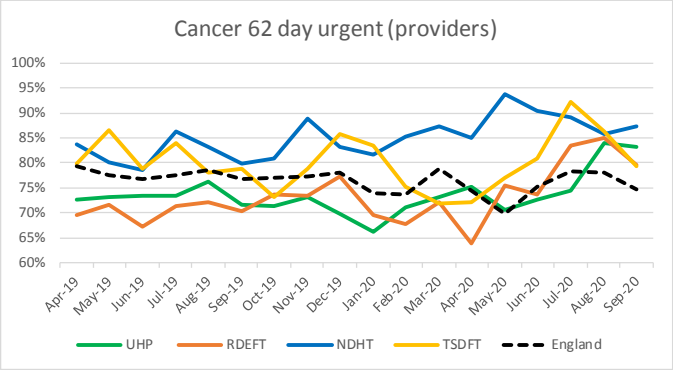
Appendix 1 shows the detailed performance information, but the key constitutional targets and other specific areas of focus are summarised below.

Cancer waiting times

As reported previously, performance against the cancer waiting times standards remained relatively stable through the initial COVID-19 period and in September continues to be strong, although performance is now coming under pressure from rising COVID cases, challenges on availability of appropriate theatre capacity and clinical staff being required to support acute COVID patients.

Performance against the **cancer 62-day urgent standard** fell in September, with the Devon Sustainability and Transformation Partnership (STP) position falling from 85.1% to 81.3%. Northern Devon Healthcare Trust was the only trust to achieve the target of 85%. University

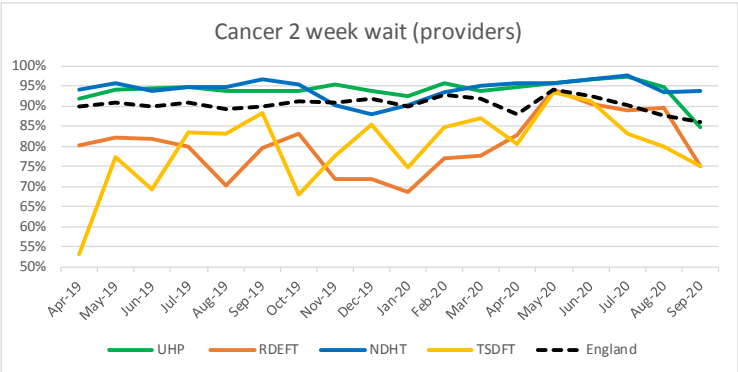
Hospital Plymouth (UHP) performance remained steady at 83.3%, the Royal Devon and Exeter NHS Foundation Trust (RDEFT) fell from 85.9% to 79.5%, Torbay and South Devon NHS Foundation Trust (TSDFT) fell slightly from 86.3% to 79.3%.



The drop in performance is due to capacity constraints – during the first COVID surge cancer services were prioritised, but, as referral rates have returned to normal, there has been an impact from other services as activity was restored. NDHT has lower volumes, so has been better able to manage with the increased demand.

Performance against the main **two-week wait standard** continues to be below target in September, falling from 88.8% in August to 79.9%. NDHT achieved the target at 93.9%, whilst RDEFT fell from 89.6% to 75.3%, TSDFT fell from 80.1% to 75.1% and UHP fell from 94.7% to 84.7%.

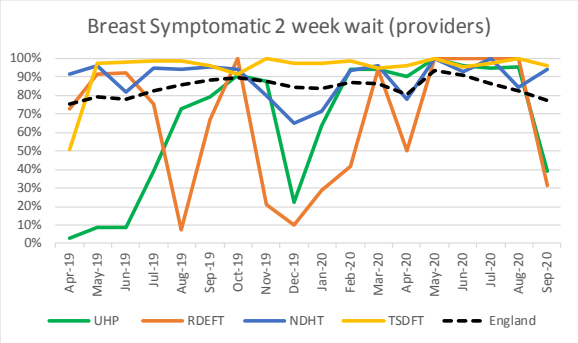
Staffing levels, as a result of increasing levels of sickness and the resulting requirement for further staff groups to self-isolate, and access to diagnostic pathways, particularly MRI and CT, continue to be the main contributors to current under-achievement. The diagnostic challenges are the focus of the Adapt & Adopt programme work to increase capacity and productivity.



Breast symptomatic performance fell across all providers except NDHT who achieved the target at 94%. Devon STP performance fell from 96.3% to 62.2%, with RDEFT falling from 100% to 32% and UHP falling from 96% to 39%.

Breast referrals are currently at 130% of expected levels. Trusts have completed their own analysis and have actions in place to support GP practices and the CCG is undertaking a deep dive of Breast Symptomatic performance, which will report next month.

The CCG is also currently seeking further information to understand the length of time these patients have been waiting and plans to drive improvement. For example, UHP has an action plan with an improving trajectory, partly due to the implementation of 7-day working.

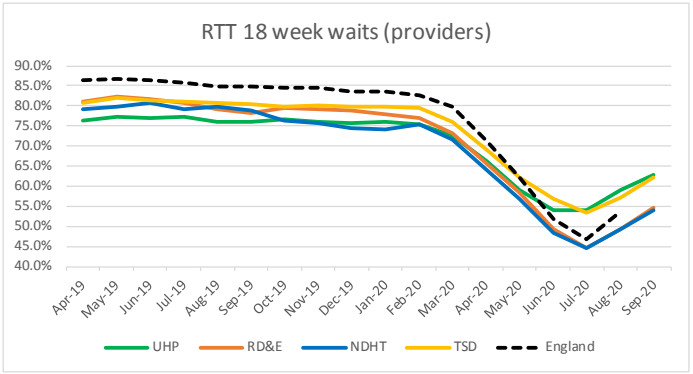


Elective Care

In the context of winter pressures and a surge of COVID-19 cases, providers continue to maximise a level of elective care that is safe, aiming to ensure a positive patient experience. However, as waiting lists grow, there is risk to both safety and experience for patients. As providers step up or down services, essential information is gained from providers, including a quality and equality impact assessment (QEIA). This information and communication process aids decisions, such as invoking mutual aid. Additionally, providers have safety processes in place to risk-stratify lists. This ensures patients are prioritised on need, rather than in solely chronological order.

Referrals to Treatment (RTT) Waiting Times

September's validated data shows an improved position for RTT 18-week performance, rising from 53.6% to 58.3% at an STP level, compared to the target of 92% and national performance of 52%.



However, waiting lists have risen in September. The table below shows the RTT waiting list movement between August and September by provider:

	RD&E	NDHT	UHP	TSD
August	32590	13026	28537	25275
September	33724	13352	30079	26366
Variance	**1134**	**326**	**1542**	**1091**

The number of long waiting patients also continues to increase, with numbers waiting over 52 weeks rising quickly at all providers in September, as can be seen in the table below. Breaches are expected to continue to rise in October.

	RD&E	NDHT	UHP	TSD
August	1486	830	881	745
September	1887	1019	997	892
Variance	**401**	**189**	**116**	**147**

The majority of the long waiters continue to be in Orthopaedics and Ophthalmology; in August there were 3,674 over 52-week breaches, of which 1,432 were trauma and orthopaedic, and 624 ophthalmology. These specialties are the focus of the surgical restoration programme, reviewing productivity data across the STP ensuring any variation is understood with opportunities identified for improvement. As winter pressures escalate, we expect to see an impact on this work.

Potential harm is managed through individual risk stratification, at department level: clinical waiting list validation is now progressing at all providers and all are actively engaged in the national e-review programme to ensure all patients are reviewed and prioritised / re-prioritised in accordance with clinical need. This will inform and support the ongoing work related to the single Devon Patient Tracking List (PTL). This work began in mid-October and we expect to have made a first contact (as a minimum) with all patients by mid-December.

The latest unvalidated weekly position (31/10/2020) shows 18-week performance for NDHT at 57.6%, RDEFT at 58.05%, TSD at 61.99% and UHP at 66.7%. A summary of long waiters for the latest week is shown below:

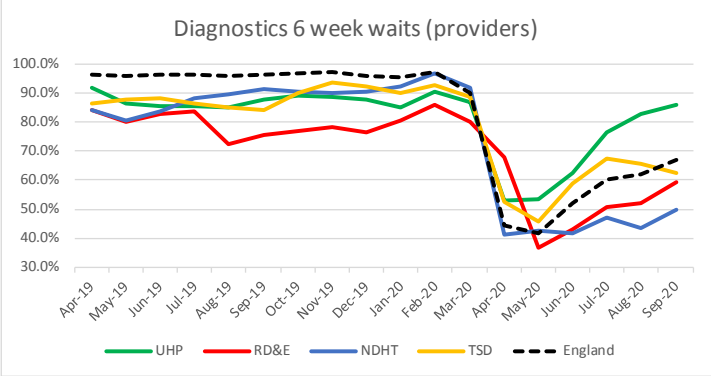
Long waiters	RD&E	NDHT	UHP	TSD
40-52wws	3802	1455	2017	2003
52+ wws	2671	1207	1267	1139
78+weeks	123	16	70	39
104+ Weeks	3	0	4	0

A new weekly data return to NHS England/Improvement which began in early October focuses specifically on the cohort of patients waiting in excess of 78 weeks, detailing the reasons for breaches, the clinical priority and actions being taken. We are seeking assurance from each provider around their processes for validation of waiting lists, utilising the learning from the national diagnostics PTL review, exploring data quality and validation opportunities, reviewing internal processes and increasing the focus on >40 week waiters.

Diagnostic Waiting Times

Diagnostic waiting times have also been significantly affected by the Covid-19 pandemic, although improvements in performance have been seen in the month. September figures show NDHT rising to 49.8% of patients seen within the 6-week timeframe, with RD&E rising to 59.1%, UHP performance increasing to 86.0% and TSD falling to 62.4%. The table below shows the number of patients seen within 6 weeks, compared to the national 99% target, and the movement between August and September. The STP position of 68.3% remains well below the 99% target and is slightly above the England position of 67%.

	RD&E	NDHT	UHP	TSD
August	51.90%	43.60%	82.70%	65.50%
September	59.10%	49.80%	86.00%	62.40%
Variance	**7.2%**	**6.2%**	**3.3%**	**-3.1%**



Actions being undertaken

The Adapt and Adopt programme continues to drive initiatives in key areas of capacity and efficiency (in addition to those underway before COVID).

Adapt and Adopt reporting demonstrates that, in terms of restoration against 19/20 activity for elective care and diagnostics, we are on plan apart from the waiting lists size in RDEFT and UHP, which have grown. However, the rising impact of COVID in the area is increasingly constraining efforts to deliver against plans.

- Possible further mitigations are in planning; applying best practice models for national exemplars eg (Get it Right First Time) GIRFT and local pathway improvements focussed on theatre productivity and length of stay and day case rates in orthopaedics, ophthalmology, upper gastrointestinal and urology.

- Efficient use of the additional capacity provided by the independent sector, where delivery volumes have consistently been above plan. The contractual arrangements for the last quarter of 2020/21 come under a national framework and, as the framework stands, this would not support our current delivery of activity in the independent sector. There is a risk that the independent providers may prefer a business model that does not reflect the case mix or volumes that the CCG needs to commission. They may also work to improve their waiting times and thus create inequalities. The CCG are meeting with the independent sector providers to mitigate this risk.

- The STP-wide Patient Treatment List (PTL) will give an overview of those patients with the highest clinical priority, as well as a chronological overview across the whole area. This is being implemented alongside a clinical review to ensure that there is a record made of those patients who will need reviews at 1, 3, 6 or 12 months.

- The mutual aid process is in place to support providers, although further opportunities to mitigate pressures via this method continue to be difficult. This is currently operational for cancer surgery, with significant mutual aid in place for UHP to ensure patients requiring urgent cancer surgery are receiving this surgery.

- To support outpatient activities, efforts continue across the system to identify additional capacity and real estate, including independent sector and other sites where available. Progress on this is reported at the Outpatient Transformation Group.

- All organisations are working on plans to implement patient-initiated follow ups (PIFU) in a number of specialties. Where PIFU exists in a service in one Trust, we have set an expectation that support is given to enable all Trusts to achieve PIFU in that service. Contact has been made with organisations outside Devon to benefit from PIFU learning and accelerate implementation.

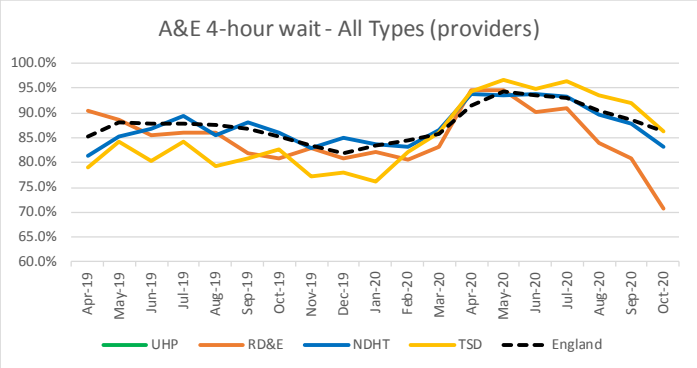
- The CCG Restoration &Transformation Cell continues to have bi-weekly meetings with those providing system leadership on each work stream, including surgical restoration and outpatient redesign, to ensure momentum continues around delivery of the phase 3 plans and provide an opportunity to contribute, receive feedback and escalate any issues to ensure impact of plans

Urgent Care

In addition to winter pressures across the system, caring for COVID-19 patients impacts on providers managing flow through their services; from primary care, to A&E and hospitals through to community settings. However, the CCG, providers and local authorities work closely together throughout the day to ensure patients are able to flow through the services safely and effectively, using a range of processes and solutions.

A&E Waiting Times – October Position

A&E attendances have been steadily increasing since May, but attendance volumes are currently 28% below those in October last year. October saw a further deterioration in performance against the 95% national four-hour standard – at 80.7% for all types and 73.3% for type 1 attendances, remaining below the standard and the England position at 86.2%.



At RDEFT, staff sickness and vacant posts are constraining the trust's ability to meet ED demand and the relative acuity of patients presenting has shifted, with a reduction in minor attendances, but corresponding increase in majors.

UHP do not report against the 4-hour standard, but urgent care within UHP remains significantly challenged; 18 patients experienced waits of more than 12 hours (trolley breaches) in October 2020. Three of these cases have been assessed as not resulting in patient harm and further information is being sought on the remaining cases, so that they can be reviewed and assessed to identify harm, including poor experience; as part of working with the provider to drive improvement, the CCG continues to seek assurance that, if long waits occur, patients were safe and well cared for.

Integrated Urgent Care Services (GP out of hours and NHS 111)
Following the Care Quality Commission (CQC) visit in July, Devon Doctors developed a detailed CQC improvement plan to improve on key areas identified within conditions imposed by the Section 31 notice. Weekly meetings take place between senior leaders from Devon Doctors (DDOC), CQC, NHS Somerset Clinical Commissioning Group (CCG) and NHS Devon CCG at which detailed documents are presented and discussed. The following are examples of actions taken to improve performance:

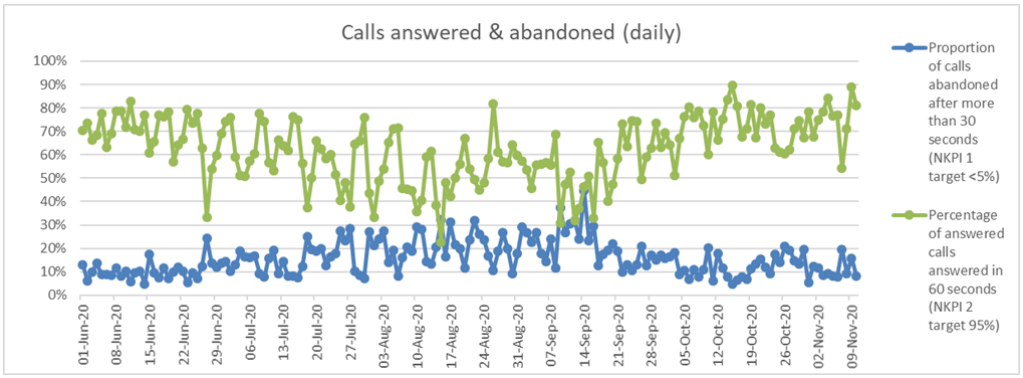
- Significant increase of call handling workforce supported by recruitment and retention plan;
- Revised governance structure including reporting;
- Comfort calling process implemented to improve patient safety when patients are waiting clinical triage;
- New role of lead clinician implemented within Clinical Assessment Service to support clinicians, review clinical priority of calls and support validation and complex triage;
- Review and improvement of rota patterns;
- Development of Programme Management Office to support delivery of improvements.

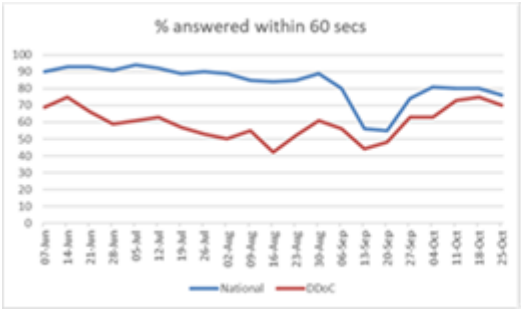
In addition to the CQC Improvement Plan, DDOC is the main provider engaged with the national Think 111 First programme, which will go live on 1st December 2020 and for which a weekly dashboard is circulated, providing additional performance information, including validation of dispositions to the Emergency Departments and 999 (category 3/ 4).

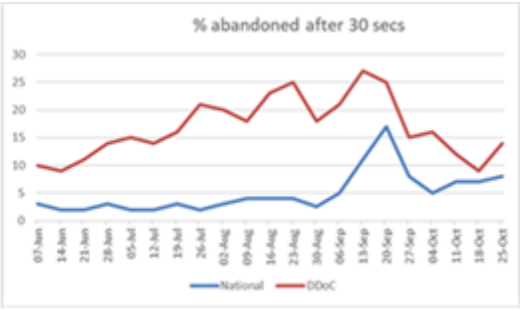
111 Performance – October Position

The proportion of calls answered within 60 seconds increased from 53.1% in September to 70.6% in October, though still below the national average of 79.1%. The call abandonment rate also remains high, at 12.4% (a better position from September) – the national average is 7% abandoned calls.

The following graphs demonstrate performance across the two key NHS 111 metrics of call answering (95% in 60 seconds) and call abandonment after 30 seconds (less than 5%):







3. Nursing and Quality Functional Performance for October 2020 (month 7)

CHC: As part of 'phase 3' restoration of services, this operational function recommenced as of 1 September 2020. There is the expectation, through the reset work, that the new backlog of assessments will be cleared. During the previous reporting period, a significant amount of work has been undertaken to put in place arrangements for the reset of the operational function, including collaboration with local authorities. As part of the 'CHC reset', to clear the backlog of the remaining CHC assessments, a range of options have been put in place to meet this target. The current backlog trajectory is being monitored by NHSEI. The CCG's current progress is on course to meet the backlog reduction.

Safety Systems & Patient Experience: NHSE/I have approved the CCG and TSDFT pilot a new process for pressure ulcer incidents that meet the threshold of a serious incidents. All pressure ulcer incidents that meet the threshold of a serious incident will continue to be reported onto StEIS. However, instead of TSDFT submitting an initial report they will submit a Skin, Surface, Keep moving, Incontinence, Nutrition & hydration (SSKIN) checklist. This

will be reviewed by the CCG (in line with the Root Cause Analysis (RCA) review process) and, if assurance is received, the incident will be closed on StEIS without further need of an RCA investigation/report to be completed. This process, if successful, will be a step towards what reporting may look like in light of the new serious incident framework. The process will be reviewed in several months.

The overall serious incident position continues to remain positive, apart from Devon Partnership NHS Trust (DPT).

Infection Prevention and Control:
Influenza (Flu): Flu vaccination rates in both the acute (frontline healthcare worker) and community settings have been high, with all organisations approaching vaccination in new and innovative ways. An extension of eligibility to 50-64 year-old cohort was announced in July. This age group is expected to be eligible later this year, dependent on vaccine availability.

COVID-19: Rates of COVID-19 have increased in Devon over the past month. The recent introduction of widespread community restrictions is intended to assist with addressing this. The outbreak on a university campus has resolved, with little evidence of spread into the wider community. However, there has been a generalised increase in cases and outbreaks among care homes, primary care and hospital settings throughout the county. Outbreak control meetings are being convened where required and hospital contingency planning has been undertaken and is being activated where needed.

Care home COVID-19 education sessions will take place, led by the community infection management service (a collaboration between the four acute trusts and the CCG) from the end of September.

4. CCG Performance Reporting – Phase 3

As reported last month, the national Phase 3 guidance (*Third Phase of NHS Response to COVID19*, dated 31 July 2020) sets out an expectation that systems would restore elective activity to:

- 100% of last year's levels for new and follow-up outpatients;
- 90% of 19/20 levels by October for elective inpatient, day case and outpatient procedures;
- 100% of 19/20 levels of MRI, CT and endoscopy procedures (by October)

The trajectories set out in the Devon System Phase 3 Plan are as follows:

	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
New Ops	81%	84%	86%	87%	93%	90%	88%
Follow up OPs	83%	91%	92%	92%	101%	96%	93%
Daycase	78%	82%	83%	83%	92%	90%	90%
Elective Inpatient	78%	83%	84%	86%	97%	88%	88%
MRI	83%	87%	92%	98%	99%	91%	90%
CT	85%	91%	84%	83%	91%	89%	88%
Scopes	67%	81%	82%	88%	98%	96%	91%

The table below shows our draft position against September's phase 3 recovery plans; due to reporting timeframes and validation processes this is not a fully signed off position. In addition, the RDEFT replacement PAS programme (MyCare) will see a small impact on reporting but the performance variation has been allowed for within the planned recovery rates.

CCG - September 2020 Recovery Rates				STP	TSDFT	RDEFT	NDHT	UHP
DEMAND	TOTAL REFERRALS	Plan	73.9%	81%	83.5%	77.9%	81.8%	82.8%
		Actual	117.4%	106%	108.4%	105.0%	111.5%	102.4%
OUTPATIENTS	OP NEW (F2F and non f2f)	Plan	77.3%	77%	73.2%	76.0%	94.3%	76.1%
		Actual	89.9%	91%	89.2%	76.0%	78.0%	94.2%
	OP NEW (non f2f)	Plan	29.8%	30%	25.0%	25.0%	48.3%	30.4%
		Actual	20.4%	22%	8.7%	16.5%	23.9%	30.5%
	OP FU (F2F and non f2f)	Plan	80.4%	82%	69.7%	75.6%	102.7%	89.3%
		Actual	81.8%	75%	101.1%	102.6%	83.8%	47.6%
	OP FU (non f2f)	Plan	39.9%	40%	25.0%	38.5%	63.4%	42.7%
		Actual	42.2%	46%	18.5%	36.2%	41.5%	84.3%
ELECTIVE	DAYCASE	Plan	67.8%	72%	67.3%	72.5%	69.1%	75.9%
		Actual	115.6%	112%	115.1%	104.9%	122.6%	111.6%
	ELECTIVE INPATIENT	Plan	61.0%	68%	42.8%	73.6%	86.2%	64.6%
		Actual	126.2%	117%	180.6%	103.2%	145.2%	110.9%
	TOTAL INCOMPLETE RTT PATHWAYS	Plan	110,129	104,706	26,218	33,892	14,870	29,726
		Actual	94,939	103,525	26,353	33,754	13,356	30,062
	RTT 52 WEEK WAITS	Plan	4,574	5,134	909	1,830	1,384	1,011
		Actual	4,475	4,795	892	1,887	1,019	997
DIAGNOSTIC TESTS	MAGNETIC RESONANCE IMAGING	Plan	72.5%	83%	81.1%	99.4%	63.9%	75.4%
		Actual	116.1%	88%	67.2%	75.6%	110.5%	108.2%
	COMPUTED TOMOGRAPHY	Plan	78.2%	85%	81.3%	99.6%	68.2%	82.7%
		Actual	120.5%	100%	70.3%	89.2%	152.8%	116.7%
	NON-OBSTETRIC ULTRASOUND	Plan	55.7%	70%	80.2%	67.8%	63.8%	69.1%
		Actual	149.2%	95%	85.6%	98.5%	106.4%	94.7%
	TOTAL SCOPES	Plan	57.7%	67%	48.2%	69.7%	88.7%	73.8%
		Actual	116.3%	77%	91.4%	19.1%	72.9%	130.1%
A&E	TYPE 1 & 2	Plan	88.5%	99%	99.2%	99.0%	99.9%	99.7%
		Actual	96.0%	88%	84.2%	80.2%	100.1%	93.6%
NON ELECTIVE	+1 LENGTH OF STAY	Plan	98.9%	95%	104.3%	89.9%	91.7%	94.9%
		Actual	105.9%	97%	89.8%	102.0%	103.1%	95.0%
	ZERO DAY LENGTH OF STAY	Plan	109.6%	107%	105.7%	132.4%	103.9%	91.9%
		Actual	110.9%	103%	101.6%	108.2%	64.4%	117.5%
	TOTAL NON ELECTIVES	Plan	102.1%	99%	104.8%	100.6%	95.4%	94.1%
		Actual	107.5%	99%	94.3%	104.0%	90.3%	101.0%
CANCER	URGENT CANCER REFERRALS (2 WEEKS)	Plan	82.6%	94%	105.0%	93.1%	100.0%	86.7%
		Actual	119.2%	189%	76.8%	212.7%	176.5%	165.8%
	CANCER TREATEMENT VOLUMES (31 DAY	Plan	78.5%	87%	95.9%	80.1%	97.4%	84.6%
		Actual	111.0%	86%	76.8%	102.4%	82.8%	80.5%

**Diagnostics and Outpatients activity taken from weekly reporting*
Green indicates activity above plan and red below plan – please note that in relation to non-elective activity red is not always an indication of poor performance.

The areas to note are:

- Referrals are in excess of planned volumes at a CCG restoration rate of 117% for September;
- New outpatient attendances are over-performing for the CCG, but NDHT is below its recovery rate, though the ambition in this plan was greater than other providers;
- Non-face-to-face are below recovery trajectory, other than UHP. There are several recording issues being explored in order to validate the position;
- Follow up outpatient attendances are being achieved at CCG level and across all

providers, other than UHP;

- Non-face-to-face recovery rates are only being achieved by UHP;
- Daycase and elective inpatient recovery rates are achieving their recovery trajectory;
- The total RTT incomplete waiting list size (the number of patients waiting, as yet untreated) for the STP is below expected, but TSD and UHP are marginally in excess of planned list size;
- 52-week waits are below expected volumes across the STP, other than RDE, who are slightly exceeding their forecasted position;
- MRI and CT recovery rates are under performing for TSD and RDE; impacted by capacity restrictions;
- Scopes recovery has largely been impacted by recording discrepancies; this is being reviewed and refreshed within the monthly reporting. This is a result of coding delays, although providers have introduced measures to reduce the impact within weekly reporting.

All of the Adapt and Adopt and other actions reported above to address performance concerns will also have a direct impact on these trajectories. We are also working to understand and address health inequalities, both through some of the work detailed above around single PTL, etc and through a specific Phase 3 work stream dedicated to this. As referenced above, the second wave of Covid-19 is challenging delivery of these ambitions.

Reporting against our phase 3 plan is also being established in relation to Mental Health activity. The agreed recovery rates are illustrated below, with August's reported position and September's trajectories.

The reported performance in August for access to Children and Young People's Mental Health Services is 40%, ahead of the September plan for 35%.

			Mental health	
			Aug-20	Sep-20
STP	Improve access rate to Children and Young Peoples Mental Health services	2019/20		11%
		Phase 3 plan		35%
		STP 2020/21	40%	
	People with severe mental illness receiving a full annual physical health check	2019/20		23.90%
		Phase 3 plan		23.60%
		2020/21		
	Perinatal Mental Health (women accessing services)	2019/20		7.30%
		Phase 3 plan		7.10%
		2020/21	6.7%	
	IAPT Roll out	2019/20		4.40%
		Phase 3 plan		7.10%
		2020/21	4.04%	
	Number of people accessing individual placement and support	Phase 3 plan		65
		2020/21		
	Out of area placements (external)	Phase 3 plan		3,064
		2020/21	3,780	
	Out of area placements (internal orexternal)	2019/20		
		Phase 3 plan		1,882
		2020/21		

5. Recommendations to members

Members of the Governing Body are asked:

- To agree the 1 April 2020 to 30 September 2020 (month 6) performance position against Constitutional Standards and routine performance standards;

- To agree the quality**,** nursing and safety performance position for the period 1 April to 31 October 2020;

- To note the update on performance against the Devon System Phase 3 trajectories, as submitted to NHS England on 5 October 2020.

Appendix 1

Governing Body (Public) – Performance Report

November 2020

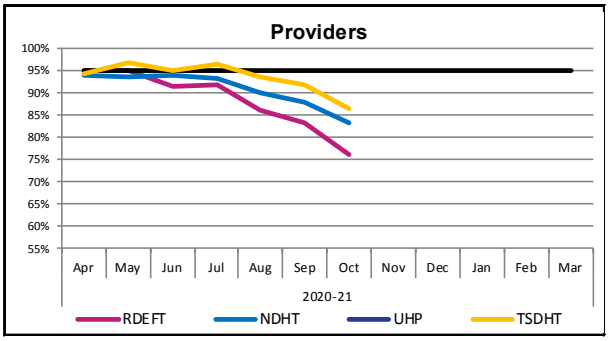
Performance and Quality indicators

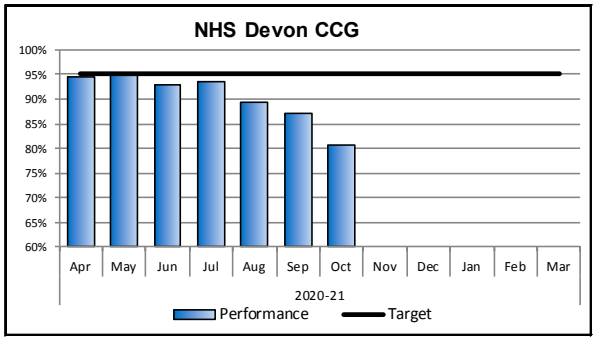
A&E Performance - Percentage of patients waiting less than 4 hours.

All types (including MIU and WiC)

Trust	Target	October	2020/21
RDEFT	95%	76.2%	87.3%
NDHT	95%	83.2%	90.3%
UHP	95%	N/A	N/A
TSDFT	95%	86.2%	93.3%

CCG	Target	October	2020/21
NHS Devon	95%	80.7%	89.9%
ENGLAND		86.2%	90.9%

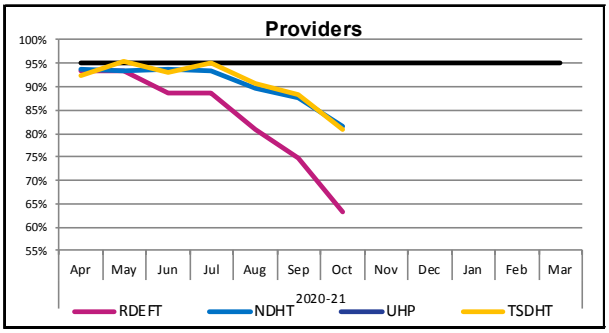


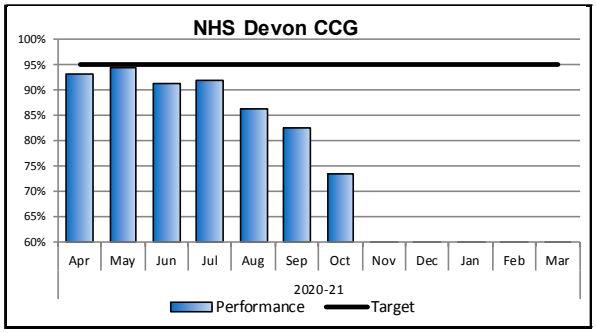


Type 1 A&E only

Trust	Target	October	2020/21
RDEFT	95%	63.2%	82.3%
NDHT	95%	81.7%	90.1%
UHP	95%	N/A	N/A
TSDFT	95%	80.7%	90.8%

CCG	Trajectory	October	2020/21
NHS Devon	95%	73.3%	87.0%
ENGLAND		80.4%	87.3%





Performance Commentary

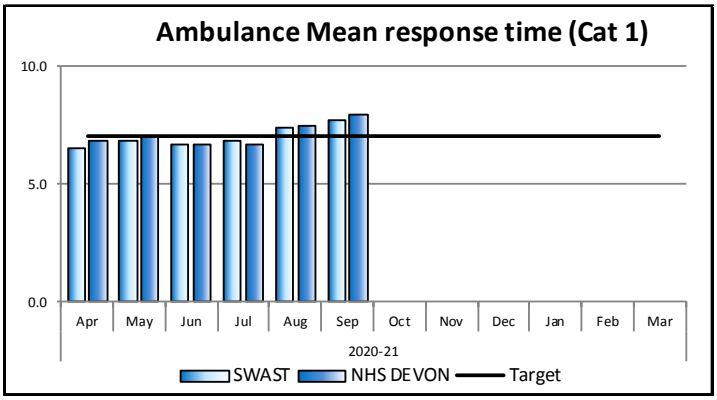
The October STP 'all types' position was 73.3%, down from 87% in September. All providers show a worsening position with TSDFT at 86.2%, with NDHT at 83.2% and RD&E at 76.2%. Type 1 performance also fell to 73.3% compared to the England position of 80.4%.

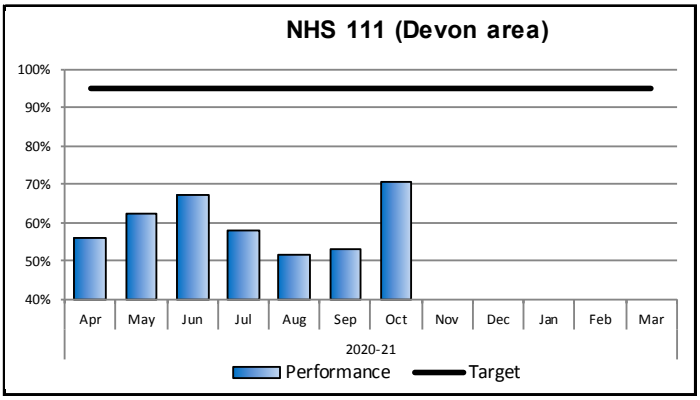
SWAST Cat 1 Mean response time

Trust	Target	September	2020/21
NHS Devon	7.00	7.90	6.90
SWAST	8.00	7.70	6.60

NHS 111 answering calls within 60 Seconds

Trust	Target	October	2020-21
DEVON	95%	70.6%	59.5%
ENGLAND	95%	65.8%	80.9%





Performance Commentary

At STP level the 7-minute response time performance was above target in September at 7.9 minutes for Devon.

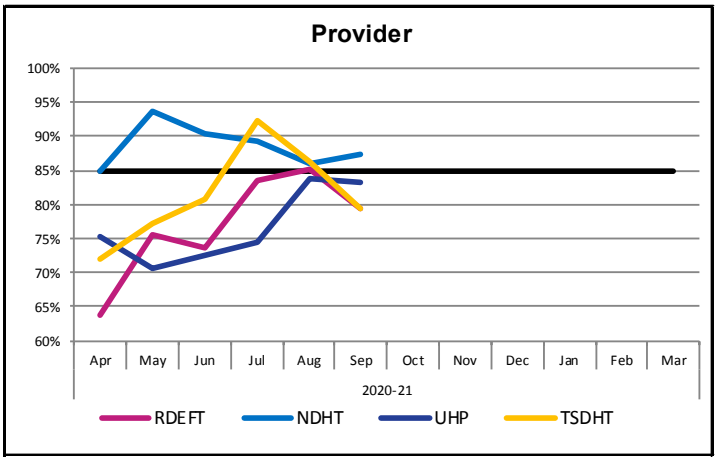
The proportion of calls answered within 60 seconds remains at 53.1% in September. Performance remains well below the target of 95% and continues to be the lowest in the South West.

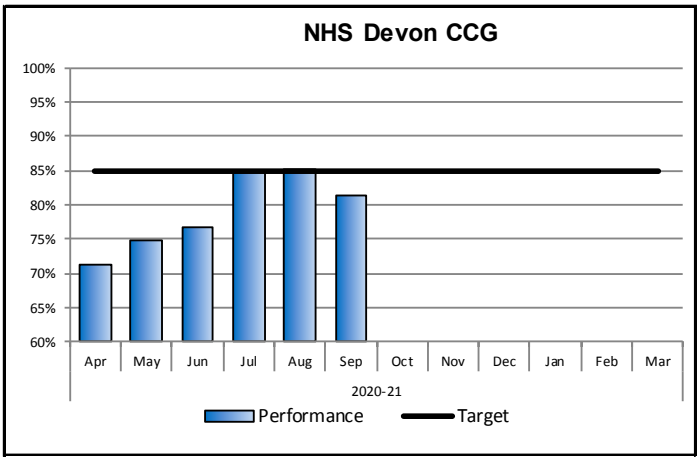
111 performance has improved in October with 70.6% calls answered within 60 seconds

Cancer 62 day Urgent Referral

Trust	Trajectory	September	2020/21
RDEFT	77.6%	79.5%	77.0%
NDHT	77.3%	87.3%	88.2%
UHP	71.1%	83.3%	76.5%
TSDFT	85.3%	79.3%	81.2%

CCG	Trajectory	September	2020/21
NHS Devon	80%	75.6%	2400.0%
ENGLAND	85%	74.7%	75.3%



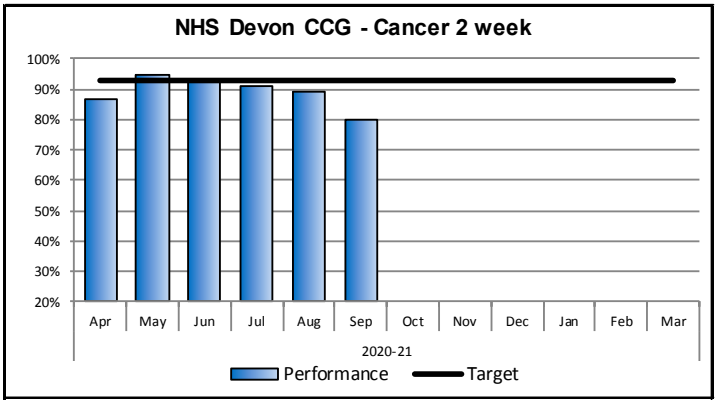


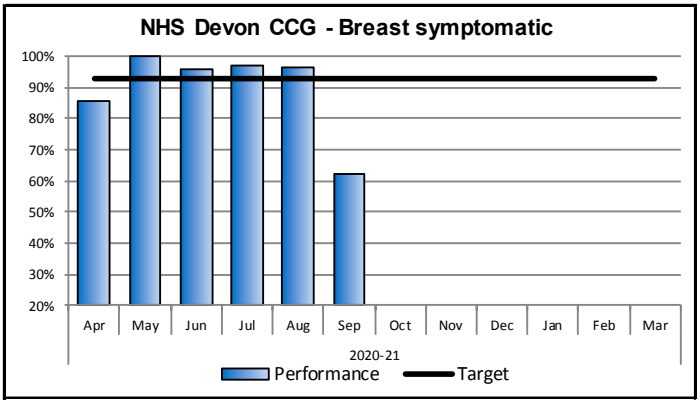
Performance Commentary

There was a further increase in performance in September with the STP position falling from 85.1% to 75.6% with all providers except NDHT seeing a worsening position. UHP fell from 83.9% to 84.7% RDEFT fell from 89.6% to 75.3% and TSDFT fell from 80.1% to 75.1%.

Cancer Targets (September-2020)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	79.9%	75.3%	93.9%	84.7%	75.1%
93%	2 week breast	62.2%	31.6%	94.4%	39.0%	95.9%
90%	62 day screening	96.8%			100.0%	100.0%
85%	62 day consultant	86.7%	85.7%	92.3%	81.0%	
96%	31 day first	96.5%	96.9%	93.9%	97.0%	97.4%
94%	31 day surgery	94.0%	90.2%	100.0%	91.7%	100.0%
98%	31 day drugs	100.0%	100.0%	100.0%	100.0%	100.0%
94%	31 day radiotherapy	96.3%	100.0%		89.0%	100.0%





Performance Commentary

TSDFT achieved six of the cancer waiting times measures in September NDHT achieved five of the targets applicable to them. At STP level six of the eight measures where achieved.

Performance against the 2ww breast symptomatic and the main 2ww target fell below target at STP level achieving 62.2% and 79.9% respectively.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

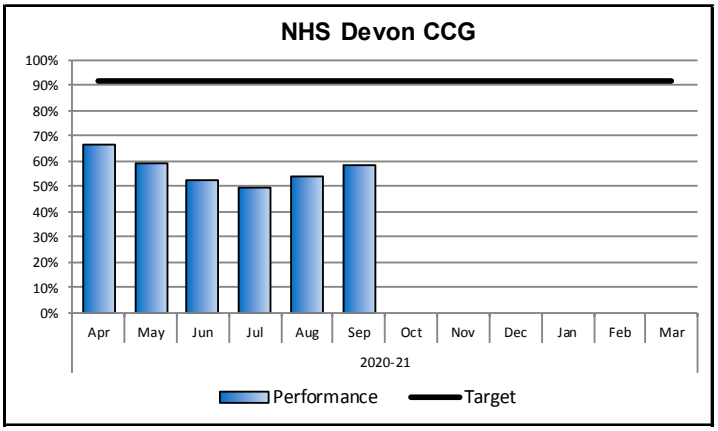
Trust	Target	September	2020/21
RDEFT	92.0%	54.7%	53.7%
NDHT	92.0%	53.8%	52.6%
UHP	92.0%	64.6%	59.6%
TSDFT	92.0%	62.1%	60.0%

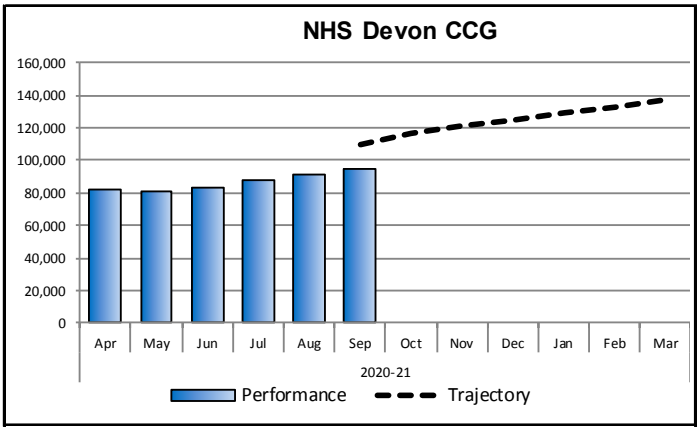
CCG	Trajectory	September	2020/21
NHS Devon	92.0%	58.3%	56.5%
ENGLAND	92.0%	60.6%	57.7%

RTT incomplete waits volume

Trust	Trajectory	September
RDEFT	33,992	33,724
NDHT	11,194	13,352
UHP	28,354	30,079
TSDFT	18,249	26,366

CCG	Trajectory	September
NHS Devon	81,454	94,939





Performance Commentary

The STP level RTT position improved slightly in September from 53.6% to 58.3% compared to the target of 92% and national performance of 53.6%. All providers saw an improving position with UHP performance increasing to 64.6%, RD&E at 54.7%, NDHT at 53.8% and TSDFT at 62.1%. All providers are under target.

The RTT waiting list increased back to pre-Covid levels with rises at all providers.

RTT Incomplete Pathways long waiters

40-52 week waits

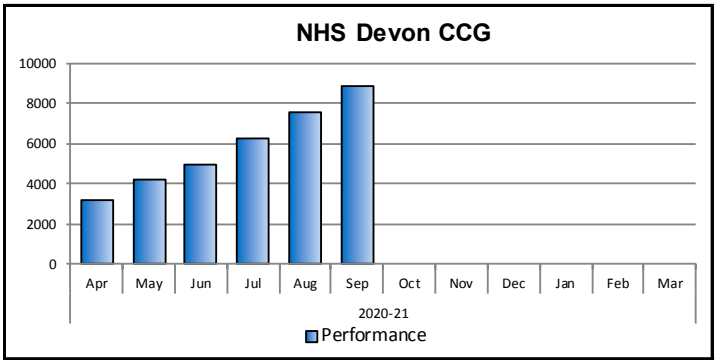
Trust	September	2020/21
RDEFT	3615	14234
NDHT	1373	6105
UHP	2080	9817
TSDFT	2055	7380

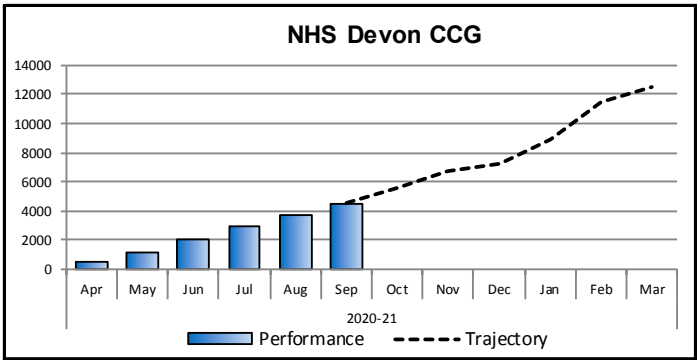
CCG	September	2020/21
NHS Devon	8835	34923

Over 52 week waits

Trust	Trajectory	September	2020/21
RDEFT	1830	1880	6153
NDHT	1384	1018	3016
UHP	1011	1006	3915
TSDFT	909	892	2790

CCG	Trajectory	September	2020/21
NHS Devon	4574	4475	14727





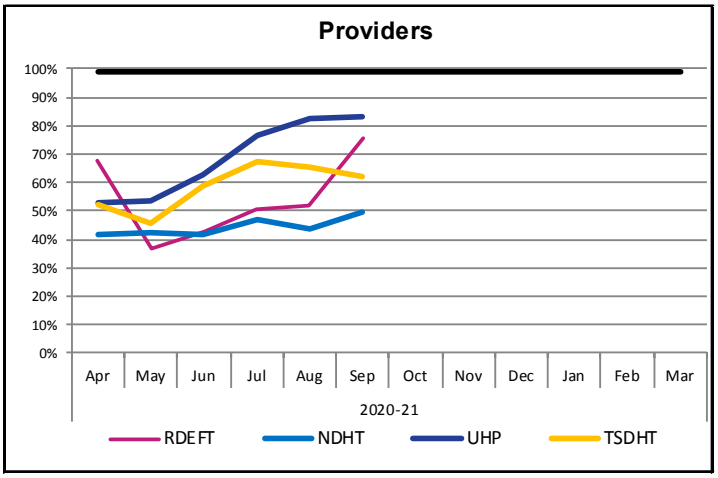
Performance Commentary

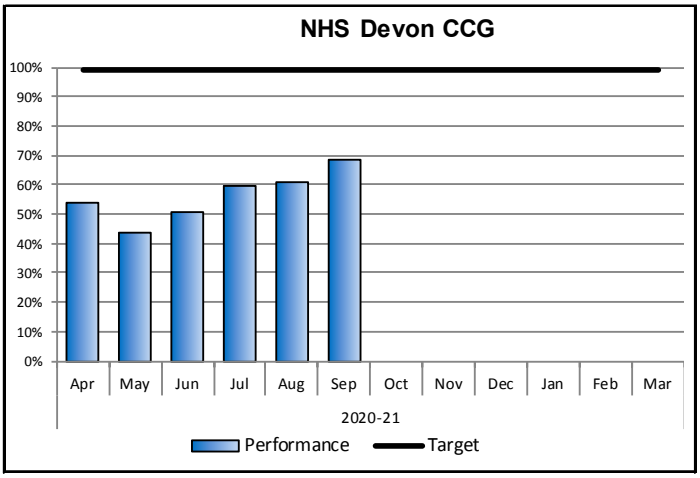
Over 52-week waits have continued to increase. There were 7,543 people waiting between 40 and 52 weeks in August and this has risen to 8835 in September. All providers have seen an increase in 52 week breaches with September figures show RD&E rising to 1800(from 1,486), UHP at 1006 (881), TSDFT at 892(745) and NDHT at 1384 (630). October is expected to show a further increase.

Diagnostic Seen within 6 weeks

Trust	Target	September	2020/21
RDEFT	99.0%	75.7%	50.8%
NDHT	99.0%	49.8%	56.4%
UHP	99.0%	83.1%	34.4%
TSDFT	99.0%	62.4%	41.0%

CCG	Target	September	2020/21
NHS Devon	99.0%	68.3%	56.4%
ENGLAND	99.0%	62.0%	53.1%





Performance Commentary

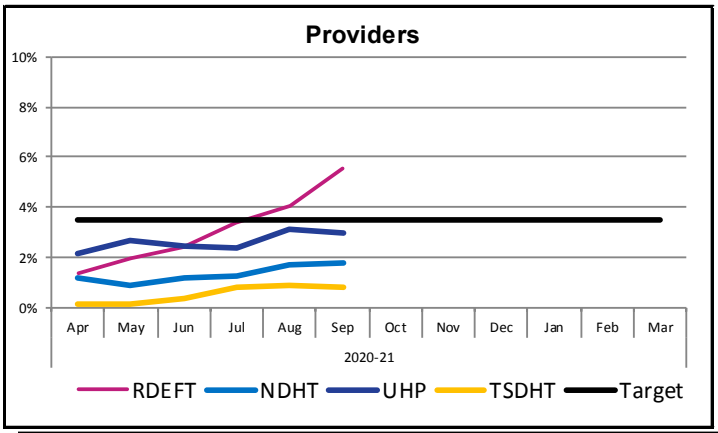
The STP position increased in September, with 68.3% of patients being seen within the 6 week target compared to a national threshold of 99% and an England position of 62%.

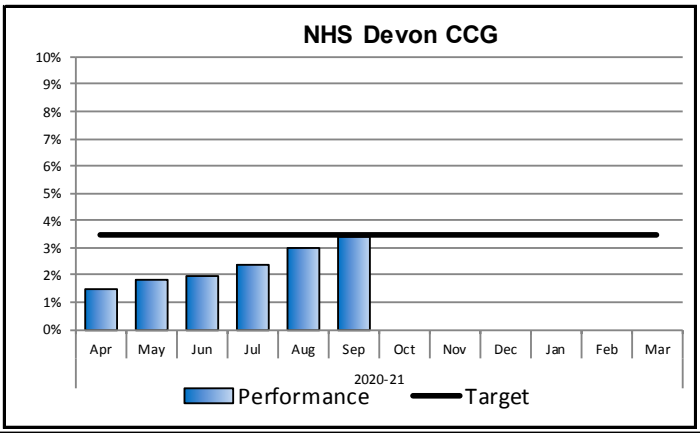
September figures show UHP performance rising from 82.7% to 86.0% RD&E remains at 51.9%, NDHT increasing from 43.6% to 49.8% and TSDFT falling slightly from 65.5% to 62.4%.

Acute Delayed Transfers of care

Trust	Target	September	2020/21
RDEFT	3.50%	5.5%	3.1%
NDHT	3.50%	1.8%	1.3%
UHP	3.50%	3.0%	2.6%
TSDFT	3.50%	0.8%	0.5%

CCG	Target	September	2020/21
NHS Devon	3.50%	3.40%	2.3%





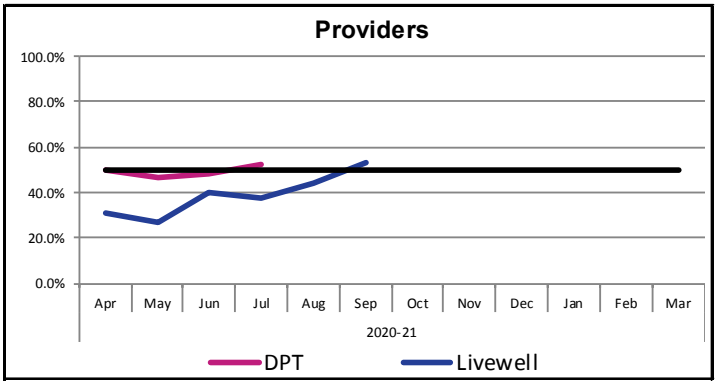
Performance Commentary

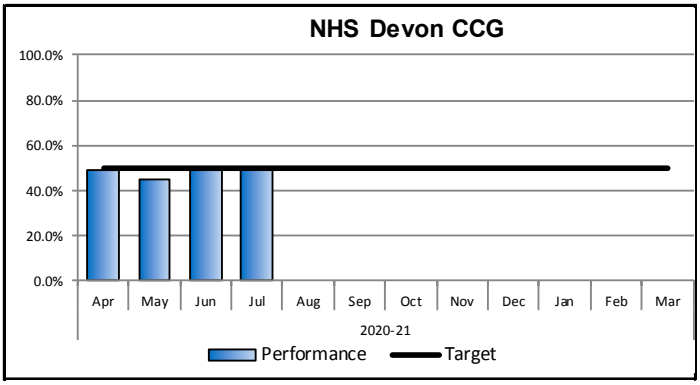
In September acute delayed transfers of care (DTOC) continued to be within the 3.5% target at 3.4%. All providers except RDEFT were meeting the target.

IAPT Recovery rate

Trust	Target	July	2020/21
DPT	50%	52.6%	49.2%
LIVEWELL	50%	52.8%	40.9%

CCG	Target	July	2020/21
NHS Devon	50%	49.6%	48.3%





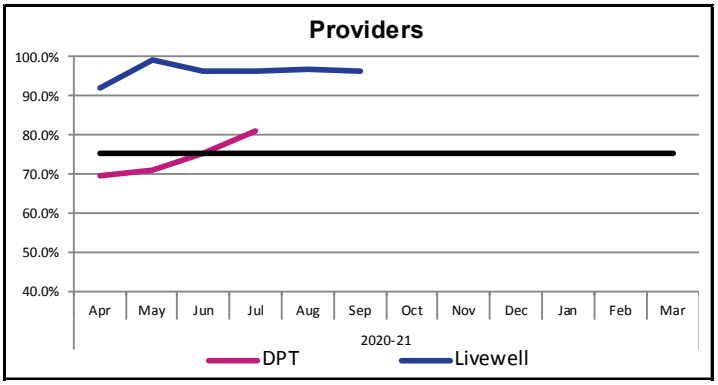
Performance Commentary

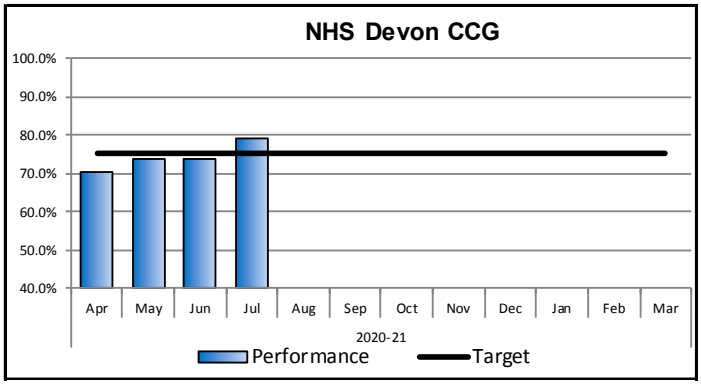
July IAPT recovery data shows performance continuing to be under the 50% target at 45.8% for the STP. DPT above target at 52.6% and Livewell September position showing an improving position at 52.8%.

IAPT waiting 6 weeks

Trust	Target	July	2020/21
DPT	75%	80.8%	74.0%
LIVEWELL	75%	96.1%	96.4%

CCG	Target	July	2020/21
NHS Devon	75%	79.3%	74.5%



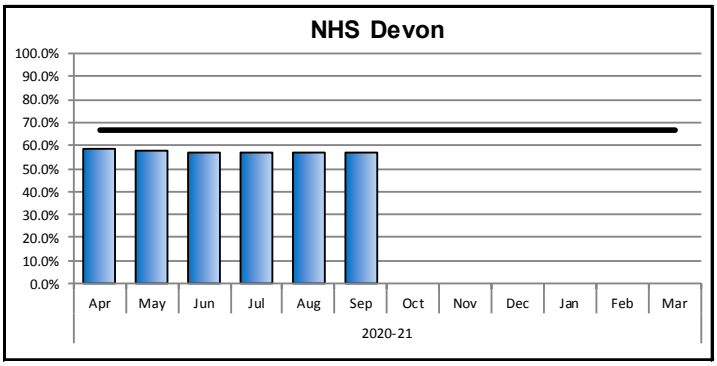


Performance Commentary

IAPT 6-week waits improved and are above target in July at 77% for the STP against the 75% target. Both providers achieved the target.

Dementia Diagnosis Rate

CCG	Trajectory	September	2020/21
NHS Devon	66.7%	56.6%	56.6%
ENGLAND	67.0%	63.0%	63.6%



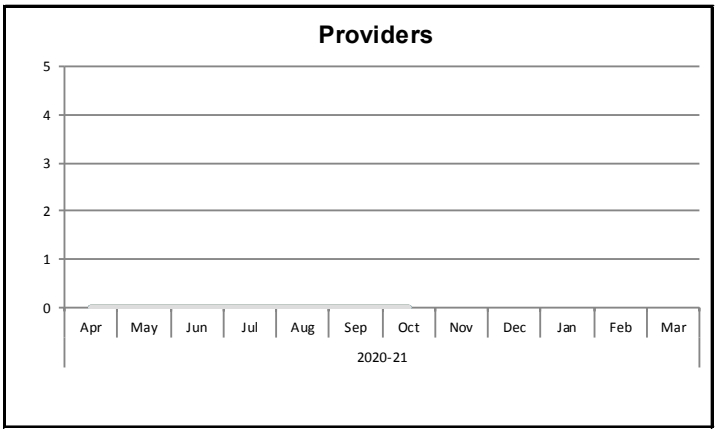
Performance Commentary

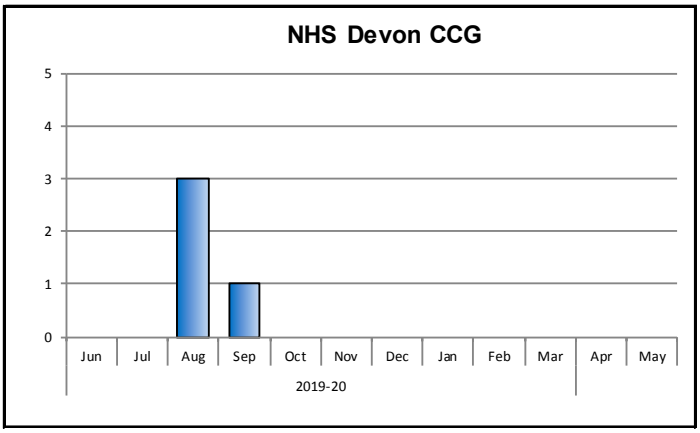
STP level performance remained static in September and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (42.2%), Mid Devon (51.1%) and Plymouth (56.5%).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

MRSA breaches

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

CCG	Target	October	2020/21
NHS Devon	0	1	4





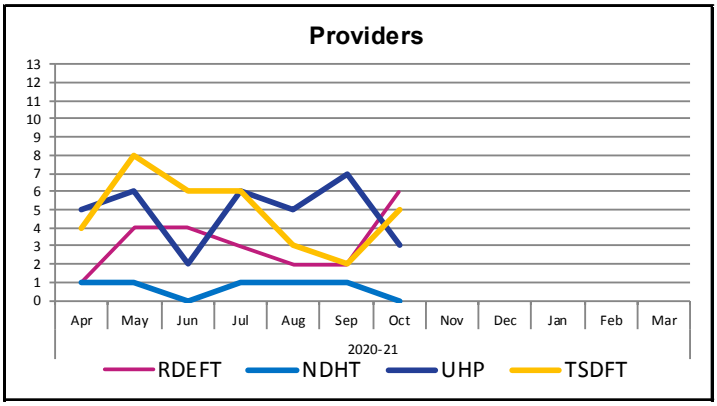
Performance Commentary

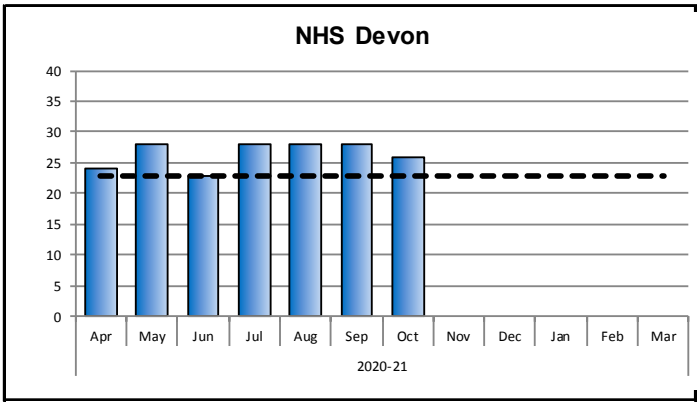
There were zero reported cases of MRSA in October for the CCG, and none in Devon providers.

C-Diff breaches

Trust	Target	October	2020/21
RDEFT	<31	6	22
NDHT	<9	0	5
UHP	<63	3	34
TSDFT	<36	5	34

CCG	Target	October	2020/21
DEVON STP	<274	26	185





Performance Commentary

There were 14 C-Diff cases acquired within the Devon acute providers and 26 across the STP in October.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Approval Emergency Preparedness, Resilience and Response Policy					
Date of committee: 26 November 2020 **Date report produced:** 16 November 2020					
Author (s) Name and Title: Phil Coutie, EPRR Lead Clare Doble, Head of Governance **Contact Details:** 01392 675369 / Philip.coutie@nhs.net Clare.doble@nhs.net			**Supporting Executive:** **Name and Title:** Sonja Manton, Accountable Emergency Officer EPRR **Contact Details:** Sonja.manton@nhs.net **Report Approved by:** **Name and Title:** Ginny Snaith, Board Secretary **Date 19 November 2020**		
Public or Private (Governing Body only):			**Public**	**X**	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A					
Purpose and scope of report:	**Consultation**		**Approval**	**X**	**Information**

Executive Summary:

The attached policy sets out how the CCG will meet its responsibilities under statute and national policy. These laws and polices require that all NHS organisations prepare for, and respond to, emergency incidents and other disruptive events that impact upon their community or their service delivery.

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

By implementing this policy, the CCG will provide leadership to its providers, integrate its response into the wider NHS response to emergencies in the community and maintain its critical functions, regardless of whether disruption affects its services.

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

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

Committees that have previously discussed/agreed the report and outcomes:
N/A
Key recommendations and actions requested:
The Governing Body is asked to approve this policy which sets out how NHS Devon Clinical Commissioning Group (CCG) will ensure that it meets its Emergency Preparedness, Resilience and Response (EPRR) responsibilities, as required by statute and national policy.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
None

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

	If Yes, please give details	No
Quality of Services		X
Health Inequalities		X
Equality (staff or public)		X
Resource and Finance		X
Legal	The CCGs' EPRR plans are required by statute (the Civil Contingencies Act 2004), national policy (the NHS England EPRR Framework) which requires compliance with the NHS England Core Standards for EPRR - a contractual requirement for all NHS organisations, and by the NHS Standard Contract.	
Engagement and Consultation		X
Risk		X

NHS
Devon
Clinical Commissioning Group

Emergency Preparedness, Resilience & Response Policy

NHS Devon

Clinical Commissioning Group

Owner(s): *Phil Coutie, EPRR Lead* *Clare Doble, Head of Governance*	Contact Details: philip.coutie@nhs.net clare.doble@nhs.net	
Review by: Clare Doble, Head of Governance Approved by: Sonja Manton, AEO and Ginny Snaith, Board Secretary	Date of formal approval **dd/mm/yyyy*	Review Date: ~~*July*~~ *November 2021*
Date Issued: **dd/mm/yyyy*		Version ~~*0.1*~~*1.1*

Document Change History:		
Version	**Date**	**Comments (i.e. reviewed/amended/approved)**
0.1 DRAFT	June 2019	New EPRR Policy for NHS Devon CCG, replacing predecessor policies and frameworks
1.0	June 2019	New policy
1.1	November 2020	Reviewed following pandemic first wave

Equality, diversity and inclusion statement

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

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

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

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

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

1. Introduction

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

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

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

2. Purpose

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

3. Definitions

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

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

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

4. Legislation & Policy

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

Legislation

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

Policy

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

5. Roles and Responsibilities

Accountable Officer

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

Accountable Emergency Officer

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

Non-Executive Director

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

Head of Governance

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

EPRR Lead

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

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

5.7. The primary functions of the role are to:

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

On-call Staff

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

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

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

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

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

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

Business Continuity Leads

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

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

Loggists

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

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

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

6. Governance

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

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

7. Resources

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

8. On-call System

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

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

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

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

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

9. Emergency Plans

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

- Emergency incidents

- Severe Weather
- Fuel disruption
- Pandemic Influenza
- Communicable Disease
- Mass Casualty

Risk Assessment

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

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

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

10. Business Continuity Management System

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

10.2. The BCMS will comprise the following elements:

- CCG Business Continuity ~~Policy and~~ Plan – maintained by the EPRR Lead
- Directorate Business Continuity Plans – maintained by Directorate Business Continuity Leads

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

11. Participation in Health and Multi-Agency EPRR Structures

Local Health Resilience Partnership

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

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

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

Local Health Resilience Group

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

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

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

Local Resilience Forum

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

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

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

12. Training and Exercising

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

Training	Who	Frequency

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

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

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

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

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

13. Annual EPRR Assurance

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

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

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

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

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GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: 26 November 2020

Dates of Committees covered in this report: 11 November 2020

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

Chair's Name and Title: Nick Ball, Non-Executive Director

Contact Details: nick.ball1@nhs.net

Reports received and noted

- Risk Report – 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. Seven new risks have been added to the corporate risk register, five of these risks are reporting to Audit committee Two further risks (126 and 132) have been added to the corporate risk register reporting to the Quality Assurance Committee and Primary Care Commissioning Committee respectively. These risks will be operationally managed to seek assurance that mitigating actions and controls are in place.

- Corporate risk 38 - Lack of clarity and visibility regarding STP and its governance. The Audit Committee agreed that this risk should remain open however requires further review.

- Incident Report – The audit committee were 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.

- Procurement Register Conflicts of Interest– The Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017 included a requirement to annually publish a procurement register which includes information on decision making and conflict of interest declarations and management. CCGs need to be able to identify and manage any conflicts or potential conflicts of interest that may arise in relation to the procurement of any services (contracts and grants). The report ensures transparency of decision making on spending public funds.

- 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. Adopts a risk-based auditing approach and maintains an Internal Audit Manual to support compliance with Internal Audit Standards. The Audit Committee received a September 2020 Internal Audit Update Report which summarises the work of ASW Assurance since the previous Audit Committee meeting in September 2020.

- 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.

- Counter Fraud Progress report - the report provided an update for the CCGs in respect of counter fraud activity.

Risk Register Review Updates

- Summary review of updates to corporate risk register and COVID risk registers as at 25 August 2020 were reviewed at this meeting and are available as appendices to this report.

Committee Decisions

The Audit Committee

- Noted Risk Report
- Noted the Incident Report
- Noted the Procurement Register Conflicts of Interest for approval at Finance and Performance Committee
- Noted the Internal Audit Update Report
- Noted the External Audit progress report
- Noted the Counter Fraud Progress Report

Items of concern to be escalated to the Governing Body

- Corporate risk 38 - Lack of clarity and visibility regarding STP and its governance

Recommendations for Governing Body

- Assurance Framework not currently fit for purpose, recommendation to GB to agree the strategic objectives which will enable the Assurance framework to be developed.

Recommendations for other Committees

- Recommendation to Finance and Performance Committee to approve the Procurement Register Conflict of Interest

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: 11 November 2020 **Date report produced: 22 October 2020**				
Author (s) Name and Title: Theresa Farris, Risk and Governance Manager theresa.farris@nhs.net **Contact Details:**		**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 22 October 2020.

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.

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 will be reported to the Senior Leadership Team meeting monthly, Audit Committee bimonthly and to Governing Body through the Audit Chairs report.

Seven new risks have been added to the corporate risk register, five of these risks will be reporting to this committee and are summarised in section 2.2. Two further risks (126 and 132) have been added to the corporate risk register reporting to the Quality Assurance Committee and Primary Care Commissioning Committee respectively. These risks will be operationally managed to seek assurance that mitigating actions and controls are in place.

The assurance framework (AF) was reviewed by the Executive leads in June 2020 and has been closed and a new version of the AF will be produced to support the CCGs revised corporate objectives when approved.

The Executive Team discussed risks which have been on the corporate risk register for over 12 months on 20 October 2020. Recommendations from this meeting are being taken forward. A further report will be seen by the executive in six months.

Report section	Item	Appendix
Section 2	Corporate Risk Register	Appendix 1 Audit Committee Risk Report Appendix 2 Corporate Risk Register - Significant Risks Appendix 3 - Risk 113 EPRR Core Standards Appendix 4 - Risk127 - Increased fraudulent activity during and following a pandemic or similar major incident Appendix 5 - Risk 128 - Shared working area confidentiality Appendix 6 - Risk 129 – Business Continuity Appendix 7 - Risk 130 – COVID19 Incident Response Appendix 8 - Risk 131 - Emergency Preparedness

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 Assurance Framework**
3. **Agree closure of risk 113** EPRR Core Standards
4. **Agree the addition of risks:**
   Risk 127 - Increased fraudulent activity during and following a pandemic or similar major incident
   Risk 128 - Shared working area confidentiality
   Risk 129 – Business Continuity
   Risk 130 – COVID19 Incident Response
   Risk 131 - Emergency Preparedness

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		
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

11 November 2020

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 22 October 2020.

2 Corporate Risk Register

2.1 At the time of writing the report there are 30 risks being monitored, one risk number 113 has executive approval to close and is presented to this committee to agree removal from the corporate risk register.

2.2 Risk 113 - EPRR Core Standards (appendix 3). This risk has been replaced by risks 129, 130 and 131 as summarised in section 2.2 and detailed in appendices 6, 7 and 8. The committee is requested to agree the removal of this risk from the corporate risk register.

2.2 There are eight risks on the Corporate Risk Register reporting to the Audit Committee, (appendix 1) with five new risks being added in the reporting period as summarised below and detailed in the attached appendices.

- Appendix 4 - Risk127 - Increased fraudulent activity during and following a pandemic or similar major incident
- Appendix 5 - Risk 128 - Shared working area confidentiality
- Appendix 6 - Risk 129 – Business Continuity
- Appendix 7 - Risk 130 – COVID19 Incident Response
- Appendix 8 - Risk 131 - Emergency Preparedness

In addition to the five new risks reporting t this committee two further risks (126 and 132) have been added to the corporate risk register reporting to the Quality Assurance Committee and Primary Care Commissioning Committee respectively. These risks will be operationally managed to seek assurance that mitigating actions and controls are in place.

Risk 38 is presented in a separate report to this committee to give the Audit Committee the opportunity to discuss the risk to understand what the perceived risks are and what actions we can take to mitigate.

Risk Number	Risk Description	Executive Lead	Risk Score
127	There is a risk that Devon CCG may be subject to fraudulent activity during and following a pandemic or similar major incident The impact of this is potential for, financial loss to the CCG, information governance breaches and perception of the CCG.	Ginny Snaith	**6** **L = 2** **I = 3**
128	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.	Ginny Snaith	**6** **L = 3** **I = 2**
129	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.	Sonja Manton	**9** **L = 3** **I = 3**
130	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	Ginny Snaith	**12** **L = 3** **I = 4**
131	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.	Sonja Manton	**6** **L = 2** **I = 3**

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

2.4 The following four risks have an increased risk score

Risk 117 - COVID-19 General Practice, has seen an increase in risk score from 6 to 12 this is due to the risk of a second outbreak now more likely and will have direct impact on General practice to ability to reinstate all services in line with Phase 3 guidance.

Risk 118 - COVID- 19 - Primary Care Team has been increased from3 to 9 this also due to the risk of second outbreak now more likely and line with phase 3 guidance team will be required to manage Business as usual and manage the pandemic.

Risk 123 Fit testing – PPE/Covid The risk score has been increased from 12 to 16 Due to the supply of masks changing imminently and the lack of fit testing capacity

Risk 109 - Underperformance Constitutional Standards Following review the risk has been reviewed and due to returning pandemic and MyCare implementation the risk score has been increased from 16 to 20.

2.5 The following three risks have a reduced risk score

Risk 11 - Seven Day Services On review the risk score has been reduced from 12 to 8 and there is regular reporting to the A&E Board were the risk is being monitored and addressed.

Risk108 - Sustainability of General Practice The risk score has been reduced from 20 to 12 as there has been successful recruitment due to investment into workforce recruitment. Introduction of PCN has provided more robust sustainable primary care setting.

Risk 104, Development of Datix has been reviewed and the risk score reduced from 12 to 6. On review by the Nursing and Quality Senior Leadership Team it has been agreed to remove the risk from the corporate risk register as actions have been put in place and the matter will be monitored locally on the directorate risk register. Approval to transfer to the Nursing and Quality Team risk register was agreed by Quality Assurance Committee in September 2020.

2.6 At the time of writing this report the CCG has six risks scored significant summarised in the table below and detailed in appendix 2.

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 regiser

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

Period of report - 25 August 2020 to 22 October 2020	
Total Risks on Corporate Risk Register	30
Low risks (scored 1-3)	0
Moderate/Medium risks (scored 4-6)	8
High risks (scored 8-12)	16
Significant/Very high risks (scored 15 to 25)	6
New Risks	7
Risk score reduced since last report	4
Risk score increased since last report	4
Total Risks Closed (detail is within the committee minutes of the following committees)	7
Quality Committee	*4*
Primary Care Committee	*0*
Finance & Performance Committee	*1*
Audit	*0*
Commissioning Committee	*2*

4 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 Risk Management Presentation

5.2 A Risk Coordinator's Teams site brings everything together in a shared workspace where the risk coordinators can chat, hold meetings online, web conferencing and share files. This will enable ongoing development and support.

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 has 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.

5 Recommendations

The Audit Committee are requested to:

1. Note that the risk is being managed appropriately through the Corporate Risk Register
2. Note current position of Assurance Framework
3. Agree closure of risk 113 EPRR Core Standards
4. Agree the addition of risks:
   - Risk 127 - Increased fraudulent activity during and following a pandemic or similar major incident
   - Risk 128 - Shared working area confidentiality
   - Risk 129 – Business Continuity
   - Risk 130 – COVID19 Incident Response
   - Risk 131 - Emergency Preparedness

NHS Devon Clinical Commissioning Group

NHS DEVON CCG
Risk Report (Audit)

Date produced: 27-10-2020 - 01:25

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners
109	We will continue to commission safe, effective and accessible services [Reporting Committee] Audit	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •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. (HISTORIC ID: Na)	For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group on a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. 01/10/2020 Long waiters reporting, supporting greater clarity of long waits, addressing volume through validation and clinical triage of acuity particular focus 78 week waiters, monitored through improved detail in weekly RTT PTL return. System wide PTL in development to address opportunities to offer patients treatment at sites in the system where they may have shorter waits Through R&T works reports now deployed providing weekly updated performance insight to support work to address National elective standards Additional capacity for IP, DC, OP and diagnostics through IS sites which will be monitored against revised trajectories from updated Phase 3 submission Ensuring maximum use of IS through close scrutiny for assurance of IS efficiency and utilisation ahead of imminent new National framework procurement Devon Urgent Care programme board now has oversight of ED standards 26/06/2020 - For the period August 20 to March 21 we are currently planning to have demand/capacity planning with quantified activity from August onwards reflecting system transformation and senior planning in relation to capital bids these will inform our trajectory for national performance standards ending 2021 [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: 09/10/2020	[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	We will work as a strategic partner in Devon [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. (HISTORIC ID: Na)	•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: 13/10/2020	[13/10/2020] System Resilience Plan to be developed by 31/10/2020,	•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	We will continue to commission safe, effective and accessible services [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)	•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: 13/10/2020	[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.,	•BC Audit undertaken annually, last completed in December 2019 •NHSEI EPRR Assurance undertaken annually, last completed in October 2019 •BC Exercise completed in March 2020 •Review of BCPs undertaken in March/ April 2020 [Assurance Gaps] •Review of CCG BC Framework and Plan due September 2020 •Complete BC Review and revision of BIAs to be undertaken in 1st Quarter 2021/22	Executive Lead: Sonja Manton Owner: Phil Coutie
113	We will make best use of resources [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 is that the CCG would be in breach of our legal and contractual responsibilities which could place the health response to an emergency at risk. (HISTORIC ID: Na)	05/08/2020 CD EPRR Lead recruited to lead on preparedness work stream; 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] 05/08/2020 CD The incident response to COVID has placed most other EPRR work on hold, meaning that wider preparedness activities are not currently being undertaken.	6 [05/08/2020] ▼ 6 (L=2 x I=3) [24/04/2020] ▲ 16 (L=4 x I=4) [29/08/2019] 6 (L=2 x I=3)	Risk Opened: 03/09/2019 Reviewed: 05/08/2020	[11/09/2019] Executives have been signed up Strategic leadership in crisis training with NHSE 14 October 2019., [11/09/2019] Internal audit is being undertaken by ASW during the second week in October to review the CCGs business continuity plans. , [11/09/2019] Severe weather plans and communications plans are being reviewed by relevant service area (Urgent control leads and communications team) and feedback awaited in anticipation of NHSE assurance visit October 2019. , [11/09/2019] Cascade lists of staff have been developed and HR have recently published a staff structure by directorate/service provision, [11/09/2019] Overarching BCP has been drafted and is to be presented to Executive for consideration of approval 24 September 2019, [11/09/2019] The Head of Governance is meeting with BCP Leads across the CCG to test their BCPs,	05/08/2020 CD - 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] 05/08/2020 CD NHSEI National have indicated thet the 2020 EPRR Assurance process will not involve the full review against the EPRR Core Standards due to the ongoing COVID incident response. A less onerous assurance is expected but has not been distributed. The two Amber rated areas identified in the 2019 EPRR Assurance have been remedied, they were: Strategic Leadership training for on-call staff - completed in Dec 2019 BCPs not up-to-date as review was ongoing - review was completed	Executive Lead: Sonja Manton Owner: Phil Coutie
127	We will make best use of resources [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)	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: 27/10/2020	[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 [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	We will continue to commission safe, effective and accessible services [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)	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 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: 13/10/2020		Entry to buildings are via smartcard. Screens lock automatically after period of inactivity Clear desk policy available 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	We will work as a strategic partner in Devon [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. (HISTORIC ID: Na)	•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: 13/10/2020	[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,	•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. •The two Amber rated areas identified in the 2019 EPRR Assurance have been remedied, they were: oStrategic Leadership training for on-call staff - completed in Dec 2019 oBCPs not up-to-date as review was ongoing - review was completed.	Executive Lead: Sonja Manton Owner: Phil Coutie
38	We will continue to commission safe, effective and accessible services [Reporting Committee] Audit	As the CCG increases its level of collaborative working within the Sustainability Transformation Partnership and as part of the wider Devon sustainability and transformation partnership governance arrangements, there is a risk 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)	12/10/2020 Risk to be presented to Audit Committee for discussion and review November 2020 06/01/2020 reviewed at Executive Team Meeting 10/09/2020 reviewed with no changes pending discussion by GB 01/11/2019 Over the next couple of months the system will be reviewing and discussing new governance mechanisms. 06/08/2019 06/The CCG is undertaking work to strengthen its internal governance and risk management mechanisms. The CCG is engaging with system partners to develop appropriate governance structures and mechanisms to support system working. These governance arrangements will ensure each organisation is able to meet its statutory requirements whilst working together to deliver system objectives. [Control Gaps] No agreed governance arrangements for the system. No agreed governance lead to undertake the work	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: 20/10/2020	[17/12/2019] Arrange workshop for system organisation Audit Chairs to review proposed system Risk Management arrangements GS,	06/08/2019 Review by PA consulting under discussion by system partners. The CCG has an approved Assurance Framework in place and further work is planned to review partner organisations strategic / principal risks. The CCG is undertaking committee mapping to strengthen its internal governance this includes three domains to manage its business which include local CCG governance arrangements, Locality working and Devon wide working. All organisations have their own processes for risk management and decision making and these take priority over system arrangements. [Assurance Gaps] Lack of non-executive oversight of system working and decision making. Lines of accountability from the Sustainability Transformation Partnership to statutory organisation are not clear	Executive Lead: Ginny Snaith Owner: Ginny Snaith

NHS Devon Clinical Commissioning Group

NHS DEVON CCG
Risk Report (High Risks Only)

Date produced: 22-10-2020 - 08:56

Produced by: theresa.farris@nhs.net

L = Likelihood | I = Impact

ID	Objectives	Risk Description	Controls	Risk Score	Dates	Action Plan	Assurances Given	Owners
109	We will continue to commission safe, effective and accessible services [Reporting Committee] Audit	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level. However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: •Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention •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. (HISTORIC ID: Na)	For the national performance standards there are operational groups, as part of the emerging local care partnerships, in place with acute provider and commissioner in each locality. These groups monitor and actively manage performance of both elective and non-elective performance accounting for expertise of commissioner and provider. A risk register is held at each locality for risks pertaining to the delivery of the national performance standard and these risks are actively managed at place, with the appropriate Associate Director. These above arrangements are in place for the elective and diagnostic standard and report into the STP wide elective operational group on a monthly basis. The non-elective performance standards are actively managed at the Acute Provider and Commissioner Group in each locality with oversight via local A&E boards and with risk registers held and managed locally. These local A&E boards, comprising of local commissioners and providers, feed into the Devon A&E board. For the national performance standards, pertaining to cancer, each locality has a local group driving delivery with risk registers held locally as part of the planned care risk register and these local groups also report to the STP wide cancer strategy group. Escalation is actively managed from providers through these groups and onto appropriate oversight groups. 01/10/2020 Long waiters reporting, supporting greater clarity of long waits, addressing volume through validation and clinical triage of acuity particular focus 78 week waiters, monitored through improved detail in weekly RTT PTL return. System wide PTL in development to address opportunities to offer patients treatment at sites in the system where they may have shorter waits Through R&T works reports now deployed providing weekly updated performance insight to support work to address National elective standards Additional capacity for IP, DC, OP and diagnostics through IS sites which will be monitored against revised trajectories from updated Phase 3 submission Ensuring maximum use of IS through close scrutiny for assurance of IS efficiency and utilisation ahead of imminent new National framework procurement Devon Urgent Care programme board now has oversight of ED standards 26/06/2020 - For the period August 20 to March 21 we are currently planning to have demand/capacity planning with quantified activity from August onwards reflecting system transformation and senior planning in relation to capital bids these will inform our trajectory for national performance standards ending 2021 [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: 09/10/2020	[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

115	We will continue to commission safe, effective and accessible services [Reporting Committee] Commissioning Committee	There is a risk that Learning Disability and Autism Programme will not meet its "building the right support" trajectory and NHS LTP metric to reduce the number of children with LD and or Autism in a hospital place by 2023/24. The impact of this is Children will be place in out of area hospital placements a long way from home and their families. There is reputational impact due to potential patient harm or perception of the CCG is impacted by patient outcomes. (HISTORIC ID: Na)	Controls are the arrangements made or precautions taken, to reduce risk. (e.g. Governance processes / statutory frameworks, management structure & accountabilities, communications & patient / public feedback, policies & procedures / reviewed at team meetings etc). Please provide details of controls in place, below: - Developing proposals to submit to Executive team - Seeking additional resources from NHSE to implement proposals - Considering existing resources which could be redirected - Re-structure adults TCP team to support Children's TCP - Recruitment process underway for Clinical lead post to March 2020 - Additional co-ordination of CETR process UPDATE 27.04.20: •In line with national guidance, the Learning Disability and Autism Programme is continuing and performance monitoring is ongoing during COVID-19. •Good progress has been made with dedicated resource focused on reducing the number of Children and Young People in placement from 16 to 8 (21.04.2020). This is regularly reviewed and overseen by a fortnightly tracker meeting and reporting to the monthly Learning Disability and Autism Programme (LDAP) Group •Risk remains, as there is increasing activity in admission avoidance,(new admissions or re admissions) acerbated by COVID and risk to children with LD & Autism being restricted within their homes. UPDATE 02.07.20: - Recruitment for Complex Care Quality Assurance Lead near complete. Interviews 7th July. Individual CYP Admission Avoidance calls chaired by CCG continue to operate with multi agency input. NHSE funded key worker pilot EoI to be submitted July 10th - in line with LTP. Function and role will support the admission avoidance agenda. Proposed review of CYP who were in Tier 4 prior to COVID to track current situation. UPDATE 07.08.2020 - Nursing & Quality Directorate: - CYP discharges continue on tract with current trajectory. - CCG Quality Assurance Lead nurse recruited to commence 2nd November 2020. CCG Clinical Lead attends or Chairs multi-agency admission avoidance calls increasing CCG capacity, previously not available Feb 20. - Dynamic risk register reviewed with all providers at fortnightly CYP tracker meetings. [Control Gaps] Additional capacity needed to deliver Greater work needed to join up system approach to service Lack of project management to deliver CAMHS Capital Tier 4 admission avoidance project	16 [02/12/2019] 16 (L=4 x I=4)	Risk Opened: 23/01/2020 Reviewed: 09/10/2020	[23/01/2020] Draft proposal to be delivered at hot topics which details plans and resources required to address risk. This has now been approved. Ongoing conversations with NHSE re assurance. UPDATE 02.07.20: - Issues and risk are escalated as appropriate through the MH/LD Cell. Annual review with NHSEI 15th June 2020. CCG Secured additional capacity (1xday/wk) of Clinical Lead. Reviewing existing resources to support Children's TCP plan. Meeting to be set up for Feb between CCG Director of Commissioning, and Directors of Children's in the Local Authorities. UPDATE 02.07.20: This did not go ahead. Changes in Personnel. Action plan reviewed and updated. Continued risk around progression of capital admission avoidance bid, however mutli agency project group established and working through 'statement of purpose' and how will link to the NHSE funded crisis bed and key worker pilot. ,	For each of the risks and controls a source of assurance is set out ie. What provides evidence that the organisation has identified the risks and has controls in place. (e.g. Internal audit report, report to Board or Board Committees) Please provide details of assurances below: TCP Tracker meeting Care and Education Treatment reviews Performance data Escalation calls from NHSE Learning Disability and Autism Programme Steering Group CYP LDAP Sub Group Fortnightly Mental Health and Learning Disability Cell CCG secured extra capacity of lead clinician to continue to lead. [Assurance Gaps] Joined up with NHSE Specialised Commissioning Linking in with Children's services, social, EHCP's	Executive Lead: Jo Turl Owner: Siobhan Grady
105	We will make best use of resources [Reporting Committee] Quality Assurance	There is a risk that patient safety will be compromised and / or harm may occur due to delays in out of hours GP response times. The impact of this is upon patient experience and safety; public and professional confidence in the system and associated reputational impact. (HISTORIC ID: Na)	October 2020 - Risk score reviewed and to remain at 16. Comfort calling continues to be applied where necessary, with rates of comfort calling improving. Lead clinician role also now in place and this provides appropriate triage of calls and monitoring of wait time breaches (SZ) September 2020 - Following the peak of the pandemic when demand for out of hours care was reduced, a significant increase in demand is now being seen leading to call stacking and patients waiting for lengthy periods for a clinical response. 'Comfort calling' is in place but capacity is not adequate and many long waiters receive no such contact. Weekly meeting with Devon Doctors Ltd to review and monitor CQC improvement plan are now in place (SZ) [Control Gaps] None identified	16 [21/08/2020] ▲ 16 (L=4 x I=4) [15/07/2020] ▼ 4 (L=2 x I=2) [15/04/2020] ▼ 8 (L=2 x I=4) [10/02/2020] ▼ 15 (L=5 x I=3) [14/10/2019] ▲ 16 (L=4 x I=4) [01/05/2019] 12 (L=3 x I=4)	Risk Opened: 01/05/2019 Reviewed: 02/10/2020	[21/05/2020] May 2020 - The CCG will monitor the impact of the increased demand on the call stack, in terms of patient experience & safety June 2020 - Demand is still increasing but call stacking is not currently an issue,	August 2020 - Ongoing monitoring indicates that calls are beginning to stack at weekends as demand for out of hours services continue to increase. No evidence of harm in relation to this has been reported (SZ) July 2020 - Devon Doctors have provided assurance that call stacking is not currently an issue, has significantly reduced & is being monitored (SZ) June 2020 - Demand is increasing although call stacking not currently an issue (SZ) May 2020 - Demand for out of hours is increasing but call stack risk remains controlled (SZ) [Assurance Gaps] None identified	Executive Lead: Darryn Allcorn Owner: Sarah Zanoni

121	We will continue to commission safe, effective and accessible services [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. (HISTORIC ID: Na)	Controls are the arrangements made or precautions taken, to reduce risk. (eg. Governance processes / statutory frameworks, management structure & accountabilities, communications & patient / public feedback, policies & procedures / reviewed at team meetings etc). Please provide details of controls in place, below: Provider oversight and management: •Daily bed management call in place chaired by DPT is in place to ensure efficient flow of beds and reduce inappropriate placements. •Review of patient flows to ensure timely discharge from in patient units in place. •DPTs existing processes and management were impactful in reducing out of area placements prior to Covid. Ensuring sufficient capacity to manage demand: •A 16 bedded inpatient unit has been commissioned and re-classified as 'in area'. •DPT have undertaken bed capacity modelling and additional beds are being commissioned to increase capacity during Covid surge (MH surge). Managing Demand: •Ensuring that care support and treatment for mental health problems is offered early in the development of need, in the community as part of a rehabilitation approach is all being considered as part of the Community Mental Health Services Framework approach. This supports reduction in demand for bed-based care and improves outcome, experiences and sustainability [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 demand and capacity planning is based upon the impact of a single wave of Covid. The potential impact of a second wave of Covid has not been modelled.	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: 30/09/2020		For each of the risks and controls a source of assurance is set out ie. What provides evidence that the organisation has identified the risks and has controls in place. (e.g. Internal audit report, report to Board or Board Committees) Please provide details of assurances below: • The revised trajectory was developed with providers as part of the phase 3 planning submission. The revised trajectories do not achieve the Long-Term Plan deliverable in the original timescale, there remains a risk that the revised trajectory will not be achieved. •The trajectories agreed are quarterly and will achieve elimination of inappropriate out of area placements by Q2 2021/22 and these were submitted as part of Phase 3 planning and submissions. •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. [Assurance Gaps] •Providers are developing action plans which fully describe the action and timescales which will support delivery of the agreed trajectories. These are expected to be shared w/c 05/10/2020.	Executive Lead: Jo Turl Owner: Liz Cosford
123	We will make best use of resources [Reporting Committee] Quality Assurance	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 (HISTORIC ID: Na)	Daily updates at system wide Care Home and Out of Hospital Care Cell Progress reviewed daily within CHC Team updates [Control Gaps] October 2020 - Fit testing training for those to be fit testers scheduled for November 2020 that will provide us with 16 more fit testers although volunteers are needed to become trainers (RC) October 2020 - A paper has been taken to the Tactical Management Cell and that agreement is being sought for a system wide response to supporting this ongoing requirement - but not yet implemented (VC) September 2020 - The risk remains as there is no current solution to ongoing system wide fit testing for carers. An SBAR has been discussed within the Care Home & Discharge cells and plans are moving forwards towards a longer term solution involving both acute's and community providers and independent providers holding responsibility for enabling their own staff to be trained to fit test, then they can fit test their own employees. Meanwhile to maintain patient safety, the CHC Team are continuing to fit test on a case by case request basis (JS) NHS Provider organisations will need to pro-actively engage with this process	16 [16/10/2020] ▲ 16 (L=4 x I=4) [06/08/2020] 12 (L=3 x I=4)	Risk Opened: 06/08/2020 Reviewed: 02/10/2020	[06/08/2020] October 2020 - The Tactical Management Group reporting through to the Outbreak boards needs to expedite rapidly the plan to increase fit testing across the system and specifically for carers of PA and PHB clients. As stocks of FFP3 run low and are replaced with different brands - all carers will need re-fit testing rapidly October 2020 - action updated to: The probability of the risk increasing as community transmission of the virus is increasing during the second wave. August 2020 - The probability of the risk will reduce as community transmission of the virus decreases, meanwhile CCG via Care Home cell to forward think next steps to develop sustainable training/fit testing programme,	October 2020 - There is a proposal that the LA will store and deliver and organise logistic support for the ongoing PPE for PA and PHB clients. The fit testing, training (including train the trainer) oversight and implementation now is being led by the CCG. There is currently no process in place and therefore there is an ongoing assurance gap that the carers will be fit tested or re-fit tested promptly (VC) Completion of the actions below will provide assurance to the CCG that the risk has reduced Action plan to be updated daily [Assurance Gaps] October 2020 - There is a proposal that the LA will store and deliver and organise logistic support for the ongoing PPE for PA and PHB clients. The fit testing, training (including train the trainer) oversight and implementation now is being led by the CCG. There is currently no process in place and therefore there is an ongoing assurance gap that the carers will be fit tested or re-fit tested promptly (VC) Provider response to be generated via Care Home Cell – not yet cited	Executive Lead: Darryn Allcorn Owner: Vanessa Crossey

102	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that the number of Devon Partnership Trusts overdue Root Cause Analysis Serious Incident (SI) reports might affect the embedding of learning and improvement. The impact of this to the CCG is a lack of assurance that patient safety improvements from incident learning are identified and actioned in a timely way (Previously linked to mirrored risk 103 which is now closed) (HISTORIC ID: Na)	October 2020 - Four weekly quality surveillance meetings were agreed between the Trust, CCG, NHSEI and the CQC following the initial Quality Surveillance Group (QSG) meeting which took place 28 August 2020. A subsequent assurance meeting has not yet taken place (SW) September 2020 - A single item Quality Surveillance Group (QSG) meeting took place on 28/08/20. The CQC & NHSEI were in attendance with the CCG & provider. Monthly meetings are now planned to monitor improvements made by the provider, DPT. Progress will be reported through the South QSG. Internally within the CCG, reporting will continue through QAC to GB (SW) August 2020 - PK is due to provide a verbal update at QAC P2 on 20/08/20. DPT have outsourced 17 RCA's so aiming to improve the number of outstanding investigations in the short term however this is not a long term solution. The CCG are yet to see any change in DPT's governance process that would suggest long term embedded change in either completing investigations or applying action/learning (IL) July 2020 - Exec to Exec level discussions continue, in relation to quality assurance & support to improve (SW) June 2020 - QAC paper planned for July 2020 (joint CCG DPT CNO's) (SW) [Control Gaps] October 2020 - The Trust have outsourced around 30 Serious Incident investigations in total now. Whilst this may improve the figure that are overdue, it still does not address a long term, sustainable process or give ownership to local teams, which could potentially change safety culture. Whilst updating this risk the number of overdue reports form DPT has risen to 24 (SW) April 2020 - The number of overdue SIs has increased. DPT remain committed to resolving but have lost staff to the COVID-19 frontline reducing their capacity to undertake RCAs (SZ)	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: 07/10/2020		March 2020 - The quality of investigations has greatly improved with less being returned for further information. The number of reported investigations has reduced to average 7 a month opposed to 12-13 a month, this is due to work with CCG / DPT/safeguarding and NHSE, reduced duplication and ensured only appropriate incidents reported. The number of overdue investigations has plateaued. There are now more clinical reviewers so more capacity in the team following training undertaken (IL) [Assurance Gaps] Action planning for overdue incidents is not visible whilst overdue. The quality of 'immediate' 72hr reporting is important in assuring that identified safety issues have been implemented.	Executive Lead: Darryn Allcorn Owner: Sara Wright

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Risk Summary: EPRR Core Standards (ID:113)

Date produced: 22-10-2020 - 11:37

Produced by: theresa.farris@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
EPRR Core Standards	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 is that the CCG would be in breach of our legal and contractual responsibilities which could place the health response to an emergency at risk.	We will make best use of resources	03/09/2019	29/08/2019	Audit

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
6	2	3	Risk reviewed and updated to reflect current status CD	05/08/2020
16	4	4	Due to Covid-19 this risk has been reviewed in line with risk management process and aligned to Covid 19 Risk register	24/04/2020
6	2	3	CCGs statutory obligations	29/08/2019

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Sonja Manton	Sonja Manton	Ginny Snaith	Phil Coutie	Theresa Farris

Controls	Control Gaps
05/08/2020 CD EPRR Lead recruited to lead on preparedness work stream; 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.	05/08/2020 CD The incident response to COVID has placed most other EPRR work on hold, meaning that wider preparedness activities are not currently being undertaken.

Assurances	Assurance Gaps
05/08/2020 CD - 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.	05/08/2020 CD NHSEI National have indicated thet the 2020 EPRR Assurance process will not involve the full review against the EPRR Core Standards due to the ongoing COVID incident response. A less onerous assurance is expected but has not been distributed. The two Amber rated areas identified in the 2019 EPRR Assurance have been remedied, they were: Strategic Leadership training for on-call staff - completed in Dec 2019 BCPs not up-to-date as review was ongoing - review was completed

Action	Date Added	Date Complete
The Head of Governance is meeting with BCP Leads across the CCG to test their BCPs	11/09/2019	
Overarching BCP has been drafted and is to be presented to Executive for consideration of approval 24 September 2019	11/09/2019	
Cascade lists of staff have been developed and HR have recently published a staff structure by directorate/service provision	11/09/2019	
Severe weather plans and communications plans are being reviewed by relevant service area (Urgent control leads and communications team) and feedback awaited in anticipation of NHSE assurance visit October 2019.	11/09/2019	
Internal audit is being undertaken by ASW during the second week in October to review the CCGs business continuity plans.	11/09/2019	
Executives have been signed up Strategic leadership in crisis training with NHSE 14 October 2019.	11/09/2019	

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Risk Summary: Increased fraudulent activity during and following a pandemic or similar major incident (ID:127)

Date produced: 27-10-2020 - 01:23

Produced by: theresa.farris@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Increased fraudulent activity during and following a pandemic or similar major incident	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	We will make best use of resources	10/09/2020	26/10/2020	Audit

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
6	2	3	Transferred from COVID RR to CRR following discussion at Exec August 2020	03/09/2020

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
John Dowell	Ginny Snaith	Ginny Snaith	Clare Doble	Theresa Farris

Controls	Control Gaps
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.	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

Assurances	Assurance Gaps
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	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

Action	Date Added	Date Complete
Transferred from COVID RR to CRR following discussion at Exec August 2020	10/09/2020	10/09/2020
On-going review of processes to mitigate fraudulent activity	10/09/2020	

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Risk Summary: Shared working area confidentiality (ID:128)

Date produced: 30-10-2020 - 01:31

Produced by: david.haines@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Shared working area confidentiality	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.	We will continue to commission safe, effective and accessible services	10/09/2020	03/09/2020	Audit

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
6	3	2	agreed with GS	03/09/2020

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Ginny Snaith		Not Given	Matt Spry	Theresa Farris

Controls	Control Gaps
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	Lack of suitable private areas where calls may be overheard and screens viewed Secure storage for CCG equipment & work

Assurances	Assurance Gaps
Entry to buildings are via smartcard. Screens lock automatically after period of inactivity Clear desk policy available 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.	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

Action	Date Added	Date Complete
Annual mandatory Data Security Awareness training for all staff and reviewed monthly and reported to the DPSG.	10/09/2020	10/09/2020
Guidance on homeworking published via staff comms	10/09/2020	08/10/2020

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Risk Summary: Business Continuity (ID:129)

Date produced: 22-10-2020 - 11:33

Produced by: theresa.farris@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
Business Continuity	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.	We will continue to commission safe, effective and accessible services	17/09/2020	17/09/2020	Audit

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
9	3	3	assessment of situation	17/09/2020

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Sonja Manton		Ginny Snaith	Phil Coutie	Theresa Farris

Controls	Control Gaps
• 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	• Primary Care Business Continuity Plan (BCP) in development, not yet reviewed by EPRR or signed off.

Assurances	Assurance Gaps
• BC Audit undertaken annually, last completed in December 2019 • NHSEI EPRR Assurance undertaken annually, last completed in October 2019 • BC Exercise completed in March 2020 • Review of BCPs undertaken in March/ April 2020	• Review of CCG BC Framework and Plan due September 2020 • Complete BC Review and revision of BIAs to be undertaken in 1st Quarter 2021/22

Action	Date Added	Date Complete
BC Review due to be complete by 12/10/2020 and outcome included in EPRR Assurance report to GB on 29/10/2020.	13/10/2020	
BC Framework and Plan to be revised by 30/11/2020.	13/10/2020	
BC Audit to be completed by 31/12/2020.	13/10/2020	

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Risk Summary: COVID-19 Incident Response (ID:130)

Date produced: 30-10-2020 - 01:33

Produced by: david.haines@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
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.	We will work as a strategic partner in Devon	17/09/2020	17/09/2020	Audit

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
12	3	4	current assessed status of risk	17/09/2020

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Sonja Manton		Ginny Snaith	Phil Coutie	Theresa Farris

Controls	Control Gaps
• 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.	No Gaps Identified

Assurances	Assurance Gaps
• 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.	• Devon was not badly affected by the virus during the first wave and so the incident response structures and Provider capacities were not tested.

Action	Date Added	Date Complete
System exercise to be delivered to exercise the response to a more severe second wave coinciding with flu, winter pressures & expected increase in staff sickness. Exercise delivered on 6th October 2020	13/10/2020	06/10/2020
System Resilience Plan to be developed by 31/10/2020	13/10/2020	

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Risk Summary: Emergency Preparedness (ID:131)

Date produced: 22-10-2020 - 11:36

Produced by: theresa.farris@nhs.net

Risk Title	Description	Corporate Objectives	Date Added to Register	Date Risk Accepted	Committee
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.	We will work as a strategic partner in Devon	17/09/2020	17/09/2020	Audit

Risk Score	Likelihood	Impact	Reason For Changing Score	Risk Score Set
6	2	3	risk score at approval of risk	17/09/2020

Exec Lead	Accepting Exec Lead	Programme Lead	Risk Owner	Risk Coordinator
Sonja Manton		Ginny Snaith	Phil Coutie	Theresa Farris

Controls	Control Gaps
• 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.	• The incident response to COVID has placed most other EPRR work on hold, meaning that wider preparedness activities are not currently being undertaken.

Assurances	Assurance Gaps
• 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.	• 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. • The two Amber rated areas identified in the 2019 EPRR Assurance have been remedied, they were: o Strategic Leadership training for on-call staff - completed in Dec 2019 o BCPs not up-to-date as review was ongoing - review was completed.

Action	Date Added	Date Complete
Ongoing refreshing of On-call pack and contact lists	13/10/2020	
Maintenance of On-call rotas	13/10/2020	
Refresher On-call training to be offered to On-call staff before 31/12/2020	13/10/2020	
On-call Induction training to be provided to new On-call staff before participating in the rota.	13/10/2020	

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GOVERNING BODY

Report title: Committee Chairs Report – Quality Assurance Committee (QAC) Public
Date of Governing Body: 26 November 2020 **Dates of Committees covered in this report: 19 November 2020**
Chair's Name and Title: Glynis Atherton Chair Quality Assurance Committee **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

Patient Experience Story
A video was presented to the Committee from the Royal Devon and Exeter NHS Foundation trust regarding their family liaison service that ran during the first COVID 19 period. The patient's daughter attended the meeting and was described her positive experiences following the work that was undertaken by the Trust with regards to her mother's care and the level of engagement from the Patient Liaison Service team whilst the family were unable to visit with her. The team ensured that her mother received daily newsletters from the family and friends, and which ultimately helped with her wellbeing and recuperation from her illness. It was suggested that this learning is rolled out across the whole Devon area.

Quality and Safety Report
Elective and Planned Care - In the context of winter pressures and a surge of COVID-19 cases, providers continue to maximise levels of elective care that is safe and ensures a positive patient experience. However, waiting lists continue to grow and there is risk to both safety and experience. The service step up and down process has been adapted to ensure essential information is gained from providers at locality level through to the Dynamic Decision Making Group. This aids decisions such as evoking the mutual aid process. The CCG's oversight and leadership role within the system includes communicating safety and quality, as well as performance issues and risks with regulators, providers and the public.

Primary Care
Serious Incident Update: During quarter two, there have been 7 identified serious incidents involving primary care. Six of those serious incidents have been identified through the CCG PITCH process. There are currently 2 overdue report investigations and the CCG are currently liaising with these practices. There is also a multi-

agency serious incident that indirectly involves a practice and the CCG are working closely with this practice to obtain the necessary details.

GP Access Survey Update: Following analysis of this year's IPSOS MORI GP Access Survey, the Primary Care and Nursing Teams have made contact with all four practices that had the lowest performance to formally present them with the data and request what their improvement plans are following the survey results. The CCG is awaiting responses, once received the teams will work closely with the practices to monitor the improvement plans.

Areas of concern

The CCG continues to work closely with the CQC where practices are identified as requiring support, due to significant challenges, including safety and workforce issues. There are currently 3 practices the CCG is working with.

- There is an ongoing concern that some patients have not been accessing primary care services, due to fear of contracting COVID-19. This is a national issue and NHSEI is leading on communications encouraging patients to attend.

CCG Functions/ Roles

Continuing Healthcare - As part of 'phase 3' restoration of services, this operational function recommenced as of 1 September 2020. There is the expectation, through the reset work, that the new backlog of assessments will be cleared. This backlog has now been assessed as 504 outstanding assessments. During the previous reporting period, a significant amount of work has been undertaken to put in place arrangements for the reset of the operational function, including collaboration with local authorities. Lists of clients have been cleansed and added to the system. As part of the 'CHC reset', to clear the backlog of the remaining 504 CHC assessments, a range of options have been put in place to meet this target. The current backlog trajectory is being monitored by NHSEI. The CCGs current progress is on course to meet the backlog reduction.

A new nationally funded, 6 week discharge process has been established from 1 September 2020. This discharge process will generate new CHC assessment referrals, as well as those generated from the community setting. These new discharge arrangements are critical, as if unsuccessful, acute hospital will experience delays in discharges and the ongoing consequences of this impacting on the system. Not all individuals will require CHC assessment, however, the CCG is working with LA partners, to ensure timely discharge , for any individuals requiring ongoing support.

Patient Experience - During the previous month the CCG received 1 formal complaint. In addition to this, the CCG received 77 Peer Improvement Tips for Care and Health (PITCH) submissions (health and care professionals reporting system). The main themes identified related to shift of workload and delayed access to treatment, mainly as a result of the impact of COVID 19. Alongside this, the CCG's patient experience team received 75 informal feedback contacts. These ranged from information around delays to appointments caused by COVID-19 to general advice and information around commissioning policy.

Safety Systems - NHSE/I have approved the CCG and TSDFT pilot a new process for pressure ulcer incidents that meet the threshold of a serious incidents. All pressure ulcer incidents that meet the threshold of a serious incident will continue to be reported onto the Serious Incident Strategic Executive Information system (StEIS). However, instead of TSDFT submitting an initial report they will submit a SSKIN checklist. This will be reviewed by the CCG (in line with the Root Cause Analysis (RCA) review process) and if assurance is received the incident will be closed on StEIS without further need of an RCA investigation/report to be completed. This process, if successful; will be a step towards what reporting may look like in light of the new serious incident framework. The process will be reviewed in several months' time.

Learning Disabilities Review - The LeDeR programme is cautiously optimistic that it will achieve its targets of all death notifications being received before 31 June 2020 having reviews completed by 31 December 2020. The team are currently RAG rated amber, as there are still concerns over resilience in our reviewer resource. We are heavily relying on external contracts which are a finite resource due to limited funding. Long term

intentions are for the Devon system to provide reviewers from provider organisations and local authorities. This is being taken through the LeDeR Steering Group and escalated to the Devon wide Quality Surveillance Group. The programme is rapidly scaling up its work on the phase two of LeDeR, with 10 key areas being identified. We have identified that there is already lots of positive work within the system for each area.

The LeDeR team are pleased to note positive working with the CCG primary care team to bring down the number of outstanding primary care notes requested, and there is now 1 outstanding, down from 12 which has meant several reviews can now be completed.

Infection, Prevention & Control - Flu vaccination rates in both the acute (frontline healthcare worker) and community settings have been high, with all organisations approaching vaccination in new and innovative ways. This has resulted in uptake high enough that vaccine stocks have been depleted and requests have been made to the national stockpile for additional vaccine. There is considerable external scrutiny of frontline healthcare worker vaccine uptake, with both fortnightly and daily data collections. Uptake continues to be high and is being limited by phased centrally controlled vaccine stocks. Once these stocks are made available the expectation is for uptake levels to continue to increase towards the 100% ambition (in frontline workers) and the 75% ambition (in vulnerable groups).

COVID-19: Rates of COVID-19 have significantly increased in Devon over the past month including evidence of nosocomial spread. Infection prevention and outbreak control measures are particularly challenging given evidence of pre-symptomatic and asymptomatic transmission. The recent introduction of widespread community restrictions are intended to assist with addressing this.

Children and Young People (CFHD) Contract Update

The paper provided the most recent position of performance, contractual and quality issues for the provider Children and Family Health Devon and Livewell South West.

CFHD have confirmed with commissioners their transformation plans have begun, but are in the early phases, due to restructure and the COVID 19 pandemic. The CCG current assessment is we that we acknowledge the next 6-12 months is unlikely to show significant changes to waiting list times in most services and improved experience for children and young people, due to the level of transformation required. Additionally, for quality to be embedded and sustained, a longer period is required for this to be evidenced.

QEIA Annual Report

This annual report provided the Committee with an overview the years activity, successes and future development plans for the Quality and Equality Impact Assessments (QEIA) process and panel. The Clinical Commissioning Group (CCG) Quality and Equality Impact Assessment (QEIA) process and panel has been successfully operating for six years. This year the process and panel had to stand down temporarily in response to the worldwide Covid-19 pandemic. The pause provided opportunity to learn from ways of working in response to the pandemic, still recognising that QEIA's remain core for the CCG's decision-making processes.

There was a significant decrease in the number of submitted QEIA's this year compared to last year, which reflects the pause of the QEIA process and panel in March 2020, reinstating activity in October 2020.

The new concise tool has been designed to allow authors to complete impact assessments with ease, which should also help to increase engagement from colleagues in the process. The new process allows the concise tool to be completed in the first instance, however throughout the tool there are prompts that might mean a full impact assessment is required to be completed. Panel members has been engaged with this large-scale change and a real culture shift has been evident as a result. Panel members supported the change and we cannot underestimate the opportunity that arose with the adaptations used during the pandemic and learning from them.

NHS England/Improvement have invited the CCG to present at a national EIA Development Session to showcase the changes the CCG have put in place in response to pandemic.

- The Committee **noted** the contents of this paper and support the future improvements to the QEIA

process and panel.

Risk Register Review Updates

Quality Risk & Assurance Report including Risk Register:
Please see below with regards to Risk Register Review (changes and pertinent areas).
Data extracted for this report on the 3 November 2020 of which it informs the Committee of any changes since the last Quality Assurance Committee (QAC) on the 15th October 2020. The organisation has thirty-five risks in total & fourteen of these report to QAC.

- Out of the fourteen risks, 6 are categorised as very high and 5 high
- Out of the fourteen risks, twelve have been reviewed between the period of 6th October and 2nd November
- Approval of:
  - 5 new risks
  - 2 risks that have moved in score
  - 2 risks that are being recommended for closure

Committee Decisions

- The Committee noted and agreed to the amendments to the Terms of Reference for the Committee

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

Quality Assurance Committee Terms of Reference
Document attached for GB approval.

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

Quality Assurance Committee
Terms of Reference

Constitutional Obligations

The Clinical Commissioning Group's Governing Body/ Board hereby resolve to establish a Committee of the Governing Body/Board known as the Quality Assurance Committee. The Committee is established in accordance with NHS Devon Clinical Commissioning Group's (NHS Devon CCG) Constitution, Standing Orders and Scheme of Delegation.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's constitution and standing orders.

The Quality Assurance Committee is an assurance committee of the Governing Body and has the ability to execute any powers assigned to it by the Governing Body and those specifically delegated in these terms of reference and/or through the CCG's constitutional scheme of delegation.

Quality was defined by Lord Darzi in the NHS Next Stage Review as comprising:

- **Effectiveness** of the treatment and care provided to patients – measured by both clinical outcomes and patient related outcomes.
- The **safety** of treatment and care provided to patients – safety is of paramount importance to patients and clinicians and it the key consideration for the delivery of high-quality NHS services
- The **experience** patients have of the treatment and care they receive – how positive an experience people have when they are in contact with the NHS or receive NHS funded care, can be even more important to an individual than how clinically effective the care has been

Furthermore the Care Quality Commission set five key questions in establishing the quality of care:

- **Are they safe? Safe**: you are protected from abuse and avoidable harm.
- **Are they effective? Effective:** your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.
- **Are they caring? Caring:** staff involve and treat you with compassion, kindness, dignity and respect.
- **Are they responsive to people's needs? Responsive**: services are organised so that they meet your needs.
- **Are they well-led? Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes

an open and fair culture.

Purpose

To quality assure, in an oversight role, the delivery of quality standards within commissioned services and to influence prioritisation of those services commissioned within the context of Devon's strategic plan and NHS long term plan. The Quality Assurance Committee will oversee performance against constitutional standards and statutory duties as well as legislation for clinical governance and escalate to the Governing Body, through the Committee Chair, any issues of concern considered to impact on the commissioning of high quality, safe care. It is the responsibility of the committee to make recommendations to the Governing Body of the CCG on determinations about the assurances received surrounding quality issues for the CCG.

Responsibilities

- The Quality Assurance Committee (QAC) will oversee performance against constitutional standards and statutory duties as well as legislation for clinical governance and escalate to Governing Body, through the Committee Chair, any issues of concern considered to impact on the commissioning of high quality, safe care.
- It shall support the objectives of NHS Devon CCG's Governing Body as outlined in the Operational Plan and provide assurance to the Governing Body that these objectives are being met and considered in line with the Committee's reporting arrangements, and also to Audit and Assurance Committee as part of the Internal Audit schedule.
- It will promote a whole system culture of continuous quality improvement, ensuring that quality sits at the heart of health and social care locally, as part of the services that the CCG commissions, whether provided by NHS or non-NHS providers.
- It will seek assurance from other committees of the Governing Body and/or from providers that all of its commissioned services are being delivered in a high quality and safe manner, including services commissioned by Public Health under a joint assurance agreement.
- It will set the strategic direction for the Governing Body to support the commissioning of high-quality services and continuous quality improvement.
- It will seek assurance that the CCG is fulfilling its statutory duties of Safeguarding, Equality, Diversity & Inclusion, Complaints, Continuing Healthcare (CHC), clinical governance, and information governance under the relevant Acts, and current national guidance.
- It will seek assurance that the commissioning strategy for the CCG fully reflects all elements of quality (patient experience, effectiveness and patient safety), keeping in mind that the strategy and response may need to change and adapt to national and local drivers.

- It will review regular reports on; the quality of services commissioned, patient's experiences, specific quality improvement initiatives and any serious failures in quality.
- It will receive assurance from the Quality and Equality Impact Assessment Panel.
- In recognition that there will be a planned transition over an agreed period of time from the 1st April 2019 with respect to delegated commissioning for primary care, a review of the Quality Assurance Committee Terms of Reference will take place by October 2019 to determine whether changes were required to further reflect quality for primary care.

Membership

The membership of the Quality Committee shall be:

- 2 Lay Members of the Governing Body
- Secondary Care Doctor
- Chief Nursing Officer or Associate Chief Nursing Officer
- Director of Commissioning
- Governing Body GP Clinical Quality Lead
- Public Health Representative
- Head of Safeguarding / Head of Quality Assurance
- Representative from Communication and Engagement

The following members have voting rights: • Lay Members of the Governing Body (Chair/Vice Chair) • Chief Nursing Officer or Deputy Chief Nursing Officer • Director of Commissioning • Governing Body GP Clinical Locality Quality Lead • Public Health representative
Lay members of the Governing Body including the Secondary Care Doctor may request that one of the additional CCG Governing Body lay members may represent them in their absence at Quality Assurance Committee. The Quality Assurance Committee may co-opt any non-voting Lead Clinicians, Executive or Managing Directors, nominated deputies and lead managers as appropriate.
Note: When a committee member is unable to attend, a nominated formal deputy with sufficient authority **must** attend in their place. It is the responsibility of the committee member to ensure that they ask a deputy to attend. Deputies will have the decision making and voting rights of the person he/she is

representing.

Quorum

The Quality Assurance Committee meetings will be quorate when at least 3 core members are present which include: Non-executive lay member (Chair), Chief Nursing Officer (Executive) and a Governing Body GP Clinical Quality Lead (or formal deputies).

A decision put to a vote at the meeting shall be determined by a majority of the votes of members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

Invited members, or those in attendance to the Committee do not have the right to vote.

Frequency of Meetings

The Committee will meet no less than eight times a year with extraordinary meetings held as required.

The Quality Assurance Committee has agreed that in the interest of expediency or when there are few items to be discussed that business of the committee can be conducted by e-mail and the actions/decision will be recorded by the Administrator for purposes of transparency and recording. Where a discussion is required, all members must respond, and the administrator will oversee this to ensure that all members are accounted for and an audit trail is evident.

The Quality Assurance Committee may convene a confidential briefing session (referred to as 'Part 2') where it is deemed necessary for the agenda item to be shared only with the voting membership of the Committee (excluding the Public Health representative) in the interest of confidentiality. Primary Care (Medical Services) reports, when requested for review, will only be shared within a part 2 meeting where they contain practice identifiable information..

This meeting will include as a minimum the lay member of the governing body (Chair), Chief Nursing Officer (Executive) or formal deputy, and Governing Body GP Clinical Quality Lead.

Reporting arrangements

The Chair of the Quality Assurance Committee shall report formally to the Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to each of the CCG Governing Body meetings in public. The Committee shall make recommendations to the Governing Body on any area within its remit where action or improvement is needed.

The committee will have full authority to commission any reports, audits, investigations or surveys it deems necessary to help it fulfil its obligations.

The committee may occasionally be required to hold a Part 2 - confidential section to allow the discussion of sensitive and confidential quality and patient safety information. The minutes of this section will not be published externally.

There will be an annual work plan which will be approved by the committee setting out the regularity with which reports will be provided to the committee and the timetable for reporting.

The committee may investigate, monitor and review any activity within their terms of reference or as directed by the Governing Body. The committee is authorised to seek any information they require from any committee, group, clinician or employee (including interim and temporary members of staff), who are directed to co-operate with any request made by it. It may form any working group, tasked for a specific purpose and for a fixed period of time, to support the delivery of any of its duties and responsibilities, or for relevant research.

Minutes and reports of the meetings will be produced and held by the Administrator of the Committee, accessible to the Chair and members of the Governance Team. Extracts from minutes will be made public as appropriate under the freedom of information act.

Five days prior to each meeting, the Administrator for the Quality Assurance Committee meeting will ensure that the meeting is quorate. If the meeting is not quorate the Chair must be contacted.

The Chair will escalate any urgent or critical issues, which may put at risk the people who use our service or the reputation of the CCG, to the relevant CCG Executive with immediate effect. Recommendations or action plans will be reported to the appropriate forum; in the case of urgent, critical issues recommendations and action plans will be reported to the relevant Executive Committee.

Conduct of the Quality Committee

The Committee shall conduct its business in accordance with national guidance and relevant codes of practice including the Nolan Principles.

Members of the committee will complete a declaration of interest at each meeting attended. If a member feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

The membership shall observe the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds and the management of the bodies concerned.

The membership shall maximise value for money through ensuring that services are delivered in the most efficient and economical way, within available resources, and with independent validation of performance achieved wherever practicable.

Risk Reporting

The Quality Assurance Committee will oversee and receive assurance that effective management of risk is in place to address quality issues. It will oversee and review the Board Assurance Framework in respect of all elements of quality.

Where timeliness is of the essence in managing a significant risk or issue, the Chair of the Quality Assurance Committee will be informed of an issue by the quickest possible means (e.g. verbally) and this will be acted upon in accordance with the risk management strategy of the CCG.

Statutory Functions, Committee Oversight and KPIs (Internal Monitoring)

The Quality Assurance Committee shall act in accordance with the CCG's scheme of delegation to ensure constitutional compliance, any deviation from this must be brought to the attention of the Governance Team.

It will review regular intelligence in respect of assurance and risk on:

- Quality of services commissioned, including jointly with commissioning partners
- Serious failures in quality
- Serious Incidents including data confidentiality incidents and Never Events
- Performance in respect of incidents, alerts and other clinical governance processes
- Patient experience feedback, including complaints, concerns (actual and trends) including those that go to the Parliamentary Health Service Ombudsman's office
- The CCG's duty in respect of Safeguarding Adults, including people with Learning Disabilities
- The CCG's duty in respect of Safeguarding Children, including Looked After Children (Children in Care) and Children's mental health
- The CCG's duty in respect of quality and safety for Individual Placements, including for people with Learning Disability and Continuing Healthcare
- Infection Prevention and Control and Healthcare Associated Infections (HCAI)
- Medicines Management Governance, including Controlled Drugs and therapeutics
- Clinical Effectiveness and Audit, including NICE guidance/standards
- Specific quality improvement initiatives
- Information Governance
- Research Governance
- Innovation and sustainability
- Workforce planning, CCG staff issues and assurance re Provider staff issues and will also receive ad hoc reports as determined necessary by the committee.
- To receive and scrutinise independent investigation material relating to patient safety issues and agree improvement plans, such as Serious Case Reviews and Homicide Reviews.
- Have oversight of the HCAI/IPC strategy and improvement plans across healthcare in Devon, including wider system work with partners on prevention (e.g. TB, influenza etc.).
- It will seek assurance through its engagement panel (a sub-group of the QAC), that engagement with the public in Devon is carried out effectively, and in line with

constitutional standards, so that their experience can influence and improve the quality of services.

- Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.
- Continuing Healthcare (CHC) including placed people governance, IPP and s117 placements
- Caldicott Guardian
- Primary Care (Medical Services), when requested
- Learning Disability
- Transforming Care
- LeDeR (Learning Disabilities Mortality Review Programme)
- ~~In recognition that there will be a planned transition over an agreed period of time from the 1st April 2019 with respect to delegated commissioning for primary care, a review of the Quality Assurance Committee Terms of Reference will take place by October 2019 to determine whether changes were required to further reflect quality for primary care.~~

Administration

The Committee will be formally minuted. Agendas and papers will be available five working days before the meeting is scheduled to take place. A formal attendance and action and decisions log will be held and reported to each meeting.

Review

An annual effectiveness review will be undertaken by governance as good governance practice and to ensure compliance with the annual governance statement of internal control.

These Terms of Reference will be reviewed annually through the committee effectiveness review or sooner if required, and any recommendations will be made via the QAC Chair to the CCG's Governing Body for approval.

END

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Commissioning Committee

Date of Governing Body: 26 November 2020

Dates of Committees covered in this report: Wednesday 28 October and Thursday 12 November 2020 (Minutes of these committee meetings 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

Wednesday 28 October Meeting

Community Urgent Care / Covid Hot Hubs

- The Committee received a brief update report on the Community Urgent Care / Covid Hot Hub arrangements within each of the localities, for information.

Thursday 12 November Meeting

Local Maternity Services Development Update

- The Committee noted the processes within the LMS Development Update paper and endorsed the priorities and governance arrangements that are taking place within the LMS Programme.

Patient requirements post Covid

- The committee were informed that a task and finish group had been set up to deliver and implement NHSE recommendations around post COVID care incorporating rehabilitation post ITU and a post COVID follow up service.

Local Plan for Recovery and Restoration

- The Committee were provided with an update on the local plan for recovery and restoration. The report provided a statement of the current position in terms of where we were against the Phase 3 plan.

Spinal Services Update and plan for future of Sentinel Contract

- The Committee were provided with a brief update on the progress made within the Spinal Services work, a further update is due to be brought back to the Committee for decision and approval at the December committee.

Risk Register Review Updates

Thursday 12 November Meeting

The Committee reviewed the risk register report and have requested for updates to the risk register to be made monthly. The committee also agreed that each agenda item presented to the Commissioning Committee would be assessed for whether a risk needed to be added to the risk register or team risk register.

Committee Decisions
Wednesday 28 October Meeting Commissioning a Trans Nasal Endoscopy Service • The Commissioning Committee approved the recommendation made within the Trans Nasal Endoscopy Report. The recommendation presented was for an implementation plan for the procedure to be developed which would include wider consultation with the clinical workforce and the development of a training programme supporting a phased implementation as soon as possible. Risk assessments will be undertaken on the current estate and procurement of necessary endoscopes will be undertaken. **Service Review Policy** • The Committee accepted the Service Review Policy for implementation within the CCG. **Lower Limb Therapy Services Review** • The Committee approved the recommendation of interim funding to general practice for the Lower Limb Therapy Service whilst the review is underway. **Thursday 12 November Meeting** Position paper: CCG funding for Children and Young People with diabetes in education settings • The Committee accepted the recommendations made within the position paper: CCG funding for Children and Young People with diabetes in education settings. Consequential stakeholder engagement is required following this decision, further details will be provided to Governing Body following this process.
Items of concern to be escalated to the Governing Body
Wednesday 28 October Meeting None **Thursday 12 November Meeting** None
Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
None

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 26 November 2020

Dates of Committees covered in this report 19 November 2020

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

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

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- Risk Register Reports – see Risk Register review below.

- Quality & Performance Report – the Committee received information on key quality and performance indicators for the period 1 April to 30 September 2020, including those contained in the NHS Constitution. The report had previously been considered at a joint Committee meeting with the Quality Assurance Committee. The Committee concentrated its discussions on the actions being taken, and planned, to address the following areas which were highlighted: -

    - Performance against the Cancer Waiting Times standards remained relatively stable through the initial Covid-19 period and has further improved in August. The STP position against the 62-day standard fell from 85.1% to 81.3%; the drop in performance being caused by capacity constraints. Only NDHT achieved the 85% target. Performance against the main two-week wait standard continues to be below target, falling from 88.8% in August to 79.9%; NDHT achieved the target at 93.9%, whilst RDEFT fell from 89.6% to 75.3%, TSDFT fell from 80.1% to 75.1% and UHP fell from 94.7% to 84.7%. Staffing levels, as a result of sickness, and access to diagnostic pathways are the main contributors to current under achievement. The diagnostic challenges are the focus of the Adapt & Adopt programme to increase capacity and productivity.

    - Referral to treatment times – an improvement in RTT 18 week performance rising from 53.6% to 58.3% at STP level compared to the target of 92% and national performance of 52%. Long wait patients continued to increase, with over 52 week waits rising quickly at all providers in September.

    - Diagnostic waiting times have been significantly affected by the Covid-19 pandemic. Despite improvements within the month, the STP position of 68.3% remains well below the 99% target and is slightly above the England position of 67%.

    - The Committee was informed that the Adapt and Adopt programme continues to drive initiatives in key areas of capacity and efficiency.

- A&E waiting times - Attendances have been steadily increasing since May, but attendance volumes are currently 28% below those in October last year. October saw a further deterioration in performance against the 95% national four-hour standard – at 80.7% for all types and 73.3% for type 1 attendances, remaining below the standard and the England position at 86.2%.

- 111 Performance - The proportion of 111 calls answered within 60 seconds increased from 53.1% in September to 70.6% in October, though still below the target of 95% and the national average of 79.1%. The call abandonment remains high at 12.4% (a better position from September) – the national average is 7% abandoned calls.

Reports received and noted

- Devon CCG Monthly Finance Report - the report reminded the Committee of the draft budget previously agreed (a deficit position of £47.8m with a savings requirement of £22.6m). This draft budget had not received approval by NHSE, who had instead put in place a temporary financial regime for the period 1 April to 30 September 2020, with an expectation that CCGs will 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. Assuming the CCG is reimbursed the month 6 top-up allocation and 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.

    - In terms of risk to this projected position, there is a risk that the CCG does not meet NHSE's assurance process for the month 6 retrospective top-up allocation of £7.584m. Should the top up fall short of the excess costs experienced we will seek to understand the reasoning and address appropriate mitigating actions to meet the NHSE objectives of a breakeven position.

    - In addition, the updated financial regime exposes the CCG to an estimated £6.0m risk in regard to Plymouth Orthopaedic Partnership (POP) and the nationally contacted independent sector activity that is being passed back to CCGs. We are awaiting further guidance and clarification.

- STP Monthly Finance Report – the paper was presented for information to the Committee, outlining the position at Month 5.

    - All providers receive block contract payments from commissioners including specialist. The current regime gives providers a top up payment where their plan shows a deficit position to bring each provider to breakeven.

    - Providers also receive a true up payment where there is an adverse variance to the planned position. Devon CCG will also receive a top-up payment where expenditure is greater than the allocation.

    - Additional expenditure for COVID-19 is covered through the top-up and true-up payments.

    - As at month 4 the Devon system required a true-up payment of £89.0m to break even after any top-up payments.

    - Total costs for COVID-19 was £90.5m for M1-5 (M4 £78.0m)

    - Year to date overspend on bank of £5.3m (£4.1m M3) is partially offset by an underspend on agency of £3.1m (M4 £2.6m)

- The Committee received an update on Operational Planning for 2021-22, which gave an early view of the

potential underlying position as we move forwards and the next steps to be pursued, both at a system level and within the CCG. The Committee felt that a similar discussion should take place as soon as possible in a Governing Body Development Session, and that wider discussion across the system would be useful, potentially including Board-to-Board meetings.

Risk Register Review (changes and areas of concern)

- There have been no changes to risk scores, no risks recommended for closure and no new risks added to the Corporate Risk Register that require reporting to this Committee.

Committee Decisions

- Procurement Register – Conflicts of Interest – the Committee was informed that there is a requirement to annually publish a procurement register, which includes information on decision-making and conflict of interest declarations and management. The Committee noted that a previous draft had been to the November Audit Committee and, having reviewed the register, agreed that it should be published on the CCG website where it will be in the public domain, subject to further minor changes to be agreed with the Finance Director and Committee Chair over the next few days.

- The Committee noted that COVID-19 information is not currently available in the format required for population of this register and that the intention was to bring this to Committee in January 2021, with publication following ASAP.

Recommendations for Governing Body

- None.

Recommendations for other Committees

- None.

Terms of Reference or other committee effectiveness issues

- None.

Management of Conflict of interests:

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 26 November 2020

Date of Committee covered in this report: 05 November 2020 (Minutes of this committee meetings to be available as an addendum)

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Reports received and noted:

The Committee noted:

Primary Care Strategy Work Plan

- The Workplan covers the 6 strategic pillars, commissioning and contracting, COVID 19 second wave * response, and phase 3 planning for reinstating services.
- The live document on TEAMS can be used for review and monitoring through PCOG as agreed by PCCC.
- The next stage is to agree set of key reporting metrics – to be brought to the committee as a draft before formal adoption.
- It will be used to design a summary performance report to replace the highlight reports as an assurance to the PCCC.

The Finance report detailing the financial position to the 30th September 2020 (month 6) and included reference to the impact of the COVID19 pandemic and the financial consequences for the CCG during 2020/21.

Covid19 Expenditure

- Costs in the reimbursement of Primary Care for their Covid-related expenditure have been funded under the month 1-6 finance regime
- From month 7 onwards the CCG has been allocated funds to cover COVID costs which will have to be managed within. This will present some level of risk as the second wave progresses.
- Break even position has been predicted.
- There is continued funding for additional and unavoidable business costs for primary care.
- This month the new claiming process (for COVID and flu) has gone live

Nikki Kanani Visit verbal report from **Alex Degan**

Nikki Kanani joined a virtual CCG meeting.

Primary Care Network representatives from all four localities showcased the work they have been doing and highlighted some concerns. Dr Kanani had been impressed with the innovative practice.

It is the intention that Nikki will come down in person next year.

Risk Register Review (changes and areas of concern)
The Risk Register was reviewed by the Committee, No risks have been closed. No new risks have been added On review, three risks have had risk scores adjusted to reflect the current circumstances: Risk 108 - Sustainability of General Practice. The risk score as been decreased from 20 to 12. An action was noted to review this decrease in risk score, bearing in mind current stressors on General Practice. Risk 117 - COVID-19 General Practice. The risk score as been increased from 6 to 12 Risk 118 - COVID- 19 - Primary Care Team. The risk score as been increased from 3 to 9 2 risks were brought to PCCC for oversight: Risk 119 – Flu vaccination programme risk 2020/21 Risk 132- Robust incident reporting across primary care
Committee Decisions
Primary Care Estates Investment Plan Prioritisation **The Committee confirmed** that the 4 updated evaluation criteria for prioritisation of Primary Care estate capital investment, met the required parameters in the areas of: • Patient benefit • Service integration and alignment • Revenue affordability • Deliverability The criteria and weightings (25% each) had previously been provisionally approved by PCCC with further feedback incorporated into the criteria • Clear links and support for PCN development and additional roles • Value for money • Quality of services
Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
A list of commonly used acronyms was attached to the board pack for information

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the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.

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NHS
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GOVERNING BODY

Report title: Locality Update Reports				
Date of committee: 26 November 2020 **Date report produced: 18 November 2020**				
Author (s) Name and Title: **Locality Triumvirates**		**Supporting Executive:** **Name and Title: Nick Ball, Vice Chair/Audit Chair** **Contact Details:**		
		Report Approved by: **Name and Title:** Locality Triumvirates **Date 18 November 2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Southern and Western Devon Localities.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				
The Governing Body are asked to receive and note the contents of the locality update reports.				
Impact on Strategic Objectives				

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

Does this report have implications in any of the areas highlighted below?		
	If Yes, please give details	**No**
Quality of Services		X
Health Inequalities		X
Equality (staff or public)		X
Resource and Finance		X
Legal		X
Engagement and Consultation		X
Risk		X

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NHS
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Locality update report

Locality:	Northern
Period covered by update:	November 2020
Locality clinical representative:	Dr John Womersley
Locality executive lead:	Andrew Millward
Locality non-executive representative:	Charlotte Burrows

Key achievements/progress

- Start-up funding of £10,000 has been secured to support a homelessness service out of the Freedom Centre in Barnstaple which will be run by Barnstaple Primary Care Network (PCN).

- The Northern Locality continues to have momentum in a number of areas, but the commissioning focus and the Trust managerial capacity has been very much re-focused on: -
    - Significant growth in Covid admissions affecting both primary and secondary care.
    - Infection prevention and control in primary and secondary care
    - Discharges from acute care, particularly focussing on
        - Packages of Care
        - Care Home Placements
        - Family support – in hospital, patients were able to see relatives, many care homes were declining visits
        - New data collection streams for the CCG at the request of region

- Despite the pressures that have come to bear, the system has: -
    - Kept Bideford Minor Injuries Unit open and working with 111 First.
    - Broadly maintained Emergency Department four-hour performance despite flow issues
    - Looked at innovation to increase Care Package capacity
    - Developed 5 extra Pathway 1 support-beds
    - Continued a commitment to plan Discharge to Assess effectively and efficiently
    - Worked very collaboratively with all parts of the system to manage issues such as the Roche reagent supply chain issue.

- The Northern Integrated Delivery Group met on 3 November. Significant progress was made in agreeing the correct data set to provide a locality report. Regular areas of focus will be urgent care, recovery and transformation, community care, mental health and prevention. Local Care Partnership (LCP) partners' winter pressures, the metrics for iBCF (improved Better Care Fund) schemes and Northern Devon Healthcare Trust's Hospital Infrastructure Project Funding (HIP2) process were also examined.

- As of 5 November, Devon has moved from Level 1 (medium) restrictions into a four-week national lockdown and the national response level has risen to four. Health and social care, with other partners, continue to work together balancing COVID-19 and non COVID-19 challenges; for health this requires the on-going safe care of COVID-19 patients, as well as other non COVID-19 care; urgent and elective.

- Work is continuing around the development of a Northern LCP. A proposal has been shared at both the NDHT Board and the One Northern Devon (OND) Partnership Board. All prospective stakeholders are members of the OND Partnership Board. A meeting took place between One Northern members and the two district councils to explore governance issues and how elected members might be further involved in local projects.

Key priorities for the next three months

- Continued support for the work established by health and social care on the short-term-services offer for discharge out of North Devon District Hospital, Barnstaple

- Continued work for the Community-Based Urgent Care work to reopen Ilfracombe and ensure Directory of Services information is accurate.

- Close work within the locality on Blue-to-Green Pathway delivery to support acute hospital capacity
  Alternatives to ED/Community Urgent Care

- **Phase 3 of the Out-of-Hospital Capacity Plan.**
  The key priorities emerging from the unplanned/out of hospital workstream in Northern are:

  1. Short term services development
  2. Implementation of the revised national Discharge Policy
  3. Market sufficiency, personal care and enhanced health in care homes
  4. Admission avoidance and keeping people at home

Issues of concern or risk

- Workforce resilience across the system is a concern going into winter. There is awareness that our staff need ongoing support as we prepare for the contiguous challenges posed by COVID, winter pressures and maintaining elective activity.

- The reprioritisation of programmes of work such as the Prevention Programme and Long-Term Conditions during Covid-19 has impacted progress. The changes to CCG structure mean that these programmes of work will be defined under new leadership and some of the arrangements are not yet in place. Locality need and enthusiasm to progress this work continue and local discussions are in place to develop a frailty programme of work alongside focus on key long-term conditions such as diabetes that will align with the emerging system strategies and programmes of work.

Support required from CCG/system or barriers to progress

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Locality update report

Locality:	Eastern
Period covered by update:	November 2020
Locality clinical representative:	Simon J Kerr
Locality executive lead:	John Dowell
Locality non-executive representative:	Glynis Atherton

Key achievements/progress

- The Eastern system has worked hard during October to meet the sustained high demand for services amid rising Covid cases and staff absence. Teams within Royal Devon & Exeter NHS Foundation Trust (RD&E) in particular have worked extremely hard to maintain performance and service delivery and balance embedding the new IT system My Care.

- Devon CCG and Devon County Council Commissioners continue to work closely to ensure sufficient capacity within out of hospital services in the locality. This includes ensuring personal care agency capacity is appropriately targeted and developing the plan for designated beds.

- The Eastern Locality Delivery Group held a session by Darin Halifax, STP Voluntary services lead, about the developing Voluntary, Community and Social Enterprise (VCSE) sector and architecture in Devon. The group also held a session covering current urgent care performance and developments in the Think 111 First Programme.

Key priorities for the next three months

- Support the Devon-wide development of Think 111 First and Emergency Department demand management and extended provision of Same Day Emergency Care services.
- Continue developments in out of hospital services and ensuring a robust winter response that maintains acute occupancy levels and elective activity.
- Embedding the longer-term clinical leadership for each care home and continuing to shape the response to care home resilience plans.

- Specify and commission leg ulcer services in response to practices notice to cease services previously provided under the Leg Ulcer Local Enhanced Service as part of a Devon-wide review of services.
- Early Supported Discharge for stroke patients across the whole of east to reduce the length of stay for this specific patient group.
- Continue the work to strengthening the role and acuity of community urgent care sites to develop them into viable alternatives for patients to attend rather than an emergency department and therefore less likely to result in a patient admission.
- Establishing an estates sit-rep for each of the community estates to form a wider locality plan for estates utilisation.

Issues of concern or risk

- Proposal from RD&E to change the base of the community nursing team from Moretonhampstead Hospital to touch down desks at Moretonhampstead, Chagford and Cheriton Bishop Surgeries as well as a wider multi-disciplinary base in Okehampton. This proposal does not change the service available to patients. The proposal would enable equity of access for patients to the community nursing team, more flexible working across the sites; reducing travel and increasing clinical time. A Quality and Equality Impact Assessment (QEIA) has been completed and will be considered by the CCG's QEIA panel.
- The operational impact of rising COVID-19 case numbers locally could further impact on CCG priorities and key workstreams.

Support required from CCG/system or barriers to progress

None specified this month.

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Locality update report

Locality:	South
Period covered by update:	November 2020
Locality clinical representative:	Dr David Greenwell
Locality executive lead:	Jayne Carroll
Locality non-executive representative:	Judy Hargadon

Key achievements/progress

Local Care Partnership (LCP) development: the LCP Delivery Group meets fortnightly and the LCP Executive Group has now met twice and will meet on a monthly basis moving forward. Terms of Reference have been agreed and a Partnership Forum is under development which aims to meet quarterly. The locality profile has been presented at both the Executive and Delivery Groups.
Urgent Care: A new template for applying a scoring system to agreeing the OPEL status has been implemented to give consistency to the escalation process. The locality team have been working closely with TSDFT to agree feeds into the new reporting schedule needed for the winter incident room.
Demand and capacity planning: The Task and Finish Group has now been adapted to become a working group focussed on discharge and flow in the system. The meetings are split into operational updates and strategic planning to reflect the Devon-wide 7-day discharge and out of hospital access meetings. The group has reviewed the discharge guidance audit and is working to ensure all the guidance is implemented for the Discharge to Assess process to succeed. Monitoring continues to take place with a daily call to review all complex discharges.
Winter planning: Working Group continues to meet on a weekly basis. Final iteration of the Winter Plan has been submitted in readiness for the Urgent Care Board later this month. Escalation and delivery at locality level completed and winter delivery and implementation plan in developed which will be updated on a monthly basis.
Public Consultation: The formal public consultation on the future delivery of services in the Teignmouth and Dawlish areas ended at midnight on 26 October 2020, with more than 1,000 people having taken part. The following activity has been recorded:

- Healthwatch in Devon, Plymouth and Torbay received 1,013 completed surveys, of which nearly half, 464, were paper copies;
- 34 letters and emails received by Healthwatch;
- 56 phone calls from local people calling with a range of queries;
- 6 online public meetings on different days of the week and at different times of the day:

Public meeting	Total audience	Households attending live event	Views of meeting recording
Fri 11/9, 2.30-4pm	**77**	12	65
Thurs 17/9, 10.30am-12pm	**54**	19	35
Wed 23/9, 6-7.30pm	**62**	17	45
Tues 29/9, 3-4.30pm	**51**	12	39
Mon 5/10, 11.30am-1pm	**46**	24	22
Sat 17/10, 11am-12.30pm	**38**	14	24

- Feedback that some people attending on behalf of a number of others, asking questions on their behalf etc. More than one person can be watching per household.
- 5 community group online meetings attended;
- CCG website – 4,000+ views of Teignmouth and Dawlish consultation pages and 410 document downloads;
- Publicised the consultation on Twitter, with 19,999 views and 174 engagements;
- Facebook posts, including paid-for posts, were viewed 47,153 times;

Population health management: Newton Abbot Primary Care Network (PCN) is taking part in the Population Health Management pilot, supported by a very multidisciplinary approach including district council, Devon Partnership NHS Trust (DPT), Torbay and South Devon NHS Foundation Trust (TSDFT) and the voluntary and community sector. The group has selected a cohort of around 60 people who are aged 18-25 and have contacted mental health services since April.
Voluntary, Community and Social Enterprise Sector (VCSE): A workstream has been established which brings together attendance/admission avoidance and discharge support initiatives.
Urgent Community Care: Task and finish group established. Developing plans for community place-based teams to provide an enhanced urgent community care offer to avoid ED attendance and respond to the 2-hour Discharge to Assess requirement.
Frailty: Frailty Partnership Group continues to progress positively. Sub-groups established, Terms of Reference and Project Plans developing. Frailty Strategy has been finalised by the Frailty Partnership Group and will be submitted to Home First for review/approval this will then be shared with other various groups/forums to ensure all system partners are sighted. TSDFT has joined the Acute Frailty Network the overall aim and driver diagram in development and a series of tests of change being discussed.
Fracture Prevention Service: Working Group stepped back up (paused due to COVID) to continue commissioning conversations, finalise service design and cost with the support of the Royal Osteoporosis Society.
Enhanced Health in Care Homes: Sub-groups established which align to the EHCH Framework components (7 elements).
Long Term Conditions: Continued progress with the redesign of diabetes patient education; further information gathering and collaboration across organisations regarding the transfer of the diabetes lipid clinics from RD&E to Torbay; application of one-off funding from NHS England submitted to improve outcomes for type 1 diabetes; collaboration across organisations to support TUPE transfer of Parkinson's Specialist Nurse from Royal Devon and Exeter NHS Foundation Trust to TSDFT; draft delivery plan developed for cardiac improvements across Torbay and South Devon; sign-off of respiratory improvement delivery plan; collaboration with clinical teams regarding respiratory virtual ward; task and finish

group established for pulmonary rehabilitation; establishment of Devon-wide respiratory steering group.
Primary care: agreed and approved PCN development plans Working with PCNs on delivery of Care Home Directed Enhanced Service. Workforce plans submitted; will inform Workforce Implementation Group planning.

Key priorities for the next three months

Locality Care Partnership: Following the sharing of the locality profile with both the Delivery and Executive Groups work will commence on identifying key messages, the setting of priorities and the development of a local strategy and locality workplan. Partnership Forum members and terms of reference to be finalised and initial forum meeting to be arranged.
Demand and capacity plan: Continue with the implementation of the out of hospital demand and capacity plan recommendations. Monitor the actions to address any gaps in the audit of the discharge audit (see above).
Urgent treatment centres/minor injury units: use of Newton Abbot Urgent Treatment Centre and Dawlish and Totnes MIUs to be reviewed.
Winter planning: Delivery and implementation plan to be completed on a monthly basis.
Public Consultation: Evaluation of alternative suggestions, finalise consultation report by Healthwatch Devon, Plymouth and Torbay and recommendations to Governing Body.
Enhanced health in care homes framework: Sub-groups continue to develop and continue to deliver objectives. Data collection from the Network Contract Directed Enhanced Service to be picked up with primary care team for assurance and completion.
Frailty: Frailty Partnership sub-groups continue to develop and deliver agreed objectives. Strategy to be endorsed, published and shared system wide.
Fracture prevention – oversee implementation of Fracture Prevention Service
Population health management: agreed cohort of patients (18-25 with contact with mental health services) to be given to Newton West practices for their review. Stakeholders to be drawn into MDT discussions.
Urgent Community Care: Options to be explored for potential care coordination hub which can link in with South Western Ambulance Service NHS Foundation Trust (SWAST).
Voluntary, community and social enterprise sector (VCSE): Taking forward specific tests and projects, including High Intensity Users, Discharge to Assess and VCSE rapid response to discharge.
Primary Care: Administering of denosumab being discussed with CCG medicines optimisation, primary care colleagues and clinical lead within the Trust (Torbay and South Devon is an outliner; delivery to be moved to primary from secondary). Safe delivery of primary care through agreed hubs; Newton Abbott, South Hams Hospital and Galmpton. Continued work on estates strategy; identifying and prioritising significant building extensions.
Long-term Conditions: Continued redesign of diabetes patient education, finalisation of lipid clinics transfer, finalisation of Parkinson's nurse TUPE transfer, finalisation and delivery of diabetes virtual workshops, diabetes resource library on GP Team Net finalised and published, Pro-active register management (PARM) tool re-launch across primary care, clear pathway forwards for delivery of pulmonary rehabilitation to reduce waiting list, key priorities identified for cardiac pathway improvements, virtual ward delivery model developed and implemented.

Issues of concern or risk

Recovery and restoration: Balancing recovery of services with challenges of COVID and winter – balancing elective care and maintain urgent care systems.
Staffing capacity: capacity to manage priorities at pace.
Workforce capacity: specifically, for care at home. This will be mitigated through the winter planning process.
Primary care: Transfer of workload from secondary to primary care. The need to take a sensible and proactive approach to ensure the best management of patients in the context of business as usual and COVID-19 response. Concern that a transactional approach may not support this.

Support required from CCG/system or barriers to progress

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Locality update report

Locality:	Western
Period covered by update:	November 2020
Locality clinical representative:	Dr Shelagh McCormick
Locality Director:	Anna Coles
Locality non-executive representative:	Nick Ball

Key achievements/progress

- Ongoing due diligence activity with NHSE/I and Preferred Bidder for Integrated Care Partnership (ICP) procurement.
- Development of locality winter plan in collaboration with partners and aligned to local authority Winter Plan to ensure demand modelling is linked to additional jointly commissioned capacity.
- Funding for COVID hot hubs in place and additional capacity available to support admission avoidance to University Hospital Plymouth (UHP).
- First successful drive-through flu clinic completed in partnership with Plymouth City Council.
- First Fair Shares proposal presented to Plymouth Local Care Partnership (LCP).
- Consolidation of Musculoskeletal (MSK) physiotherapy services agreed with effect from 1st November.
- Direct booking from 111 now live into In-hours Primary Care.
- Alignment of care homes to a Primary Care Network (PCN) complete.
- Two PCNs (Pathfields PCN, Plymouth and West Devon) are wave 2 pilots for Population Health Management.

Key priorities for the next three months

- ICP procurement including regional Integrated Support and Assurance Process (ISAP).
- Implementation of winter plan and management of urgent care system during first COVID winter.
- Ongoing oversight and scrutiny of impact of urgent care pressures on delivery of planned activity.

- Ongoing Development of Western Locality profile to support the delivery of the Out of Hospital Strategy and provide clear commissioning intentions for the Western Locality.
- Continued close working with Primary Care Commissioning function to support COVID vaccination mobilisation, estates strategy in partnership with Plymouth City Council and progression of Sherford procurement.

Issues of concern or risk

- Staffing capacity across the commissioning team to manage priorities and operational demand.
- COVID-19 – system-wide risks including to patients due to non-availability of services across both health and care.
- Workforce capacity across all providers including nursing, domiciliary care, pharmacy, voluntary sector.
- Community capacity for future COVID-19 peaks including Care Homes, surge beds and community care as outbreak numbers increase.
- Cornwall capacity across community both Care Home provision and Dom Care which impacts on flow from UHP.
- PCNs may not be able to recruit to additional roles effecting their ability to deliver the DES requirements.

Support required from CCG/system or barriers to progress

- Continued deployment of additional capacity to support Integrated Care Partnership (ICP) procurement.
- Capacity to support co-ordination of urgent care system through winter.
- Alignment of resources to support delivery of operating plan at locality.