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

Via MS Teams - joining details included in formal invitation

28 January 2021 10:00 - 28 January 2021 10:55

AGENDA

#	Description		Owner	Time
1	Welcome and Apologies Verbal		Chair	10:00
2	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 202101...	4	Chair	10:05
3	Minutes of last meeting and action log Paper 1 Draft Public GB minutes 17.12.2020 v1.1.docx Copy of Master Action Log - PUBLIC v3 nc.xlsx	9 19	Chair	10:10
4	Chair's Report Verbal		Chair	10:15
5	Accountable Officer's Report Paper NHS Devon CCG - Governing Body - 28 January 2...	20	Accountable Officer	10:20
6	ASSURANCE COMMITTEE UPDATES Paper(s)		Committee Chair's	10:25
6.10	Audit including Assurance Framework 1.0 Audit Committee Chair Report 14.01.21.docx 4.0 Audit Commitee Risk Report 05 January 2020... 4a Appendix 1 Audit Committee Risks @ 31 Decem... 4b Appendix 2 Corporate Risk Register showing Si... 4c Board Assurance Framework with Sub Objective... 4d Appendix 4 COVID Incident Risk Register - Wav...	25 28 37 40 46 73		

#	Description	Owner	Time
6.20	Finance and Performance [P] 1 Finance Committee Chair Report 28 January 202... 77 [P] 2 (v3) Finance and Performance Committee ToR a... 84		
6.30	Quality [P] QAC Chair Report Part 1 21 January 2021.docx 89		
6.40	Primary Care Commisssioning [P] Committee Chair Report - Public PCC - January 20... 91		
6.50	Commissioning [P] Commissioning Committee Report 18.01.2021.docx 93		
7	Locality COVID-19 Updates Verbal	Locality Representatives	10:40
8	BREAK		10:55

Declaration of Interests Register - Governing Body

Register updated and generated by the Governance Team - 18 January 2021

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	Action taken to mitigate risks	Employer Organisation
	Allcorn	Darryn	Chief Nursing Officer Caldicott Guardian	Member of Governing Body Member of Quality Assurance Committee Senior Leadership Team (SLT) CCG Executive Team Meeting Member of Devon JCEG Commissioning Committee (CC DOI) Member of Audit Committee Member of Primary Care Commissioning Committee (PCCC)	Honorary Associate Professor University of Exeter Seconded to NDHT (to 18 September 2020) Strategic Chief Nurse, Nightingale Hospital Exeter System Chief Nurse, Devon STP		11/05/2020		27/08/2020	Direct	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Appleby	Gaynor	Non Executive Lay Member (Allied Health Professional)	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee (PCCC) Member of Remuneration and Workforce Committee	CQC Specialist Advisor Therapy Lead for Health and Social Care for North Devon		01/11/2019		05/05/2020	Non Financial	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Atherton	Glynis	Non Executive Lay Member- Quality Geographical remit - Eastern	Member of Governing Body Member Quality Assurance Committee (Chair) Member Primary Care Commissioning Committee (PCCC) Member of Remuneration and Workforce Committee	Consultancy for FORCE cancer charity – not CCG funded but has a relationship with RD&E hospital Trustee for St. Margaret's Hospice, Somerset Volunteer for Hospiscare, Exeter – helping at events and proof reading applications to charitable trusts Volunteer for University of Exeter – mentoring students Member of the Labour party Member of the Devon Ethical Reference Group		14/05/2019		01/09/2020	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Bailey	Helen	Associte Director, Urgent Care	Devon Urgent Care Board Senior Leadership team (SLT) Governing Body (presentation) Executive Committee (deputy) Northern Integrated Delivery Group	Owner and director of Wayside Health & Care Ltd, a provider of consultancy and interim management services.		18/11/2020		18/11/2020	Financial, Personal	Direct	Whilst employed by NHS Devon CCG, will not take on any work within eayside Health & Care, but ill remain as owner/director. No information generated by work undertaken for Devon will be disclosed to clients of Wayside Health & Care Ltd. Without the permission of NHS Devon CCG. Should any instance occur where discussions or decisions under discussion be of potential benefit to the company, Helen Bailey will declare this interest and where necessary remove herself from said discussion.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geographical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 , Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		19/11/2020	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	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 Devon Urgent Care Board	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		13/11/2020	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
	Brown	Steven	Director of Public Health (DCC)	Governing Body Strategic Commissioning Partnership STP Directors ICS Partnership Board	No interests declared		19/11/2020		19/11/2020				Devon County Council
	Burrows	Charlotte	Non Executive Lay Member - Patient and Public Involvement Geographical remit - Northern	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Member Primary Care Commissioning Committee (PCCC)	Self-Employment business consultant from September 2019 Associate for Research In Practice Feb 2020 Associate for Research In Practice Supplier/Associate for SWAHSN (Feb 2020) Within my role as SWAHSN associate will be part of their project team which is supporting the Think 111 project Associate for Devon Communities Together		04/04/2019		04/08/2020	Financial/Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

	Carroll	Jayne	Interim Chief Operating Officer	Member Governing Body Member of Senior Leadership Team (SLT) Commissioning Committee (CC DOI) Member of Finance and Performance Committee Devon Urgent Care Board	Independent member of Fostering Panel for Pathway Care.		08/08/2020	08/08/2020	Professional	Indirect		NHS Devon CCG
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for CFO)	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt School Governor for Tavistock Primary and Nursery School	Partner is employed by Livewell Southwest in position of influence	26/09/2017	17/09/2020	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Coles	Anna	Locality Director - Plymouth	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning) Strategic Commissioning Partnership Meeting	No interests declared		12/03/2019	22/10/2020				Plymouth City Council
	Davis	Alison	Associate Non-Executive Director	Attendee Governing Body	Plymouth City Council – Foster panel Chair Torbay Council- Foster panel Chair Pathway Care Fostering- Ashburton- Independent Reviewing Officer University of Exeter – student mentor Somerset County Council- casual employee		19/10/2019	20/10/2020	Personal, Professional & Financial	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Strategic Commissioning Partnership Meeting	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015	20/10/2020			Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Doble	Clare	Head of Governance Deputy Senior Information Risk Owner (SIRO)	Attendee of Audit Committee Quality Assurance Committee Primary Care Commissioning Committee (PCCC) Governing Body (ad hoc) Health and Safety Group Joint Chair Staff Partnership Forum Data Protection Steering Group	Member of Taunton & Somerset NHS Foundation Trust Godmother to member of governance team's daughter Trustee for Lyme Disease Action Charity Secondment one day a week to offer strategic oversight/direction for DPT IG team whilst they recruit a DPO	Partner on secondment to CCG Business Intelligence Team	22/08/2017	26/11/2020	Non-Financial, Financial and Personal Interests	Indirect/Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Dowell	John	Director of Finance	Governing Body Finance and Performance Committee CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Commissioning Committee (CC DOI) Primary Care Commissioning Committee (PCCC)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	20/10/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
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 Member of Strategic Commissioning Partnership Meeting	Director of Public Health for Local Authority		26/10/2016	18/08/2020	General	Direct		Plymouth City Council

	Harris	Penny	Director - In Hospital Commissioning	Attendee of Governing Body CCG Execs and Clinical Chairs Senior Leadership Team (SLT) Strategic Commissioning Partnership Meeting CCG Executive Team Meeting Finance and 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) Eastern Locality Delivery Group	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Manton	Sonja	Executive Director SRO for Integrated Care Partnership (Western Devon)	Member of Governing Body CCG Executive Team Meeting Joint Staff Partnership Forum Senior Leadership Team (SLT) Attendee Audit Committee Chair of Integrated Care Partnership Executive Group	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit	03/04/2017	25/09/2020	Professional & personal	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Lead Clinical Representative (Western) – CCG Governing Body Strategic Clinical lead - Maternity Clinical Lead - Western Locality Clinical lead - Mental Health	Member of Governing Body Member of Quality Assurance Committee Member of QEIA Panel Member of Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) Member of Individual Packages of Care Panel (IPOC) Member of Local Maternity System (LMS) Board and Operational Committee	Elected member (and Deputy Chair from September 2019), South West Regional Council of BMA GP Appraiser (NHS England) Shareholder GlaxoSmithKline Working at Church View Surgery as self-employed sessional GP Elected to the Medical managers Committee of the BMA from September 2019	Partner is: Medical Secretary and Board member of Devon LMC GP Partner, Church View Surgery, Plymstock Clinical Director of Mewstone Primary Care Network(PCN)	26/09/2017	20/10/2020	Financial, Professional & Personal Interests	Direct & Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Chief Communications, IT and People Officer, NHS Devon CCG	Member of Governing Body CCG Executive Team Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	04/03/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Pearson	Virginia	Chief Officer for Communities, Public Health, Environment and Prosperity/Director of Public Health, Devon County Council System Director of Population Health and Wellbeing, Devon STP	Co-opted Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Strategic Commissioning Programme Board	Member, STP Directors Group Member, STP Programme Delivery Executive Group Member, Devon Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Association of Directors of Public Health Member, British Medical Association Honorary Clinical Professor, University of Exeter College of Medicine and Health		02/02/2017	22/04/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Devon County Council

	Quartermaine	Jade	Senior Administrator	Administrative support to: CCG Senior Leadership Team (SLT) Exec Team Meeting Governing Body	No interests declared		01/08/2016	20/08/2020				NHS Devon CCG
	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee of Quality Assurance Committee Attendee of Finance and Performance Committee Attendee of Audit Committee Attendee of Remuneration and Workforce Committee Attendee of Commissioning Committee (CC DOI) Attendee of Primary Care Commissioning Commitee (PCCC) CCG Executive Team Meeting Senior Leadership Team (SLT) Working with Industry and Sponsorship Group System Restoration and Transformation Group Member of Strategic Commissioning Partnership Meeting	No interests declared		22/03/2019	10/08/2020				NHS Devon CCG
	Tapley	Simon	Interim Accountable Officer for NHS Devon CCG. Director of Commissioning for NHS Devon CCG Joint Adult Social Care Lead (South Devon), Devon County Council	Member of Governing Body Strategic Commissioning Partnership CCG Executive Team Senior Leadership Team (SLT) Attendee Audit and Assurance Committee (Audit Committee) Finance and Performance Committee Commissioning Committee (CC DOI)	Secondment agreement with Torbay Council (1 July 2017 for six months) Joint role with DCC as Adult Social care lead (south Devon)	Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	21/10/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	Associate Director of HR and OD	Attendee of Remuneration and Workforce Committee Joint Staff Partnership Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel CCG R&T Project Team meeting	No interests declared		16/10/2018	19/10/2020				NHS Devon CCG
	Turl	Jo	Executive Director of Commissioning - Out-Of-Hospital	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Strategic Commissioning Partnership Meeting Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Quality Assurance Committee	No interests declared		13/08/2015	19/10/2020	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee (Chair)	Co-opted Councillor on Budleigh Salterton Town Council (Independent Member – non-political)	Son employed by Care Quality Commission as an Information Analyst	16/10/2019	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
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (Non exec rem) Northern Integrated Delivery Group	Member of One Ilfracombe Board Chair of One Northern Devon Partnership Board		14/02/2017	28/09/2020	Personal	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

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

NHS
Devon
Clinical Commissioning Group

NHS Devon Governing Body Meeting
DRAFT minutes held in PUBLIC

Date: 17 December 2020 Time: 14:30 – 17:12pm Location: Via Microsoft Teams

Item	Discussion	*Action*
1	**Welcome and Apologies** The chair welcomed everyone to this meeting held in public for December. PJ noted that the technology being used would be as user friendly as possible, and presentation slides and films that would be shown during the meeting would be displayed on screen. PJ drew attention to additional information that Devon CCG had received from Devon County Council (DCC) Overview and Scrutiny relating to Modernising Health and Care Services in the Teignmouth and Dawlish Area and this information would be made available on our website as an addendum to the papers for this meeting. PJ noted that there would be many comments and questions raised in relation to agenda item 7.1 and he explained the process for members of the public to follow when asking a question. Apologies were recorded for: Dr Caroline Dimond Dr Ruth Harrell Penny Harris It was noted there was no written questions submitted by members of the public in advance of this meeting. The chair explained that a short video would be played, featuring local health and care staff which would explain how the current model of care works and how a health and wellbeing centre in Teignmouth would further support it.	
2	**Register of Interest (ROI)** PJ referred to the ROI included in the pack and no amendments or new declarations were made. There were no conflicts of interests declared pertaining to the agenda items scheduled for this meeting. **The Governing Body received and noted the ROI**	
3	**Minutes of the last meeting** PJ led a page by page review of the minutes of the last meeting held on 26 November 2020. These were approved as a true and accurate record of the meeting.	

	Action Log 1. This action had been taken forward and Devon CCG are waiting for a response from Picker, who carry out research. The outcome of the response would be reported back to the members and it was agreed to formally close this action.	
4	**Chairs Report** PJ acknowledged this was the last Governing Body meeting of the year and was aware the key issue for this meeting was around modernising health and care services in Teignmouth and Dawlish. He wanted to use this verbal report as an opportunity to reflect, give thanks and to look forward. PJ referred to a recent Panorama programme which brought back memories and different phases of the pandemic and mentioned the 23 March when the country was placed into lock down. He touched on a shift to virtual working for primary care, emptied wards to be prepared and the greatest challenge early on was personal protective equipment (PPE). Care homes were an area of concern and the CCG became involved and supported local authorities and delivered primary care webinars. PJ thanked the Governing Body members who did not stop caring, supporting and working hard. This was massively helpful for all the staff in the CCG including the executive directors and the staff awards demonstrated what people are capable of. PJ also gave thanks to staff for adapting to new ways of working and health and care staff beyond the CCG and risks they had taken for patients who have worked above and beyond in keeping the public and community safe. PJ felt that in many ways the past year is one that we may choose to forget but one to remember to build and learn from. In looking forward to the start of a new year as one ends with the coronavirus still present and the vaccine there was hope we would return to normality. It was recognised this would be challenging to rebuild and restore services and to catch up. **The Governing Body received and noted the verbal Chair's report.**	
5	**Accountable Officer's Report** ST referred to when he was informed of the outbreak of the pandemic initially in Torbay and how the CCG immediately responded and has continued to respond throughout the process including our provider colleagues. He acknowledged this has been difficult but has brought the best out from health and public services. ST drew attention to section 6 and was proud that the CCG had retained its green star rating for engagement which was pertinent given the main emphasis of this meeting. The CCG has retained the ability to engage with the public in innovative settings using digital platforms and virtual voices. We have built upon reaching people to take views good and bad which feeds into our decision making, we have continued to do this through this difficult year. It was wondered whether the Governing Body would have a chance to review the Integrated Care System (ICS) national engagement process and ST confirmed there would be an opportunity for members and individuals to comment and contribute and this would be further discussed post submission at the Governing Body in February.	

	ACTION 1 **NC to add ICS national engagement process submission to the Governing Body forward planner for 25 February 2021. Post meeting update: This action has been completed and recommended for closure.** JWo passed on his congratulations to the engagement team for the recent green star rating and wondered if there were any plans for digital access to engagement to be available for localities similar to the Sustainability Transformation Programme (STP) and the CCG so they can engage effectively with local people. ST responded and confirmed that a request for this had already come through. SK formally thanked the primary care team for their help in making the transformation changes during our response to the pandemic. He drew attention to section 8 European Exit (EU) Transition and measures for mitigation regarding potential issues that might arise. SM explained the planning assumption process and stressed the importance of the preparations that had been put in place earlier in the year, which remain in place and still applied. CB welcomed the update in the AOs report on domestic violence and the appointment of the CCGs first domestic abuse and sexual violence lead. **The Governing Body received and noted the contents of the AOs Report.**	
6	**Modernising Health and Care Services in the Teignmouth and Dawlish Area** PJ thanked the members of the public for joining the meeting for this item. He acknowledged the comments and questions that have been raised throughout the consultation and that the consultation won't be revisited but welcomed questions and clarification around the process at this meeting and this would be done through the chat bar of Microsoft Teams and would cover as many questions as possible. PJ reminded the Governing Body that they would be asked to decide on the recommendations and asked the members to fulfill the following requirements before any decision making: • Assure themselves the case for change had been presented in a robust way • Assure themselves the consultation process happened sufficiently • Assured themselves that the output of the consultation had been properly assessed and considered the final proposals presented PJ handed over to JT who described her role in leading this programme of work. She acknowledged the team effort and personally thanked Healthwatch for undertaking the consultation and producing the report, the public and extended her thanks to the wider team for their input. JT clarified the areas that the CCG were consulting on and the CCG's duty and responsibility for quality of services and changes to where and how they are delivered. She noted that the CCG would not be consulting on the health and wellbeing centre or the movement of the general practice in Teignmouth into the health and wellbeing centre. JT explained who would be supporting the delivery of the power point presentation and that there would be an opportunity for members of the public to comment. JT gave a potted history of the background and journey to date and handed over to DG.	

DG talked through the reasons for change and drew attention to the new model of care to look after people more effectively and how the new service will support people to have more control over their own health. He referred to the collection and robust analysis of data gathered regarding the rehabilitation beds and that we can look after more people with new model and safeguard the future of GP practices.

He moved through in detail the four proposals taken to the consultation and handed over to Alex Cameron (AC) who talked through the elements of the consultation which included how long this ran for, how we reached people which included a mixed approach using remote technology and traditional methods to reach all demographics.

AC referred to the delivery of documentation to local households, social media campaigns including facebook, advertising in newspapers and a prominent homepage on the CCG's website for the digital audience. Press releases were used during the consultation campaign and was reported locally through the news and radio.

The digital approach and on-line public meetings were hosted by Healthwatch to ensure impartiality and independence and offered the opportunity for questions and answers for people watching. There was also an offer to attend local groups for more direct engagement through smaller meetings. He was pleased to report that response levels to consultation was good and all activity was recorded.

JT confirmed the pre- consultation business case was approved by NHS E and the Governing Body in February. This resulted in asking the public's view and to seek alternative options. The return rate was good, and most respondents were from the Teignmouth and Dawlish area over the age of 55. JT talked through the proposal slide in detail including the model of care and overall support. She reported that feedback from the survey showed a support for integration of services however it was noted the concerns around the lack of parking, transport and the loss of a community asset and local services.

JT mentioned that in November during the consultation period a petition was received by Health and Adult Care Scrutiny Committee which included 467 signatures emphasising the value of the community asset and letters had also been sent to Anne-Marie Morris MP.

JT explained the role of Healthwatch and the evaluation of the proposal and to identify if there were any other options the CCG may not have thought of. The quality, equality and impact assessment (QEIA) options were updated in January and further refreshed in December 2020 and full details were available in the board pack including the benefits of a more modern facility that would conform with safety standards to improve patient experience.

JT referred to the 5 tests of strong public engagement, consistency of patient choice, clear clinical evidence and patient care test and further talked through the gunning principles.

JT attended a Health and Adult Care Scrutiny Committee in September 2020 to provide and update on the process and methodology used. At that meeting it was minuted that the quality and clarity of the material provided and distributed during the consultation was commended by the scrutiny committee who gave confidence and assurance.

JT drew attention to a late paper received from scrutiny following a spotlight review on 14 December on the consultation and the CCG's proposal and wanted the members to be made aware of their concerns and she talked through them in detail.

PJ offered for any points of clarification or questions from the Governing Body members:

- How were the evaluation stakeholder group members made up?
    - Members included coastal engagement group and voluntary sector representatives.
- How much data modelling has been undertaken to ensure there is community and social care capacity to maintain a sustainable model of care?
    - Every effort has been taken as possible to get GPs into the right buildings and integrate services in primary care as the next step towards sustainability. More services in the community does make it a more attractive place to work and add to workforce retention.
- Recognition that there was an expansion on the range of demographics who have contributed to the consultation compared to past experience, and that it was important to get wider views from members of public regarding healthcare provision

JT introduced Liz Davenport Chief Executive Officer, Torbay and South Devon Foundation Trust (TSDFT) and she described the work that will be developed to support sustainability for the future including caring for people at home, workforce modelling, therapy models and capacity planning. She further added that TSDFT is forward thinking and working with their partners around education, recruitment and retention.

PJ referred to a question submitted by a member of the public enquiring about:

- care at home
- emergency admissions over 70
- emergency readmissions after discharge and delayed transfers of care.

LD responded and described the current position around delayed transfers of care and acknowledged the challenges. She noted TSDFT is working closely with partners to address the issues which has led to a significant improvement around the coordination of care discharge.

JH referred to the scrutiny report and asked if the CCG was surprised to receive these comments. JT noted the CCG had been working closely with the scrutiny committee over the past 6 months who had been supportive of the process so far but hoped that the Governing Body were reassured at this meeting of the process that had been undertaken.

PJ drew attention to a question received from Cllr Sylvia Russell who asked if the Governing Body had considered alternative options to deliver options at an enhanced campus. JTur confirmed that this option has been evaluated twice and consideration was given to do a new build or refurbishment. This was discounted as it didn't add integration of primary care and the building was not sustainable, fit for purpose or adequate access and the decision was made to not to take this proposal forward to the Governing Body.

PJ gave the Governing Body the opportunity to raise any concerns regarding this alternative option and no concerns were raised.

GT thanked the presenters for delivering a thorough presentation and report and gave congratulations on the consultation exercise which was exemplary and that this should be used as best practice for others to follow.

GT drew attention to the parking and transport issues and acknowledged that transport was not a health service or social care responsibility. He wondered if we could facilitate initiatives with regards to transport and proposed adding an additional recommendation into the proposal. To support, enhance and develop the implementation of this we could work with the TSDFT, Local Authority and voluntary sector to see if we can make things easier for the vulnerable to get access to excellent services.

JT responded and agreed that this was a good suggestion and gave assurance to the Governing Body that access to transport would have affected some of the negative responses and positively supported this recommendation.

NK asked if the CCG had investigated whether public transport providers would possibly consider increasing services and is there more we can do. JT confirmed that the CCG and TSDFT would take this suggestion forward and will work with the district council to further explore transport options including cycle routes to help resolve this issue.

GAth asked whether it had been considered following the pandemic for the future there would be a move to more digital appointments. JT stated that prior to the launch of the consultation the CCG had started to work with providers to understand where positive changes could be made regarding digital consultations. LD added that following our response to the pandemic we are seizing the opportunity to continue to build on our strong intentions to progress the digital strategy for our communities

JWo commended the Healthwatch report and understood that social challenges need to be addressed but clinical model remains the priority.

JT thanked Sarah Bickley and Kevin Dixon for their support during the consultation process.

PJ noted that it was helpful to hear from LD who reiterated the commitment from TSDFT and the delivery of services albeit from a new site and also the commitment in continuing to build out of hospital home based services to enhance quality and expand the community facing offer into the future.

The members were assured that beyond this consultation process the CCG is committed to engagement with the voluntary sector and community providers to build on the success of previous engagement. JT noted the importance of engaging with all groups and carers to ensure the CCG has close link in making sure that voices are being heard consistently especially when developing services.

SMc asked whether the assessment and impact around parking difficulties and staff impact had been considered. LD confirmed that staff had been engaged and that work continues with the council around optimum parking and all options are being explored to make a difference how staff work and the reduction in travel.

JT directed the Governing Body to the slide deck and asked the members the following questions:

1. Was the Governing Body assured that the evidence and rationale is clear for the location of the high-use community clinics in the Health and Wellbeing Centre?

2. Was the Governing Body assured that the evidence and rationale is clear for the location of the specialist clinics (except ear, nose and throat and orthopaedics) in Dawlish Community Hospital?
3. Was the Governing Body assured that the evidence and rationale is clear for the location of the ear, nose and throat and orthopaedics specialist clinics in the Health and Wellbeing Centre?
4. Was the Governing Body assured that the evidence and rationale is clear for the location of the day case procedures in Dawlish Community Hospital?
5. Was the Governing Body assured that the case for continuing with community-based intermediate care and reversing the decision to have 12 rehabilitation beds at Teignmouth Community Hospital has been robustly made?
6. Was the Governing Body assured that all options were adequately reviewed and is in agreement with the decisions made by the Steering Group during the evaluation process?
7. Was the Governing Body assured that the feedback from the consultation (including the suggestions from the public) and the Quality and Equality Impact Assessments have been taken into account?
8. Was the Governing Body assured that the CCG has met the Gunning Principles for public consultation?
    - Public bodies need to have an open mind during a consultation and not have already made the decision
    - They must give enough reasons for proposals to permit 'intelligent consideration'. People involved in the consultation need to have enough information to make an intelligent choice and contribute to the consultation
    - There must be adequate time for consideration and response
    - The feedback and responses given at consultation must be conscientiously taken into account

There were no comments or questions raised with regards to each of the eight questions asked.

After a lengthy discussion and scrutiny of the case for change, public consultation Process, feedback and the evaluation process PJ directed the members of the Governing Body to the recommendations:

The members of the Governing Body approved the recommendations and the amendment to recommendation (h).

a) Approved the move of the most frequently used community clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre
b) Approved the move of specialist outpatient clinics, except ear nose and throat clinics and specialist orthopaedic clinics, from Teignmouth Community Hospital to Dawlish Community Hospital, four miles away
c) Approved the move of day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital
d) Continue with a model of community-based intermediate care, reversing the decision to establish 12 rehabilitation beds at Teignmouth Community Hospital
e) Approved the move of specialist ear, nose and throat clinics and specialist orthopaedic clinics to the Health and Wellbeing Centre
f) Request Torbay and South Devon NHS Foundation Trust consider in detail the suggestions put forward for additional services at the Health and Wellbeing Centre
g) Request Torbay and South Devon NHS Foundation Trust consider providing

	secondary office space at Dawlish Community Hospital for physiotherapists, occupational therapists and district nurses **h) Request Torbay and South Devon NHS Foundation Trust work with Teignbridge District Council to mitigate parking issues and with the voluntary sector and bus operators to further support and enhance the development of community transport to mitigate transport issues when accessing services at Dawlish Community Hospital for staff and patients as far as possible.** SMC asked about the x-ray facilities available at Dawlish and the impact on the Health and Wellbeing Centre. This had been discussed and LD confirmed that the details around efficient pathways for x-ray facilities were being worked through. On behalf of the Governing Body the chair thanked JT, JTur, AC, the wider team and the public and their contribution in the engagement and consultation process. He also thanked the Governing Body for their decision in benefitting the South Devon area and looked forward to seeing the on-going development and co-location of home support for the coastal region.	
7	**NHS Devon CCG Engagement Highlights 2019/20** AM was pleased to report for the second year that the CCG on behalf of system has gained green star rating for engagement, labelled outstanding out of four categories. He highlighted some of the work we have been doing, such as the long term plan where we have engaged with members of public and patients about was important for Devon, and with NHS funding we have formed a virtual voices panel and used them actively during the first wave of the coronavirus to understand barriers which has helped our campaign in reassuring patients to come to hospital and continue with their appointments. We have sensitively worked with diverse groups and Dame Suzi Leather, Devon STP Independent Chair with regards to the ethical framework which has been put in place during our response to coronavirus which gave us a chance to ask local people views and this work is active and on-going. The CCG is keen to continue to involve local communities more such as Holsworthy and more engagement brings benefits to the health service and can help tailor services to meet people's needs. AM personally thanked Nellie Guttman, Jean Almond and Jon Sewell for their engagement work in designing different ways of engaging people to reach out to them using different technology and techniques. PJ further added and passed on his thanks to the communications and engagement team as this was a testament to AM's leadership and their skills. GAth congratulated AM on the green star award but asked what we are we doing about engaging with people without access to a digital platform AM acknowledged that this was challenging however we have started to work with local communities the voluntary sector, providers and local authorities to increase our engagement. AM also noted that training is being put in place with our commissioners with regards to the commissioning cycle and he has also spoken with Dame Suzi Leather how we design an engagement process for the 5 local care partnerships.	

	SMc referred to equalities and health inequalities and asked if we are doing enough communication with people with disabilities such as deafness and blindness. AM replied that we were not doing enough in that area and we need to do more to contact hard to reach groups and people with challenges and diverse communities. However, AM did assure the Governing Body there were pockets of good practice to build on for the year ahead. PJ was pleased to hear that there were plans to improve further from where we are, in effective communications. AM further added that the CCG does have ambitions and will bring plans back to a future Governing Body meeting. On reflective learning around engagement CB felt it was an important factor to learn how the commissioning cycle works to strengthen and be effective in going forward and she passed in her congratulations to the communications team. **The Governing Body received and noted the contents of the NHS Devon CCG Engagement Highlights 2019/20 Report.**	
9	**Assurance Committee(s) - items of escalation** The assurance committee Chair's reports were taken as read and there were no items of escalation to bring to the attention of the Governing Body. **The Governing Body noted and received the assurance committee Chair's reports**	
10	**Localities – items of escalation** There was nothing further to add to these reports and no items of escalation to bring to the attention of the Governing Body.	
11	**Any other business** There were no further business items raised for discussion. The Chair wished everyone a Merry Christmas and a more hopeful 2021.	
12	**The meeting closed at 17.12**	

Attendees (attended** / apologies [A])	
Name and initials	*Title and organisation*
Alison Davis (AD) **	Associate Non-Executive Director, Devon CCG
Andrew Millward (AM) **	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Caroline Dimond – Dr (CD) [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) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG

Graham Turner (GT) **		Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG
James Wooldridge (JW) **		Associate Non-Executive Director, Devon CCG
Jayne Carroll (JC)**		Chief Operating Officer, Devon CCG
John Dowell (JD) **		Chief Finance Officer, Devon CCG
John Womersley – Dr (JWo) **		Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **		Executive Director – Commissioning out of Hospital, Devon CCG
Judith Hargadon (JH) **		Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF) A (in absence of DG)		Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **		Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **		Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) **Chair** **		Clinical Chair, Devon CCG
Penny Harris – (PH) **		Executive Director, Commissioning out of Hospital, Devon CCG
Ruth Harrell - Dr (RH) A		Director of Public Health, Plymouth City Council
Simon Kerr – Dr (SK) **		Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc)**		Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST)**		Interim Accountable Officer, Devon CCG
Sonja Manton – Dr (SMa) **		Executive Director and SRO for Integrated Care Partnership (Western Devon), Devon CCG
Steve Brown (SB) **		Director of Public Health, Devon County Council
In Attendance		
Nikki Coombes (NC) ** **Minute Taker**		Executive Assistant, Devon CCG
Alex Cameron (AC) ** **item only**		Media and Publications Manager, Devon CCG
Jenny Turner (JTur) ** **item only**		Head of Integrated Care – South, Devon CCG
Liz Davenport (LD) ** **item only**		Chief Executive, Torbay and South Devon NHS Foundation Trust
Sarah Bickley (SB) **		Healthwatch Representative
Kevin Dixon (KD) **		Healthwatch Representative
Minutes approved	Date:	Signed by chair:

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**		**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential order	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action is very clear to the owner and the committee members	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions 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	17-Dec-20	NC to add ICS national engagement process submission to the Governing Body forward planner for 25 February 2021. Post meeting update: This action has been completed and recommended for closure.	28-Jan-20	Nikki Coombes	07.01.2020 Post meeting update: This action has been completed and recommended for closure.				**FOR CLOSURE**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Accountable officer report				
Date of committee: 28 January 2021 **Date report produced:** 19 January 2021				
Author (s) Name and Title: Simon Tapley, accountable officer Sam Cush, internal communications manager		**Supporting Executive:** **Name and Title:** Simon Tapley, accountable officer **Contact Details:** **Report Approved by:** **Name and Title:** Simon Tapley, accountable officer **Date:** 19 January 2021		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

1. System leadership arrangements
2. National lockdown
3. Responding to coronavirus
4. CCG priorities
5. Coronavirus vaccinations
6. EU exit

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

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

N/A

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

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

Reference to other documents or accompanying papers:

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

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

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

Accountable officer's report

1. System leadership arrangements

From Monday 18 January, I took on the role of executive lead for Devon's system on an interim basis, following the departure of Philippa Slinger.

I'd like to thank Philippa for her fantastic leadership over the past couple of years, including overseeing the development of the NHS Nightingale Hospital Exeter, and wish her all the best in her new role in the east of England.

I will undertake the system role alongside my CCG accountable officer one until Jane Milligan joins us in spring.

2. National lockdown

England entered a new national lockdown until mid-February at the earliest, the Prime Minister announced in early January.

The measures are in response to rising coronavirus cases and a new more infectious variant.

The UK has also moved to threat level 5, the highest level, which means there is a danger of the NHS being overwhelmed.

The Prime Minister has asked everyone to stay at home, except for specific reasons, including essential shopping, to work, if they cannot work from home, to exercise, to seek medical help, and to escape domestic abuse.

The government has published full guidance on what people are permitted to do during lockdown in England.

Although the numbers of those infected are relatively low here in Devon compared to many other areas, the situation remains as serious as ever.

We are working with our partners across the county and beyond to keep people safe, care for them when they are unwell and provide the latest information.

We're also continuing to support our staff to stay well with every individual being invited to one-to-one wellbeing conversations with our wellbeing champions and HR team over the coming weeks.

Our staff webinars and newsletters also feature a range of resources and staff stories to support people to stay well.

3. Responding to coronavirus

The NHS in Devon has been under immense pressure to maintain services, treat COVID-19 patients and roll out the biggest vaccination programme in its history.

Our staff are working tirelessly to support local people and the system, and I'd like to thank them again for all they have done - and continue to do.

There is no doubt that vaccination is the single most important thing we can do to beat COVID-19 and help our hospitals over the coming weeks.

Nationally, those who have been vaccinated have not needed hospitalisation.

Despite our efforts to keep COVID-19 cases low in Devon, they are now at the highest level we have seen since the start of the pandemic, and they continue to rise.

The new virus strain is spreading more easily, and this is placing additional pressures on our health and social care system.

To ensure our services are in the best possible position to meet this increase in demand, we are taking a number of actions:

1. **Working with our regional partners**

We will work more closely with our neighbours across the south west. This may involve mutual support and sharing services where capacity is available.

We have already seen small numbers of patients transferred into our local system from areas who have capacity issues.

One of the greatest strengths of having a *national* health service is that we have tried and tested plans for managing significant pressures and this has always included hospitals working together to provide the best care for patients.

2. **Increasing the use of the Nightingale Hospital**

We are fortunate to have a Nightingale Hospital in Exeter, and much work has been undertaken to make sure it's ready to deal with an increase in cases.

It is a regional resource and, as such, we may see patients from other areas being treated there.

3. **Increasing capacity to treat COVID-19 patients**

To free up resources and capacity in our hospitals, we will temporarily stand down any surgery that is not urgent or life-threatening.

Essential services, such as emergency care and cancer, will continue where it is safe to do so.

We will continue to work closely with the independent sector and increase the use of the sector to support us.

4. Coronavirus vaccinations

Thanks to the outstanding support of CCG staff and colleagues across Devon, we are making significant progress with vaccinating local people:

1. In line with the rest of the country, Devon continues to deliver **vaccinations** to priority groups. This is testimony to the huge effort across our system from GPs, nurses and other staff – and also, of course, volunteers.
2. All four of our **main hospitals** – in Plymouth, Exeter, Torquay and Barnstaple – are administering the vaccination to priority groups.
3. All our 123 **GP practices** via primary care networks are now offering the vaccination to eligible patients at 20 sites.
4. We're making good progress in vaccinating staff and residents in **care homes** across the county.

Large-scale vaccination centres serving wide areas are also planned nationwide and more details will follow on arrangements in Devon when they are confirmed.

NHS England also announced that the first six community **pharmacy** sites for vaccination go live nationwide this week to test the model before further rollout.

Nationally, 200 community pharmacies are due to come online over the coming weeks as more vaccine supplies become available.

Along with our partners, we are looking at a range of measures, including additional **mobile teams**, to bring vaccination facilities closer to people in more rural parts of the county.

All the above paints the picture of a health and care system that is working incredibly hard to support local people.

The CCG is playing no small part in this, and I'd like to thank our staff for everything they are doing to support the coronavirus programme and our other priorities.

5. CCG priorities

To support the local coronavirus effort, we have set out our CCG priorities over the coming weeks.

We may ask staff who are not currently working in these areas to support them.

Our staff have been nothing short of incredible throughout the pandemic and continue to go above and beyond to ensure we are in the best possible position.

Priority 1	Priority 2	Priority 3
1. Vaccinations 2. Coronavirus response	1. Think 111 First 2. Long COVID and oximetry at home 3. Keeping essential services running (e.g. cancer and emergency services)	1. Annual accounts 2. Strategic commissioning framework 3. Hospital Improvement Programme (HIP2) 4. Operational planning 5. Community mental health framework

6. EU exit

The UK formally left the EU on 31 January 2020 and, following an eleven-month period of transition, left the EU single market and customs union on 31 December 2020.

Over the previous two years, a significant amount of preparatory work has been undertaken, locally and nationally, to mitigate any risks arising from leaving the EU, whether or not a trade deal was signed. The trade deal that was signed has reduced the risk of disruption to the delivery of healthcare.

The CCG has a senior responsible officer with executive authority to lead our response through any supply chain disruption related to the end of the EU Exit transition period.

Until further guidance is received from NHS England and Improvement, the CCG and our providers will maintain the current level of preparedness. Suffice to say, we are not aware that the EU exit transition period has adversely affected the delivery of healthcare to our population.

NHS
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GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: 28th January 2021

Dates of Committees covered in this report: 13th January 202a

(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

- Committee Effectiveness Oversight – The audit committee approved the implementation of the Committee Effectiveness process, approved checklists for committees and approved the annual timetable for self-assessments.

- Corporate risk 38 - Lack of clarity and visibility regarding STP and its governance. The Audit Committee agreed that the risk now has a clearer description however requested a further review of mitigating the control gaps.

- 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. Eight new risks have been added to the corporate risk register and there has been an introduction of the Covid wave 2 risk register. The Covid risk register is being used in a much more proactive way, alternative weekly reviews by execs and Covid huddle.

- Draft Board Assurance Framework (BAF)– The audit committee were asked to note the current position of the draft BAF. The audit committee identified the need to construct mid-level objectives in order to be able to map the exec identified risks to the objectives.

- Policy Status Report - The Committee was requested to note this annual report for information and assurance regarding the status of the organisational policies for NHS Devon CCG.

- Annual Accounts Timetable – The committee noted the timetable.

- Internal Audit Update Report – The internal audit service provides a service in accordance with the requirements set out in the mandatory Public Sector Internal Audit Standards, comprising the Definition of Internal Auditing, the Code of Ethics and the International Standards for the Professional Practice of Internal Auditing. The Audit Committee received an Internal Audit Update Report which summarises the work of ASW Assurance since the previous Audit Committee meeting in November 2020. Head of Internal Audit Opinion is on track to be delivered. The audit committee decided that the Continuing Healthcare recommendations were to be extended until the end of July.

- 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 as at 31 December 2020 were reviewed at this meeting and is available as appendix to this report.
- Draft Board Assurance Framework was reviewed at this meeting and is available as an appendix to this report.
- Post meeting note: An amended BAF in addition to the BAF discussed at Audit Committee is available as an appendix to this report.

Committee Decisions

The Audit Committee

- Noted Lack of clarity and visibility regarding STP and its governance update to risk
- Approved Committee Effectiveness Oversight
- Noted Risk Report
- Noted the Draft Board Assurance Framework
- Noted the Policy Status Report
- Noted to Annual Account Timetable
- Noted the Internal Audit Update Report – **decision made that all Continuing Healthcare audit recommendations be extended until the end of July given the current Covid pandemic**
- Noted the External Audit progress report
- Noted the Counter Fraud Progress Report

Items of concern to be escalated to the Governing Body

- N/A

Recommendations for Governing Body

- Approval of the Board Assurance Framework with mid-level objectives.

Recommendations for other Committees

- N/A

Terms of Reference or other committee effectiveness issues

- N/A

Management of Conflict of interests:

Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided

and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.

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

NHS
Devon
Clinical Commissioning Group

AUDIT COMMITTEE

Report title: Risk Report				
Date of committee: 05 January 2021 **Date report produced: 31 December 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 31 December 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.

In the reporting period eight new risks (133, 134, 135, 136, 137, 138, 139 and 140) have been added to the corporate risk register reporting to the Quality Assurance Committee, Commissioning Committee and Finance and Performance Committee. These risks are summarised in section 2.2 of this report and will be operationally managed to seek assurance that mitigating actions and controls are in place.

Following the approval of corporate objectives for the period December 2020 to March 2022 a revised board assurance framework (Appendix 3) has been produced and is currently being populated by the Executives. The template is attached for the committee's information and will be reported at each Audit Committee going forward for review and provide assurance that these risks are being actively managed.

A risk register (Appendix 4) to record all risks identified from the Corporate Risk Register (CRR) and Team Risk Registers (TRR) which relate to COVID, in addition to new risks related to winter pressures, EU Exit (D20) and system pressures. The Executive leads have been asked to review and provide updates and comments to the Risk and Governance Manager to ensure that the COVID risk register meets requirements for this current wave of the pandemic. The COVID risk register will be reviewed fortnightly by the Executive team and the COVID Huddle.

section	Item	Appendix
Section 2	Corporate Risk Register	Appendix 1 Audit Committee Risk Report Appendix 2 Corporate Risk Register - Significant Risks
	Board Assurance Framework	Appendix 3 Draft Board Assurance Framework 2020 – 2022
	COVID Wave 2 Risk Register	Appendix 4 COVID Risk Register Wave 2 v2

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. Note the addition of risks: 133, 134, 135, 136, 137, 138, 139 and 140 to the corporate risk register
4. Note the introduction of a COVID wave 2 risk register

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
Assurance Framework

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

05 January 2021

1. Introduction

1.1 This paper provides the Audit Committee with relevant assurances regarding the risk process that is embedded within the CCG through the risk management framework policy. The data for this report was accessed on 31 December 2020.

2 Corporate Risk Register

2.1 At the time of writing the report there are 35 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 There are seven risks on the Corporate Risk Register reporting to the Audit Committee, (appendix 1).

In the reporting period eight new risks (133, 134, 135, 136, 137, 138, 139 and 140) have been added to the corporate risk register reporting to the Quality Assurance Committee, Commissioning Committee and Finance and Performance Committee. These risks are summarised below and will be operationally managed to seek assurance that mitigating actions and controls are in place.

Risk Number	Risk Description	Executive Lead	Committee	Risk Score
133	There is a risk that decisions to make changes to services commissioned by the CCG through providers are done so without full cognoscente, clinical oversight and agreement whilst responding to the COVID 19 outbreak and management of capacity and resource. The impact: a) decisions made in isolation may impact on other services or capacity in system b) inequitable access for patients to services (Previously Covid risk 07)	Darryn Allcorn	Quality Assurance Committee	10 L = 2 I = 5

134	There is a risk that Children and Family Health Devon do not recover the current position of increased waiting times and deteriorating RTT positions for CAMHS; Occupational Therapy; Speech and Language; Autism Assessment services. The impact of this is that children experience delay in accessing assessment, support and services for their physical, mental and communication development needs which may experience poorer quality and outcomes. CFHD are not yet achieving contracted service standards and NHS Devon cannot be confident that they will deliver the service improvements and transformation as set out in the contract agreed with NHS Devon CCG. There continues to be a lack of operational clarity in terms of service management and different service offer between Devon and Torbay, increasing wait times, regular queries and comments from families and schools, together with concerns regarding leadership and workforce capacity within the services that indicate CFHD are not yet achieving contracted service standards. The issues have been further intensified by the pause in a number of services as a result of COVID 19 and services are not currently being provided at the standard expected with increased wait times and reduced access to services	Jo Turl	Commissioning Committee	15 L = 5 I = 3
135	There is a risk that some aspects of our core business of continuing healthcare will be exposed to additional risk as a result of the changes to the emergency framework period guidance and associated financial framework, particularly with the reset in relation to CHC assessments. a) There is a reputational risk that the CCG may be challenged through the undertaking of virtual assessments and the view that patients, their representatives and advocates may not see this process as robust enough to make a recommendation on levels of need; b) There is a risk that we are unable to take the same assurance with regard to the clinical safety and quality of care being provided to eligible individuals in the absence of face to face assessments; c) There is a financial risk associated with the increasing backlog of CHC assessments, and the cessation of emergency funding for new and enhanced CHC packages of care. The financial risk of approx. £3m is captured for 2020-21 and is managed as part of the CCGs overall financial risk assessment and delivery; These risks are to be recorded on the Corporate Risk Register and monitored and managed through the CCG's risk management processes. The current backlog has to be reduced by 31st March 2021 and therefore steps to mitigate the risks as a result.	Darryn Allcorn	Quality Assurance Committee	16 L = 4 I = 4

136	There is a risk that care home placements and care at home could become compromised, due to Covid outbreak risks, lack of Personal Protective Equipment (PPE), staffing and pathway issues. The impact is that patients will be unable to be discharged from hospital in a timely manner to create acute capacity for new admissions. The safety & quality of an individual's care could be at risk due to inadequate packages of care, staff capacity, equipment and training. (Previously Covid risk 09)	Darryn Allcorn	Quality Assurance Committee	16 L = 4 I = 4
137	There is a risk that the impact of implementation of National Guidance during COVID- 19 may lead to patients who require planned care, including diagnostics, being delayed, deferred or choosing to self-defer, resulting in harm; both safety and experience could be affected. Note: This impact could be further exacerbated if changes in predictions of disease prevalence for the SW Peninsula result in a period of deferment in excess of that recommended by the national guidance. The impact to the CCG is commissioning impacted services that may result in: a) escalation requiring emergency admission and / or treatment for patients. b) early death, harm, including reduction of treatment options and poor experience for patients. c) reputational damage as a result of longer waiting times for patients across the County. (Previously Covid risk 29)	Darryn Allcorn	Quality Assurance Committee	20 L = 4 I = 5
138	There is a risk that NHSE/I and NHS Devon CCG will be unable to deliver the mass COVID-19 vaccination programme. NHSE/I and CCGs are responsible for the planning and resources of a phased programme of vaccination. The programme may be affected by several factors, including: • The recruitment programme not being as effective and the impact on BAU for health and social care • PPE requirements for healthcare workers delivering the vaccination clinics will be high, increasing the risk of a PPE shortage • Location, choice of venues and accessibility • Wastage of vaccine due to limitations in timeliness of distribution and safe storage • Impact should the uptake reduce for the second vaccine, following any side effects, increasing vulnerability both individual and system wide • Impact on the booking system should there be technical failure of IT systems • Likelihood of additional costs associated with delivering the vaccinations in different ways and to additional cohorts, resulting in cost pressures for the CCG if the dedicated funding support runs out • Potential legal challenge under the Equality Act if equal access to the vaccination programme is not provided • Reputational impact due to potential harm or perception that the CCG is impacted by patient outcomes, as one of the lead organisations responsible for delivery of this vaccination programme The impact of this is if NHSE/I and the CCG fail to deliver a phased programme of vaccination addressing delivery via vaccine hubs, primary care and any large scale vaccination sites it could result in a reduced safe and effective vaccine, adequate vaccinator capacity, cold chain management and public safety issues.	Darryn Allcorn	Quality Assurance Committee	9 L = 3 I = 3

139	There is a risk that there is insufficient capacity within the CCG infection control workforce to meet both the duties of the COVID-19 pandemic and those of normal Infection Prevention & Control (IPC) business. The impact of this is on: * Normal business; reduced focus on prevention & monitoring functions, including rates of notifiable hospital-acquired infections, reduced ability to attend and gain assurance from provider infection control meetings, change in focus of IPC sub teams due to COVID-19 support and reduction in capacity to monitor and support the Devon flu vaccination programme * COVID-19 business; potential to fail to gain assurance on COVID-19 outbreaks, programmes of work and overall status within the Devon footprint and potential to not provide operational advice in a timely fashion when requested	Darryn Allcorn	Quality Assurance Committee	12 L = 4 I = 3
140	There is a risk to the CCG delivering a financially balanced plan which achieves breakeven within the resources allocated for 2021-22. The high-level view submitted to NHS England as part of the Operational Plan process in response to the long-term plan highlighted that the CCG position would improve with a return to financial balance in 2022-23 and delivery of a small surplus in 2023-24. With the operational planning process suspended for 2020-21 and the emergency financial framework in place it is unclear at present whether any worsening in underlying position will, as a result of the current climate, be mitigated in part or in full with a revised settlement for the CCG and system for 2021-22. The potential impact of this is that the plan would be unsupported by NHS England for the CCG and in the context of the wider system financial plan and that it either pushes the CCG to deliver an improvement plan through escalation or issues further direction and/or intervention as a result.	John Dowell	Finance and Performance Committee	9 L = 3 I = 3

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

2.4 The following three risks have an increased risk score

Risk 108 - Sustainability of General Practice, has seen an increase in risk score from 12 to 16 this is due to demand on GPs has increased significantly and this is reflected in the number of GP practice alerts and requests for pastoral and resilience support services.

Risk 117 - COVID-19 General Practice has been increased from 12 to 16 as practices are now having to manage second wave whilst reinstating services and mobilising for mass vaccinations.

Risk 118 - COVID- 19 - Primary Care Team The risk score has been increased from 9 to 12 as primary care team are now having to managing business as usual as well as Phase 3 recovery and supporting mobilisation of designated sites for mass vaccinations.

2.5 The following five risks have a reduced risk score

Risk 105 - Devon Doctors Call Stacking On review the risk score has been reduced from 16 to 12 as patients continue to have to wait for call backs but this is now mitigated with embedded comfort calling and lead clinician processes, which ensure appropriate triage and check for worsening symptoms..

Risk106 – Sustainability The risk score has been reduced from 12 to 9 as it was considered to high when discussed at Finance & Performance Committee. This was in relation to the current level of uncertainty with regard to allocation arrangements for future years, 'possible' was deemed more appropriate in the circumstances.

Risk 122 - Backlog of LeDer Reviews & System Workforce Capacity has been reviewed and the risk score reduced from 12 to 4. Trajectory backlog has now been cleared. New reviewers identified and trained. Processes in place with a weekly sign off panel. Local Area Contact has a dedicated increase in hours to support the programme. Datix now in place enabling detailed information. Nationally LeDeR programme reviewed to inform types of review being recommended. The risk will be present to the Quality Assurance Committee in January for closure.

Risk 123 - Fit testing – PPE/Covid Following review the risk has a reduced score from 16 to 12 at 10 December 2020 there will have been over 50 people trained to be fit testers in Devon & a further 16 to be fit tester trained later in December. At least 3 of the 16 will be Devon system fit testers and accepted job offers until the end of March 2021. New masks are in good supply

Risk 133 - Changes to services commissioned by the CCG. Following review, the risk has a reduced score from 15 to 10 as Commissioning Committee is now in place and has clinical membership and input from CNO and GP Clinical leads. Commissioning checklist required to be completed for all papers recommending commissioning decision with a robust QEIA process to support this decision.

2.6 At the time of writing this report the CCG has nine 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 register

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

Period of report - 22 October 2020 to 31 December 2020	
Total Risks on Corporate Risk Register	35
Low risks (scored 1-3)	0
Moderate/Medium risks (scored 4-6)	7
High risks (scored 8-12)	19
Significant/Very high risks (scored 15 to 25)	9
New Risks	8
Risk score reduced since last report	5
Risk score increased since last report	3
Total Risks Closed (detail is within the committee minutes of the following committees)	
Quality Committee	*2*
Primary Care Committee	*0*
Finance & Performance Committee	*0*
Audit	*1*
Commissioning Committee	*0*

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 and has been shared with al staff Risk Management Presentation

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

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

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

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. Note the addition of risks: 133, 134, 135, 136, 137, 138, 139 and 140
4. Note the introduction of a wave 2 risk register

NHS Devon Clinical Commissioning Group

NHS DEVON CCG
Risk Report (Audit)

Date produced: 31-12-2020 - 08:18

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	[05/11/2020] Reviewed by Executive Team 19 October 2020, [02/10/2020] 01/10/2020 Fortnightly NHSE/I elective care recovery meetings with system partners, consistent meeting to be established with providers under new Performance Team identity to assure against Phase 3 plan trajectories, [27/08/2019] System performance meeting monthly with providers,	Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. 13/01/2020 scrutiny at Dec SPG has provided assurance on these plans and elective board [Assurance Gaps] none identified	Executive Lead: Jayne Carroll Owner: John Finn

130	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)	12/11/2020 Risk reviewed no changes identified PC •Incident Management Team comprising of Incident Director, Incident Manager, admin support, Loggists and Cells to lead on specific workstreams, in place •Overview of the incident response maintained by Executive Team •Regular reviews of the Incident response structures and responsiveness are being undertaken •Regular co-ordination and update meetings scheduled, internally, across the system and with Region; these meetings are reviewed and the frequency adjusted to meet the needs of the response. Currently the System meetings are only held if an issue is identified. [Control Gaps] No Gaps Identified	12 [17/09/2020] 12 (L=3 x I=4)	Risk Opened: 17/09/2020 Reviewed: 17/11/2020	[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)	12/11/2020 Risk reviewed no changes identified PC •Business Impact Analysis undertaken at least annually •Business continuity risks reviewed by Directorates at least annually •Business continuity audit undertaken annually •NHSEI EPRR assurance, incorporating business continuity, undertaken annually and reported upon to GB •Trained Directorate BC Leads in place •EPRR Lead now in place with responsibility to maintain oversight [Control Gaps] •Primary Care Business Continuity Plan (BCP) in development, not yet reviewed by EPRR or signed off.	9 [17/09/2020] 9 (L=3 x I=3)	Risk Opened: 17/09/2020 Reviewed: 17/11/2020	[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
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)	12/11/2020 Risk reviewed no changes identified PC •EPRR Lead recruited to lead on preparedness workstream; •An EPRR workplan in place to ensure that preparedness is maintained and that new requirements are implemented in a timeous manner; •Suite of business continuity plans and emergency plans in place •On-call system in place, supported by trained on-call staff, available to initiate a response 24/7; •Trained Directorate Business Continuity Leads in place to maintain their business continuity plans •Regular training is undertaken by On-call staff and BC Leads to maintain knowledge and skill sets •Regular exercising of business continuity plans and participation in the exercising of multi-agency emergency plans is undertaken to ensure skills are maintained, plans are tested and the CCG is integrated into the multi-agency response to emergencies; •EPRR Lead is engaged with NHS and multi-agency (LRF) EPRR planning to ensure the CCG is integrated into these plans. •EPRR Lead will fulfil the CCG responsibility of undertaking an annual assurance of Providers preparedness in line with the NHSEI EPRR Core Standards and annual assurance process, and reporting upon this to the AEO & GB. [Control Gaps] •The incident response to COVID has placed most other EPRR work on hold, meaning that wider preparedness activities are not currently being undertaken.	6 [17/09/2020] 6 (L=2 x I=3)	Risk Opened: 17/09/2020 Reviewed: 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] 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
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)	16/12/2020 Risk reviewed by Head of Governance, update to assurances added Arrangements for invoice processing under continuous review by budget holders IT undertake regular phishing and spam email checks – clear process for staff to alert IT to any concerns which is logged and reviewed through both the CCGs IT provider and the NHS spam alert system. Counter Fraud Specialist in place as part of contract with internal audit provider Circulation of information to relevant staff on specific issues via Counter Fraud Specialist and other experts within the CCG raising issues in relation to fraudulent behaviours through team meetings and staff communications. [Control Gaps] Directorate managers across the CCG to review internal standard operating procedures for their areas of responsibility with support from the Governance team as necessarily to ensure relevant procedures are in place to monitor for fraudulent activity and address these with the CCGs counter fraud specialist	6 [03/09/2020] 6 (L=2 x I=3)	Risk Opened: 09/09/2020 Reviewed: 17/12/2020	[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 16/12/2020 Head of Governance contacted Counter Fraud to enquire of any guidance / documentation to assist with discussions at directorate level to embeded good practice around vigilance of fraudulant activity. [Assurance Gaps] Directorate managers across the CCG to review internal standard operating procedures for their areas of responsibility with support from the Governance team as necessarily to ensure relevant procedures are in place to monitor for fraudulent activity and address these with the CCGs counter fraud specialist	Executive Lead: John Dowell Owner: Clare Doble

128	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)	16/12/2020 Risk Reviewed no changes identified MS 12/11/2020 Risk reviewed no changes identified MS 08/10/2020 'Homeworking' guidance created for all staff Screen lock (manual & timed) Clear desk Policy/Audit Secure lockers/cupboard Confidential waste bins/collections Secure printing via ID cards [Control Gaps] Lack of suitable private areas 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: 17/12/2020		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
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)	11/11/2020 Discussed at Audit Committee. the committee agreed the risk is still pertinent and requested a review of wording to better express the risk. 12/10/2020 Risk to be presented to Audit Committee for discussion and review November 2020 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: 23/12/2020	[05/11/2020] Reviewed by Executive Team 19 October 2020, [17/12/2019] Arrange workshop for system organisation Audit Chairs to review proposed system Risk Management arrangements GS,	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: 31-12-2020 - 08:20

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	[05/11/2020] Reviewed by Executive Team 19 October 2020, [02/10/2020] 01/10/2020 Fortnightly NHSE/I elective care recovery meetings with system partners, consistent meeting to be established with providers under new Performance Team identity to assure against Phase 3 plan trajectories, [27/08/2019] System performance meeting monthly with providers,	Monthly national reporting is reviewed at the appropriate locality or cancer system wide group. This then reports to the System Performance Group, reporting to PDEG. 13/01/2020 scrutiny at Dec SPG has provided assurance on these plans and elective board [Assurance Gaps] none identified	Executive Lead: Jayne Carroll Owner: John Finn

137	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that the impact of implementation of National Guidance during COVID- 19 may lead to patients who require planned care, including diagnostics, being delayed, deferred or choosing to self-defer, resulting in harm; both safety and experience could be affected. Note: This impact could be further exacerbated if changes in predictions of disease prevalence for the SW Peninsula result in a period of deferment in excess of that recommended by the national guidance. The impact to the CCG is commissioning impacted services that may result in: a) escalation requiring emergency admission and / or treatment for patients. b) early death, harm, including reduction of treatment options and poor experience for patients. c) reputational damage as a result of longer waiting times for patients across the County. (COVID risk 29) (HISTORIC ID: Na)	December 2020 - Robust process in place to risk assess, manage/balance risk, escalate and maximising potential mutual support when required (SW) Holding providers to account for following national guidance for management of planned and elective care referrals and treatments. For example: cancer patients during the coronavirus outbreak (publications approval reference: 001559), assurance was sought that each patient has been clinically reviewed based on their individual clinical risk factors. For some, postponement of treatment has been assessed as clinically the safest thing to do. The Restoration & Transformation Cell has oversight of all service changes that fall outside of national guidance; step down and up. The process includes providers having to complete a QEIA and is reviewed by both commissioning and quality senior leads. The CCG is also informed by and seeks assurance through: •Provider Governance Committees to monitor provider processes for measuring impact of implementing national guidance. (assurance) •Provider led Clinical Reference Groups. (assurance) •Service line restoration groups, facilitated by the CCG, informing the R&T Cell workstream. (information and assurance) •Reporting of the CCG commissioned Population Needs workstream (information). [Control Gaps] None identified	20 [29/10/2020] 20 (L=4 x I=5)	Risk Opened: 02/11/2020 Reviewed: 26/11/2020	[26/11/2020] CCG led processes: locality returns through to R&T cell, through to COOs and the DDMG and Gold,	December 2020 - Significant collaboration between CCG and providers across the system to ensure elective pathways remain where possible and patients are fully informed (SW) May 2020 - Head of Nursing & Quality embedded in restoration & transformation cell to support quality oversight & impact on all restoration work programmes (LW) [Assurance Gaps] Full impact is not yet known locally or nationally	Executive Lead: Darryn Allcorn Owner: Sara Wright
135	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that some aspects of our core business of continuing healthcare will be exposed to additional risk as a result of the changes to the emergency framework period guidance and associated financial framework, particularly with the reset in relation to CHC assessments. a)There is a reputational risk that the CCG may be challenged through the undertaking of virtual assessments and the view that patients, their representatives and advocates may not see this process as robust enough to make a recommendation on levels of need; b)There is a risk that we are unable to take the same assurance with regard to the clinical safety and quality of care being provided to eligible individuals in the absence of face to face assessments; c)There is a financial risk associated with the increasing backlog of CHC assessments, and the cessation of emergency funding for new and enhanced CHC packages of care. The financial risk of approx. £3m is captured for 2020-21 and is managed as part of the CCGs overall financial risk assessment and delivery; These risks are to be recorded on the Corporate Risk Register and monitored and managed through the CCG's risk management processes. The current backlog has to be reduced by 31st March 2021 and therefore steps to mitigate the risks as a result. (HISTORIC ID: Na)	December 2020 - Risk score to remain the same. Fortnightly returns to NHSE so far have assured currently we are on target to meet our trajectory for clearance of the backlog however we anticipated this progress will not be sustained due to the Christmas period, slow mobilisation plans within the Western Locality and now significant vacancies within the core CHC teams who operationally deliver the process. Recruitment is underway to mitigate these risks however new starters will require induction therefore trajectory may be off target until end of February. Mitigation will be to increase the contract value of cases with the external company undertaking assessments on our behalf. A financial incentive has also now been offered to the care homes to support the process in terms of information gathering and sharing. Some face to face visits are now happening which are identifying early where quality issues may be apparent, some resulting in onwards referrals to safeguarding. (JS) October 2020 - We will develop a risk assessment tool enabling us to identify which individuals we consider do require a face to face visit to undertake the assessment. We will work closely with our partner organisations to utilise where possible a Trusted Assessor model for gathering information in order to reduce footfall into care homes and people's own homes. We will work with partner agencies to establish where there are areas of quality concern and seek to address these jointly. We will communicate clearly with individuals and their representatives the process of assessment and rationale for virtual meetings. We will share our risks within the regional workshops and seek assurance from NHSE Regional Lead regarding our approach. We will monitor financial expenditure via the agreed reporting mechanisms and hold each locality structure to account for delivery on their targets. We will put in place supportive measures to ensure completion of assessments within a timely way, escalating issues with partners for resolution as they occur. The plan is to reduce the deferred assessments backlog by approx., 30 cases every two weeks until the end of December 2020, then increase to a reduction of approx., 60 cases every two weeks until the end of March 2021. The CCG will measure performance against this risk using this trajectory (JS) [Control Gaps] December 2020 - Fortnightly returns to NHSE so far have assured currently we are on target to meet our trajectory for clearance of the backlog, however we anticipated this progress will not be sustained due to the Christmas period, slow mobilisation plans within the Western Locality and now significant vacancies within the core CHC teams who operationally deliver the process. The virtual assessment process risk currently does not appear to be manifesting, although CHC Leads do report the end to end process is taking at least 1-2 weeks longer to complete (JS) October 2020 - There are some gaps relating to information sources and data reports that we are currently addressing.	16 [29/10/2020] 16 (L=4 x I=4)	Risk Opened: 29/10/2020 Reviewed: 18/12/2020	[29/10/2020] Workplan being progressed. ,	October 2020 - Regular reporting to CHC Control Centre and performance oversight. Reporting the Executive team. Risk assessment tool in draft 02/10/20. Weekly meetings with Local Authority representatives to align assessment processes and agree priorities. Care Home and Home Care Cell cited on areas of risk relating to care delivery, separate risk logged for this (Jo Shill owner). Sitrep reporting every two weeks to NHS E. Communications with individuals will be undertaken prior to assessment scheduling. Weekly regional assurance calls in place with NHSE. Data feeds being developed to monitor progress on backlog of deferred assessments plus financial outturn. Local team performance management/supervision sessions in place. Use of ring fenced Covid funding to fund resources required to undertake the deferred assessment backlog (JS) [Assurance Gaps] October 2020 - To be Confirmed – plan to follow	Executive Lead: Darryn Allcorn Owner: Jo Shill

136	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	There is a risk that care home placements and care at home could become compromised, due to Covid outbreak risks, lack of Personal Protective Equipment (PPE), staffing and pathway issues. The impact is that patients will be unable to be discharged from hospital in a timely manner to create acute capacity for new admissions. The safety & quality of an individual's care could be at risk due to: inadequate packages of care, staff capacity, equipment and training. (Covid risk 09) (HISTORIC ID: Na)	December 2020 - Risk score to remain the same. Risks continue to be escalated and addressed proactively via the Care Home and Home Care Cell x 3 per week Covid outbreaks have increased due to frequency of testing of both of residents and staff. Mitigations include tactical support via the LAs to homes in outbreak, financial support packages to support market sustainability. PPE Cell now in place and process for obtaining supplies in place. Risk remaining related to hospital discharge where patients continue to test Covid positive and cannot be discharged to a care home for 14 days or if remaining symptomatic. Actions taken to agree local interpretation and implementation over the four localities. Delays currently affecting 7 inpatients at present. (JS) October 2020 - Previously held on the Covid RR. Risk score reviewed and increased to 16 as second wave pandemic now beginning to surge (JS) June 2020 - Development of a wider care home and home care cell specifically to address these concerns. Support programme includes inputs from Medicines Optimisation Team, Primary Care, clinical nominated leads, IPC training, Covid testing, digital and market support, CQC and Quality Assurance Teams from each locality June 2020 - It was noted that training and support packages are in place for care homes, and there will be a further change recommended in due course to reduce the impact score again once we get the local outbreak plans. SM described an offer from the AHSN to support digitalisation and rapid evaluation and learning from the care homes cell. PK will pick this up outside of the meeting. May 2020 - CCG led, multi partner Care Home & Care at Home Cell commenced 25.5.2020. CCG working closely with Local Authorities to support provision of care in Care Homes. CCG continue to support the LAs, care homes and home care through Care Home, PPE and Discharge Cells. Includes training and supply of PPE. [Control Gaps] December 2020 - National guidance is conflicting (JS)	16 [29/10/2020] 16 (L=4 x I=4)	Risk Opened: 02/11/2020 Reviewed: 18/12/2020		Assurance on system support is gained from each locality x 3 per week during the Care Home and Home Care Cell meetings. Actions are documented and circulated prior to the next meeting. Issues related to outbreaks and any required support are discussed with each participating organisation requesting and receiving support as required. The notes and action log are updated frequently. Training on IPC/PPE has been relaunched. Designated bed offer being explored and implemented across the county. CCG is exploring a contract with NHSP to potentially provide an enhanced staffing resource to care homes where there are gaps in staffing rotas. [Assurance Gaps] Nothing identified	Executive Lead: Darryn Allcorn Owner: Jo Shill

108	We will make best use of resources [Reporting Committee] Primary Care Commissioning	There is a risk that due to current and forecast significant challenges, the sustainability of general practice (including workforce, demand and capacity) is severely affected. The impact is that the delivery of general practice is compromised, and all areas of the healthcare system, including patient safety, could be affected. It is acknowledged that the risk will vary from locality to locality over time, with the need to focus resources where need is identified. This risk replaces risk 09 (SDT) and 68 (NEW Devon) (HISTORIC ID: Na)	GP Strategy STP Workforce Group & Strategy Locality Workforce Groups GP Provider Collaborative Groups Regional Workforce Board 100 day plan in design for Plymouth system Regular review at Primary Care Operational Group Regular review at Primary Care commissioning committee Feb 19 - The GP framework associated with the long term plan, having been released, is being reviewed for opportunities to further mitigate this risk Apr 19 - Work continues to support practices in working closer together and with wider parts of the system and also building on the skill mix development as outlined in the contract reform GP International Recruitment Scheme. Three candidates offered positions on the GPIRS following interviews and educational needs assessments 20 Jun 19 - risk reviewed at Primary care operational group. No further update Jul 19 - 100 day plan in design for Plymouth system 7 Aug 19 - Reworked as Plymouth Prospectus; financial implications being reviewed; on track for 1 Sept 19 launch. 2 Sept 19 - Plymouth Prospectus circulated to Plymouth practices. Others were sent to practices in South Hams, West Devon and the rest of Devon to inform them of the prospectus and encourage them to send expressions of interest for when CCG launch our longer term transformation plans 10 Oct 19 - BMJ Job Fayre in London on 4th & 5th October 19; stand promoting SW region - supported by CCG staff and Plymouth GP. 14 Nov 19 - Risk score has been reviewed in light of CQC contract suspension of one practice within Western system, given (material) impact on 3 practices covering circa 25,000 patients. Score has not been adjusted as this was felt to be a manifestation of the risk rather than an escalation of it. 16.12.19 risk score not adjusted due to current list dispersals (from 2 practice closures) 6 Oct 20 - LMC GP alert system sent out on weekly basis highlights either localities or practices of concern. It is acknowledged that the risk will vary from locality to locality over time, with the need to focus resources where need is identified. Oct 20 - CCG attending virtual BMJ job fayre - stand promoting SW region [Control Gaps] Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support In part a lack of evidenced change to new models	16 [02/12/2020] ▲ 16 (L=4 x I=4) [06/10/2020] ▼ 12 (L=3 x I=4) [29/05/2019] 20 (L=5 x I=4)	Risk Opened: 29/05/2019 Reviewed: 02/12/2020	[02/12/2020] Reviewed by Executive Team 19 October 2020 2 Dec 20 - Work to increase investment in workforce and GP resilience programme. , [06/10/2020] 10 Aug 20 - Proposal regarding reporting, claiming and payment methods for LES and DES payments beyond 31st July to be shared with Execs. 8 Sept 20 - Local income protection agreed at PCCC. 6 Oct 20 - income protection extended to 31st March 2021. ,	Encouraging collaborative working on a locality basis to establish increased resilience. Work with the Provider Organisations to establish broader based models of care. practice resilience toolkit Heat map devised to identify vulnerable GP practices Regular resilience meetings with Devon LMC Work continues to develop Primary Care Networks and fill roles [Assurance Gaps] None identified	Executive Lead: Jo Turl Owner: Rob Payne
117	We will continue to commission safe, effective and accessible services [Reporting Committee] Primary Care Commissioning	There is a risk that COVID-19 outbreak could adversely affect GP practices ability to deliver their core business as usual services. The impact of this is that the delivery of general practice is compromised and could impact all areas of the healthcare system. (HISTORIC ID: Na)	CCG Primary Care COVID lead identified Primary Care participation in CCG Daily COVID calls Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Regional NHS England and Public Health England updates Daily COVID updates from comms team to GP practices CCG providing resource to support implementation of e-Consult and implementing changes to online booking and triaging within practices. CCG purchased additional laptops to support practice business continuity plans to enable remote working [Control Gaps] None Identified	16 [02/12/2020] ▲ 16 (L=4 x I=4) [02/12/2020] = 16 (L=4 x I=4) [07/10/2020] ▲ 12 (L=3 x I=4) [10/08/2020] = 6 (L=2 x I=3) [08/07/2020] = 6 (L=2 x I=3) [06/07/2020] ▼ 6 (L=2 x I=3) [10/06/2020] ▼ 8 (L=2 x I=4) [12/03/2020] 12 (L=3 x I=4)	Risk Opened: 12/03/2020 Reviewed: 02/12/2020	[02/12/2020] 10 Aug 20 - Proposal regarding reporting, claiming and payment methods for LES and DES payments beyond 31st July to be shared with Execs. Implications of Phase 3 letter - action plan to completed as part of Restoration and Transformation workstream. 8 Sept 20 - Local income protection agreed at PCCC. Continuing to progress Phase 3 action plan in line with local system and national timescales. 7 Oct 20 - Local income protection agreed until 31st Mar 2021. Reinstated primary care cell in order to manage and regularly review risk to service delivery 4 Nov 20 - Primary care cell now increased to twice weekly. 2 Dec 20 - GP capacity expansion plan has now been agreed and additional investment has been made in general practice. ,	COVID report due to monthly Primary Care Committee CCG gathering assurance from practices re business continuity plans. [Assurance Gaps] None Identified	Executive Lead: Jo Turl Owner: Rob Payne

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: •Providers agreed and submitted trajectories as part of Phase 3 planning which would achieve the elimination of out of area placements by Q2 2021/22. • Providers submitted action plans which describe the actions being taken to delivery the trajectories •We are receiving weekly reporting of the position from both providers and the providers are working to break the information down to appropriate granularity (i.e. internal outliers/ appropriate/inappropriate [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 but is and remain actively monitored. At present the routine mechanisms for further challenge and assurance are not in place (i.e Contract Review Meetings) which limits potential for commissioners to seek further assurance against the plans.	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: 01/12/2020		Trajectories are agreed which would achieve elimination of inappropriate out of area placements by Q2 2021/22 and these were submitted as part of Phase 3 planning and submissions. Proivders have action plans in place which describe the actions being taken to delivery the trajectories. •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. •Current monitoring of DPT position indicates positive progress at a pace which is consistent with achieving the Phase 3 trajectory within the agreed timescales (if maintained). •Current monitoring of LW position indicates limited progress, though it should be noted the volumes of people placed out of area inappropriately in LW are smaller. [Assurance Gaps] •We need to ensure that LW have fully implemented the original action plan, and, if they have work to agree a remedial action plan in place to ensure that they are progressing with delivery of the planned trajectory.	Executive Lead: Jo Turl Owner: Liz Cosford
102	We will continue to commission safe, effective and accessible services [Reporting Committee] Quality Assurance	The CCG is not assured that DPT can appropriately demonstrate safe and effective services, due to leadership and governance processes, including risk management; the number of overdue RCA Serious Incident reports will impact on the trusts ability to embed learning, drive improvement, avoid patient harm and poor experience. The impact may also have implications on the wider health economy and partners, and CCG reputational damage. (HISTORIC ID: Na)	December 2020 - CCG/Provider meeting to discuss new SI framework took place as per previous update. Plans to support provider in place. NHSE/I IDM process to be implemented - first meeting planned for Jan 2021 (SW) November 2020 - Currently the risk score remains unchanged. DPT have made short term improvements in their outstanding number of RCA's, utilising outsourcing rather than changing their process, they are linking in closely with the Safety System team to give updates on precise numbers. There is a planned meeting in the diary for 13th Nov between NHS E / CCG and DPT to consider longer term approaches to Serious Incident reviews taking into consideration the new patient safety framework coming into play next year (IL) 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) [Control Gaps] November 2020 - The demonstration of sustained and trust wide improvement / learning through DPT following incident investigations is still not clearly evidenced, examples being in-patient incidents / improvement in care planning. This was also picked up by CQC and NHS E in recent inspections. The follow up meeting to the Single item quality surveillance group has not taken pace yet (IL) 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: 07/12/2020	[02/11/2020] Planned meeting in the diary for 13th Nov between NHS E / CCG and DPT to consider longer term approaches to Serious Incident reviews taking into consideration the new patient safety framework coming into play next year.,	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] December 2020 - Quality of SI reports improved. On-going concern in relation to number of SI reports. CCG supporting provider to drive improvement which includes CCG CNO and CCG DON meetings (SW)	Executive Lead: Darryn Allcorn Owner: Sara Wright

134	We will improve the physical and mental health of our population [Reporting Committee] Commissioning Committee	There is a risk that Children and Family Health Devon do not recover the current position of increased waiting times and deteriorating RTT positions for CAMHS; Occupational Therapy; Speech and Language; Autism Assessment services. The impact of this is that children experience delay in accessing assessment, support and services for their physical, mental and communication development needs which may experience poorer quality and outcomes. CFHD are not yet achieving contracted service standards and NHS Devon cannot be confident that they will deliver the service improvements and transformation as set out in the contract agreed with NHS Devon CCG. There continues to be a lack of operational clarity in terms of service management and different service offer between Devon and Torbay, increasing wait times, regular queries and comments from families and schools, together with concerns regarding leadership and workforce capacity within the services that indicate CFHD are not yet achieving contracted service standards. The issues have been further intensified by the pause in a number of services as a result of COVID 19 and services are not currently being provided at the standard expected with increased wait times and reduced access to services (HISTORIC ID: Na)	Increased contact between the CCG and the provider CFHD has been put in place to discuss and scrutinise the performance of services especially in light of the response and pressures of COVID. There are fortnightly meetings to monitor the ASD assessment wait list and recovery plan. Where concern is raised this is escalated to Associate Director and action taken in direct discussion with CFHD Directors. Associate Director of Commissioning (Community Services) formally wrote to CFHD on 20/11/20 requesting that a copy of their Integrated Performance Report and Integrated Governance Group Report are shared with the CCG by 27/11/20. Trajectories for the services which are behind agreed performance level have been requested and submitted. These will be monitored through the Liaison and Restoration meetings that are already established and recovery plans monitored on an individual service level with the appropriate service manager to ensure that the agreed actions are being implemented. [Control Gaps] Current formal contract management has been paused in line with National guidance during the COVID – 19 period. Issues with service delivery during this period are raised through the contracting email and through the Restoration / Liaison Meetings which have recently been instated.	15 [27/10/2020] 15 (L=5 x I=3)	Risk Opened: 27/10/2020 Reviewed: 01/12/2020	[01/12/2020] Alliance Board Performance and Governance Reports requested to be submitted by 27.11.2020. Not received, escalated to Lorraine Webber. ,	•Performance and assurance meeting papers for meetings described above •Reports to Quality Assurance Committee (Quarterly) •Executive and Senior Manager escalation meetings with CFHD provider eg Safeguarding and CAMHS. •Presentations / reports for local authority scrutiny meetings eg. CAMHS and Autism presented to the Devon County Council Children Scrutiny Group on September 8th 2020 and Devon Children And Family Partnership meeting on October 13th. [Assurance Gaps] Some assurances have been provided however there remains concerns relating to governance processes, monitoring of incidents, experience for long waiting patients and referral management process. These are being followed up directly with CFHD Quality lead.	Executive Lead: Jo Turl Owner: Siobhan Grady

Board Assurance Framework (BAF) 2021 to 2022 With sub objectives V1.2		26/01/2021										
	CCG Objectives	Board Assurance Framework Risk Ref	Principle Risks *There is a risk that.....*	Delivery Date	Corporate Risk Register mapping	Initial Risk Score	Updated score at last review	Risk Movement (Trend)	Risk Appetite /Target Score	Assurance Score	Lead Director	Date BAF Risk Reviewed	*Comments*
1	**Commission high-quality and safe services that reduce health inequalities and improve health outcomes**												
	We will ensure that we are clear about the outcomes we are commissioning from new and existing services and ensure that contracts are agreed to achieve these.	BAF 1a	We do not commission services based on the outcomes that they will achieve	Mar-22		9	0		6	8	Jo Turl Penny Harris	19/01/2021	
	We will work with our partners to reduce health inequalities and deliver on the 8 Urgent Actions outlined in Phase 3	BAF 1b	We do not deliver the CCG contribution to the Phase 3 Inequalities action plan	Sep-21		16	0		4	8	Ginny Snaith	13/01/2021	
	We will embed the commissioning cycle so that our decision making is based on a strategic evidence base and prioritisation framework	BAF 1c	We do not base our decision making on robust evidence of good practice and strategic intelligence	Mar-21		9	0		6	9	Kelvin Grabham	07/01/2021	
		BAF 1d	We do not implement a Population Health Management approach throughout the organisation	Jun-21		9	0		8	10	Jo Turl Penny Harris	19/01/2021	
	We will consider the use of new technology during the process of commissioning new services	BAF 1e	We do not make the most of opportunities to use digital technology	Dec-00		6	0		6	8	Jo Turl Penny Harris	19/01/2021	
	We will ensure that patient and public views are sought in everything we do	BAF 1f	Our plans do not reflect the views of patients and the public	Dec-00		6	0		4	12	Andrew Millward	14/01/2021	
2	**Improve service performance**												
	We will ensure that we have robust mechanisms for monitoring progress on delivery of our plans	BAF 2a	The CCG does not meet its statutory requirements and objectives because it does not have effective mechanisms for monitoring progress	Dec-00		15	0		6	9	Jayne Carroll	21/01/2021	
		BAF 2b	The System and Locality Care Partnerships do not establish robust mechanisms for performance management	Dec-00		6	0		4	11	Jayne Carroll	21/01/2021	
	We will work with our partners to ensure delivery of the operational system plan	BAF 2c	We do not have full commitment from system partners to deliver operational system plan so change is not delivered	Dec-00		8	0		4	8	Jayne Carroll	21/01/2021	
	We will have robust processes in place for identifying and responding to emerging risks	BAF 2d	The system does not have robust mechanisms for identifying and responding to emerging risks	Dec-00		9	0		4	8	Ginny Snaith	13/01/2021	
	We will deliver the phase 3 restoration plan to maximise planned care during winter and corona virus	BAF 2e	We do not implement the phase 3 restoration plan including maximising planned care during winter and corona virus	Dec-00		15	0		4	8	Jayne Carroll	21/01/2021	
3	**Achieve financial sustainability**												
	We will ensure that the CCG delivers a break-even position for 20/21.	BAF 3a	We do not deliver a break-even position for the current financial year.	Mar-21		3	0		4	12	John Dowell	19/01/2021	
	We will agree a medium-term plan that will deliver against the financial ambition of the LTP	BAF 3b	We cannot agree a medium-term plan that will deliver against the financial ambition of the LTP	Dec-00		16	0		6	12	John Dowell	19/01/2021	
	We will deliver our agreed efficiency programme for 21/22	BAF 3c	We do not deliver our agreed efficiency programme for 21/22	Dec-00		9	0		6	10	John Dowell	19/01/2021	
		BAF 3d	We do not deliver efficiencies from CCG running costs which at least mitigate the cost of inflation and pay progression	Dec-00		4	0		4	12	John Dowell	21/01/2021	
4	**Be an effective, well-led organisation with an empowered and inclusive workforce**												
	We will increase staff satisfaction by addressing the issues raised in the staff survey	BAF 4a	We do not address the issues raised in the staff survey	Dec-00		3	0		4	12	Andrew Millward	14/01/2021	
	We will support staff through the ICS transitions process	BAF 4b	We do not manage the transition process for CCG to ICS well.	Dec-00		9	0		4	10	Andrew Millward	14/01/2021	
	We will achieve an improved NHSE assurance rating	BAF 4c	We do not improve our NHSE Assurance rating	Dec-00		8	0		6	8	John Dowell	19/01/2021	
	We will grow and develop our staff to meet their potential and the organisation's needs	BAF 4d	We do not grow and develop our staff to meet their potential and the organisation's needs	Dec-00		0	0		0	0	Andrew Millward	14/01/2021	
	We wil increase the diversity of our staff to reflect that of the Devon population	BAF 4e	We do not increase the diversity of our staff to reflect that of the Devon population	Dec-00		0	0		0	0	Andrew Millward	14/01/2021	
5	**Lead the system's response to the coronavirus pandemic**												
	We will support staff health, wellbeing and morale during the COVID pandemic	BAF 5a	There is a risk that staff will become tired and overworked so we do not have sufficient capacity	Dec-00		6	0		4	12	Andrew Millward	14/01/2021	
	We will deliver our Primary Care strategy to increase capacity and capability in Primary Care	BAF 5b	There is insufficient capacity and capability in Primary Care to meet demand	Dec-00		12	0		8	8	Jo Turl	19/01/2021	
	We will maintain robust incident management arrangements	BAF 5c	There is a risk that we do not deliver our objectives as a system leader because we do not have robust incident management arrangements	Jan-21		9	0		4	8	Sonja Manton	05/01/2020	

Risk Assessment Scoring Guidelines

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

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

Assessing the likelihood/probability of risk

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

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

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

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

Overarching Risk Score and Management Response

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

Summary of Risk Appetite and Acceptable Risk Score

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

Adequacy of Assurance scoring

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

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

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

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

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

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

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

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Jo Turl - Director Out of Hospital Commissioning Penny Harris - Director In Hospital Commissioning
Risk: BAF 1a – we do not commission services based on the outcomes that they will achieve				**Reviewer** **Jo Turl**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**19/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	Existing contracts which do not fully articulate the outcomes expected.
Risk score at last review	0	0	0	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date	Mar-22			
Controls: (What are we currently doing about this?)				**Assurances:**
A service review document which clearly articulates the outcomes required. Ensures that as commissioners we are clear about the outcomes we want to commissioning from a new or existing service. We are including training for commissioners on the use of the service review document Implemented the use of the commissioning proposal checklist which ensures commissioner s need to have considered Locality profiles identify needs				Commissioning Committee meets monthly which requires all commissioning reviews and decisions to follow the service review guidelines and checklist Identified contracts due to expire in next 18 months and identified lead to take forward process
Control Gaps				**Assurance Score:**
Existing contract which may not have the outcomes articulated Ensure that when we made a commissioning decision ensure we have been through the evaluation process				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
As we review services or contracts coming up for renewal we will follow the commissioning review guidance to ensure we embed the outcomes in future commissioning arrangements Currently described in the QIPP process we are set to undertake a review of the non statutory contracts in priority order				Non identified
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Commission outcomes-based services, for example the western integrated care partnership*	on track	Mar-21	
07/01/2021	Training for the Commissioning Team	on track	Mar-21	

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Ginny Snaith - Board Secretary
Risk: BAF 1b – we do not deliver the CCG contribution to the Phase 3 Inequalities action plan				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**13/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	4	4	16	Operational capacity of staff to consider health inequalities as part of commissioning process
Risk score at last review	0	0	0	
Appetite:	2	2	4	**Rationale for risk appetite:**
Delivery Date	Sep-21			
Controls: (What are we currently doing about this?)				**Assurances:**
Inequalities workplan agreed by system Project team				E I exec leader ship group chaired by Chair of STP Phase 4 assurance meeting Reporting to partnership board
Control Gaps				**Assurance Score:**
Access to data - i.e. provider and BI capacity to analysis Operational capacity of staff to consider health inequalities as part of commissioning process				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
				QEIA process is not being routinely followed
Narrative of anticipated timeline				Narrative update

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	ongoing monitoring and delivery of the Health inequalities workplan	In progress	Sep-21	

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Kelvin Grabham - Director of Strategic Intelligence
Risk: BAF 1c – we do not base our decision making on robust evidence of good practice and strategic intelligence				**Reviewer** **Kelvin Grabham**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**07/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	reflects current situation and work
Risk score at last review	0	0	0	
Appetite:	2	3	6	**Rationale for risk appetite:**
Delivery Date	Mar-21			
Controls: (What are we currently doing about this?)				**Assurances:**
Developing the commissioning cycle to support the decision making which includes creation of a strategic evidence base and prioritisation framework Training for commissioners to access and use best available evidence				Strategic Intelligence in place Commissioning Committee provided with assurance that decision are based on evidence and best practice
Control Gaps				**Assurance Score:**
Evaluation of existing services due to lack of clarity of outcomes				9
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Building on the current process develop process to review existing services				no gaps identified
Narrative of anticipated timeline				In line with development of the commissioning cycle

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

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Jo Turl - Director Out of Hospital Commissioning Penny Harris - Director In Hospital Commissioning
Risk: BAF 1d – we do not implement a Population Health Management approach throughout the organisation				Reviewer Jo Turl
Corporate risks				Date Last Reviewed:
Risk Scores				19/01/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	3	3	9	
Risk score at last review	0	0	0	
Appetite:			8	Rationale for risk appetite:
Delivery Date	Jun-21			
Controls: (What are we currently doing about this?)				Assurances:
we have a population health management STP programme in place Commissioning checklist and service review document includes population health management (PHM) as a core part of the needs assessment? The CCG have identified BI resources to develop of PHM data Locality Directors will have the responsibility for ensuring the PHM data is used at place and PCN level				Commissioning committee will review all commissioning decisions are being made to ensure a full needs assessment undertaken PHM being led by the Chair of the CCG Intensive investment in development and learning
Control Gaps				Assurance Score:
There is a need for additional BI capacity Population health data not currently available at CCG/Place level Support for PCNs to engage in PHM				10
Mitigating Actions: (What should we do?)				Gaps in Assurance: (What additional assurances should we seek?)
Currently developing a business case for additional BI support Currently reviewing Primary Care team structure and locality teams to better support PCNs to utilise the PHM approach				
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Jo Turl - Director Out of Hospital Commissioning Penny Harris - Director In Hospital Commissioning
Risk: BAF 1e – we do not make the most of opportunities to use digital and modern technologies to commission services to meet best practice				**Reviewer** **Jo Turl**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**19/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	2	6	
Risk score at last review	0	0	0	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
All commissioned services should be in accordance with national best practice as indicated in the commissioning checklist QEIA will identify areas of inequalities and actions will be taken to mitigate the lack of access to digital technologies				Commissioning Committee and forward planner for the committee
Control Gaps				**Assurance Score:**
Ensure there is a follow up to any areas of inequality identified Service policy is not fully aligned to the IMT policy Service policy not fully aligned to the HIP 2 strategy				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
				Alignment with the STP digital strategy
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Commission high-quality and safe services that reduce health inequalities and improve health outcomes				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 1f – our plans do not reflect the views of patients and the public				**Reviewer** **Andrew Millward**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**14/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	2	3	6	The rationale is that we have just been given a GREEN STAR rating (rated Outstanding) for our engagement by NHS England for the second year running
Risk score at last review	0	0	0	
Appetite:	2	2	4	**Rationale for risk appetite:**
				Risk level will fluctuate with time (e.g. when large or contentious consultation underway) so plan is to maintain risk at current level by actions outlined.
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
We have a citizens panel - 1700 people from across Devon. This panel is totally representative of the Devon population and enables us to engage with them on a regular basis. 16/06/2020 Engagement strategy/Plan agreed CCG-wide communications strategy written and published. 16/06/2020				NHSE Annual Assurance on engagement NED for Patient and Public Engagement Engagement Panel with patient representatives
Control Gaps				**Assurance Score:**
non identified				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Continue to develop all staff within the CCG to increase capacity supporting engagement Continue to support and develop PPGs to deliver their practice role and to increase their involvement in wider engagement initiatives				No gaps identified
Narrative of anticipated timeline				Business as usual
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Improve service performance				Director Lead: Jayne Carroll - Chief Operating Officer
Risk: BAF 2a – the CCG does not meet its statutory requirements and objectives because it does not have effective mechanisms for monitoring progress				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**21/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	5	3	15	**the risk is scored 15, as the CCG will not meet its statutory targets in 20/21. However, this is not due to the lack of effective mechanisms, but to the COVID pandemic**
Risk score at last review	0	0	0	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Performance Leads in post who are assigned to localities to monitor performance against constitutional standards and performance targets and also provide a lead on specific systemwide areas of focus R&T cell have been co-ordinating delivery of phase 3 plan and reports regularly to commissioning committee and executives on a weekly basis The CCG Patient Safety & Quality team has maintained regular dialogue with providers regarding the impact of failures to achieve statutory targets and, through provider quality committees, has ensured a focus on preventing harm.				Formal sub committee of Board - Finance & Performance committee Access to provider quality committees & CCG Quality Assurance Committee Quality surveillance group System performance group Exec to Exec provider meetings
Control Gaps				**Assurance Score:**
Vacancy for x1 Performance lead lack of capacity to support Regular performance review meetings agreed by system to stand down				9
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Recruited to vacancy above System performance group will be reconvened in Feb 2021 Performance framework being developed to set out how LCPs will approach performance and appropriate level of engagement/ check and challenge with providers Design and deliver an integrated performance reporting framework (includes dashboards) to address challenging performance and reduce inequalities Ensure 21/22 contracts set out clear expectations around performance improvement				SPG not meeting during COVID incident Exec to Exec provider meetings not in place for all contracts
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Jan-21	Recruitment of Performance Lead	in progress	01-Apr-21	

Corporate Objective: Improve service performance				Director Lead: Jayne Caroll - Chief Operating Officer
Risk: BAF 2b – the System and Locality Care Partnerships do not establish robust mechanisms for performance management				Reviewer
Corporate risks				Date Last Reviewed:
Risk Scores				21/01/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	2	3	6	it is unlikely that the LCPs will not establish robust mechanisms for performance management. The impact is moderate, as there are Heads of Performance in place and will be other governance structures within the ICS with a focus on performance.
Risk score at last review	0	0	0	
Appetite:	0	0	4	Rationale for risk appetite:
Delivery Date				
Controls: (What are we currently doing about this?)				Assurances:
Performance Leads in post who are assigned to localities to monitor performance against constitutional standards and performance targets Heads of Performance use provider board reports and provider internal performance forums to gather intelligence on issues and to track action plans				Through the ICS governance and NHSEI oversight
Control Gaps				Assurance Score:
NEW LCP West has recently been agreed and infrastucture to support is being developed LCPs are still under development and require infrastucture to ensure performance Regular performance review meetings agreed by system to stand down Vacant Head of Performance post in southern locality				11
Mitigating Actions: (What should we do?)				Gaps in Assurance: (What additional assurances should we seek?)
Recruited to vacancy above Performance framework being developed to set out how LCPs will approach performance and appropriate level of engagement/ check and challenge with providers Design and deliver an integrated performance reporting framework (includes dashboards) to address challenging performance and reduce inequalities Ensure 21/22 contracts set out clear expectations around performance improvement				
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update
Dec-20	Design and deliver an integrated performance reporting framework to address challenging performance and reduce inequalities (link to action in risk 2a)		Mrach 2021	

Corporate Objective: Improve service performance				Director Lead: Jayne Caroll - Chief Operating Officer
Risk: BAF 2c – we do not have full commitment from system partners to deliver operational system plan so change is not delivered				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**21/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	2	4	8	Likelihood of partners not committing to improve performance is very low. However, the potential impact if this did happen is significant.
Risk score at last review	0	0	0	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
LCPs are under development and all partners are contributing to this There is sign up by all system CEOs to a 21/22 operational planning process that uses system work streams and a				CEO oversight of the 21/22 planning process
Control Gaps				**Assurance Score:**
				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Narrative of anticipated timeline				Narrative update

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

Corporate Objective: Improve service performance				Director Lead: Ginny Snaith - Board Secretary
Risk: BAF 2d – the system does not have robust mechanisms for identifying and responding to emerging risks				**Reviewer** **Ginny Snaith**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**13/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	good controls in place but need to be tightened and maintained
Risk score at last review	0	0	0	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Regular reporting to committees Head of Governance and Risk Manager attendance at directorate team meetings Regular Risk Co-ordinators meetings and training Training available via teams Chairs reports template to identify risk escalation to GB				Committee overview Audit Committee oversight of BAF/CRR/COVID Executive review of risk Governance forward planner for risk reporting in place and embedded Assurance scoring mechanism is available on web based register Directorate team meetings
				Internal audit review of risk annually
Control Gaps				**Assurance Score:**
Risk Management training at board level Lack of understanding between issues and risks				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
regular reporting by SLT, and members of Exec and senior officers attending SLT can discuss and identify any emerging risks for consideration, action and escalation.				Directorate regular discussion to be considered monthly Actions are followed through to ensure emerging risks are recorded and actioned appropriately through the risk management framework policy. Assurance scoring on web based register currently not used
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Improve service performance				Director Lead: Jayne Caroll - Chief Operating Officer
Risk: BAF 2e – We do not implement the phase 3 restoration plan including maximising planned care during winter and corona virus				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**21/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	5	3	15	First time this has been reviewed.
Risk score at last review	0	0	0	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
R&T cell co-ordinate delivery of phase 3 plan and reports regularly to commissioning committee and to executives on a weekly basis Delivery plan in place for Phase 3 - leads are held to account for progress against phase 3 actions, through regular meetings with the R&T cell On a weekly basis, the Devon system is held to account on elective restoration and its Adapt & Adopt plan. Meetings are attended by the System CEO and restoration lead.				Formal sub committee of Board - Finance & Performance committee Report through regional work streams - eg: Adapt & Adopt Elective & outpatient recovery - as of mid-December 2020, the system was on plan. Howewer, it has significantly deteriorated since mid-Dec.
Control Gaps				**Assurance Score:**
				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Use of mutual aid through the Devon Mutual Aid group The System is planning to require surge in the Independent Sector provision, to meet gaps in urgent elective/cancer capacity.				As of 18 Jan 2021, the regional assurance process has been stood down, to start again in the second week of Feb 2021.
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Implement the phase 3 restoration plan, including maximising planned care during winter and during the coronavirus pandemic		Mar-21	
Dec-20	Deliver Devon's system winter plan and develop the 2021/22 system operating plan		Apr-21	

Corporate Objective: Achieve Financial Sustainability				Director Lead: John Dowell - Chief finance officer
Risk: BAF 3a – we do not deliver a break-even position for the current financial year.				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**19/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	1	3	3	**all mitigations in place and year end forecast indicates we will deliver breakeven**
Risk score at last review	0	0	0	
Appetite:			4	**Rationale for risk appetite:**
Delivery Date	Mar-21			
Controls: (What are we currently doing about this?)				**Assurances:**
Financial plan approved by Governing Body Budgetary control over expenditure Monthly review of financial risks and mitigation				Regular reporting to Finance Committee and Governing Body Internal audit of all financial control process Report to NHS England on risks and mitigations
Control Gaps				**Assurance Score:**
Non identified				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Narrative of anticipated timeline				31-Mar-21
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Deliver a break-even position for the current financial year	in progress	Apr-21	

Corporate Objective: Achieve Financial Sustainability				Director Lead: John Dowell - Chief finance officer
Risk: BAF 3b – we cannot agree a medium-term plan that will deliver against the financial ambition of the LTP				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**19/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	4	4	16	**required recovery trajectory not yet issued by NHS England** Financial allocation not yet issued by NHS England
Risk score at last review	0	0	0	Savings and efficiency plans require further development
Appetite:			6	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Medium Financial plan approved by Governing Body Budgetary control over expenditure Financial recovery trajectory agreed with NHS England Savings and efficiency plans approved by Governing Body and delivery responsibility assigned to executive team leads				Regular reporting to Finance Committee and Governing Body Internal audit of all financial control process Report to NHS England on risks and mitigations
Control Gaps				**Assurance Score:**
Further control required to achieve the shift in investment towards out of hospital services				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Narrative of anticipated timeline				
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Reset the medium-term plan to ensure that we deliver against the financial ambition of the Devon Long-Term Plan. This includes shifting the balance of investment towards out of hospital services by 2023/2024 and will mean financial sustainability with expenditure contained within allocated resources on an ongoing basis (living within our means)	In progress	Apr-21	

Corporate Objective: Achieve Financial Sustainability				Director Lead: John Dowell - Chief finance officer
Risk: BAF 3c – we do not deliver our agreed efficiency programme for 21/22				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**19/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	
Risk score at last review	0	0	0	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Efficiency programme based on realistic assessment of improvement opportunity Detailed delivery plans in place and regularly monitored				Regular review at Executive team and reporting to Finance committee Internal audit review of process
Control Gaps				**Assurance Score:**
Identify process to address any financial shortfall identified through the controls above				10
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Continuous process to identify pipeline of efficiency opportunity				
Narrative of anticipated timeline				

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

Corporate Objective: Achieve Financial Sustainability				Director Lead: John Dowell -Chief Finance Offocer
Risk: BAF 3d – We do not deliver efficiencies from CCG running costs which at least mitigate the cost of inflation and pay progression				Reviewer John Dowell
Corporate risks				Date Last Reviewed:
Risk Scores				21/01/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	2	2	4	
Risk score at last review	0	0	0	
Appetite:			4	Rationale for risk appetite:
Delivery Date				
Controls: (What are we currently doing about this?)				Assurances:
Budget setting. Budgetary control over recruitment and non-pay expenditure				Reporting to Finance Committee and GB. Internal Audit of budgetary control processes
Control Gaps				Assurance Score:
No gaps indentified				12
Mitigating Actions: (What should we do?)				Gaps in Assurance: (What additional assurances should we seek?)
				No gaps indentified
Narrative of anticipated timeline				
	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update
Dec-20	Deliver efficiencies from CCG running costs which at least mitigate the cost of inflation and pay progression; and make best use of available resources		Apr-21	

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 4a – We do not address the issues raised in the staff survey				Reviewer Andrew Millward
Corporate risks				Date Last Reviewed:
Risk Scores				14/01/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	1	3	3	We have had the 2020 staff survey results and these show improvement again. Devon CCG was classed in the top quartile of improving CCG. There are still some areas requiring improvement and will be addressed during the year.
Risk score at last review	0	0	0	
Appetite:	1	4	4	Rationale for risk appetite:
				It is within the CCGs powers to address many of the issues raised in the staff survey and it is important to maintain key staff
Delivery Date				
Controls: (What are we currently doing about this?)				Assurances:
Each Directorate will review the results of their staff survey and agree actions We now have agreed new CCG objectives Increased staff engagement and listening events Well embedded organisational Vision and Values Celebrate You now an annual event				Remuneration and Strategic Workforce Committee HR Dashboard to SLT, Execs and Governing Body Monthly meeting of Staff Partnership Forum
Control Gaps				Assurance Score:
				12
Mitigating Actions: (What should we do?)				Gaps in Assurance: (What additional assurances should we seek?)
Staff Partnership Forum is continually focused on addressing the issues from the survey. Implementing quarterly survey to obtain ongoing feedback Develop and implement organisational development programme				
Narrative of anticipated timeline				Business as usual
	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update
Dec-20	Directorates have been asked to review the 2020 staff survey and come up with an action plan for their teams by ??	in progress		
Dec-20	Implementation of talent management approach including talent conversations	in progress		
Dec-20	Implementation of Health and Wellbeing Strategy - launch of strategy and health and wellbeing champions	in progress		

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 4b – We do not manage the transition process for CCG to ICS well.				**Reviewer** **Andrew Millward**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**14/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	**Waiting for national direction**
Risk score at last review	0	0	0	
Appetite:	2	2	4	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Executives have discussed this and once we have clear directions will agree an action plan Staff Partnership Forum				Workforce and Remuneration Committee
Control Gaps				**Assurance Score:**
NHSE to issue direction on futures of CCGs expected early spring 2021				10
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
We are actively monitoring national changes so that we can act accordingly				
Narrative of anticipated timeline				Changes expected to take effect spring 2022
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Prepare staff and the organisation to work within the new Integrated Care System (ICS), including support to staff to undertake development assignments		Sep-21	

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: John Dowell - Chief finance officer
Risk: BAF 4c – We do not improve our NHSE Assurance rating				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**19/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	2	4	8	**there is a plan in place which will improve assessment against criteria**
Risk score at last review	0	0	0	
Appetite:			6	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Review of current performance against 2019/2020 assessment criteria has been completed Action plan in response to 2019/2020 inadequate rating in place Executive team leadership responsibility assigned for delivery of action plan Corporate objectives support delivery of changes that will improve assessment outcome				Regular reporting to finance committee, Quality Committee and Governing Body
Control Gaps				**Assurance Score:**
2020/2021 and 2021/2022 criteria unknown				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
ongoing dialogue with NHSE to obtain the assessment criteria				
Narrative of anticipated timeline				
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 4d – we do not grow and develop our staff to meet their potential and the organisation's needs				Reviewer Katy Kerley
Corporate risks				Date Last Reviewed:
Risk Scores				14/01/2021
	Likelihood	Impact	Risk Score	Reason for current score:
Initial Risk Score:	0	0	0	
Risk score at last review	0	0	0	
Appetite:	0	0	0	Rationale for risk appetite:
Delivery Date				
Controls: (What are we currently doing about this?)				Assurances:
Control Gaps				Assurance Score:
Mitigating Actions: (What should we do?)				Gaps in Assurance: (What additional assurances should we seek?)
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	Action	Action Status	planned completion date	Narrative update
Dec-20	Grow and develop staff to meet their potential and the organisation's needs: Implement an improved talent management process, linked to Appraisals Develop and implement a graduate and apprenticeship strategy		Mar-21	

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 4e – we do not increase the diversity of our staff to reflect that of the Devon population				**Reviewer** **Nelli G**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**14/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	0	0	0	
Risk score at last review	0	0	0	
Appetite:	0	0	0	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Control Gaps				**Assurance Score:**
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
	Drive to increase the current diversity of our staff (3.4%) to reflect that of the Devon population (6.9%)			

Corporate Objective: Be an effective, well-led organisation with an empowered and inclusive workforce				Director Lead: Andrew Millward - Chief communications, IT and people officer
Risk: BAF 5a – that we do not have sufficient capacity as staff are tired and overworked				**Reviewer** **Sam Tribble**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**14/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	2	3	6	
Risk score at last review	0	0	0	
Appetite:	2	2	4	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
Wellbeing champions in the organisation All directorates are routinely checking in on staff Focus of the staff partnership forum Ensured corporately that every member of staff has had a formal wellbeing and home work assessment				Workforce and remuneration Committee Staff Partnership Forum Executive Team Staff Survey
Control Gaps				**Assurance Score:**
Non identified				12
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Narrative of anticipated timeline				Regular rolling programme
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
Dec-20	Support staff health, wellbeing and morale	on going	on-going	
Dec-20	Be a learning organisation: Use COVID-19 learning to improve services and working practices Deliver quality improvement and commissioning cycle training Further develop the CCG's mentoring programme	on going	Sep-21	

Corporate Objective: Lead the systems response to the coronavirus pandemic				Director Lead: Jo Turl - Director Out of Hospital Commissioning
Risk: BAF 5b – there is insufficient capacity and capability in Primary Care to meet demand				**Reviewer**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**19/01/2021**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	4	12	
Risk score at last review	0	0	0	
Appetite:	2	4	8	**Rationale for risk appetite:**
Delivery Date				
Controls: (What are we currently doing about this?)				**Assurances:**
CCG have agreed a framework for GPs to work within to allow them to prioritise urgent care to patients CCG primary care team are working with general practice to reduce bureaucratic burden on them Primary Care including MO actively supporting practices where there are resilience or capacity issues CCG have allowed the flexible use of funding to support the delivery of COVID vaccinations Undertake the PC webinar to allow feedback from PC relating to capacity issues which the PC team can respond to				Risk reports through to the PC committee, where we have GP members who can feedback areas of concern
Control Gaps				**Assurance Score:**
				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Provide support to GP to fully utilise the additional roles reimbursement scheme				
Narrative of anticipated timeline				Narrative update
	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**

Corporate Objective: Lead the systems response to the coronavirus pandemic				Director Lead: Sonja Manton - Incident Director
Risk: BAF 5c – that we do not deliver our function as a system leader because we do not have robust incident management arrangements				**Reviewer** **Sonja Manton**
Corporate risks				**Date Last Reviewed:**
Risk Scores				**05/01/2020**
	Likelihood	**Impact**	**Risk Score**	**Reason for current score:**
Initial Risk Score:	3	3	9	**current status of support being missing**
Risk score at last review	0	0	0	
Appetite:	2	2	4	**Rationale for risk appetite:**
				all controls in place
Delivery Date	Jan-21			
Controls: (What are we currently doing about this?)				**Assurances:**
We have a robust incident structure and process in place designed by EPRR experts with appropriate cell structure to support				Wave one incident review and resulted in a action plan. The action plan is being regularly reviewed by the executive team
Have in place a daily/weekly meeting rhythm to ensure appropriate information flows across the system				Regular updates at Governing Body
Clear roles and responsibilities within the arrangements				Part of the regional and national response structure which includes daily reporting
Staffed by deploying staff from across the CCG to provide resilience and share the experience across a wider cohort of people				Daily calls with regional operational centre were we are held to account for our response.
				Oct 2020 system exercise to test our COVID response and preparedness for wave 2
Control Gaps				**Assurance Score:**
In the incident management arrangements we have some areas in which resilience could be improved i.e. administration and meeting support and EPRR expertise.				8
Mitigating Actions: (What should we do?)				**Gaps in Assurance: (What additional assurances should we seek?)**
Increase the pool of admin and meeting support Broaden the pool of the incident management role Considered alternative support for EPRR				No external review robustness of access to external EPRR in the event of in house absent of EPRR leads
Narrative of anticipated timeline				Aim to have update by end of January

	Update on actions taken			
Date	**Action**	**Action Status**	**planned completion date**	**Narrative update**
05/01/2021	Increase the pool of admin and meeting support end of January	open	31-Jan-21	
05/01/2021	Broaden the pool of the incident management role	open	31-Jan-21	
05/01/2021	Considered alternative support for EPRR	open	31-Jan-21	

COVID Incident Risk Register - Wave 2

v2 @ 30 December 2020

Appendix 4 Audit Committee 05 January 2021

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

Risk Reference	Risk also held on CRR - Corporate Risk Register Team Risk Register	Risk ID on CRR or TRR	Area of Risk	Risk Title	There is a risk that.....	The Impact is	Mitigating Actions in Place	Exec Lead	Risk Owner	Further Action Required	Last Reviewed	Date Added	Likelihood	Impact	Risk Score	Current Status/Updates
COVID 04 (Wave 2)	CRR	100	Nursing & Quality	SWASFT Call Stacking	There is a risk that the population of Devon will not receive timely access to 999 emergency ambulance care when needed.	The impact of this is upon patient experience and safety; public and professional confidence in the system and associated reputational impact.	SWASFT will continue to review this on a weekly basis. No information has been provided to the CCG to indicate that call stacking is a particular risk in Devon at the current time (SZ) June 2020 - Awaiting update from Dorset CCG discussion with SWASFT about scoring this risk (SZ)	Darryn Allcorn	Sarah Zanoni		03/12/2020	09/01/2019	4	3	12	
COVID 05 (Wave 2)	CRR	109		Underperformance Constitutional Standards	There is a risk of underperformance against some key constitutional standards (including but not limited to 52 week waits, Diagnostics, 62 day cancer standard A and E 4 hour waits) The risk of underperformance (and mitigating actions) is included in the risk registers of provider organisations (and will be part of system risk management arrangements) and is appropriately managed at this level.	However there are a number of impacts that mean the CCG must make every effort to support achievement of standards. These impacts are: • Loss of credibility with regulators leading to increased levels of scrutiny, assurance and external intervention • There is reputational impact due to potential patient harm or perception of the CCG is impacted by patient outcomes. • Diversion of resources from transformational programmes of work required to achieve financial and performance sustainability.	Fortnightly 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	Jayne Carroll	John Finn		09/10/2020	06/06/2019	5	4	20	
COVID 06 (Wave 2)	CRR	117	Primary Care	COVID-19 General Practice	There is a risk that COVID-19 outbreak could adversely affect GP practices ability to deliver their core business as usual services.	The impact of this is that the delivery of general practice is compromised and could impact all areas of the healthcare system.	CCG Primary Care COVID lead identified Primary Care participation in CCG Daily COVID calls Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Regional NHS England and Public Health England updates Daily COVID updates from comms team to GP practices CCG providing resource to support implementation of e-Consult and implementing changes to online booking and triaging within practices. CCG purchased additional laptops to support practice business continuity plans to enable remote working COVID report due to monthly Primary Care Committee CCG gathering assurance from practices re business continuity plans	Jo Turl	Rob Payne		02/12/2020	12/03/2020	4	4	16	
COVID 07 (Wave 2)	CRR	118	Primary Care	COVID- 19 - Primary Care Team	There is a risk that COVID-19 outbreak could adversely affect the primary care teams ability to deliver current workplan and business as usual tasks.	The impact of this is that the delivery of general practice is compromised and could affect all areas of the healthcare system.	CCG Primary Care COVID lead identified Primary Care participation in CCG Daily COVID calls Regular Primary Care COVID-19 meetings scheduled Action log created and monitored daily Regular contact with incident control room Regional NHS England and Public Health England updates Team reviewing daily COVID updates from comms team COVID report due to monthly Primary Care Committee Team business continuity plan Team whats app group enabled Working from home processes enabled	Jo Turl	Rob Payne		02/12/2020	12/03/2020	3	4	12	
COVID 08 (Wave 2)	CRR	119	Nursing & Quality	Flu vaccination programme risk 2020/21	There is a risk that the 2020/21 influenza (flu) vaccination programme will be affected by a number of factors, including the ongoing COVID-19 situation. 1) Flu vaccination in frontline healthcare workers (FHCW) 2) Flu vaccination in primary care, including vulnerable patients	Both elements of this risk have the potential to lead to a situation where flu vaccination rates are low, increasing vulnerability- both individual and system-wide- in the event of an outbreak of flu leading to system capacity stretch. This may occur in the context of system pressure from circulating COVID-19 and if a Covid-19 vaccine should become available there will be a double vaccine programme requirement.		Darryn Allcorn	Jonathan Plumb		11/12/2020	19/06/2020	3	4	12	
COVID 09 (Wave 2)	CRR	120	Primary Care	COVID-19 – Transference of work to Primary Care	There is a risk that COVID-19 outbreak may lead to the possible work transference from secondary care into General Practice, impacting on GP practices ability to undertake routine work	The impact of this is that the delivery of general practice is compromised and there may be funding implications if additional funding is sought.	CCG Primary Care COVID lead identified Regular COVID updates from comms team to GP practices. CCG providing resource to support implementation of e-Consult and implementing changes to online booking and triaging within practices. CCG purchased additional laptops to support practice business continuity plans to enable remote working. Gen Practice representation to key Restoration and Transformation (R&T) workstreams being developed. R and T matrix style review of interdependencies arranged. Work being undertaken by Mandy Seymour and John Finn to identify the work transfer and to ensure that this is achieved in a planned way. COVID report due to monthly Primary Care Committee LMC impact meetings	Jo Turl	Rob Payne		02/12/2020	13/07/2020	3	3	9	
COVID 10 (Wave 2)	CRR	122	Nursing & Quality	Backlog of LeDer Reviews & System Workforce Capacity	There is a risk that the Devon CCG LeDer programme have insufficient LeDer reviewers due to system workforce capacity and competing priorities.	The impact of this is the current backlog will continue to rise without a dedicated workforce, the CCG will not be able to disseminate learning from these deaths and ensure recommendations are acted on in a timely manner. Furthermore the NHSE 6 month target applied for completion is at risk of not being met.		Darryn Allcorn	Sue Harvey		09/12/2020	29/07/2020	1	4	4	pending closure QAC Jan 2021
COVID 11 (Wave 2)	CRR	123	Nursing & Quality	Fit testing – PPE/COVID	There is a risk that some carers may be exposed to COVID 19 because their FFP3 masks do not fit correctly. This would occur if the cared for individual were COVID positive and transmitting the virus when aerosol generating procedures were being undertaken. This risk has been identified as there are not enough fit testers available to manage the incoming demand for carer testing. Factors: likelihood will increase as carers have not been fit tested to ensure the face masks worn are sealed correctly around their faces which would prevent the virus being inhaled during the procedure.	The impact of this is significant to the CCG as this is an identified, known clinical risk and although there are plans in place to address the backlog of carers that require fit testing, there are significant delays in achieving this. There is a reputational impact due to potential harm or perception that the CCG is impacted by patient outcomes, as the lead organisation responsible for the oversight, organisation and implementation of fit-testing for PHB clients	December 2020 - A stock take of PHB patients show the majority have sufficient mask supply to last a few months. The Devon system fit testers should have enough capacity to reach these before the supply of old masks run out, these will be prioritised as most urgent and clinical need. Risk score reviewed and to be reduced to 12 (RC) November 2020 - Risk score to remain at 16 - we are right at a cross over period with testers limited and we are running out of the old masks (RC) Daily updates at system wide Care Home and Out of Hospital Care Cell. Progress reviewed daily within CHC Team updates	Darryn Allcorn	Vanessa Crossey		11/12/2020	04/08/2020	3	4	12	
COVID 12 (Wave 2)	CRR	124		Delivery of Control Total	There is a risk that the CCG will not be able to deliver its agreed control total of break even for the second 6 months of 2020-2021 as a result of the required savings to stay within the pre-COVID rate of expenditure on which the revised NHSE allocation is based. This total may also be affected by a lack of funding for non-COVID related overspends and increased costs of service provision due to ongoing of impact of COVID in some cases		Review and reinstatement of CCG QIPP processes. Ongoing dialogue with NHSE and stp partners regarding the funding envelope for the second half of the financial year. No new recurrent expenditure commitments entered into in advance of knowledge of the revised allocation. Regular monthly reporting to the Finance Committee/Governing body on the inherent risk in the savings plan. Monthly finance working group meetings with system partners to discuss progress on delivery of the STP financial position against overall envelope	John Dowell	Kevin Wheller		29/10/2020	06/08/2020	3	4	12	
COVID 13 (Wave 2)	CRR	128	IG	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 i.e. home working during COVID Incident	The impact of this could be the CCG's ability to maintain patient, staff and/or corporate confidentiality.	Homeworking guidance created for staff Screen lock (manual & timed) Clear desk Policy/Audit Secure lockers/cupboard Confidential waste bins/collections Secure printing via ID cards	Ginny Snaith	Matt Spry		03/12/2020	03/09/2020	3	2	6	

COVID 14 (Wave 2)	**CRR**	**130**	**EPRR**	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.	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	Sonja Manton	Phil Coutie		**17/11/2020**	17/09/2020	**3**	**4**	**12**	
COVID 15 (Wave 2)	**CRR**	**131**	**EPRR**	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.	EPRR Lead recruited to lead on preparedness workstream; • An EPRR workplan in place to ensure that preparedness is maintained and that new requirements are implemented in a timeous manner; • Suite of business continuity plans and emergency plans in place and updated in March and August 2020 respectively. Internal audit review in place for Q4 2020/21 • On-call system in place, supported by trained on-call staff, available to initiate a response 24/7; • Trained Directorate Business Continuity Leads in place to maintain their business continuity plans • Regular training is undertaken by On-call staff and BC Leads to maintain knowledge and skill sets • Regular exercising of business continuity plans and participation in the exercising of multi-agency emergency plans is undertaken to ensure skills are maintained, plans are tested and the CCG is integrated into the multi-agency response to emergencies; • EPRR Lead is engaged with NHS and multi-agency (LRF) EPRR planning to ensure the CCG is integrated into these plans. • EPRR Lead will fulfil the CCG responsibility of undertaking an annual assurance of Providers preparedness in line with the NHSEI EPRR Core Standards and annual assurance process, and reporting upon this to the AEO & GB.	Sonja Manton	Phil Coutie		**30/12/2020**	17/09/2020	**2**	**3**	**6**	
COVID 16 (Wave 2)	**CRR**	**132**	**Primary Care**	Robust incident reporting processes not in place across primary care	There is a risk that until robust reporting processes are embedded in general practice that there will be reduced assurance to fully understand how the learning from incidents will be shared and actions implemented. Additionally, there is an associated risk that until comprehensive and robust systems are in place to monitor quality and patient safety that only limited surveillance will be able to be implemented.	The impact of this is that a failure to recognise the need for reporting incidents, completing a robust report in a timely manner and learning from incidents will be lost and the incident may therefore reoccur. That until the learning is embedded in practice the risk of the same incident reoccurring is not reduced and could occur repeatedly.	October 2020 - A report and live demo on the Early Warning System is to be presented at the PCCC on 1st October and at the QAC in November (VC) September 2020 - Incident reporting processes are in place: The agreed process currently in place is to monitor safety incidents through a variety of systems, SEA, SI, Yellowcard/PITCH. Each month the incidents are required to have a clinical lead to review and follow-up: • Potential SI reported and currently in decision making process • SI review process in place • SI review shared with NHSE Performance Advisory Group • SEA themes are regularly identified and learning shared. • PITCH themes analysed and learning shared We have access to 2 x Band 7 Primary Care Nurses who can support the work with the Safety Systems team to identify if the actions within both SEA's & SI's are completed & the learning embedded in practice. All primary care SI's will have 2	Jo Turl	Rob Payne		**08/12/2020**	16/09/2020	**4**	**3**	**12**	
COVID 17 (Wave 2)	**CRR**	**133 (COVID Wave 1 risk 07)**	**Nursing & Quality**	Changes to services commissioned by the CCG	There is a risk that decisions to make changes to services commissioned by the CCG through providers are done so without full cognoscente, clinical oversight and agreement whilst responding to the COVID 19 outbreak and management of capacity and resource.	The impact: a) decisions made in isolation may impact on other services or capacity in system b) inequitable access for patients to services	December 2020 - R and T cell process (twice weekly call meeting has oversight). LocalityCCG/Provider meetings with trigger forms to R and T, DDMG, COOs, etc, (SW) November 2020 - Commissioning Committee is now in place and has clinical membership and input from CNO and GP Clinical leads. Commissioning checklist required to be completed for all papers recommending commissioning decision with a robust QEIA process to support this decision. Risk to be reduced - impact still high although likelihood much less now (SW) October 2020 - Process in place for CCG AO sign-off of all proposed service changes - This includes risk assessment and clinical input. QEIA requested by CCG is assessed as required. QEIA has been streamlined/ adapted for COVID pandemic period service changes. Clinical Reference Group review Service Change log on a weekly basis. Service changes also reported to the CCG Governing Body on a monthly basis	Darryn Allcorn	Sara Wright		**26/11/2020**	21/10/2020	**2**	**5**	**10**	
COVID 18 (Wave 2)	**CRR**	**134**		Operational delivery by Child and Family Health Devon	There is a risk that Children and Family Health Devon do not recover the current position of increased waiting times and deteriorating RTT positions for CAMHS; Occupational Therapy; Speech and Language; Autism Assessment services. The impact of this is that children experience delay in accessing assessment, support and services for their physical, mental and communication development needs which may experience poorer quality and outcomes. CFHD are not yet achieving contracted service standards and NHS Devon cannot be confident that they will deliver the service improvements and transformation as set out in the contract agreed with NHS Devon CCG.	There continues to be a lack of operational clarity in terms of service management and different service offer between Devon and Torbay, increasing wait times, regular queries and comments from families and schools, together with concerns regarding leadership and workforce capacity within the services that indicate CFHD are not yet achieving contracted service standards. The issues have been further intensified by the pause in a number of services as a result of COVID 19 and services are not currently being provided at the standard expected with increased wait times and reduced access to services	Increased contact between the CCG and the provider CFHD has been put in place to discuss and scrutinise the performance of services especially in light of the response and pressures of COVID. There are fortnightly meetings to monitor the ASD assessment wait list and recovery plan. Where concern is raised this is escalated to Associate Director and action taken in direct discussion with CFHD Directors. Associate Director of Commissioning (Community Services) formally wrote to CFHD on 20/11/20 requesting that a copy of their Integrated Performance Report and Integrated Governance Group Report are shared with the CCG by 27/11/20. Trajectories for the services which are behind agreed performance level have been requested and submitted. These will be monitored through the Liaison and Restoration meetings that are already established and recovery plans monitored on an individual service level with the appropriate service manager to ensure that the agreed actions are being implemented.	Jo Turl	Siobhan Grady		**01/12/2020**	27/10/2020	**5**	**3**	**15**	
COVID 18 (Wave 2)	**CRR**	**135**	**Nursing & Quality**	CHC Assessment Backlog	There is a risk that some aspects of our core business of continuing healthcare will be exposed to additional risk as a result of the changes to the emergency framework period guidance and associated financial framework, particularly with the reset in relation to CHC assessments. a) There is a reputational risk that the CCG may be challenged through the undertaking of virtual assessments and the view that patients, their representatives and advocates may not see this process as robust enough to make a recommendation on levels of need; b) There is a risk that we are unable to take the same assurance with regard to the clinical safety and quality of care being provided to eligible individuals in the absence of face to face assessments; c) There is a financial risk associated with the increasing backlog of CHC assessments, and the cessation of emergency funding for new and enhanced CHC packages of care. The financial risk of approx. £3m is captured for 2020-21 and is managed as part of the CCGs overall financial risk assessment and delivery; These risks are to be recorded on the Corporate Risk Register and monitored and managed through the CCG's risk		December 2020 - Risk score to remain the same. Fortnightly returns to NHSE so far have assured currently we are on target to meet our trajectory for clearance of the backlog however we anticipated this progress will not be sustained due to the Christmas period, slow mobilisation plans within the Western Locality and now significant vacancies within the core CHC teams who operationally deliver the process. Recruitment is underway to mitigate these risks however new starters will require induction therefore trajectory may be off target until end of February. Mitigation will be to increase the contract value of cases with the external company undertaking assessments on our behalf. A financial incentive has also now been offered to the care homes to support the process in terms of information gathering and sharing. Some face to face visits are now happening which are identifying early where quality issues may be apparent, some resulting in onwards referrals to safeguarding. (JS)	Darryn Allcorn	Jo Shill	The current backlog has to be reduced by 31st March 2021 and therefore steps to mitigate the risks as a result.	**18/11/2020**	28/10/2020	**4**	**4**	**16**	

COVID 19 (Wave 2)	**CRR**	**136**	**Nursing & Quality**	Care Home & Care at Home	There is a risk that care home placements and care at home could become compromised, due to COVID outbreak risks, lack of Personal Protective Equipment (PPE), staffing and pathway issues. The impact is that patients will be unable to be discharged from hospital in a timely manner to create acute capacity for new admissions. The safety & quality of an individual's care could be at risk due to: inadequate packages of care, staff capacity, equipment and training. (COVID risk 09)		December 2020 - Risk score to remain the same. Risks continue to be escalated and addressed proactively via the Care Home and Home Care Cell x 3 per week Covid outbreaks have increased due to frequency of testing of both of residents and staff. Mitigations include tactical support via the LAs to homes in outbreak, financial support packages to support market sustainability. PPE Cell now in place and process for obtaining supplies in place. Risk remaining related to hospital discharge where patients continue to test Covid positive and cannot be discharged to a care home for 14 days or if remaining symptomatic. Actions taken to agree local interpretation and implementation over the four localities. Delays currently	Darryn Allcorn	Jo Shill		**18/12/2020**	29/10/2020	**4**	**4**	**16**	
COVID 20 (Wave 2)	**CRR**	**137 (COVID Wave 1 risk 29)**	**Nursing & Quality**	Impact of implementation of National Guidance	There is a risk that the impact of implementation of National Guidance during COVID- 19 may lead to patients who require planned care, including diagnostics, being delayed, deferred or choosing to self-defer, resulting in harm; both safety and experience could be affected. Note: This impact could be further exacerbated if changes in predictions of disease prevalence for the SW Peninsula result in a period of deferment in excess of that recommended by the national guidance.	The impact to the CCG is commissioning impacted services that may result in: a) escalation requiring emergency admission and / or treatment for patients. b) early death, harm, including reduction of treatment options and poor experience for patients. c) reputational damage as a result of longer waiting times for patients across the County.	December 2020 - Robust process in place to risk assess, manage/balance risk, escalate and maximising potential mutual support when required (SW) Holding providers to account for following national guidance for management of planned and elective care referrals and treatments. For example: cancer patients during the coronavirus outbreak (publications approval reference: 001559), assurance was sought that each patient has been clinically reviewed based on their individual clinical risk factors. For some, postponement of treatment has been assessed as clinically the safest thing to do. The Restoration & Transformation Cell has oversight of all service changes that fall outside of national guidance; step down and up. The process includes providers having to complete a QEIA and is reviewed by both commissioning and quality senior leads. The CCG is also informed by and seeks assurance through: • Provider Governance Committees to monitor provider processes for measuring impact of implementing national guidance. (assurance) • Provider led Clinical Reference Groups. (assurance) • Service line restoration groups, facilitated by the CCG, informing the R&T Cell workstream. (information and assurance) • Reporting of the CCG commissioned Population Needs workstream (information).	Darryn Allcorn	Sara Wright		**26/11/2020**	29/10/2020	**4**	**5**	**20**	
COVID 38 (Wave 2)	**CRR**	**138**	**Nursing & Quality**	COVID-19 Vaccination programme	There is a risk that NHSE/I and NHS Devon CCG will be unable to deliver the mass COVID-19 vaccination programme. NHSE/I and CCGs are responsible for the planning and resources of a phased programme of vaccination. The programme may be affected by several factors, including: • The recruitment programme not being as effective and the impact on BAU for health and social care • PPE requirements for healthcare workers delivering the vaccination clinics will be high, increasing the risk of a PPE shortage • Location, choice of venues and accessibility • Wastage of vaccine due to limitations in timeliness of distribution and safe storage • Impact should the uptake reduce for the second vaccine, following any side effects, increasing vulnerability both individual and system wide • Impact on the booking system should there be technical failure of IT systems • Likelihood of additional costs associated with delivering the vaccinations in different ways and to additional cohorts, resulting in cost pressures for the CCG if the dedicated funding support runs out • Potential legal challenge under the Equality Act if equal access to the vaccination programme is not provided • Reputational impact due to potential harm or perception that the CCG is impacted by patient outcomes, as one of the lead organisations responsible for delivery of this vaccination programme	The impact of this is if NHSE/I and the CCG fail to deliver a phased programme of vaccination addressing delivery via vaccine hubs, primary care and any large scale vaccination sites it could result in a reduced safe and effective vaccine, adequate vaccinator capacity, cold chain management and public safety issues.	December 2020 - UHP have begun vaccinating, as have mass immunisation sites and PCN sites (JP) December 2020 • NHSE/I have been undertaking planning with dedicated capacity for several months. A system programme board exists chaired by CCG Chief Nursing Officer (with PH representation) to oversee planning and delivery. • QEIA completed on delivery programme • Communication plan to manage attitudes for vaccination take up	Darryn Allcorn	Jonathan Plumb	December 2020 • Change of plan announced on 09.11.20 for Primary care to deliver vaccination programme but plan may still involve mass vaccination sites. • Impact on BAU if CCG staff recruited to deliver vaccines Variations in guidance and detail updated from national on a daily basis means there is complexity in monitoring consistent gaps.	**21/12/2020**	18/12/2020	**3**	**3**	**9**	
COVID 39 (Wave 2)	**CRR**	**139**	**Nursing & Quality**	Infection control team capacity	There is a risk that there is insufficient capacity within the CCG infection control workforce to meet both the duties of the COVID-19 pandemic and those of normal Infection Prevention & Control (IPC) business. * COVID-19 business; potential to fail to gain assurance on COVID-19 outbreaks, programmes of work and overall status within the Devon footprint and potential to not provide operational advice in a timely fashion when requested	The impact of this is on: * Normal business; reduced focus on prevention & monitoring functions, including rates of notifiable hospital-acquired infections, reduced ability to attend and gain assurance from provider infection control meetings, change in focus of IPC sub teams due to COVID-19 support and reduction in capacity to monitor and support the Devon flu vaccination programme	December 2020 • Improvements to structure of IPC team to improve resilience, including the short-term reallocation of staff members to the team to cover specific workstreams • Improved definition of community infection management service roles, both in an out of a pandemic scenario • Work with local authority partners to recruit additional staff • Move to generic IPC email address • Quarterly IPC report to Quality Assurance Committee • Section in monthly quality report to Quality Assurance Committee	Darryn Allcorn	Alastair Harlow	December 2020 • Delay to new staff recruitment through local authority • Unanticipated and unpredictable pandemic workload • Additional unanticipated workstreams- for example, avian flu Team email address and action log only recently set up and not fully integrated into process	**21/12/2020**	21/12/2020	**4**	**3**	**12**	

COVID Incident Risk Register - Wave 2

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

Risk Reference	Risk also held on CRR - Corporate Risk Register Team Risk Register	Risk ID on CRR or TRR	Area of Risk	Risk Title	Exec Lead	Risk Owner	Last Reviewed	Date Added	Likelihood	Impact	Risk Score	Risk Score Movement @ last review date
COVID 01 (Wave 2)			COO	Winter Pressures	Jayne Carroll	Al Wilkinson					0	0
COVID 02 (Wave 2)		(COVID Wave 1 risk 17)	Staff	Staff Capacity and Resilience	Andrew Millard	Piers Tetley		23/12/2020	3	3	9	9
COVID 03 (Wave 2)			COO	Pressure on System	Jayne Carroll	Al Wilkinson					0	0
COVID 04 (Wave 2)	CRR	100	Nursing & Quality	SWASFT Call Stacking	Darryn Allcorn	Sarah Zanoni	03/12/2020	09/01/2019	4	3	12	12
COVID 05 (Wave 2)	CRR	109		Underperformance Constitutional Standards	Jayne Carroll	John Finn	09/10/2020	06/06/2019	5	4	20	20
COVID 06 (Wave 2)	CRR	117	Primary Care	COVID-19 General Practice	Jo Turl	Rob Payne	02/12/2020	12/03/2020	4	4	16	16
COVID 07 (Wave 2)	CRR	118	Primary Care	COVID- 19 - Primary Care Team	Jo Turl	Rob Payne	02/12/2020	12/03/2020	3	4	12	12
COVID 08 (Wave 2)	CRR	119	Nursing & Quality	Flu vaccination programme risk 2020/21	Darryn Allcorn	Jonathan Plumb	11/12/2020	19/06/2020	3	4	12	12
COVID 09 (Wave 2)	CRR	120	Primary Care	COVID-19 – Transference of work to Primary Care	Jo Turl	Rob Payne	02/12/2020	13/07/2020	3	3	9	9
COVID 10 (Wave 2)	CRR	122	Nursing & Quality	Backlog of LeDer Reviews & System Workforce Capacity	Darryn Allcorn	Sue Harvey	09/12/2020	29/07/2020	1	4	4	4
COVID 11 (Wave 2)	CRR	123	Nursing & Quality	Fit testing – PPE/COVID	Darryn Allcorn	Vanessa Crossey	11/12/2020	04/08/2020	3	4	12	12
COVID 12 (Wave 2)	CRR	124		Delivery of Control Total	John Dowell	Kevin Wheller	29/10/2020	06/08/2020	3	4	12	12
COVID 13 (Wave 2)	CRR	128	IG	Shared working area confidentiality	Ginny Snaith	Matt Spry	03/12/2020	03/09/2020	3	2	6	6
COVID 14 (Wave 2)	CRR	130	EPRR	COVID-19 Incident Response	Sonja Manton	Phil Coutie	17/11/2020	17/09/2020	3	4	12	12
COVID 15 (Wave 2)	CRR	131	EPRR	Emergency Preparedness	Sonja Manton	Phil Coutie	17/11/2020	17/09/2020	2	3	6	6
COVID 16 (Wave 2)	CRR	132	Primary Care	Robust incident reporting processes not in place across primary care	Jo Turl	Rob Payne	08/12/2020	16/09/2020	4	3	12	12
COVID 17 (Wave 2)	CRR	133 (COVID Wave 1 risk 07)	Nursing & Quality	Changes to services commissioned by the CCG	Darryn Allcorn	Sara Wright	26/11/2020	21/10/2020	2	5	10	10
COVID 18 (Wave 2)	CRR	134		Operational delivery by Child and Family Health Devon	Jo Turl	Siobhan Grady	01/12/2020	27/10/2020	5	3	15	15
COVID 18 (Wave 2)	CRR	135	Nursing & Quality	CHC Assessment Backlog	Darryn Allcorn	Jo Shill	18/11/2020	28/10/2020	4	4	16	16
COVID 19 (Wave 2)	CRR	136	Nursing & Quality	Care Home & Care at Home	Darryn Allcorn	Jo Shill	18/12/2020	29/10/2020	4	4	16	16
COVID 20 (Wave 2)	CRR	137 (COVID Wave 1 risk 29)	Nursing & Quality	Impact of implementation of National Guidance	Darryn Allcorn	Sara Wright	26/11/2020	29/10/2020	4	5	20	20
COVID 21 (Wave 2)	Contracting	2- 20201026		Implications of Covid	John Dowell	Rebecca Clarkson		26/10/2020	4	3	12	12
COVID 22 (Wave 2)	DRSS	DRSS 008	DRSS	Delivery Team	Penny Harris	Steve Matson		03/11/2020	3	4	12	12
COVID 23 (Wave 2)	Governance	GOV 016	EPRR	Communicable Disease Pandemic Incorporating National & LRF Risks of • Pandemic Influenza • Emerging infectious disease pandemic (e.g. Covid-19, Suspect.)	Ginny Snaith	Phil Coutie		12/12/2020	4	4	16	16
COVID 24 (Wave 2)	Meds Op	MO 9	Medicines Optimisation	PCMO Strategic Group MO SMT	Jo Turl	Leanna Brown					0	0
COVID 25 (Wave 2)	Nursing and Quality	N&Q0003	Nursing & Quality	Covid-19 System Impact	Darryn Allcorn	Sue Drew					0	0
COVID 26 (Wave 2)	Nursing and Quality	N&Q0005	Nursing & Quality	Impact on not accessing services in a timely way	Darryn Allcorn	Sue Drew					0	0
COVID 27 (Wave 2)	Locality Risk Register	Localities (COVID Wave 1 risk 33)	COO	Seven day discharge	Chief Operating Officer						0	0
COVID 28 (Wave 2)	Locality Risk Register	Localities (COVID Wave 1 risk 35)	COO	Capacity planning for urgent care	Chief Operating Officer						0	0
COVID 29 (Wave 2)	Locality Risk Register	Localities (COVID Wave 1 risk 36)	COO	Delayed discharges	Chief Operating Officer						0	0
COVID 30 (Wave 2)	Locality Risk Register		COO	Voluntary sector - recruitment	Chief Operating Officer	John Finn					0	0
COVID 31 (Wave 2)	Locality Risk Register		COO	Discharge 2 Assess	Chief Operating Officer						0	0
COVID 32 (Wave 2)	Locality Risk Register		COO	Pulmonary Rehab	Chief Operating Officer						0	0
COVID 33 (Wave 2)	Locality Risk Register		COO	Cardiac Rehab	Chief Operating Officer						0	0
COVID 34 (Wave 2)	Locality Risk Register		COO	Spirometry	Chief Operating Officer						0	0
COVID 35 (Wave 2)	Locality Risk Register	Localities (COVID Wave 1 risk 34)	COO	Acute bed occupancy	Chief Operating Officer						0	0
COVID 36 (Wave 2)	Locality Risk Register		COO	Stroke Performance	Chief Operating Officer						0	0
COVID 37 (Wave 2)	Locality Risk Register	Localities (COVID Wave 1 risk 37)	COO	Discharge and OOH Cell	Chief Operating Officer	Lorraine Webber					0	0
COVID 38 (Wave 2)	CRR	138	Nursing & Quality	COVID-19 Vaccination programme	Darryn Allcorn	Jonathan Plumb	21/12/2020	18/12/2020	3	3	9	9
COVID 39 (Wave 2)	CRR	139	Nursing & Quality	Infection control team capacity	Darryn Allcorn	Alastair Harlow	21/12/2020	21/12/2020	4	3	12	12
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NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 28 January 2021

Dates of Committees covered in this report: 17 December 2020 and 21 January 2021

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

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

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

Members of the Committee discussed the following reports at 17 December 2020 meeting:

- **Risk Register Reports – see Risk Register review below.**
- **Quality & Performance Report – the Committee received information on key quality and performance indicators for the period 1 April to 31 October 2020, including those contained in the NHS Constitution. The Committee concentrated its discussions on the actions being taken, and planned, to address the following areas which were highlighted: -**
    - **Although performance against the Cancer Waiting Times standards remained relatively stable through the initial Covid-19 period, the second wave of COVID19 has presented challenges for availability of appropriate theatre capacity and clinical staff.**
    - **The STP position against the 62-day standard fell from 81.3% to 71.4%; 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 79.9% in September to 78.1% in October. All providers were below target with NDHT falling from 93.9% to 90.1%, whilst RDEFT fell from 75.3% to 71.5%, TSDFT fell slightly from 75.1% to 74.8% and UHP fell 84.7% to 83.2%.**
    - **Staffing levels, as a result of sickness, and access to diagnostic pathways continue to be 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 58.3% to 60.4% at STP level compared to the target of 92% and national performance of 52%. However, long wait patients continued to increase, with over 52 week waits rising quickly at all providers in October.**
    - **Diagnostic waiting times have been significantly affected by the Covid-19 pandemic.**

Performance remains static this month, with the STP position of 67.6% remaining well below the 99% target and below the England position of 70.8%.

- **The Committee was informed that the Adapt and Adopt programme continues to drive initiatives in key areas of capacity and efficiency.**
    - **A mutual aid process is in place for all surgery, although opportunities to mitigate via this method continue to be difficult.**
    - **For Outpatients, physical capacity remains the main issue across the system and recovery volumes are falling behind recovery targets. At RDEFT the EPR go-live led to a fall in activity. Patient-initiated follow up (PIFU) has now been implemented within a number of specialties across the system - the BI team is leading the work to understand the beneficial impact. Trust leads and clinicians are committed to learning from each other and external partners to accelerate local implementation. In line with the Adapt and Adopt ambitions, this should create further capacity in Q4.**
    - **Innovative pathway work in Dermatology and Orthopaedics has been presented to the outpatient leads and clinicians by UHP and NDHT respectively.**
    - **Drive-through glaucoma and cardiac pacemaker clinics at UHP are being considered as a model for other trusts.**
    - **The backlogs in CT are being addressed at each provider.**
    - **Efficient use of the independent sector has continued to provide additional capacity, with significant delivery above plan in outpatient and theatres becoming the norm now that service models have become established.**
    - **The NHSEI notice on the current independent sector contract will be rescinded and the new contract will commence on 1 January and continue to 31 March 2021. The form of this arrangement is more likely to match the needs of commissioners for patients in Devon and the Q4 contract is expected to reflect the service delivery used to date and continue to offer additional capacity to support recovery.**
- **A&E waiting times - Attendances volumes are currently 28% below those in October last year. November saw an improving performance against the 95% national four-hour standard – at 82% for all types and 75% for type 1 attendances, remaining below the standard and the England position at 80.4%.**
- **111 Performance - The proportion of 111 calls answered within 60 seconds increased from 70.6% in October to 74.2% in November, though still below the target of 95% and the national average of 80.8%. The call abandonment remains high at 11.1% (a better position from October) – the national average is 4.2% abandoned calls. The following actions have been taken this month:**
    - **Ongoing recruitment of call handling workforce supported by recruitment and retention plan, resulting in an overall increase of 90% more resource;**
    - **Ongoing developments and refinements to the governance structure including reporting with support being provided from CCG colleagues;**

- **Comfort calling process extended to those patients waiting a home visit, improving patient safety for a vulnerable cohort;**

- **Transition has commenced to an operating model based on the 111 disposition codes, providing improved safety as patients will be treated by the IUCS based on their clinical priority rather than short timescale prioritisation;**

- **Mobilisation of the Think 111 First service from 1 December 2020, including further validations of dispositions to the Emergency Departments and 999 (category 3/ 4).**

Members of the Committee discussed the following reports at 21 January 2021 meeting:

- **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 November 2020, including those contained in the NHS Constitution. The Committee noted the following: -**

  - **The STP position against the 62-day standard rose from 71.4% to 79% but the latest surge of COVID 19 is expected to be evident in deteriorating performance in the coming months.**

  - **Staffing levels, as a result of sickness, continue to challenge and access to diagnostic pathways remain the focus of the Adapt & Adopt programme to increase capacity and productivity.**

  - **Referral to treatment times – a further improvement in RTT 18 week performance rising from 60.4% to 61.5% at STP level compared to the target of 92% and national performance of 68.2%. However, long wait patients continued to rise quickly at all providers in November.**

  - **Diagnostic waiting times have been significantly affected by the Covid-19 pandemic. Performance has improved slightly this month, with the STP position of 68.3% remaining well below the 99% target and below the England position of 72.5%.**

  - **The Committee was updated on the Adapt and Adopt programme initiatives in key areas of capacity and efficiency:**

    - **A mutual aid process continues for all surgery.**

    - **For Outpatients, physical capacity and staffing remains the main issue across the system and performance has dropped significantly.**

  - **A&E waiting times - Attendances volumes are currently 22% below those in December last year. December saw a slight fall in performance against the 95% national four-hour standard – at 80.5% for all types and 74.1% for type 1 attendances, remaining below the standard and the England position at 75.5%.**

  - **There continues to be significant delays in ambulance handover at UHP. In December there were 1,413 delays (that is handovers that took more than 15 minutes) leading to a lost resource time of 627 hours. By way of comparison, RD&E had 624 delays and lost 62 hours of resource time; TSD had 549 delays with 104 lost resource hours and NDHT had 194 delays with 22 hours of lost resource time. Work continues with the Western system to try and better understand the root cause of the handover delays.**

  - **111 Performance - continues to improve, with an increased proportion of calls answered**

and fewer abandoned, continuing the improvements from the poor position in October. The proportion of calls answered within 60 seconds has risen from 70.6% in October to 74.20% in November 2020 and, by 10 January, DDOC had been at or above national performance each week for the sixth consecutive week, 82% compared to national average of 58%. However, they are expecting to see a drop in performance due to the impact staffing and capacity issues due to COVID 19.

Reports received and noted

<u>Members of the Committee discussed the following reports at 17 December 2020 meeting:</u>

- **<u>Devon CCG Monthly Finance Report</u> - the report again reminded the Committee of the draft budget previously agreed (a deficit position of £47.8m with a savings requirement of £22.6m). This draft budget had not received approval by NHSE, who had instead put in place a temporary financial regime for the period 1 April to 30 September 2020, with an expectation that CCGs would break even during this time.**
    - **A revised financial framework has been published for the period October 2020 to March 2021 and the allocation calculation methodology for the CCG is generally consistent with the approach used for the first 6 months, although this now includes system top-up and COVID19 allocations, previously paid directly to providers. In addition to this CCGs will continue to be reimbursed for eligible costs in relation to the Hospital Discharge Programme.**
    - **Assuming the CCG is reimbursed for the NHSE approved Hospital Discharge Programme costs that the CCG has and will incur then we are forecast to balance our position for the year ended 31st March 2021.**
    - **The updated financial regime exposes the CCG to an estimated £6.0m risk in regard to Plymouth Orthopaedic Partnership (POP) and the nationally contracted independent sector activity that is being passed back to CCGs. We are awaiting further guidance and clarification.**
- **<u>STP Monthly Finance Report</u> – the paper was presented for information to the Committee, outlining the position at Month 6.**
    - **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 6 the Devon system required a true-up payment of £106.4m to break even after any top-up payments.**
    - **Total costs for COVID-19 was £102.4m for M1-6 (M5 £90.5m)**
    - **Year to date overspend on bank of £5.9m (£5.3m M5) is partially offset by an underspend on agency of £3.5m (M5 £3.1m)**
- **<u>Annual Contracting Team Update</u> – the Committee received an update on the work of the CCG's**

Contracting Team between January and December 2020, including contractual business undertaken and issues arising. The Committee noted that it had been a difficult and challenging year, with staff redeployment, secondments, working from home, amended job roles but the Committee was delighted to hear that the team had been nominated and shortlisted for a Celebrating You Award.

Members of the Committee discussed the following reports at 21 January 2021 meeting:

- **Devon CCG Monthly Finance Report – a further report detailed the financial position for the period ending 31st December 2020, as well as the forecast outturn (FOT) for year ending 31st March 2021. The assumption remains that, subject to being reimbursed for the NHSE approved Hospital Discharge Programme costs, the CCG is forecast to balance our position for the year ended 31st March 2021.**

- **STP Monthly Finance Report – a further report the Committee outlined the position at Month 7.**

    - **The STP moved into phase 3 of the financial framework for months 7-12 of 20/21.**

    - **The STP submitted a plan for months 7-12 which showed a deficit of £7.8m relating entirely to a shortfall in private / commercial income. The new plan includes an adjusted block contract payment to each provider.**

    - **A system allocation for COVID was received, but costs relating to Nightingale, COVID testing, PPE and Hospital Discharge Programme will be funded separately. An elective incentive scheme, whereby a penalty is enacted based on a shortfall in activity, was estimated to be £7.8m at the planning stage.**

        - **As at month 7 the Devon system had a YTD favourable variance of £2.6m.**

        - **The forecast outturn at M7 showed a £0 variance to plan.**

        - **As at M7, there has been £84.3m of COVID related spend, with an additional £25m spent on Nightingale and £1.1m spent on virus testing.**

        - **M7 year to date overspend on bank of £1.1m (M6 £5.9m), forecast overspend on bank is £2.0m**

        - **YTD overspend on agency £0.5m (M6 underspend £3.5m), forecast overspend on agency £2.0m.**

        - **The spend on substantive staff is underspent by £3.7m as at M7 and forecast to be underspent by £2.5m at the year-end.**

    - **The Committee asked for more information to a future meeting on two issues: -**

        - **Capital Delegated Limits (CDEL) is overcommitted, with a risk of future years' allocation being reduced.**

        - **An explanation of the growth in system workforce (WTEs).**

- **Phase 4 Planning Approach – 2021/22 Devon System Operating Plan – the Committee noted that a letter had been published on 23 December 2020, setting out the operational priorities for winter and 2021/22, asking systems to continue to:**

    - **Recover non-COVID services in a way that reduces variation in access and outcomes, aiming for top quartile performance in productivity on high volume pathways**

(ophthalmology, cardiac services and orthopaedics). In advance of targeted funding for addressing backlogs, delivering productivity and outpatient transformation, systems should appoint a board-level executive lead per trust and per system for elective recovery;

- **Strengthen delivery of local People Plans;**
- **Address the health inequalities that COVID has exposed (making progress on theeight urgent actions set out in the letter of 31 July 2020);**
- **Accelerate the planned expansion in mental health services through delivery of the MHIS;**
- **Prioritise investment in primary and community care to deal with the backlog and likely increase in care required for people with ongoing health conditions and support prevention through vaccinations and immunisations;**
- **Build on the development of effective partnership working at place and system level. The letter goes on to set out the key features of the 21/22 financial framework and resolves to circulate underlying financial numbers early in the new year.**

- **The Committee further noted that to reflect the ongoing progression to an ICS, the ambition is to develop a System Plan, built up from our five LCPs and constituent provider plans, utilising the emerging ICS governance for development and sign off of the plan.**

Risk Register Review (changes and areas of concern)

There have been no risks recommended for closure. At the December meeting, the risk score for risk 106, Sustainability, was reduced from 12 to 9 (L = 3 I = 3). At the January meeting, a new risk was agreed by the Committee to cover 2021/2022 financial delivery - with the operational planning process suspended for 2020-21 and the emergency financial framework in place, it is unclear at present whether any worsening in underlying position will, as a result of the current climate, be mitigated in part or in full with a revised settlement for the CCG and system for 2021-22.

Committee Decisions

<u>Members of the Committee discussed the following reports at 17 December 2020 meeting</u>

- **<u>The NHSE/I Independent Financial Review</u> - Following earlier discussions in February and October 2020, regarding the conclusions of the NHSE/I Independent Financial Review report:**
  - **The Committee agreed an action plan that had been reviewed by the System Finance Working Group. This set out the main actions and recommendations contained within the final NIST report together with examples of where action has already been taken, what future action is still required and where the recommendations are felt no longer applicable.**
  - **The Committee was pleased to note that that the report and action plan was being taken to each Organisation's Finance Committee (or equivalent) to ensure a total system response, and that this had been forwarded to the SW Regional Director of NHSE/I. The Committee asked for monthly updates.**

- **The Committee received a further update on the <u>development of a system financial framework and financial plan for 2021-22</u>, and considered, tested and agreed with an early view of the**

assumptions, principles and contracting intentions.

Members of the Committee discussed the following report at 21 January 2021 meeting:

- **2019/20 Annual Assessment – the Committee received a report outlining the process going forward following the publication of the CCG rating of 'Inadequate' in November 2020. A letter had been sent to the Regional Director of NHSE/I, setting out actions to be taken forward. The Committee noted that delivery plans to support this work are in process and requested a further update to the April or May meeting.**

Recommendations for Governing Body
• **Updated Terms of Reference were agreed by the Committee at its January meeting, to reduce the number of clinical leads on the Committee from two to one, as one member is being released to support other important, time critical, work. The Governing Body is now asked to approve these revised Terms of Reference, attached.**
Recommendations for other Committees
• **None.**
Terms of Reference or other committee effectiveness issues
• **As noted above, updated and amended Terms of Reference were agreed at the January meeting, for approval by Governing Body.**

Management of Conflict of interests:

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

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

Finance and Performance Committee
Terms of Reference

1. Constitution

1.1	The Governing Body of NHS Devon Clinical Commissioning Group (the CCG) hereby resolves to establish a Committee of the Governing Body known as the Finance and Performance Committee. The Committee is established in accordance with the CCG's Constitution, Standing Orders and Scheme of Delegation. These Terms of Reference set out the membership, responsibilities and reporting arrangements of the group and shall have effect as if incorporated into the CCG's constitution.

2. Purpose

2.1	The Finance and Performance Committee is the overarching finance assurance committee. To provide assurance that the commissioning of services is; evidence based, in line with the strategic objectives of the CCG, and inclusive of national and local requirements.
2.2	Oversee CCG performance against statutory duties and legislation for financial governance, escalating any issues considered to impact on the commissioning of services.
2.3	To provide assurance to the Governing Body and Audit Committee that the CCG is achieving the commissioning, financial and performance elements of its plan. This is to be achieved through judgement, scrutiny, and independent and objective review.
2.4	To have oversight of budget, financial plans and any financial recovery plans.
2.5	Review and approve finance and performance reports prior to submission to the Governing Body.
2.6	To objectively assess and assure the Governing Body that the internal business support services are operating effectively, are responsive to the business need and offer value for money.
2.7	Oversee care pathways and services that support the financial plans and vision of the CCG. Consider clinical quality and safety in all commissioned services and make recommendations to the Quality and Assurance Committee or Governing Body as appropriate.
2.8	Ensure a clear escalation process, including appropriate trigger points, is in place to enable the committee to respond when the CCG is under financial pressure.
2.9	The committee will meet jointly with the Quality Assurance Committee on a regular basis, as determined in the corporate calendar, to ensure that there are robust and functioning systems in place to commission safe, economical and effective treatment and care for patients, and that the experiences of patients are cost effective and positive.

3. Membership

3.1	The membership of the Finance and Performance Committee will be: • Clinical lead (1) • Non-Executive Directors/Lay Members (3) • Director of Finance • Director of Commissioning

	• Chief Operating Officer
3.2	The role of Chairman and Vice Chairman will be undertaken by either a clinical lead or Non-Executive Director/Lay Member.
3.3	Members are required to attend a minimum of 75% of meetings, other than absence due to sickness.
3.4	Membership will be reviewed regularly to adjust for changes as required by the purpose of the Committee.
3.5	The membership of the Committee will be shown in the CCG's Annual Report
3.6	The Committee is empowered to request any other officer employed by the CCG to attend meetings for the purpose of providing advice, clarification, recommendation or explanation in respect of any matter that falls within the responsibilities of the Committee. In this instance attendance shall be by invitation for part of the agenda where relevant to their area of accountability. As necessary, the Committee may also require the production of any document if it relates to the business of the Committee.
4. Quorum	
4.1	A minimum of four members will constitute a quorum, provided this includes a Non-Executive Director, two of the named directors on the membership, or in their absence, a nominated deputy through agreement with the Chair, and one clinical representative. In the absence of the Chair of the Committee, one of the Non-Executive Directors present will chair the meeting.
4.2	When a committee member is unable to attend, a nominated deputy with sufficient authority should be asked to attend where necessary. Deputies will have the decision-making and voting rights of the person he/she is representing.
4.3	A decision put to a vote at the meeting shall be determined by a majority of the votes of members and deputies present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.
4.4	Where agreed with the Chair, members of the Committee may participate in meetings by telephone, by the use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting using these methods shall be deemed to constitute presence in person at the meeting.
5. Frequency of Meetings	
5.1	The committee shall meet no less than 6 times a year to carry out its responsibilities. The chair of the committee may call for additional meetings as required.
6. Conduct of the committee	
6.1	The Committee shall conduct its business in accordance with national guidance and relevant codes of practice including the Nolan Principles and the Standards of Business Conduct.
6.2	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.
7. Administration	
7.1	The Finance Directorate will provide administrative support for the Committee under the direction of the Director of Finance. This administrative support shall be responsible for

	keeping minutes of the meetings and providing any required advice to the Committee.
7.2	The committee administrator will maintain a forward planner detailing regular items for presentation to the committee to include performance reporting, advising contributors of required papers and giving deadlines.
8. Accountability and Reporting	
8.1	The Committee is a Sub-Committee to the Governing Body. Minutes from the meeting will be received by the Governing Body along with a covering report that identifies any specific issues to be brought to the attention of the Governing Body. An annual report of the Committee's performance, membership and Terms of Reference will be submitted to the Governing Body.
8.2	Assurances shall be received from the following: • Sustainability Transformation Partnership • QIPP / CIP • Executive members of the Committee • Contracting • Business Intelligence.
8.3	Assurance will also be received regarding the effectiveness of each committee, in full at least annually, and a committee effectiveness report from this committee will subsequently be presented to the CCGs Audit Committee.
9. Responsibilities	
9.1	Treasury Management • Scrutinising and recommending to the Governing Body the CCG's five-year financial plan and all long term (in excess of one year) borrowing proposals. • Scrutinising the delegated arrangements for day to day treasury management. • Scrutinising regular reports from the Director of Finance on transactions undertaken on behalf of the CCG.
9.2	Capital Expenditure • Monitoring performance against the approved capital plan. • Scrutinising and recommending to the Governing Body the CCG's proposed five-year capital programme. • Scrutinising and recommending to the Governing Body the approval of all business cases for expenditure in excess of £2m. • Scrutinising and approval of all business cases for expenditure between £0.5m and £2m. • Scrutinise post implementation reviews of business cases for schemes with expenditure above £1m
9.3	Financial Planning • Review the CCG's proposed annual financial plans and detailed budget to recommend for formal approval by the Governing Body. • Review the CCG's 'In year' financial position. Receive a detailed report of the financial position and progress towards meeting the targets within the CCG financial plan and approved budgets. • Where financial plans are off target, monitor progress against these plans ensuring that formal corrective plans are considered at the Committee and presented formally to the Governing Body for approval. • Implementation and monitoring of recovery schemes. Receive updates on both the financial and activity performance of each scheme. • Contract sign off over de-minimus level (relates to procurement, tendering and contracting) to ensure no deviation from plan (the majority of this will be covered via the annual planning and approvals process).

	• Detailed financial review and formal recommendation to Governing Body in relation to section 75 agreements. • Review how the supporting strategies link to the financial and operational plans. • Sign off financial envelopes • Implement and monitor transformation schemes. Receive updates outlining financial performance, activity and delivery against key performance indicators for each scheme.
9.4	Procurement • Approve the procurement strategy for onward approval by the Governing Body. • Approve the annual procurement plan. • Develop and review procurement policies and procedures for approval by the Governing Body. • Approve decisions to procure through open tender or other approved processes for services with a value in excess of £2m.
9.5	Financial Risks • Active identification and review of mitigations for financial risk within the corporate risk register and assurance framework.
9.6	Quality Innovation Productivity and Prevention • Responsible for Quality, Innovation, Productivity and Prevention (QIPP) plan, performance monitoring, and governance.
9.7	The principal responsibilities include but are not limited to; • Prepare the CCG's operational scheme of delegation, which sets out key operational decisions delegated to the Director of Finance • Prepare detailed financial policies that underpin the CCG's prime financial policies • Approve detailed financial policies • Approve arrangements for managing exceptional funding requests • Provide assurance on the financial performance and delivery of any remedial action plans • Review and approval of financial (operational) schemes of delegation authority limits • Financial business cases scrutinised prior to approval • Approval of the CCG's contracts for any commissioning support (in the event this is not provided in-house) – subject to financial limits as set out within the operational scheme of delegation • Approval of the CCG's contracts for corporate support (in the event this is not provided in-house) – subject to financial limits as set out within the operational scheme of delegation • Receive and review proposals and business cases in line with limits as identified in the operational scheme of delegation • Oversight of system savings reports for assurance and comment
10. Risk Reporting	
10.1	• Internal - Quality and safety performance. Compliance with Statutory requirements. • External - Provider performance.
10.2	The Committee will review the Finance cut of the assurance framework each month. The agenda will be proportionate to the level of the risk highlighted within the assurance framework, and deep dives will occur on a planned basis into the highest scoring quality risks.
11. Process for Monitoring Compliance with Terms of Reference	
11.1	Five days prior to each meeting, the Administrator for the Committee will ensure that the meeting is quorate. If the meeting is not quorate the Chair must be contacted.

11.2	The Chair will escalate any urgent or critical issues, which may put at risk the people who use our service or the reputation of NHS Devon CCG, to the relevant Committee/Persons 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 CCG Strategic Leadership Committee
11.3	An effectiveness review will be undertaken by the Head of Governance no less than annually.

12. Terms of Reference Review	
12.1	These terms of Reference will be reviewed on an annual basis or sooner if required following an effectiveness review which will be performed annually in line with next review date shown on this document.

Version	**Approved By**	**Approval Date**	**Next Review Date**
V2.0	**Finance & Performance Committee (21.01.2021)**	**21.01.2021**	**Q4 2020/2021**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 28 January 2021

Dates of Committees covered in this report: 21 January 2021

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

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

The Committee received updated reports as detailed below

Reports received and noted

Quality and Safety Report
Highlights from the report are:-

- CFHD: Concerns continue as to the progress of the safeguarding action plan. Key areas escalated.
- Significant pressure has been reported in all localities.
  Workforce remains a challenge, with staff absent due to COVID and non COVID reasons across all acute hospitals, and others being asked to move areas or their focus of work to manage workload and mitigate risk.

Community Deprivation of Liberty Report
This is a financial risk to the CCG arising from people who are deprived of their liberty who do not have a community deprivation of liberty authorisation. There are measures in place to mitigate the risk; however significant gaps remain. The main barrier to legal compliance is staff time within provider services to complete the necessary court applications. The Committee agreed that this risk should remain on the corporate risk register; noted that the pandemic meant that that provider teams were unable to make significant progress on this issue at present; endorsed the request to provider services to consistently identify and prioritise those who require deprivation of liberty authorization.

Safeguarding Quarterly Report

- Children In Care - There has been a 6.5% increase since March 2020 of children entering care across the CCG footprint.
- Devon and Torbay Safeguarding Adults Boards have merged to form the Torbay and Devon Safeguarding Adult Partnership.
- Multiagency Risk Assessment Conferences (MARAC) - high risk domestic abuse cases are discussed at monthly meetings. There is inconsistency in the engagement of primary care in the MARAC process.

Risk Register Review Updates

Quality Risk & Assurance Report including Risk Register:

Risk Register Review (changes and pertinent areas). Data was extracted for this report on the 6 January 2021 of which it informs the Committee of any changes since the last Quality Assurance Committee (QAC) on the 17 December 2020. The organisation has 34 risks in total and fourteen of these report to QAC. The Committee • Agreed two new risks,138 and 139 • Noted that three risks have moved in score, increase in risk 100, decrease in risk 123 and 122. • Agreed to close risk 122
Committee Decisions
• None
Items of concern to be escalated to the Governing Body
• None
Recommendations for Governing Body
To note the reports received and positions of assurance by the Quality Assurance Committee.
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 28 January 2021

Date of Committee covered in this report: 07 January 2021 (Minutes of this committee meetings to be available as an addendum

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

This was a shortened form of PCCC meeting to approve 2 papers only. The usual PCCC meeting was stepped down due to pressures on the capacity of the Primary Care Team during their support of Primary Care during priority COVID Vaccination

Committee Decisions

1 Teignmouth Practices Relocation to Health and Wellbeing Centre:

An 8-week public consultation ran from 01 September 2020 on a proposal to modernise health and care services in the Teignmouth and Dawlish area by backing Torbay and South Devon Foundation Trust's (TSDFT) plans to build a new Health and Wellbeing Centre so that GP services, health and care and voluntary sector services can co-locate.

The Committee noted the CCG Governing Body's approval of the overarching redesign regarding the modernisation of health and care services in the Teignmouth at its meeting on 17 December 2020.

The Committee formally approved:

- The relocation of Channel View Medical Group to a new Health and Wellbeing Centre (due to open in 2022) in Brunswick street, Teignmouth, approval being subject to the formal contractual and regulatory processes associated with such a relocation, including the requirement for proportionate patient consultation, being satisfactorily adhered to and put before Committee at future meeting for ratification.

2 Procurement Update for the Provision of Primary Medical Services in Sherford

The Committee reviewed the Contract Award Recommendation Report (CARR) in relation to the procurement for the provision of Primary Medical Services in Sherford.

Discussions between the CCG and the Sherford Partnership Board have established the immediate need to provide sustainable, gradually expanding, financially viable and long-term General Practice (GP) facilities to the population of Sherford.

The committee approved the allocation of the Sherford Primary Care contract work to the Beacon Medical Group
Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Commissioning Committee

Date of Governing Body: Thursday 28 January 2021

Dates of Committees covered in this report: Thursday 10 December 2020 & Thursday 14 January 2021 (Minutes of the committee meeting are to be available as an addendum)

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

Presented by Dr Nick Kennedy, Independent Secondary Care Clinician

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

Reports received and noted

Thursday 10 December 2020 Meeting
Leg Ulcers

- The Committee received a report update on the proposal for Leg Ulcers. The committee requested that further information was provided for a decision to be made at the January committee.

Community Mental Health Framework

- The Committee were provided with a presentation update on the Community Mental Health Framework and the implementation plans that would be put in place when the final version of the Community Mental Health Framework had been submitted on 20th January.

Thursday 14 January 2021 Meeting
Referral to Treatment – Patient Treatment List

- The Committee were provided with an update on the Referral to Treatment Patient Treatment List and the current position. It was noted that a piece of work has taken place with the clinicians of the trusts to provide a single patient treatment list across Devon, this is looking to be implemented with a new IT service within the next 3-4 months.

Risk Register Review Updates

Thursday 10 December 2020 Meeting:
The Committee accepted the recommendations made within the risk report and to close the action log action for risk ID 20 from Finance Committee.

Thursday 14 January 2021 Meeting:
The Committee endorsed the recommendations within the risk report to:

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

Committee Decisions

Thursday 10 December 2020 Meeting
Diagnostics

- The Committee approved the direction of travel for the diagnostics work and agreed that a further paper will be brought back to a future committee with preferred option for network governance.

Recommendation of Rosuvastatin for the prevention of cardiovascular disease
The Committee accepted the recommendation made by Clinical Policy Committee for rosuvastatin for the prevention of cardiovascular disease.

Thursday 14 January 2021 Meeting
Leg Ulcers
The Committee approved the recommendations within the Leg Ulcer paper to:

- Consider the indicative funding implications of approximately £550k to £1.057m of the proposed service specification and approve next steps on this basis.
- Note and consider the financial risk associated with withdrawing funding from existing block arrangements if competitive procurement was to be necessary.
- Support the recommendation for a direct award, based on the evidence presented in section 4 and appendix 3.
- Agree to the proposal to adopt a total purchase prescribing model, for the reasons outlined in sections 3.2.

Integrated Urgent Care Services
The committee were provided with a paper on the Integrated Urgent Care Services (IUCS) and approved the following recommendation:

- Competitive procurement but preceded by a short-term direct award to current provider (the length of which will be agreed by CCG Executives). The short term direct award is designed to allow sufficient time for a variety of factors, including ensuring a robust, safe and effective competitive procurement process (based partly on feedback from the market following a recent market engagement questionnaire) and to allow potential bidders time to embed Think 111 First and respond to the pandemic.

Primary Care Streaming in Western
The Committee approved the recommendations made for Primary Care Streaming in Western paper, as outlined below:

- To give immediate notice to DDOCS for the primary care streaming element of the contract for the western local (adjunct to IUCS) - £200,000.
- To agree to vary the UHP contract by £200,000 per annum with the specific requirement of providing medical leadership and medical input into the Urgent Treatment Centre, thereby increasing their capacity and

capability. (with effect from 1st April 2021 or date to be agreed). • To leave £27,000 contribution in the contract with Devon Doctors to acknowledge the need to fund the ad-hoc community hospital attendances in line with the rest of the county.
Items of concern to be escalated to the Governing Body
None.
Recommendations for Governing Body
None.
Recommendations for other Committees
None.
Terms of Reference or other committee effectiveness issues
None.

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