NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting
APPROVED minutes held in PUBLIC

Date: 26 November 2020 Time: 13:30 – 16:40 Location: Via Microsoft Teams

Item	Discussion	*Action*
1	**Welcome and Apologies** The chair welcomed everyone to the meeting and noted that the meeting would be recorded for members of the public to view and he reminded the members to conduct themselves in a way that was in keeping with their professional positions. PJ welcomed and was pleased to have Julia Boas (JB), deputy director of Intercom Trust and Darin Halifax (DH), Sustainable Transformation Programme (STP) Lead for the Voluntary, Community and Social Enterprise present to support the patient experience item on the agenda. Apologies were noted from: Caroline Dimond	
2	**Patient Experience** CB thanked and welcomed JB to the meeting and offered for her to share experiences of people that Intercom Trust support and this was an opportunity for the members to think about service users in lesbian, gay bisexual and trans (LGBT) communities in vulnerable positions. JB described the LGBT support across Devon and Cornwall and individual barriers service users may face in accessing healthcare. In a recent survey it was identified that this community are not accessing healthcare providers through fear or due to their own experiences. JB noted that she was aware of people from an older generation who have lived through criminalisation and who have been pathologised but have now reached certain freedoms. JB gave some examples of personal experiences and pointed out the duty equality act to meet the needs of service users. JB was pleased to report that good progress has been made and that we have a duty to become more aware and how we sensitively work with people that are LGBT. Currently we are encountering gender variants with no service available for users or some people being asked to go away as opposed to looking at a pathway for treatment. Being dismissed or turned away can be harmful, being able to have openness at a referral pathway would be of benefit as to how we treat people with dignity and respect. Feedback/ comments from members included: • JB confirmed that small training packages can be offered for staff that can be delivered remotely	

	• Acknowledgement that top down regulation sometimes gets in the way of sensitive conversations • Systems to be designed with LGBT in mind which will create more diverse identifies • Principles around informed consent to support decisions and having open conversations and understanding • Creation of a safe space for someone from the LGBT community to share their experience • Recognition that signage is not always non-binary and we need to make sure that service users' public areas such as toilets are available to everyone JB explained employer difficulties and the lack of understanding and not taking responsibility in challenging bullying in the workplace. AM referred to the newly formed Equality and Diversity Group and the work that the CCG has started regarding diversity and issues with Black, Asian, Minority Ethnic (BAME) community. This work has highlighted that we don't do enough for staff, patients and the public and felt that the CCG could also support some work in moving forward with the LGBT community. SMC pointed out that the NHS England annual staff survey was lagging as it only allows staff to state if they are male or female. AM responded and committed to feed this back to NHS England via our human resources (HR) department. **ACTION 1** **AM to liaise with HR regarding the NHS England annual staff survey and gender options for staff to state.** CB thanked JB for her time today and showed her appreciation for sharing service users' experiences. *JB and DH left the meeting.*	
	Questions from the Public There were no questions submitted in advance of the meeting by members of the public.	
2	**Register of Interest (ROI)** PJ referred to the ROI included in the pack and no amendments or new declarations were made. SMC declared that she would be taking on the clinical lead role for mental health. There were no conflicts of interests declared pertaining to the agenda items scheduled for this meeting. **The Governing Body received and noted the ROI and the additional declarations made.**	
3	**Minutes of the last meeting** PJ led a page by page review of the minutes of the last meeting held on 29 October 2020. Subject to a minor amendment on page 10 section 15 these minutes were approved as a true and accurate record of the meeting.	

	Action Log Actions 1-2 had been completed and it was agreed for these to be formally closed	
4	**Chairs Report** <u>System Lead Executive and Devon CCG Accountable Officer</u> PJ informed the members that following an interview process on the 18 November 2020 a candidate has been recommended and put forward to NHS England for their approval. Once the CCG has received formal approval, we will then proceed to making plans and formally announce the successful appointee and PJ was optimistic of a positive outcome. **The Governing received and noted the contents of the Chair's Report.**	
	Accountable Officer's (AO) Report ST noted that there were 250 people with COVID-19 in hospital beds, with 18 of them in intensive care and reported that the Nightingale Exeter would be receiving its first patients today being transferred from the Royal Devon and Exeter Hospital (RDE). SM highlighted that the increases in COVID-19 for Devon have exceeded wave 1 and we are experiencing competing pressures and capacity for services. It was recognised that teams in the CCG are working hard with our provider partners and that we have seen a slight impact in case rates and prevalence since the second national lockdown. We continue to manage and balance risk and acknowledge and recognise the efforts of staff. SK asked for assurance around keeping non COVID work going to support people to get access to Non COVID services and it was confirmed that we are using the independent sector to make sure we direct appropriate planned care from urgent care. This is challenging and there has been requests for mutual aid from hospitals who are also experiencing higher volumes of staff absence. Infection control measures are in place and virtual clinics are on-going. The opening of the Nightingale Exeter will have an effect and will also free up more than just beds. NK wondered whether the transfer of patients to the Nightingale Exeter would have a negative impact on ambulance services. SM responded to confirm that arrangements have been out in place including the working through of pathways for the clinical model and transport has been booked over and above what is expected. GT asked if the Governing Body would have an opportunity to review the Integrated Care System submission prior to submission and approval by NHS England. ST confirmed this, and that our partner boards will receive the same paperwork before final submission is made in January 2021. GAth congratulated ST on the staff awards ceremony which was indicative and inclusive of the culture of the CCG. **The Governing Body received and noted the contents of the Accountable Officer's Report.**	
	Winter Plan JC referred to draft system plan which reflected the system approach for planning for winter. This is an Integral part of phase 3 and she thanked all colleagues who have worked together as a system to bring together this overarching plan which has been overseen by the system wide urgent care board.	

	JC described the approach taken which has built on the learning from last winter and phase 1 of our response to COVID and she reported that we have delivered operational, locality and system initiatives. JC gave an overview of the document and signposted the members to section 3, 4 and 5 and noted that extensive work that has been undertaken looking at out of hospital capacity led by localities to help inform and understand gaps in capacity. Section 6 detailed individual plans for localities to address issues of capacity and section 7 provided information on escalation and governance arrangements. The operations centre acts in a coordinated response in line with the escalation framework around risk-based decisions. Section 8 described enabling plans for line services and it was recognised that the year has been challenging for all and supporting colleagues for resilience and wellbeing is fundamental as well as effective communications for members of the public. Section 9 identified the risks and monitoring review progress which is done on a regular basis and JC noted the importance of balancing capacity to maintain elective activity. As part of our assurance process regional colleagues will be reviewing our response to demand, capacity and surge and we are awaiting formal sign off. Positive feedback received has recognised a big step change in system working, and our plans will be used to share good practice. JC stressed the importance of working together as a system not just for health and social care but for voluntary sector and the wider system. PH reiterated the level of engagement which has been positively recognised by NHSE GApp asked about the high demand of packages of care and domiciliary care especially for the two weeks over the Christmas period where sometimes it is difficult to get packages of care. ST responded to confirm that we are in the process of recruiting additional staff to backfill the gaps in personal care hours, and this is a joint community response with better mitigation than previously. JH was pleased that the CCG plans will be shared with other systems shown as good example. JH was concerned around communications following the national announcement of lowering the offer of flu vaccinations to people over 50 and are we supplementing information for our local services. AM confirmed that we use national materials and adapt locally for our own needs. NK sought assurance against Think 111 staffing based on agency staff, and JT responded and explained the progress of the project. NK further asked about paediatric mental health and younger children ending up in acute beds and was this being addressed as part of the winter plan. ST described two recent issues and explained the current process and that the CCG is working with the Director of Children's services in the local authorities to ensure with have the right facilities in place. DG asked if imaging capacity would be reduced following the opening of the Nightingale Exeter. JC confirmed that it has been agreed to move the Magnetic Resonance Imaging (MRI) scanner to University Hospitals Plymouth (UHP) and discussions are underway with the Nightingale Exeter regarding the use of the Computerised Tomography (CT) scanner.	

	SK highlighted that workforce resilience was an issue with providers who are struggling. JC said the this remains a spotlight and is monitored through the Devon Urgent Care Board meetings and risks can and will be escalated through to the Dynamic Decision-Making Group (DDMG) as appropriate. GAth queried the increased in demand for palliative care and risk factors and asked if there was confidence this would be mitigated. JC confirmed that additional funding has been approved recognising the current challenges with demand and reduced funding through charitable donations. A temporary non-recurrent funding has been identified to support the needs and this will be further discussed at the commissioning committee on basis of need, and support needs are currently being scoped. PJ referred to section 5.7 and the reality that modelling was not consistent with our challenges, and JC confirmed that as part of our phase 3 submission we have seen a different picture and this has been tracked through the Devon Urgent Care Board as to how we can ensure recovery of elective activity in our phase 3 trajectory. PJ thanked JC, Ali Wilkinson and Lauren Benham for their contribution and effort in the development of a comprehensive Winter Plan. **The Governing Body received and approved the Winter Plan.**	
	Month 7 Finance Report JD directed the members to the finance report in the pack for the period to the end of October. JD reminded the Governing Body that for the first half of year we have been working in an emergency financial framework during our response to the pandemic and retrospective reimbursement costs were detailed on page 94. All but £7.6m COVID-19 costs have been reimbursed and we are going through a final check. He assured the Governing Body there was no reason to be concerned the remaining costs would not be recovered. At the half year point the CCG achieved a break-even position. For the remainder of the financial year months 7-12 the CCG has moved back to a fixed allocation and we are expected to manage our costs including COVID-19 related costs within this fixed allocation and the year end forecast will be continued to be revised through to the end of this year. JD referred to appendix 3 the which detailed the operating expenditure and signposted the members to page 88 and the year end adverse variance of £29m which was one element outside of reimbursement. The fixed allocation is a continuation of the hospital discharge programme. The assumption taking in all reimbursement will move the CCG back to an overall break-even position. JD drew the members attention to a £6m risk which related to commissioning of work with the independent sector and was a financial risk at the time of writing this report, this has been mitigated and not passed back to the CCG. SMC queried equity shares which did not appear to be mentioned in the report and JD explained the commitment of equitable resources and that we are working with local systems to develop plans to work forward and implement this for the final quarter of this financial year. SK wondered about the early discharge scheme and JD explained the two aspects of the scheme.	

	PJ asked if there was a sense that the CCG would be in a financial position of strength from April 2021 and JD confirmed that for 2021/22 the CCG would be in a challenging position but following a recent announcement with regards to additional funding for the NHS this would be helpful, but we will undoubtedly need to continue to deliver our savings programme and identify savings efficiencies will need to be considered. **The Governing Body received and noted the contents of this month 7 year to date financial performance report including the current risks.**	
	Performance and Quality Report JC presented this report and noted that the unvalidated data was for the period to the end of September and this report for the first time included performance on our phase 3 response. Cancer waiting times through the first phase of the pandemic was stable but in September there were variations for our providers who are now seeing challenges with COVID-19 activity and capacity. There is a focus on symptomatic breast standards and this will be further discussed at the next Quality Assurance Committee. There has been an increase in demand and staff sickness and self isolation has added to the challenge. Elective care is being looked at closely and there has been an increase in waiting lists for 52 weeks with most long waiters in Ophthalmology and Orthopaedics and the restoration programme is focusing on this area. The risk of harm is being managed by providers through a clear risk stratification process including prioritisation and review of all patients to ensure they are checked and reassessed. Diagnostics has seen a marginal improvement in September and performance remains below the national target. JC referred to the adapt/ adopt programme and the use of the independent sector which is crucial as we approach the last quarter of year and moving towards a national framework. There has been agreed changes to the model and we are in negotiation with providers for flexibility to support the elective restoration programme. Urgent care performance has seen an increase in COVID-19 and activity flows through hospitals which has resulted in impacts in emergency departments (ED) who have seen attendance increases since May, but lower than in previous years. We are below the national four-hour standard and challenges remain with regards to flows through hospitals and loss of beds due to COVID-19 outbreaks. DA informed the members that 111 is seeing a slow steady improvement in performance. We are reporting national average performance for call abandonment and we are focusing on eliminating comfort calling. We are continuing to see high numbers in the Western System, and we are undertaking an end to end review of these cases to ensure that we are not seeing any harm, and this is a whole system approach. We are paying attention to the impact of staffing absences and resilience and the impact this is having on our elective capacity.	

Continuing Healthcare (CHC) remains on track despite challenges in some areas to reduce backlog.

There have been high numbers of COVID-19 positives and symptomatic spread and as a system we are collectively using best practice infection control measures and we are asking providers to expediate the flu campaign for completion by the 7 or 14 December at the latest.

JC directed the members to section 4 and the first time we are reporting trajectories against phase 3. We are looking at different ways of information activity and we are looking to refine reporting. This data does give a sense of our overall position for the month of September.

PJ asked about the process for potential harm in cancer pathways. DA replied that we are taking a harm review system wide approach, and this is not just about harm but also a risk stratification approach. JC further added that the cancer prioritisation group will also be considering outpatients and two week waits.

AD asked for an update on the current situation with regards to serious incident reviews for Devon Partnership Trust (DPT) and it was confirmed the outstanding backlog of reviews had improved and the CCG was confident of a further improved position by the end of December.

JWo queried as to whether it was recorded how often mutual aid support was requested and JC confirmed that a formalised process had been in place for the system for some time and that a decision making framework approach is taken and this will help towards documenting requests.

JT gave an example of other systems in place across the system to manage pathways such as virtual consultations, and e-consults and we are using digital platforms for maximum effect in Devon.

JC confirmed that we are pushing independent sector provision as far as we can and we are aiming to maximise capacity and flexibility to support the needs in relation to demand and waiting lists and working in line with the national framework which is not as flexible as previously.

JT clarified the pilot sites for reduction in emergency department (ED) attendance and that to date these have shown a positive impact on ED's. We have good communications in place for all parts of the system and primary care commissioning committee will consider any potential impacts and a communication plan will be developed to mitigate anxieties and risks if this becomes a reality.

PJ remarked this was a good performance and quality report and welcomed the opportunity to focus and concentrate on key issues, which will be monitored as part of our delivery of phase 3. He further noted that collaboration had been mentioned throughout this report and this gave a sense of how effectively plans come to fruition when using this mechanism.

The Governing Body:

- **Noted the 1 April 2020 to 30 September 2020 (month 6) performance against Constitutional and routine performance standards;**
- **Noted the quality, nursing and safety performance position for the period 1 April to 31 October 2020;**

	• **Noted the update on performance against the Devon System Phase 3 trajectories, as submitted to NHS England on 5 October 2020.**	
	Emergency Preparedness Resilience Response (EPRR) Framework GS presented this policy which set out how the CCG meets it responsibilities under statute and national policy which is updated on an annual basis. The policy included in the pack had tracked changes applied, but GS confirmed the changes for this year were minimal and these have been made in line with other policies. **The Governing Body:** • **Approved this policy which set out how NHS Devon Clinical Commissioning Group (CCG) will ensure that it meets its Emergency Preparedness, Resilience and Response (EPRR) responsibilities, as required by statute and national policy**.	
	Audit Committee Chair's Report NB presented this report and highlighted that although the current assurance framework was not fit for purpose this will still be used until the new framework had been fully developed. It was anticipated that the new assurance framework would be developed and mapped against Devon CCG's objectives by January 2021. **The Governing Body:** • **Noted that the Assurance Framework was not currently fit for purpose, and that following agreement of Devon CCG's objectives this will enable the Assurance framework to be developed.**	
	Quality Assurance Committee Chair's Report GAth referred to this report and noted that the terms of reference (ToRs) for this committee had been amended and was attached to this report for final approval by the Governing Body GAth noted that there were changes as to how this committee conducts its business and this includes the inclusion of Care Quality Commission (CQC) domains and a greater emphasis on patient experience and a patient engagement panel report which will also be presented to the quality committee. **The Governing Body** • **Noted and received the contents of the Quality Assurance Committee Chair's Report and positions of assurance by the Quality Assurance Committee** • **Approved the updated Quality and Assurance Committee Terms of Reference**	
	Commissioning Committee Chair's Report There was nothing further to add to this report. **The Governing Body received and noted the contents of the Commissioning Committee Chair's Report.**	
	Finance Committee Chair's Report There was nothing further to add to this report.	

	The Governing Body received and noted the contents of the Finance Committee Chair's Report	
	Primary Care Commissioning Committee Chair's Report There was nothing further to add to this report. **The Governing Body received and noted the contents of the Primary Care Commissioning Committee Chair's Report.**	
	Locality Updates **Northern Locality** JWo was pleased to report that for the Northern locality as a smaller part of the system during the response to the pandemic they have worked collaboratively and innovatively with local teams. He referred to the integrated delivery group which is functioning well and has a good data set to work from and has a self-regulated system to review performance and look at change. Population Health Management is a significant part of how the Northern local system will assess what needs are required to progress and change to improve health inequalities. The HIP 2 system has started looking at a process of how to improve for the future. JWo also noted that people are working well together to review workforce challenges. JW brought the members attention to One Northern Devon who are finalists in the Health Service Journal awards for collaborative working. **Eastern Locality** SK highlighted that the Eastern Locality delivery group meet on a weekly basis working through a rolling programme looking at common themes and noted that this has resulted in closer working relationships and builds on the opportunities to create different service pathways. He noted that there were concerns regarding the RDE proposed change in services for Moretonhampstead practices and this is being monitored closely. Active work is underway in developing a leg ulcer service and there has been a re-emergence of the local care partnership executive who will be looking at population health management data to improve better outcomes for the Eastern Locality population. **Southern Locality** DG confirmed that Derek Blackford, associate locality director is now providing additional support to the Southern Locality. He was pleased to report that Torbay and South Devon Foundation Trust (TSDFT) hospital admissions relating to COVID-19 has started to reduce and that vaccination centre sites were being explored. DG acknowledged the Local Care Partnership (LCP) development was lagging but was pleased to confirm that the LCP delivery group had been reconvened and he reported a recent meeting had been productive and he was encouraged with progress.	

	Western Locality SMC referred to the frailty project which is being managed by the Plymouth LCP. This has been favourably received and will be presented to the commissioning committee for investment consideration. The Plymouth LCP is in advanced stages of development and the next Western Locality report will detail and reflect the practicalities to demonstrate progress to the Governing Body. SMC was pleased to report positive news with regards to COVID-19 hot hubs which are continuing and are an example of collaborative working and has motivated GPs to support the local system. Vaccination sites are being explored and one has been identified as a favoured. Concerns were raised regarding Western LCP development and how patients, the population and practices in Western are going to be effectively supported in the system as a small LCP. NB added that it was important to establish a principle that is applied to all LCPs to ensure there was the right level of involvement. ST suggested for proposals to be developed and discussed at the Governing Body development session in January. **The Governing Body received and noted the contents of the locality updated reports.**	
	Any other business There were no other business items raised.	
	The meeting closed at 16:37	

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) **		Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **		Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF) A (in absence of DG)		Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **		Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **		Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) Chair **		Clinical Chair, Devon CCG
Penny Harris – (PH) **		Director, Devon CCG
Ruth Harrell - Dr (RH) **		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
Darin Halifax (DH) ** **item 2 only**		STP Lead for the Voluntary, Community and Social Enterprise
Julia Boas (JB) ** **item 2 only**		Deputy Director, Intercom Trust
Minutes approved	Date: 17 December 2020	Signed by chair: Dr Paul Johnson, Chair