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

Four Greens Wellbeing Hub, 15 Whitleigh Green, Plymouth, PL5 4DD

30 January 2020 15:00 - 30 January 2020 17:30

AGENDA

#	Description		Owner	Time
1	Welcome and Apologies		Chair	15:00
2	Questions from Members of the Public		Chair	15:05
3	Register of Interests (ROI)		Chair	15:10
	DOI NHS Devon CCG Governing Body @ 15 Janua...	4		
4	Minutes of the last meeting and action log		Chair	15:15
	1. DRAFT minutes of the GB meeting held in Publi...	9		
	2. Master Action Log - PUBLIC v2 nc.xlsx	16		
5	Chair's Report		Chair	15:20
	1 cover sheet chair's report.docx	17		
	2 Chair's Report Januuary v1 PJ.docx	19		
6	Accountable Officer's Report		Accountable Officer	15:30
	1 Cover sheet template (002) AO Report Public Jan...	21		
	2 AO Report Public Devon CCG January 2020.docx	23		
7	PERFORMANCE			
7.1	Quality Assurance Chairs Report		Chair of Quality Assurance Committee	15:40
	1 QAC December Public Committee Chair Report F...	27		
	2 Appendix 1.pdf	32		
	3 QAC January 2020 Public Committee Chair Repo...	45		
7.2	Quality and Performance Report		Director(s) of Commissioning - Northern, Eastern, Southern and Western	15:45
	01 Quality and Performance cover sheet.docx	49		
	02 Qualtiy and Performance report.docx	51		
8	GOVERNANCE			
8.1	Audit Committee Chair's Report (including full risk register)		Chair of Audit Committee	16:00
	Audit Committee Chair Report on 8th January 2020...	78		

#	Description		Owner	Time
8.2	Environmental Policy		Board Secretary	16:10
	[P] Environmental Policy cover sheet GB v1.docx	81		
	[P] NHS DCCG - Environmental Policy draft v2.1.docx	83		
8.3	Establishment of an Ambulance Joint Commissioning Committee		Board Secretary	16:20
	[P] 1 NHS Devon CCG - Joint committee GB Jan 20.do...	101		
	[P] 2 Appendix 1 Ambulance Joint Commissioning Co...	108		
	[P] 3 Appendix 2 Draft Delegation - v 3 271219 clean.d...	118		
9	FINANCE			
9.1	Finance and Performance Committee Chair's Report		Chair of Finance and Performance Committee	16:35
	[P] Finance Performance Committee Chair Report for...	121		
9.2	Month 9 Finance Report		Director of Finance	16:40
	[P] FPC_Report_FPC_Month 9_FINAL_2019-20 (GB C...	123		
	[P] FPC_Report_FPC_Month 9_FINAL_2019-20 (GB V...	126		
10	INFORMATION			
10.1	Primary Care Chair's Reports		Chair of Primary Care Committee	16:55
	[P] January +JH Committee Chair Report - Public PCC...	148		
11	Locality Updates		Locality Triumvirates	17:00
	[P] 0 Locality Updates Cover Sheet.docx	150		
	[P] 1 Northern Locality Report Jan 2020.docx	152		
	[P] 2 Eastern locality GB report for January 2020.docx	157		
	[P] 3 GB Report January 2020 - WL Report - Approved...	161		
	[P] 4 Southern Locality Report - Jan 2020.docx	163		

Declaration of Interests Register - NHS Devon Clinical Commissioning Group

Report generated by the governance team on 14 January 2020

Title	Surname	Firstname	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date Interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Appleby	Gaynor	Non Executive Lay Member (Allied Health Professional)	Member of Governing Body Member of Quality Assurance Committee Member of Primary Care Commissioning Committee Member of Remuneration and Workforce Committee	CQC Specialist Advisor		01/11/2019		01/11/2019	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 Geograhical remit - Eastern	Member of Governing Body Member Quality & Assurance Committee (Chair) Member Primary Care Commissioning Committee Member of Remuneration and Workforce Committee (Chair)	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		14/05/2019		21/05/2019	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Ball	Nick	Vice Chair/Non Executive Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geograhical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 ,Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		10/05/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Blackford	Derek	Deputy Chief Finance Officer	Attendee of Audit Committee (Deputy for CFO) Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO)	Governor - Torbay and South Devon NHS Foundation Trust (April 2017)	Partner works within NHS Devon CCG	28/04/2017		15/02/2018	Non-Financial Interest Professional	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. No line management responsibility from effective date of interest	NHS Devon CCG
	Burrows	Charlotte	Non Executive Lay Member - Patient and Public Involvement Geograhical remit - Northern	Member of Governing Body Member of Quality and Assurance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC)	I am chair of the Devon Maternity Voices Partnership (MVP) a collective of parents (and parents to be) and organisations who support maternity services (health professionals, charities, Healthwatch, non-health professionals) working together to review and contribute to the development of local maternity care across Devon. Devon CCG provide funding to the MVP (ceased September 2019) Self-Employment business consultant from September 2019		04/04/2019		02/10/2019	Financial/Personal Interest	Direct	Resigned as Chair from the Devon Maternity Voices Partnership. (formally leaves July 2019) 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
	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	Partner is employed by Livewell Southwest in position of influence	26/09/2017		15/10/2018	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	Director of Integrated Commissioning Seconded to CCG to Associate Director of Commissioning (Western)	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning)	No interests declared		12/03/2019		12/03/2019				Plymouth City Council
	Davis	Alison	Associate Non-Executive Lay Member	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		19/10/2019				NHS Devon CCG
	Dimond	Caroline	Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council Contract CDT in Torbay		04/09/2015					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

	Dowell	John	Director of Finance NHS Devon CCG Devon STP system lead for Finance	Member of Governing Body Member of Finance and Performance Committee Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Member of Primary Care Commissioning Committee (PCCC) Strategic Commissioning Programme Board	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015	19/06/2018	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.	NHS Devon CCG
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration and Workforce Committee(Non exec rem)	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	08/11/2018	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	NED on Board of Restorative Solutions CIC Ltd	Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	23/09/2019	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	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC)			26/10/2016	26/10/2016	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
	Harris	Penny	Management Consultant	Attendee of Governing Body Senior Leadership Team (SLT) Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Strategic Commissioning Programme Board	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training		23/07/2019	24/07/2019	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.	KERR Darnley Ltd
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG	Member of Governing Body (Chair) Member of Remuneration and Workforce Committee Transition Sub Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	GP Partner, Cricketfield Surgery (ceased December 2019) Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Clinical Chair NHS Devon CCG 1 March 2017 Church Warden Holy Trinity Church Spouse works in emergency department at RDE and for Exeter Medical School Primary Care Network - Templar Care Network		21/08/2015	04/10/2018	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	Secondary Care Doctor	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	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer Partner, Staplegrove Anaesthetists LLP, Taunton Partner Blackdown Orthopaedic and Spinal Services, Taunton Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of Data safety monitoring committee (DSMC), The GAP study (safety of gabapentin) United Hospitals Bristol 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		26/09/2017	06/10/2018	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 Member of Integrated Commissioning Executive (ICE) Attendee Remuneration Committee (REMCOM) Attendee of Audit Committee Northern and Eastern Preparatory Group Strategic Commissioning Programme Board	Chair of East Devon GP Members Forum Partner Coleridge Medical Centre Undertakes DDOC shifts 5. Shareholder in Devon Doctors Ltd Shareholder in Devon Health Member of East Devon Health Practice part of the East Devon Federation (March 2018) Chair of East Devon Members forum. Chair Eastern Locality Delivery Group Primary Care Network - Honiton/Ottery/Sid Valley (HOSMS)	Spouse works for Social Services	14/02/2017	13/05/2019	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Lees	Sarah	Representative of Director of Public Health for Plymouth City Council	Member of Governing Body (Deputy) Member of Primary Care Commissioning Committee (PCCC)	School Governor, College Road Primary School, Plymouth	Husband is an employee of Livewell Southwest	10/11/2017		Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Manton	Sonja	Director of Strategy Interim Director of Commissioning. Northern, Eastern and South Devon and Torbay	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Transition Sub Committee Senior Leadership Team (SLT) Member of Quality and Assurance Committee Attendee Audit Committee	Member of the Academic Health Science Network SW Board	Spouse employed by South Central and West Commissioning Support unit from 1st Nov 2018	03/04/2017	09/10/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Governing Body Clinical Lead – Western Locality Chair of Western Primary Care Partnership	Member of Governing Body Member of Quality Assurance Committee Clinical Cabinet QEIA Panel STP Collaborative Board Remuneration and Workforce Committee (Non exec rem) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG)	Elected member, South West Regional Council of BMA Occasional Locum (self-employed) at Access Health Ltd Plymouth. GP Appraiser (NHS England) 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 Partner is GP Partner, Church View Surgery, Plymstock	26/09/2017	25/09/2019	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.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Director of Communications and HR functions NHS Devon CCG	Member of Governing Body Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Joint Staff Partnership Senior Leadership Team (SLT) Attendee Audit Committee	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University.		19/06/2018	19/12/2019	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
	Pearson	Nick	Head of Communications and engagement	Senior Leadership Team (SLT) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for Director of Communications)	Member of the Labour Party Member of the Exeter City Supporters Trust	Spouse is owner of Pearson Creative	13/01/2017	14/08/2019	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. Will not be commissioned by employee	NHS Devon CCG
Dr	Pearson	Virginia	Director of Public Health, Devon County Council Co-opted member of Governing Body	Member of Governing Body Member of Primary Care Commissioning Committee Member of Integrated Commissioning Executive (ICE) Strategic Commissioning Programme Board	Member, Devon Health and Wellbeing Board Member, Exeter Health and Wellbeing Board Member, Devon Safeguarding Adults Board Member, Devon Safeguarding Children Board Attends Governing Body of Devon CCG Council Member, Association of Director of Public Health Member, British Medical Association		02/02/2017	02/02/2017	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
	Polak	Tracey	Public Health Consultant (Devon Council) Honorary Clinical Associate Professor – University of Exeter Medical School	Member of Governing Body Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Northern and Eastern Preparatory Group	Honorary contract with Exeter University	Spouse: Deputy Chief Nursing Officer and Interim Director of Quality Assurance (July 2019) Devon CCG	24/10/2017	21/01/2019	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

Sansom	Solveig	Associate Director of Commissioning	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning - Northern, Eastern and South Devon and Torbay) Senior Leadership Team meeting Business Meeting South Devon and Torbay Executive Delivery Group South Devon and Torbay System Improvement Board Long Term Conditions Meeting Risk Share Oversight Group SDT Preparatory Group Local Partnership Delivery Group SDT A & E Delivery Board	Sister in law is employed by the RDEFT		28/04/2019	09/06/2019			Will not engage in meetings or decisions affecting the relevant service	NHS Devon CCG
Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee Audit Committee CCG Executive Team Meeting Senior Leadership Team (SLT) Strategic Commissioning Programme Board	No interests declared		22/03/2019	09/04/2019				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 Member of Integrated Commissioning Executive (ICE) CCG Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Attendee of Remuneration and Workforce Committee Strategic Commissioning Programme Board	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	07/09/2019	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	STP Director of HR	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)	No interests declared			16/10/2018				NHS Devon CCG
Turl	Jo	Director of Commissioning - Western	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Integrated Commissioning Executive (ICE) 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	DELT Board Member, CCG Devon nominated director		13/08/2015	03/09/2019	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	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
Webber	Lorraine	Associate Chief Nursing Officer (South & West) Interim Director of Nursing (Caldicott Guardian) July 2019	Member of Quality Assurance Committee A & E Delivery Board QEIA Panel Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Member of Governing Body CCG Executive Team Meeting	No interests declared		14/03/2017	29/08/2018				NHS Devon CCG
Wheller	Kevin	Locality Chief Finance Officer (Northern & Eastern)	Attendee of Audit Committee Member of Finance and Performance Committee Senior Leadership Team (SLT) Member of Governing Body (Deputy for CFO) Northern and Eastern Preparatory Group		Spouse is employed as a finance manager at Castle Place Surgery in Tiverton. The Surgery is operated by the Royal Devon & Exeter NHS FT	22/10/2015	25/01/2018	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (Non exec rem) Northern and Eastern Preparatory Group	General Practitioner at Coombe Coastal Practice in Ilfracombe (ended 10/09/2017) Member of Royal College of General Practitioners Director of One Ilfracombe Our Place Programme Chair of One Northern Devon	14/02/2017	31/01/2019	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
	Wooldridge	James	Associate Non Executive Lay Member	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: 19 December 2019 Time: 15:15 – 17:15

Location: Daw Committee Suite, County Hall, Topsham Road, Exeter, EX2 4QD

Item	Discussion	*Action*	
1	**Welcome and Apologies** PJ, chair welcomed everyone to the meeting and apologies were noted from: • VP – TP deputy • JT - AC deputy		
2	**Register of Interest (ROI)** PJ directed the members to the ROI included in the pack and there were no amendments or new declarations made. **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 meeting held on 28 November 2019 and it was agreed these were a true and accurate record of the meeting.		
4	**Patient Experience – Jackie and Ron's story** CB introduced this film which showed how the Live Life Well team supported Jackie and Ron to improve their lives. Ron's mobility had decreased with age, meaning he was able to do less and was more reliant on Jackie to care for him and this impacted on their lives, so Jackie contacted the social care team for support. The Live Life Well Team helped Ron and Jackie understand what was important to them and helped them get the help they needed to improve their lives. The Governing Body agreed that it was good to be able to see first hand teams working together to improve lives and AM acknowledged that the use of films such as Jackie and Ron's story would be powerful when consulting with the public to help them understand the reasons for change. On behalf of the Governing Body PJ thanked the communications team for producing this film.		
5	**Chair's Report** There was nothing further to add to the report other than on 17 December, both PJ and ST attended National NHS England senior leaders meeting in London. PJ mentioned the discussions were very useful which included: • A post-election commitment from NHS England and support for schemes for additional nurses and GPs		

	• Demand on the NHS – benchmarking of levels of demands • National Director of Finance – made a point of managing financial systems and CCG debt and referenced how this will be dealt with • Chief People Officer – talked about people plan and changes SK asked that the CCG consider development for primary care nursing as currently there is limited structure for career progression, and he felt that we should think about being more flexible with clinical workforce. LW mentioned that there will be a primary care leadership conference next year and has been encouraging nursing colleagues to join and that we need to encourage Primary Care Networks to think differently about practice nurses and support them to step into leadership roles. **The Governing Body received and noted the Chair's Report.**		
6	**Accountable Officer's Report** ST did not propose to go through his report in detail however mentioned that the Executive Directors would be scrutinising Operational Plans for 20/21 on 13 January and requested that associated paperwork needs to be submitted by the deadline set. ST was pleased to report that the recent NHS Staff Survey for 2019 had an improved response rate of 83.3% which was above the national average. ST informed the members that this Governing Body meeting of 19 December was the last one that SP would be attending as he was retiring from the CCG at Christmas. ST personally thanked SP for his many years of service and especially the last six months with stepping into the void following the retirement of the Chief Nursing Officer, Lorna Collingwood-Burke. His contribution has been helpful and balanced. SK mentioned the Peninsula Clinical Services Strategy (PCSS) and is keen to establish connections with Primary Care Networks and be more proactive as commissioners. ST replied that in January there will be a deep dive into PCSS, and ST encouraged the clinical locality representatives to let him know of any priorities for their locality**.** **The Governing Body received and noted the contents of the Accountable Officer's Report.**		
7	**NHS Devon CCG Priorities** ST delivered a slide deck presentation and gave an overview of the CCG's current priorities and highlighted: • A&E - metrics have now been populated • 52-weeks wait tasks include development of single waiting list, outsourcing and development of standard operating procedure • Diagnostics – IT has impacted and has caused delays for diagnostic waits which was not immediately reported to Chief Operating Officers. LW confirmed that analysis work is underway to look back over the last twelve months and ST confirmed that the reporting process has now been changed • A&E – concerns raised around the trajectory for the Torbay and South Devon System and it was noted that the 111 clinical triaging system is the best performing in the regions however we remain in the lower decile for calls answered within 60 second and this remains a regional and national focus • CHC – this remains on track for the savings plan with QEIA and CHC part of QIPP. SP confirmed there were still risks associated with high cost cases for children's placements		

	• Medicines optimisation – lack of pharmacists in practices and it was acknowledged this remains a challenge and we are looking to mitigate actions and continue to review the workforce skill mix as to whether we could align with Primary Care Networks • Demand Management – ST asked that we reset the Western focus and how we can better support and put in other mechanisms in place to assist practices with high referral rates • Strategic Commissioning – a significant amount of work is being developed with our regulators, but it was recognised that this is not visible with our providers we need to improve how we articulate this • Local Care Partnerships – current resource is being mapped along with an assessment of capacity and capability • Quality Improvement – we must ensure that we send the right people on courses and identify the right areas of programmes of work for change management • Policy Shaping – we are being proactive to improve relationships with key influencers and we have an emerging issues process put in place and we will regularly share information with our Governing Body Members **The Governing Body received and welcomed this update on the CCG's priorities and the opportunity to see the work that is happening to achieve delivery. ST confirmed that there would be a further update at the Governing Body meeting held in February.** **ACTION** **NC to add CCG Priorities update to the Governing Body forward planner for February 2020. Post meeting update this action has been completed.**		
8	**Primary Care Committee Chair's Report** There was nothing further to add to the report included in the pack. **The Governing Body received and noted the contents of the Primary Care Committee Chair's Report.**		
9	**Primary Care Strategy** MP presented the draft strategy for general practice in Devon which set out our ambitions and vision for general practice over the nest five years. He did not propose to go through the strategy in detail but summarised the changes that have been made. One of which was bringing digital first and broadening of multi-disciplinary teams and both changes meet patient need without necessarily seeing the patient face to face. This might not be a GP but would be with a professional used appropriately. This will help with delivering benefits of working at scale and may see some mergers of practices, single large practices are not unusual in rural areas but a change in urban areas. MP mentioned fit for purpose premises whereby currently there are some Victorian small practices and there is a need for bigger more functional ones to deliver services and co-location. We are working through in-house primary care investment plans and there is also a need for us to get more sophisticated with capturing date and data sharing. Concerns were raised as to whether we believe the partnership model is right and does this strategy protect it as Devon does have a mixed economy. PJ felt that this isn't a definite steer but the Primary Care Committee recognises it as an important element of		

	Devon General Practice. JH recognised that strategy had been previously discussed at Primary Care and Quality Assurance Committee and urged the Governing Body to look at primary care issues alongside other areas of work rather than separately to make sure that everyone understands what the CCG is trying to achieve. SMc thought this was an excellent collaborative piece of work and that we do need to make sure we are mindful with parallel pieces of work. **Following discussion PJ asked the Governing Body to vote on approval of the Draft Primary Care Strategy and the Governing Body voted unanimously to approve**. *Caroline Dimond left the meeting.*		
10	**Quality Assurance Committee Chair's Report** There was nothing further to add to this report. The Governing Body received and noted the contents of the Quality Assurance Committee Chair's Report.		
11	**Quality and Performance Report** **SMa presented this latest quality and performance report for December 2019 highlighted the following areas:** <u>52 weeks wait</u> This target remains a key focus for the CCG and is a main area of risk. RDE has received a visit from the national team who are reviewing the plans: there was a particular focus on orthopaedics and cardiology. They are concentrating on sourcing additional capacity internally and externally. Additional funding has been identified for 52 week waits and diagnostics and the regional team are looking where to deploy resources, and this will be finalised in the first week of January 2020. <u>Orthopaedics</u> This remains a challenge across the system and we are seeking capacity from independent providers and with winter pressures this remains a risk. <u>Diagnostics</u> SMa was pleased to report that performance has improved, and we are forecasting to hit 7.4% target by year end. There has been new surveillance guidance for a cohort of patients which will positively impact on diagnostic demand: this is being implemented for new patients and Trusts are reviewing existing patients. Trusts will confirm process for reviewing these patients and impact of implementation of guidance on activity and performance in January 2020. <u>Emergency Department Performance</u> In year performance continues to fluctuate and as reported for December to date this remains at 84% and caution remains. The Hospital Ambulance Liaison Officer (HALO) service at UHP and TSDFT has now commenced and will run until the 21 February 2020. Early signs already show that this has had a positive impact on handover times and reduction therein in the Emergency Departments.		

	Torbay and South Devon performance remains fragile and additional assurance mechanisms will be put in place to gain confidence. LW confirmed that regular calls remain in place with the regional NHS E director around quality and safety impacts especially as we are progressing towards winter period demands and the CCG have been asked to share their emergency department quality review work with partner organisations and PJ was pleased to hear that Devon is sharing good practice. SMa reported that the System Performance Group closely looking into the detail around cancer referral growth to understand demand. SK mentioned that most of the Trusts have not been able to deliver the planned activity but there was a lack of capacity and wondered what the CCG were going to do if the situation got worse. SMa confirmed there was a joint piece of work around capacity planning for next year and that we are looking to fund demographic growth and acknowledged that it was important that we work with our partners and regulators to agree what the best possible performance can be within the agreed finances. **The Governing Body received and noted the contents of the Quality and Performance Report for December 2019 and the assurance given.**		
12	**Locality Updates** <u>Northern</u> The report was taken as read, but JWO noted that funding options are being explored with the CCG to support One Northern Devon. <u>Eastern</u> SK did not propose to go into detail of this report but highlighted the Integrated Care Model work plan and the refocus of GP member forums. He raised concern around the lack of support for rehabilitation, falls prevention and mental health provision. <u>Southern</u> DG reported that Coastal recently hosted a successful visit by NHS E/I Director of Strategy and Transformation to listen and talk through the models of care in Teignmouth and Dawlish. DG mentioned that A&E performance for TSDFT remains a concern and is being closely scrutinised. GT wondered about the minor injuries' units and closures and whether we have a sense of impacts on ED performance. SMa assured the Governing Body that the impacts of closures of MIUs is being reviewed. <u>Western</u> There was nothing further to add to this report. **The Governing Body received and noted the contents of the individual Locality Update Reports.**		
13	**Any other business** PJ expressed his thanks to SP for his contribution and challenge as a Governing Body member over the past 6 months and on behalf of the Governing Body he wished him all the best in his next adventure. SP responded to say that he had enjoyed his time being on the Governing Body and acknowledged that there were some low points, and that he will miss his CCG colleagues.		

	PJ took the opportunity to thank all Governing Body members for their hard work and contribution over the last twelve months and felt that the Governing Body is now stronger and untied and focused. He wished everyone a Merry Christmas and a rewarding and well-deserved break and looked forward to seeing everyone in January ready to meet the next challenges.		
14	The meeting closed at 17:30pm		

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
Anna Coles (AC) **	Director of Integrated Commissioning (interim) Devon PCC
Caroline Dimond – Dr (CD) **	Director of Public Health, Torbay Council
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Dr Matt Fox (MF) A (in absence of DG)	Clinical Representative, Southern Locality, 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
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Womersley – Dr (JWo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) A	Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Lorraine Webber (LW)**	Interim Director of Nursing, Devon CCG
Nick Ball (NB) **Vice Chair** A	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
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) **	Interim Director of Commissioning – North, East and South, Devon CCG
Tracey Polak (TP) ** (for VP)	Assistant Director Public Health, Devon County Council
Virginia Pearson – Dr (VP) A	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) ** **Minute Taker**	Executive Assistant, Devon CCG
Simon Polak (SP) **	Interim Director of Quality Assurance, Devon CCG

Minutes approved	Date:	Signed by chair:

NHS Devon Clinical Commissioning Group

GOVERNING BODY - PUBLIC ACTION LOG									
Action Number	**Date of Meeting**		**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential	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	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 undertakenYes/No confirmation if all actions		This will be the lead or person to whom the action was	Confirmation that committee that raised the action is content the action	Confirmation if action complete
1	19-Dec-19	NC to add CCG Priorities update to the Governing Body forward planner for February 2020.	30-Jan-20	Nikki Coombes	Post meeting update this action has been completed.				**FOR CLOSURE**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Chair's Report				
Date of committee: 30 January 2020 **Date report produced: 20 January 2020**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive:** **Name and Title:** **N/A** **Contact Details:** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date: 20 January 2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

- Clinical representation election process
- Police and Crime Commissioner Meeting
- Governing Body Organisational Development
- Primary Care Networks – South West AHSN
- Devon STP Clinical and Professional Cabinet
- Devon MPs

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

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

N/A

Key recommendations and actions requested:
This report is for information and the Governing Body are asked to note the contents.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
None
Does this report have implications in any of the areas highlighted below?

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

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

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GOVERNING BODY – CHAIR'S REPORT

1. Clinical Representatives Election Process

Three of our locality clinical representatives – Shelagh McCormick (Western), John Womersley (Northern) and Simon Kerr (Eastern) will have completed their three-year term of office at the end of March 2020. In order to ensure we have ongoing membership representation and clinical expertise on Governing Body, an election process is underway for all three posts with our member practices. The opportunity for GPs from within those localities to express interest closes on 31 January and will be followed by a panel review run jointly with the LMC to confirm eligibility of the applicants followed by an election process from 10 to 24 February.

All three current representatives are eligible to stand again, and I would like to thank them for all their commitment and enthusiasm over the last three years (two within NEW Devon CCG and with Devon CCG since April 2019).

This represents an exciting opportunity for member practices of the CCG to ensure there is representation of local general practice within the CCG and on the Governing Body, and for us to continue to benefit from the skills and experience of our GPs.

I will hopefully be able to confirm the outcome of this process at the next Governing Body meeting.

2. Police and Crime Commissioner Meeting

On 7 January, Simon Tapley and I met with Melanie Walker (Chief Executive, DPT), Alison Hernandez (Police and Crime Commissioner for Devon and Cornwall), Fran Hughes (OPCC Chief Executive), Paul Netherton (Deputy Chief Constable for Devon and Cornwall Police) and Jim Nye (Assistant Chief Constable and lead for Mental Health). There are many really good areas of collaboration between health and criminal justice that were great to share, but a general agreement that the vulnerable population we both serve would benefit from better strategic collaboration between our organisations. A strategic Mental Health Planning meeting has been arranged for March to try and start addressing this.

3. Governing Body Organisational Development

As a Governing Body responsible for the commissioning of the majority of health services in Devon it is vital, we are equipped and capable of providing the level of challenge and assurance and able to make the right decisions. A small working group of GB members met with Katy Kerley and Fran Lowery to agree a work plan for the next 12 months to ensure we have the right Organisation Development for the Governing Body.

4. Primary Care Networks – South West Academic Health Science Network (SWAHSN)

On 9 January, I joined a number of our Primary Care Network (PCN'S) clinical directors at the AHSN offices, joined by Ben Gowland of Ockham Healthcare to discuss some of the challenges that PCNs have had to try and overcome in 2019 and the opportunities ahead. Despite significant pressures in primary care and the challenge of developing new ways of working as PCNs, there remains much optimism and energy amongst many of our PCNs that will be really important for future collaboration and sustainability of healthcare in our communities.

5. Devon STP Clinical and Professional Cabinet

The CCG is represented at the Devon STP Clinical and Professional Cabinet by Nick Kennedy, David Greenwell and myself. The meeting now incorporates the Joint Clinical Effectiveness Group which allows it to combine more specific operational clinical decisions, such as Hydroxychloroquine monitoring, with wider strategic priorities, such as the Peninsula Clinical Services Strategy.

6. Devon MPs

Following the result of the General Election I wrote to all Devon MPs offering to meet with them. It is important that our local elected representatives in Government understand the challenges and pressures within our system and that we hear from them the areas they are concerned about within their communities. I will be meeting with a number of them over the next few months, ensuring we develop these useful constructive relationships.

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GOVERNING BODY MEETING

Report title: Accountable Officer's Report				
Date of committee: 30 January 2020 **Date report produced: 9 January 2020**				
Author (s) Name and Title: Simon Tapley, Accountable Officer Nick Pearson, Head of Communications and Head of Policy, Chief Executive's office Molly Bishop, Executive Assistant to Accountable Officer		**Supporting Executive:** **Name and Title:** Simon Tapley, Accountable Officer **Report Approved by:** **Name and Title:** Simon Tapley, Accountable Officer **Date** 17 January 2020		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL): N/A				

Executive Summary:
This report contains updates on:

- NHS Long Term Plan update
- CCG Operating Planning Process for 2020/21
- CCG Operating Model
- CCG Senior Leadership Recruitment
- NHS Staff Survey
- EU exit preparations
- Key meetings and visits
- Integrated Commissioning Executive meeting

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 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:
N/A
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality	Safety: Effectiveness: Experience:	✓
Equality		✓
Resource and Finance		✓
Legal		✓
Engagement and Consultation		✓
Risk		✓

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

NHS
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Accountable Officer's Report

1. Introduction

I would like to firstly take this opportunity to thank all our CCG staff and colleagues for their work over the last year and extend my warmest wishes for a prosperous New Year ahead.

I would also like to offer my congratulations to the local people below who were amongst those who have been recognised in the Queen's New Year's Honours list, as follows:

OBE

- Michael Ernest Charles Lock. Headteacher, Combe Pafford Special School. For services to Children with Special Educational Needs and Disabilities (Devon)

MBE

- Professor John Lennox Campbell. Professor of General Practice and Primary care, University of Exeter. For services to General Practice.
- Jill Marion Elson. For political and community service in Exmouth.
- Rebekah Louise Mitchell. Executive Personal Assistant, Environment Agency. For services to HIV Awareness.

Empire Medal

- William Colin Hamon. Lately Paramedic, South Western Ambulance Service NHS Foundation Trust. For services to the community in South West England.
- Heather Anne Penwarden. Chair, The League of Friends of Honiton Hospital. For services to the community in Honiton.
- Lisa Claire Wallis. Founder and lately Chair, ChemoHero. For services to people with cancer and their families.

2. NHS Long Term Plan update

Plans for the publication of the *Better for You, Better for Devon* (Devon Long Term Plan) will be submitted to NHS England on 17 January 2020. The final document, along with a summary version, is due to be published later this year.

3. CCG Operating Planning Process for 2020/21

Our operational planning process for 2020/21 is well underway. We are required to submit draft plans to NHS England & Improvement (NSHEI) by the end of February, with a further, final iteration in early April.

As part of this process, the CCG issued commissioning intentions to our system providers towards the end of last calendar year, and more detailed intentions will be issued following approval by Governing Body this month. The CCG operating plan sits within an overall Devon STP context, and we will develop detailed action plans for each of the deliverables for which the CCG holds a lead responsibility.

In terms of financial planning, the financial position for the CCG and the wider Devon NHS is extremely challenging. As reported in the finance report in the Governing Body papers for this meeting, the CCG is forecasting to be some £39.5m off plan in this financial year. Our operational plan for 2020/21 will therefore need to demonstrate progress in recovering this to a more financially sustainable position, whilst also dealing with the increasing demands on the services that we commission. To achieve this, we are working closely with our Devon STP system partners.

4. Development of a CCG Operating Model

As an executive team we are working on the development of an operating model for the CCG. The purpose of this is to establish a way of working for the future, which follows the commissioning cycle and is consistent with our CCG values, and which enables us to respond to the challenges described. I will bring this back to a Governing Body meeting in coming months for a further discussion.

5. CCG Senior Leadership Recruitment

System and CCG Chief Nursing Officer

Following the retirement of our former Chief Nursing Officer, we have been out to recruit to a permanent Chief Nursing Officer for the CCG and Devon system. Whilst we are still in the process of completing the necessary paperwork, I am pleased that we have been able to progress on this recruitment, and I hope to be able to update further in due course.

CCG Chief Operating Officer

Following a recent review, and endorsement by the Remuneration Committee and Governing Body, a process is underway to recruit a CCG Chief Operating Officer on an interim basis. This role will be fundamental in ensuring robust plans are in place to deliver our strategic and operational objectives in partnership with the senior leadership team, and to the delivery of our constitutional standards.

Executive Consultation

As the Governing Body will be aware, following a recent review, we have been in a process of consultation with our executive team which has now concluded. There are no material amendments to the model proposed, and we will now move forward with implementation.

6. NHS Staff Survey

The NHS Staff Survey results have recently been received and I am extremely pleased that over 83% of our staff participated. This is not only higher than the previous year but is also higher than the national average for CCGs, and feedback will be invaluable to shaping the future of our organisation. I would like to take this opportunity to thank staff and colleagues for taking the time to complete the survey.

There was some variation in results between directorates, therefore all feedback received will be considered in our upcoming senior leadership team and staff partnership forum meetings to form part of an on-going action plan. We will present this to Governing Body in more detail in due course.

7. EU-Exit Preparations

On 9 January 2020, Professor Keith Willett, EU Exit Strategic Commander, has confirmed that following the vote at second reading of the Withdrawal Agreement Bill on 20 December, the government has stepped down preparations for a no-deal exit from the European Union. The Department of Health and Social Care has informed NHS England and NHS Improvement that for the health and care system this means that no-deal preparations should cease. The national EU Exit team have highlighted that it is key that we maintain the important learning and organisational memory gained from all the work to date that has been undertaken by staff working on no-deal preparations, and have requested details of a key point of contact for each NHS organisation in case we need to stand up an operational response in late 2020 and to support embedding agreed legacy items. The CCG's single point of contact has been identified as Clare Doble, Head of Governance and can be contacted via D-ccg.governance@nhs.net.

8. Key meetings and visits

- I have had various meetings with my Chief Executive colleagues across the Devon System, and our Directors of Finance, as a System Financial Recovery Board. We have met weekly in January to agree our financial submission in the Devon LTP. On 17 January, we received feedback to this submission from our regulators, which we will work through at pace in the coming weeks.
- On 7 January, Dr Paul Johnson and I had an extremely helpful and productive meeting with Devon and Cornwall Police and Devon Partnership NHS Trust colleagues to discuss local partnership working within mental health, and I look forward to continuing this close working in the future.
- I met with our executive team and programme leads on 13 January to go through a number of the recovery and savings plans for the CCG, including demand management, medicines optimisation, continuing healthcare (CHC) and running costs. We also took this as an opportunity to discuss our operating plan for 2020/21 and our commissioning intentions.
- I attended a number of meetings to discuss our Local Care Partnership (LCP) developments in the South, East and West. I also attended the Strategic Commissioning Programme Board, where we discussed the programme of work to develop the future strategic commissioning function, including the links to commissioning at place and primary care networks.

9. Integrated Commissioning Executive meeting

The Integrated Commissioning Executive (ICE) meeting is a meeting of CCG and Local Authority partners. It provides a mechanism for joint planning and shared decision making by the relevant responsible senior officers, who have the authority to act in accordance with the decision-making framework of each partner organisation.

Key areas of discussion recently have been:

- Long Term Plan metrics and the outcomes framework
- Progress on Local Care Partnerships development and strategic commissioning, including the development of the monthly Strategic Commissioning Programme Board, to set the vision and develop a framework for strategic commissioning going forwards.
- We received a presentation from colleagues in Devon County Council on liberty protection safeguards, where we discussed the opportunities for joint working.

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GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee (QAC)

Date of Governing Body: 30 January 2020

Dates of Committees covered in this report 12 December 2019

Chair's Name and Title: Glynis Atherton, Lay Member (Chair)

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

- **Quality Risk & Assurance Report including Risk Register**
  Please see below with regards to Risk Register Review (changes and pertinent areas).

- **Quality Assessment Framework (QAF) – including Flash Reports:**
  Key individual provider issues were described for: Children & Family Health Devon (CFHD): Information sharing and long waits; System Issues: Urgent Care: impact of long waits; Planned Care: impact of long waits (including diagnostics and 52 week waits); Primary care: quality issues, including workforce; Mortality: information Management. QAC noted the key issues outlined in the flash reports, observing that quality surveillance continues and agreeing the positions of partially assured unless otherwise stated.

- **Urgent Care:** Long waits continue to be recorded within Emergency Departments across Devon including 12-hour mental health breaches. Devon Partnership Trust are leading a system working group to seek solutions and will report through the Devon A&E Delivery Board. At the time of reporting significant evidence of solutions and improvement has not yet been observed by the CCG. Action to progress consistent reporting and review of 12 hour breaches is underway and a report will be shared at the January 2019 Quality Assurance Committee (QAC). QAC noted the need for a consistent approach across Devon.

- **Planned Care**: Across Devon, there remains varied performance within NHS providers of planned care, potentially impacting on quality; experience and safety. There are a significant number of patients waiting long periods of time for diagnostic pathways and others beyond 52 weeks for operations/ procedures. An evaluation of evidence in relation to harm experienced due to long waits for diagnostics was presented to QAC.

- **Primary care:** QAC was provided with an update on the transition of patients registered with Barton Surgery in Plymstock following the contract holder's decision to stop providing GP services with immediate effect. This follows a temporary suspension put in place by the Care Quality Commission on 28 October 2019. A number of quality and safety reviews have been undertaken in the immediate period following the suspension, including a comprehensive notes review and a deep dive into the areas of concern identified. These have been shared with the provider, the LMC and the NHSE PAG team. The PACT/PALS teams have worked in collaboration with the primary care and communications team to ensure that patients are supported throughout this process and a suite of documents has been created to fully inform patients throughout this process. A number of Safeguarding reviews have taken place for vulnerable patients registered with the practice.

- **Mortality:** information challenges persist across Devon in relation to mortality information. In addition, from April 2020, Medical Examiners will be mandated to review 100% of hospital deaths. At the inaugural Devon Quality Surveillance Group (QSG) 11 November 2019, system partners across the Devon agreed to pool their resources into a single mortality working group to address issues and seek system solutions. Terms of reference will reflect governance and reporting process through QSG.

- **Children & Young People**: A Joint Targeted Area Inspection (JTAI) for Plymouth Services who work with children was undertaken during the week of 18th November. Initial CQC inspector feedback was positive with some identified areas for improvement, but no immediate actions required. The full report will be reported through Quality Assurance Committee.

- QAC noted the weekly operational look forward (WOLF) calls and associated winter planning. QAC also noted that there will be serious incidents reported for General Practice included in the January agenda.

- **Safeguarding Annual Report (2018/19)**
  QAC noted the report on Safeguarding (CCGs) Looked After Children, Safeguarding Adults, Safeguarding Children and that the Safeguarding annual report for 2019/20 will be received at the May 2020 meeting. The purpose of the report was to provide assurance to the CCG Quality Assurance Committee, Governing Body and external agencies that it is fulfilling its statutory responsibilities in relation to all safeguarding services.
  .
- **Devon Partnership NHS Trust Report**
  An update report was provided detailing the significant work undertaken by the trust in relation to their application of the Serious Incident framework. The trust leadership have been fully involved and supported and will remain so until the issue has been resolved, which is anticipated in March, at which point QAC will review the risk. A summary from the trust's CQC inspection report was received. QAC noted the work to progress issues identified in mental health services locally has been significantly enhanced by the CCG Patient Safety & Quality (PSQ) Lead who has made connections between services. The positive change in reporting overall by the provider was noted by QAC. QAC noted the current position of partial assurance, with a trajectory to improve over coming months and will be reported to the Committee. QAC to consider reporting as a risk, until resolved. QAC thanked the PSQ Lead for the excellent quality of the paper.

- **Children with Specialist Education Needs and Disabilities (SEND)**
  QAC received a paper providing an update on the CCG arrangements for meeting SEND requirements and the activities that have been undertaken by commissioners, the CCG Designated Medical Officer (DMO) and Designated Clinical Officer (DCO). Following the joint Ofsted/CQC SEND inspection in December 2018, much of the DMO/DCO work has been focused in the Devon County Council area. The CCG is taking a lead on a range of areas in the Written Statement of Action (WSOA) which was required following the Inspection, particularly in relation to autism. There has also been significant activity to build effective communication and relationships with Torbay Council, in order to build a position of strength and to be able to respond to an inspection which is expected imminently (Torbay is one of the few councils yet to receive a SEND inspection).

- A significant strength of the CCG is the investment made for additional capacity and recruitment to a full time Designated Clinical Officer in April 2019. The team of DCOs and DMOs work as part of a Devon-wide virtual team, with a single contact email address. The team has a 'Who We Are' document which has been shared with partners to use in communication to wider stakeholders and families via the local offer website and CCG website. There still remain a number of challenges in particular in relation to the improvement in the quality of health contributions to Education Health Care (EHC) plans as well as the timeliness of the submissions. Consistent engagement of health providers in planning groups and quality audit meetings has been of some concern. This is in part due to capacity and uncertainty over roles whilst the new provider Children and Family Health Devon undertook a period of consultation with its workforce. It is anticipated that this will now improve.

- QAC discussed the possible risks associated with not having timely plans completed, and seasonal anomaly for August and September based on school term times, and the increase for requests in July. The CCG are working with partners to address the areas identified for improvement. QAC were assured that the services are being received by the child, in spite of the issues identified with regards to timely plans. QAC noted the new IT system to upload plans and supported the action to discuss associated issues with the System Transformation Partnership (STP) Chief Information Officer. QAC also noted the governance arrangements in place, including provider and commissioner representation at system meetings.

- **Autism update and partnership working arrangements**
  QAC noted the report that provided the committee with an update on the improvement programme underway with providers to address the waiting times families with children and young people have to get an assessment. As well as update on the work being done to map and understand the gaps that exist across the STP geography for pre and post diagnostic support the QAC also received information on the business plan for investment to address these gaps. QAC noted that the business cases for adults and children are aligned and the potential for an all age service should be considered. QAC noted the increase in risk as documented on the risk register and requested that commissioners provide a report to QAC with regards to autism following the detailed work that is currently underway.

- **Children & Family Health Devon:**
  QAC received a report and subsequent verbal update based on assurance received this week, reflecting on the process for the contract award, confirmed commissioner actions and assurance from the provider including a briefing on particular service area concerns. These include autism and mental health. The report provided assurance on the quality, workforce and performance concerns (not finance for the purpose of this report). QAC noted the issues with regards to workforce and the actions being taken. QAC noted the significant work undertaken to date and improvements made, as well as the importance of how the learning from the new provider in identifying significant issues and making the improvements, are communicated.

- **Diagnostics: Patient Safety & Quality Report: (Appendix 1)**
  QAC received a report which identified that across Devon, there remains varied performance within NHS providers for planned care, including diagnostics, which has the potential to impact on quality; experience and safety. The CCG seek assurance from providers that patients are not adversely impacted upon when they experience long waits. The purpose of this paper is to describe levels of assurance around quality of care, specifically for patients waiting for a diagnostic procedure or diagnostic reporting that impacts on their diagnosis and treatment options. QAC noted the significant work undertaken by the CCG Nursing and Quality team to understand any harm caused to patients and that this has been acknowledged and shared regionally. QAC also supported that the scope is widened to include harm / impact on staff (emotionally / workload) and recognised that the findings are based on available evidence and that primary care intelligence was limited.

- **Individual Funding Review Policy**
  QAC noted that the policy has been under development for some time, arising from the need for effective communication and clarity of the existing process, supported by a SOP, and Terms of Reference, with a QEIA undertaken. Quality Assurance Committee approved the policy.

- **Devon-wide Emergency Department Quality Reviews**
  QAC received a presentation summarising the outputs from the multiple quality reviews undertaken between June and September 2019 in all Emergency Departments, identifying areas of positive practice and areas for further learning. All reviews have been shared with individual providers in order to maximise individual and system learning from exemplar cases, including additional provider to provider observations for the purpose of learning. QAC noted the significance of culture and partnership working in the exemplar case. GB will be receiving the (updated) report content in January 2019 and will also be shared with Devon Quality Surveillance Group and the A&E Delivery Board.

Reports received and noted
• As above, and papers for Information: • Notes of Joint Clinical Effectiveness Group • Learning Disabilities Mortality Review update (LeDeR) • Flu update
Risk Register Review (changes and areas of concern)
• QAC received a report that effective risk management processes are in place to identify, assess, manage and mitigate risk, informing of any changes since the last QAC meeting of 14 November 2019. • QAC noted that the risk data had been extracted, with currently 21 risks aligned to QAC. Of those risks, three risks are categorised in the very high category, which QAC considered each of. QAC noted that as of yesterday, 19 of 21 risks have received timely review. • QAC noted that the risk score for Risk 100 is likely to increase to 25 at the request of the provider and further work is being done to accurately describe this risk as there is no evidence of harm, which is not in line with a risk scoring of 'catastrophic'. QAC noted that the position in Devon is better than in other areas, Requests made by multiple CCGs during the regulator led Quality Surveillance Group for data provided by CCG footprint has still not been met. QAC noted the previous CQC report findings, that a culture survey has been undertaken in the past 12 months and the associated action plan, the significant actions that are in place, and that the increase in risk score is associated with delays and call stacking which reflects the continued pressure experienced across Devon. Risk 105 is being reviewed by the Provider, and a report has been requested. Risk 102 regarding Serious Incidents is a paper on the agenda. Risk 44 regarding childrens services is being reviewed in order to be more accurately described, providing the opportunity for monitoring progress. • QAC agreed the removal of risks 45 and 75 from the corporate risk register in line with the report. The risk co-ordinator will identify the action of a single risk being identified and added to the register about dementia diagnosis.
Committee Decisions
• None.
Recommendations for Governing Body
• To note the reports received and positions of assurance by Quality Assurance Committee. • In particular, Governing Body to note Risk 100 and the proposal to increase the scoring to 25 by the provider. • Excellent report re Diagnostics re findings of IT as a contributory factor and the need to align to digital programme.- Appendix 1.
Recommendations for other Committees
• None

Terms of Reference (ToR) or other committee effectiveness issues
• QAC noted that no amendments are required to enable the Committee to approve policies as this power has been granted by Governing Body. A review of the ToR for QAC will take place after the development session in February 2020.

Management of Conflict of interests:

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

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

NHS
Devon
Clinical Commissioning Group

QUALITY ASSURANCE COMMITTEE

Report title: Delays within Diagnostic Pathways: Impact on Patients					
Date of committee: 12/12/19 **Date report produced: 26/11/19** **Date report approved: 26/11/19**					
Author (s) Name and Title: **Sara Wright, Interim Deputy Director of Nursing** **Contact Details: sara.wright4@nhs.net**		**Supporting Executive: Lorraine Webber** **Title: Interim Director of Nursing & Caldicott Guardian** **Report Approved by: Lorraine Webber** **Title: Interim Director of Nursing & Caldicott Guardian** **Date: 29/09/2019**			
Public or Private (Governing Body only):		**Public**		**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**		**Approval**		**Information**	**X**
Does this report place individuals at the centre?		**Yes**	X	**No**	

Executive Summary: Across Devon, there remains varied performance within NHS providers for planned, elective care, including diagnostics, which has the potential to impact on quality; experience and safety. The CCG seek assurance from providers that patients are not adversely impacted upon when they experience long waits. The purpose of this paper is to describe levels of assurance around quality of care, specifically for patients waiting for a diagnostic procedure or diagnostic reporting that impacts on their diagnosis and treatment options.

The analysis includes reviews of serious incidents reported on the Strategic Executive Information System (StEIS) within the last 12 months under the category “diagnostic incident including delay”, including “failure to act on test results” and any relevant serious incidents with the category of “treatment delay” that could have been impacted by diagnostic delays. Also included are reviews and analysis of CCG formal complaints and concerns from enquiries and yellow cards associated with diagnostic delays due to waiting.

Whilst the number of serious incidents are few, some involve many patients. However, from completed SIs, there is little evidence of physical harm as a result of the delay. In addition, at the time of reporting, the CCG is awaiting the conclusion of a serious incident involving 250 patients and is unable to confirm

if physical harm was a result of the delay. Initial information provided appears to indicate no impact on safety.

With the acknowledgment that classification of the delay (the reason) is challenging to collate for this purpose, there is evidence that IT and human error contribute significantly to delays in many cases, rather than capacity.

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:

Nil

Key recommendations and actions requested:

The Quality Assurance Committee are asked to:

- Agree the contents of this report.
- Agree a summary of this report be included in the Governing Body Report from Quality Assurance Committee- to provide information and assurance.
- Agree the proposed System Wide Principles of Checking for Harm (see appendix 2) be discussed at System Performance Group, with the aim of seeking system agreement and sign up to these.

Reference to other documents or accompanying papers:

N/A

Have the legal implications been considered?

Yes

Equality Impact Assessment: N/A

Who does the proposed piece of work affect?	**Patients**	✓	**Carers**	✓
	Staff	✓	**Public**	✓

	Yes	**N**
1. **Will the proposal increase discrimination for people in protected groups?**		✓

2. **Will the proposal reduce discrimination for people in protected groups?**	✓	
3. **Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?**		✓
4. **Will there be a positive benefit to the patients or workforce as a result of the proposed work?**	✓	
5. **Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?**		✓
If the answer to any of the above questions is yes (other than questions 2 and 4) or you are unsure of your answers to any of the above, you should provide further information using Quality and Equality Impact Assessment. If a quality and equality impact assessment is not thought to be required briefly explain why and provide evidence for the decision.		

***Please add N/A if any of the sections are not relevant*

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.

Delays within Diagnostic Pathways: Impact on Patients

1.0 Executive Summary

Across Devon, there remains varied performance within NHS providers for planned, elective care, including diagnostics, which has the potential to impact on quality; experience and safety. The CCG seek assurance from providers that patients are not adversely impacted upon when they experience long waits.

The purpose of this paper is to describe levels of assurance around quality of care, specifically for patients waiting for a diagnostic procedure or diagnostic reporting that impacts on their diagnosis and treatment options.

The analysis includes reviews of serious incidents reported on the Strategic Executive Information System (StEIS) within the last 12 months under the category “diagnostic incident including delay”, including “failure to act on test results” and any relevant serious incidents with the category of “treatment delay” that could have been impacted by diagnostic delays. Also included are reviews and analysis of CCG formal complaints and concerns from enquiries and yellow cards associated with diagnostic delays due to waiting.

Whilst the number of serious incidents is few, some involve many patients. However, from completed SIs, there is little evidence of physical harm as a result of the delay. In addition, at the time of reporting, the CCG is awaiting the conclusion of a serious incident involving 250 patients and is unable to confirm if physical harm was a result of the delay. Initial information provided appears to indicate no impact on safety.

With the acknowledgment that classification of the delay (the reason) is challenging to collate for this purpose, there is evidence that IT and human error contribute significantly to delays in many cases, rather than capacity.

An SBAR (Situation, Background, Assessment, Recommendation) Tool has been used to present the report.

2.0 Situation

Deterioration in planned care performance has been observed across Devon. All Trusts have taken steps to improve this position and some evidence significant improvement, such as Northern Devon Healthcare Trust (NDHT) in collaboration with Royal Devon & Exeter NHS Foundation Trust (RDEFT). However, there remains concern within the CCG that improvement is not moving at the pace required and subsequent impact on patients may be significant. Diagnostic pathways have seen some of the greatest challenge.

Many pathways depend on an element of diagnostics and a delay here either in the diagnostic procedure or in the reporting of the findings from the diagnostic procedure could lead to further delays, potentially subsequent treatment and longer term impact on disease progression (physical harm). In addition, patient experience may be adversely impacted; patients, carers and families may be impacted by significant anxiety if diagnostic care is delayed and the wider impact of pain or discomfort on lifestyle and activities of daily living.

The CCG Governing Body's priorities include improvement in diagnostic pathways and the 2019-2020 STP Operation Plan describes actions to drive significant improvement in performance and quality for care in Devon, including developing a county-wide diagnostic provision plan to improve performance, better manage demand and minimise cost through collaboration and productivity initiatives.

3.0 Background

3.1 Actions taken to ensure quality: all long waits:

In seeking assurance from providers of healthcare, the CCG monitors performance and quality. This is undertaken through a triangulation of information and evidence base, to inform the Quality Assurance Framework (QAF).

In response to performance across Devon, the CCG undertook a series of actions to establish the impact on quality of care when patients experience extended waits. 5 areas of preventable harm were shared with partner organisations, a key line of enquiry (KLOE) gathered information from all four Devon acute Trusts and development of subsequent principles around harm are in progress. (see Appendices 1&2).

Assurance has been reported through the CCG Quality Assurance Committee (QAC). Additionally, information has been presented at the STP Clinical Cabinet and the Devon, Cornwall, Isles of Scilly Quality Surveillance Group, chaired by NHSE/I.

3.2 Harm due to extended waits within 'diagnostic pathways':

Discussions and reports across the STP appear to concur that diagnostic pathway delay cases have the potential to cause harm through the 'underutilization of care'; undiagnosed patients may suffer disease progression that was preventable, experience prolonged pain, anxiety and suffer extended complications.

However, evidence of actual harm and the degree of severity is difficult to separate from natural disease progression that is unpreventable or unpredictable. It may not always be possible to determine whether a treatment, assessment or test would have been more effective if administered earlier, nor to what extent symptoms could be alleviated; disease progression often varies between individuals, as do symptoms. A poor experience of NHS services will undoubtably occur with delayed pathways.

4.0 Assessment:

The following assessment describes information in relation to actual patient harm, both physical and emotional, including experience, that has formed part of the CCG evidence base on diagnostic delays.

5.0 Assessment: Serious Incidents:

5.1 Methodology:

All serious incidents (SI's) reported from 1 September 2018 to 31 August 2019 were analysed to collate those that referenced 'diagnostic care'. These were then broken down into further groups to identify the reasons for the delay, but also if harm occurred as a result in delay due to capacity. It is key to note, it is the 'underutilization of care' that could lead to potential harm in these cases.

5.2 Data Sources & Limitations:

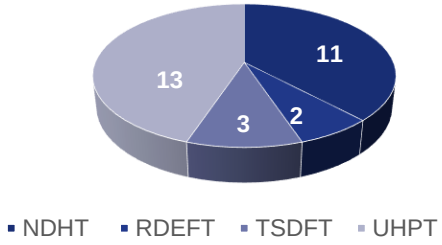
a) SI's reported onto the Strategic Executive Information System (StEIS) with the category of "diagnostic incident including delay meeting SI criteria", "failure to act on test results".

b) Relevant SI's reported on StEIS (11) by acute providers with the category of "treatment delay" - that could have an impact on diagnostic delays.

5.2 Total Number of SIs Reported- Diagnostic incident including delay meeting SI criteria, including failure to act on test results:

A total of 29 SIs were reported by the four acute providers in Devon. This is illustrated in figure 1 below. It should be noted that 27 of the SIs were regarding an individual patient, but two involved multiple patients; one SI involved 907 patients and one 160 patients. A total of 1,094 patients were involved in the incidents. All SIs reported are investigated to identify the root cause. The investigation includes an assessment of the severity of harm and if the incident contributed to any likelihood of disease progression.

Figure 1: Diagnostic incidents including delay meeting SI criteria (including failure to act on test results)



Of note, 29 of the diagnostic SIs reported, had a significant delay between the incident occurring and the time the provider reported it. This is because, in these cases, the incident is often not identified until the delay is discovered. One example is where x ray reports from 2017 were filed, but not acted upon until the patient re represented in 2019 and the previous reports were identified.

5.3 Total number of delays by category:
22 of the reported SIs clearly identify 'delay in diagnostics' within the reason/ cause of the SI. Several identified multiple contributor factors. Within 'delay', three categories were then identified. The following shows the number of SIs per category:

- 1 delay SI regarding equipment
- *2 delays SIs regarding an IT error.
  Note: a single SI involved 907 patients potentially impacted upon.
- 19 delays SIs regarding 'other'

***IT Example:** One of these cases involved 907 patients. The root cause described a system, put in place following the implementation of a new IT system, failed. The report states that there is no identified harm to the cohort of patients included within the investigation.

To understand the category, 'other' incidents in more detail, the group was further broken down into the following sub categories:

- 2 communication
- 11 process* .
  Note: a single SI involved 160 patients potentially impacted upon:

- 4 clinical findings
- 1 human error
- 1 capacity

***Process Example:** One SI involved 160 patients affected by "delay in process". The root cause describes the original process for highlighting examinations to be reported involved providing a list of examinations sent to x organisation each day. The result of this is that when the file was not picked up correctly, there was no process to identify this risk. Out of 160 patients, 135 reports were reported as normal but 25 show some abnormality of varying significance. This does not include one patient who was found to have malignancy. However, for this patient, the investigation has confirmed the images were reported on within 2 weeks, due to the GP contacting the radiology department for an urgent report.

5.4 Total Number SIs Reported- "treatment delay" with potential to lead to a delay in diagnosis:

A further 11 relevant serious incidents were reported by acute providers with the category of "treatment delay" that could have impacted on a delay to diagnosis. One of these affected 250 patients. Not all of the 11 serious incidents have had a completed RCA investigation at the time of report, to determine the root cause, but from the initial information provided they fall into the following categories:

- 1 regarding IT
- 4 regarding processes
- 3 were unknown.
- *3 regarding capacity (waiting lists).

***Capacity Example:** One incident involved 250 patients. The investigation is on-going. At the time of this report, the root cause or level of harm has not been determined

6.0 Assessment: People's Experience

6.1 Method:
The following assessment outlines data, themes and trends from patient and public feedback and health and care professional feedback captured by the CCG between 01 September 2018 and 01 September 2019.

The data is drawn from the following sources within the CCG:

- Patient Advice and Liaison Service cases (informal feedback, general enquiries, advice and support).
- Formal Complaints.
- Yellow Card (health and care professional reporting system).

6.2 Data Sources & Limitations:

It should be noted that the data used within this report is information gained from experiences and feedback shared directly with the CCG via its patient, public and health and care professional feedback methods. It does not include data held by the Trusts.

Themes and trends have been determined from records within the CCGs database (Datix). Data captured is subjective and may not be representative of all issues or concerns within a particular area.

Coding of intelligence is determined by interpretation and so it is broadly subjective in nature.

Determining if harm has been caused through patient experience is challenging, but the CCG can, to some extent, evidence the impact that delays and long waits have had on people's experience. It is also difficult to determine categorically if the delay has been caused by human or systems error or caused by long waits as a result of demand and capacity, or a combination of both.

For case examples, please see Appendix 3- 6.

6.3: Total number - by Feedback Mechanism:

Feedback Mechanism	Number: Access & waiting: all pathways TOTAL	Number: Access & waiting: *diagnostic pathways* (sub set of TOTAL)	Notes
Patient Advice & Liaison Cases	158	45	Not all related to long waits, some were cancellations of appointments, others were around expectation not being set at initial referral.
Formal Complaints	3	1	
Yellow Cards/ healthcare professional feedback	211	62	

7.0 Analysis: Serious Incidents

With the information gathered for the purpose of this report, the CCG are able to confirm all providers have robust processes in place to report delays, including diagnostic pathway delays, through incident reporting processes. In addition, their processes are highlighting cases where the serious incident criteria have been met, they are reporting onto StEIS and communicating informally with the CCG in addition to the formal reporting mechanisms.

Providers are then following processes that establish immediate risk and/ or actions that are required to mitigate against further risk and ensure patients are not further impacted upon.

Whilst the number of serious incidents are few, some involve many patients. However, from those completed SIs, there is little evidence of physical harm as a result of the delay.
In addition, at the time of reporting, the CCG was awaiting the conclusion of a serious incident involving 250 patients and is unable to confirm if physical harm was a result of the delay. Initial information provided appears to indicate little or no long term impact on disease progression (physical harm).

With the acknowledgment that classification (the reason) of the delay is challenging, there is evidence that IT and human error are often the cause of the delay in many cases, rather than capacity.

8.0 Analysis: People's Experience:

Themes raised by patients and healthcare professionals are broadly the same across all specialties, with delays in accessing services causing concern for people. People are contacting the CCG to explore their options of being referred elsewhere to avoid further delay.

It has been identified that delays are often incorrectly attributed to the DRSS booking service, and that expectations are not set during referral i.e. that DRSS cannot directly book appointments some cases.

When looking into the experiences shared, the CCG has found that for all issues being reported, a lack of clarity or breakdown in communication appears in every case.

From the information the CCG has, there is no evidence of poor clinical care from patient or healthcare professional feedback. We can therefore assume that the clinical care offered to patients is safe, but that the perception of poor clinical care possibly comes from a generally poor experience of their interactions, communication or care pathway, rather than the clinical treatment. This largely stems from expectations not being met or lack of clarity or communication.

Acknowledging exactly what 'diagnostics' means to patients is challenging, the largest data set/ information is in relation to orthopaedics, from patients who consider they are eligible for hip or knee replacement surgery, and the perception that the initial access for this pathway via an Extended Scope Practitioner (ESP) is not beneficial or is seen as a 'tick box' exercise – in all of these cases, the patient reported they were either not told or provided with any information as to why they must see an ESP first. This early part of the pathway includes assessment *to determine correct course of action*, as well as providing other benefits for the patient.

For some patients who have had hip or knee replacement in the past, this has been a change, as they didn't have to go through ESP previously. Therefore, patients see this 'diagnostic' in effect, as a barrier to accessing surgery. In addition, some patients see this as undermining the decision of their referrer (usually a GP) and forming another part of the diagnosis through assessment.

The difference or perceived difference in the geographical availability of services has also been raised on several occasions, particularly where in some areas some minor treatments and procedures can be carried out in a community setting rather than an acute hospital. For example, some diagnostic testing can be delivered in a GP practice.

In addition to negative feedback, the CCG has received two 'compliments' these were both in relation to orthopaedics, both compliments highlighted communication and being involved in decisions as the key areas.

One formal complaint was the only example of a delay in one area causing a knock-on effect to the patient both in terms of other pathways of care, but also their experience and the related impact on their responsibility as a carer. However, as soon as the patient got the date for the surgery, they no longer felt that a complaint was required, thus it could be suggested that clear communication and setting realistic timeframes is most important to a patient from the outset.

9.0 Recommendations:

The Quality Assurance Committee are asked to:

- Agree the contents of this report.
- Agree a summary of this report be included in the Governing Body Report from Quality Assurance Committee- to provide information and assurance.

- Support the proposed System Wide Principles of Checking for Harm (see appendix 2) be discussed at System Performance Group, with the aim of seeking system agreement and sign up to these.

10.0 Appendices:

Appendix 1: 5 Areas of preventable harm:

These included developing potential principles, based on 5 areas of preventable harm[1]:

- Underutilization of care: This includes all delays in assessments and treatment of care or healthcare. These can occur anywhere in the patient pathway and multiple occasions.
- Care delivery: This is the harm of care delivery such as; care failure, incidents, healthcare acquired infection etc.
- Experience of care delivery. This harm relates to the patient or their families' physical or emotional negative experience of care including examples such as; dignity, compassion and anxiety etc.
- Overutilization of care: This harm relates to over treatment of patients and the harms that arise from excessive stays in hospital / care, physical deconditioning, unnecessary testing, treatments.
- Reduction of long-term independence: This relates to outcomes leading to long term dependence of care and/or carers and the personal loss of autonomy.

[1]The Health of Populations – Beyond medicine Jack E James

Appendix 2: Proposed System Wide Principles:

- Where performance is reduced, we assume harm, unless we can evidence otherwise.
- Performance and quality go hand in hand – poor performance will lead to harm, which then increases poor performance, and this is not acceptable for people receiving services.
- All members working in the system own and share the risk and responsibility to improve the position in performance and quality across the partner system.
- Regardless of where the issue 'appears' to sit – the risk is a joint one, for example cancer waits.
- The system and system members will hold itself and each other to account for improving quality and performance.

Appendix 3: Patient Story (shared with patient and family consent)

On the 2 May this year, Dad attended an appointment at his GP practice for a problem he was encountering with his ability to swallow. That day, a referral was made to the local hospital and Dad was seen for an endoscopy on the 16 May 2019 where biopsies were also taken. At this appointment, we were told that a tumour had been seen in Dad's oesophagus. At this meeting, Dad asked if I could be the point of contact for all communication and appointments to take some of the pressure off both him and my Mum (who are both in their 80's).
21 May – phone call from hospital to advise that at this point no malignant cells had been found in the biopsies taken on the 16 May. However, in the opinion of the doctor this needed further investigation and he was not satisfied with these results. At this point he had graded the tumour 'Stage 3 N1'. I was also advised at this point that 2 further tests would also be required – an endoscopic ultrasound r in a different local hospital along with a Positron Emission Tomography (PET) scan which could be undertaken even further away. . I was informed that the next test 'should happen within the next 2 weeks'.
3 June – PET scan took place
18 June – phone call from hospital to advise that the PET scan had shown 'localised disease. biopsy results still unavailable.
21 June – phone call from hospital to advise that PET scan had shown 'avid' prostate. Magnetic Resonance Imaging scan (MRI) of prostate along with blood test for prostate required. I said that I would arrange test with GP.
28 June – appointment with a doctor in Oncology Department at hospital. Options given to Dad re treatment moving forwards. His preferred option was to be considered for surgery. Advised that he would potentially be referred to see surgeon on 9 July.

5 July – Lung function test and echocardiogram at Heart and Lung Department.
8 July – Phone call from different hospital to advise that Dad had appointment there soon.
10 July – saw doctor at different hospital. No apparent problems seen with echo and lung function test. . Dad still asking for surgery as preferred option. Advised will need cardiopulmonary test at different hospital and that he should get an appointment within 2 weeks. We asked if this could be done in original hospital if they had a shorter waiting list or even privately due to the length of time Dad had already been diagnosed but not had treatment. Advised that the test would have to be performed by anaesthetist this specific hospital.
17 July – phone call from hospital to advise that test appointment was on the 30 July. I advised them that we had been told that Dad would have an appointment within 2 weeks and that this was 3 weeks since he was seen. I was informed that he was originally on a list for August and that an extra list had been added due to the number of people needing the test. At this point, I advised them that I was aware that Dad had now breached the national guidance on the timings for urgent referral to commencement of treatment. As he was referred on the 2 May and was not being seen until the 30 July for the final test, he would be at 89 days since referral and still not have received any treatment.
18 July – phoned PALS at the hospital. Outlined my concerns about the drift and delay in Dad's case. I was advised that the hospital has 6 weeks to investigate a complaint. PALS repeatedly told me that she did not see 'what difference making a complaint would make'. My response to her was '62 days versus 89' and that everyday living with cancer and not receiving treatment is a day too long when you are the patient.
I advised that I would be writing in a letter of complaint on behalf of my Dad. PALS asked that he called to confirm he was giving consent for this to happen which he has done.
18 July - Just after having this conversation with PALS I had a call from hospital to advise that Dad had been given an appointment on the 2 August for an oesophagectomy (provided he passed the cardiopulmonary test on 30 July). Also informed me that he would need to start the Liver Reduction Diet on the 19 July.

Dad had surgery on the 2 August - 92 days since his urgent referral.

This letter is not a complaint about any of the reception staff, nursing teams or consultants – who have to our belief have done their best in the circumstances in which they find themselves. It is a complaint about a delay in having appropriate tests completed to enable a treatment plan to be discussed and implemented. It is also to ask why this occurred and why the guidance on the time frame for implementation of treatment has been severely breached. What mechanisms are in place to ameliorate the risk of drift and delay?

I would like this letter sent to the Clinical Commissioning Group to allow them to read about the impact an overstretched service is having on patients who are impotent as they wait in the queue for treatment.

Appendix 4: Patient Advice and Liaison Case examples:

Service Line	Type	Summary
Urology	PALS	Patient has raised his dissatisfaction with delays in getting a urology appointment and it being cancelled due to an emergency. He has also advised he has raised this with Royal Devon and Exeter Patient Advice and Liaison Service. Passed to PALS team at RDE to respond.
Unknown	PALS	Patient unhappy that when he called referral service they were unable to book an appointment for him directly due to long waits and advise that the hospital would contact him directly. Advised that all services experiencing delays at the moment, the CCG couldn't expedite at the moment but to keep in contact.
Neurology	PALS	Client unhappy that he had to call DRSS only for them to say that the provider had long waits and that they would contact him within 6-8 weeks to advise of an appointment date. Client is very anxious and questioning the point of such a process. Explained to cline the purpose of DRSS and that unfortunately unable to book anything for him at this moment, suggested speaking directly to provider PALS.
Orthopaedics	PALS	Client is unhappy that he was originally referred to a private provider under the NHS, but they rejected his referral. He is now on a long waiting list for an NHS hospital service, he specifically chose the private provider so he would be seen quicker. On looking into it was clear that the client shouldn't have been booked into the private service in the first place because he has health conditions that make the surgery higher risk, the private

		provider rejected this referral on the basis of risk. Explained this to the client and whilst he remains unhappy, he understands the rationale.
Gynaecology	PALS	Patient has been referred to gynae keeps on trying to book appointment been told it has been rejected. On speaking with DRSS, there were several referrals made by the GP but each one missed particular information relating to the tests required so had to be sent back to the GP to complete. Explained this to the client, she has since been back to GP who has now completed all that is needed for the referral to proceed.

Appendix 5 Formal Case Examples

Service Line	Type	Summary
Orthopaedics	Formal complaint	Client is waiting to receive an appointment for surgery for a hip replacement, he is very angry about the long wait. He explained he is a carer for his wife and needs to be able to secure a date for the surgery so he can plan caring responsibilities. Advised the client that a formal complaint is unlikely to initiate an earlier appointment date but. Client still wished to pursue a formal complaint. Further contact from the client who explained that since the investigation began, his situation has deteriorated, increased pain, lack of sleep all of which affecting his caring responsibilities, discussing with Devon carers for additional support next week and re-visiting GP. Further communication from client, who advised that he was meant to take his wife to an appointment in Birmingham but was unable to take her due to the pain he was experiencing. He has also written directly to the consultant to see if he can speed up his hip replacement. Additional contact with the client, he advised that pain is still quite high. But he has since been to his GP and following a routine blood test, they identified some abnormalities for which they need to carry out a biopsy to determine the cause. The problem is due to his hip pain he can't lay in the position required for the biopsy. Spoke with the trust who would look at what they could do. Further contact from the client – has now had the biopsy and was very grateful that the team took good care of him in terms of the pain from his hip and he was able to tolerate it. Client advised result of biopsy confirmed prostate cancer. Client is concerned that this will delay hip surgery. Client contacted me again to advise cancer team has been really great and that a treatment plan will start ASAP but the nurse is concerned that in order to proceed with treating cancer, he needs to have hip surgery first. Further follow up call to the client, he advised that he has now got an appointment for his hip replacement as they have bought it forward because of his cancer diagnosis, which can't start until his hip replacement has been completed. Client felt no need to pursue complaint any further.

Appendix 6: Yellow Card case examples

Service Line	Type	Summary
Oncology	Yellow Card	2ww referral sent on 6.11.2018. Appointment has been booked for 13.12.18 - 5w & 3d from referral date.
Oncology	Yellow Card	Patient given an urgent 2 week referral and told by breast clinic that the wait is 4-6 weeks so she needs to get a referral to Exeter.
Oncology	Yellow Card	2 week colorectal referral sent on 8.11.18. Deferred to provider and appointment booked for 17.12.18 - 5 weeks and 4 days from referral date.

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Report Approved by: Lorraine Webber, Interim Director of Nursing & Caldicott Guardian

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GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee (QAC)

Date of Governing Body: 30 January 2020

Dates of Committees covered in this report 09 January 2020

Chair's Name and Title: Glynis Atherton, Lay Member (Chair)

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

- **Quality Risk & Assurance Report including Risk Register**
  Please see below with regards to Risk Register Review (changes and pertinent areas).
- **Quality Assessment Framework (QAF) – including Flash Reports:** Key individual provider issues were described for: Devon Doctors: call abandonment; South Western Ambulance Service NHS Foundation Trust (SWASFT): call stacking; Devon Partnership Trust (DPT): Deprivation of Liberties Assessment. System Issues: Urgent Care: impact of long waits; Primary Care: Barton Surgery; Mortality: information management. QAC noted the key issues outlined in the reports, observing that quality surveillance continues and agreed the assurance levels.

- **Devon Doctors:** The CCG is working closely with Devon Doctors to improve the quality and performance of call answering, and a planned programme of urgent safety updates to the CAScade system is due for completion by 20 January 2020.

- **SWASFT**: As anticipated, the risk score with regards to call stacking has been increased by SWASFT based on recent activity. This item will be discussed at the Partnership Board, and Devon Quality Surveillance Group (QSG). The CCG risk score will remain until there is further intelligence to support a change. Any proposals to change the risk score will be brought to the Quality Assurance Committee in accordance with the Risk Management process.

- **DPT**: The CCG is awaiting further updates from DPT regarding the outstanding Deprivation of Liberty assessments and associated actions. Concerns were noted for cases that were RAG rated as red. On the 22 November 2019 the Trust Director of Nursing confirmed that internal investigation and assurance would be provided to the CCG, which will be reported to QAC.

System:

- **Urgent Care**: Long waits continue to be recorded within Emergency Departments (ED) across Devon including 12-hour breaches for individuals with mental health escalation. DPT are leading a system working group to review the pathway and the findings will be resented to Devon Urgent Care Board. The proactive ED quality review work by NHS Devon CCG has been recognised and shared with other areas.

- **Primary care:** Following the CQC temporary suspension at Barton Surgery from Monday 28 October 2019 until Monday 25th November 2019, the Surgery formally closed on the 31 December 2019. The CCG has been working closely with the practice and local providers to ensure that all patients are allocated to a new practice, the priority is to guarantee that all patients have ongoing access to a full range of GP services and care. Patients have been informed they have been allocated to a new provider. A number of reviews have been undertaken in the immediate period following the suspension, including a comprehensive notes review and a Quality Equality Impact Assessment (QEIA). A high level and early review of lessons learned has also been undertaken and reported in line with CCG Assurance processes.

- **Mortality Information:** Medical Directors from all Trusts, and Partners from across the STP have agreed to work together to implement improvements and to standardise reporting. Actions are underway to ensure that issues are robustly identified, investigated and learned from.

- **Safeguarding Annual Report Adults and Children (Quarterly)**
  Terms of Reference (ToR) for the CCG Safeguarding Steering Group have recently been reviewed, to establish broader membership from across the organization. Safeguarding adults reviews (SAR) and serious case reviews (SCR) remain ongoing, with outcomes reported through Safeguarding Partnership Boards. Preparation for the Devon County Council Peer Challenge (March 2020) is underway which will focus on partnership working and how duties are exercised. Training compliance rates are close to 85% target: (Safeguarding Children 84.72% and Safeguarding Adults 80.67%). Review of health assessments targets and actions for Looked After Children remain under close monitoring arrangements. Child Protection Information System (CPIS) has been implemented regionally with the exception of Torbay Local Authority. The decision not to implement has been raised as part of a recent Ofsted visit and assurance has been sought locally. Audit and follow up with provider organisations to test information flows confirms that there is currently no evidence to suggest risk. This will however remain under review, with close working between the CCG, NHS England, the Local Authority and through the Safeguarding Board. The recent Plymouth Joint Targeted Area Inspection (JTAI) had positive verbal feedback around partnership working and proactive approaches by health partners in supporting children & young people with mental health needs. The full inspection report is awaited.

- **Friends and Family Test**
  QAC received a paper outlining the main changes to the friends and family test which comes into effect from 01 April 2020. The changes are nationally prescribed.Full revised guidance can be found on the NHS England website **https://www.england.nhs.uk/wp-content/uploads/2019/09/using-the-fft-to-improvepatient-experience-guidance.pdf** The staff friends and family test remains unaffected by these changes. Response rates will no longer be published.
  QAC supported the recommended actions.

- **Quality Surveillance Group**
  Quality Surveillance Groups (QSGs) bring together different parts of the health and care system, to share intelligence about risks to quality. The inaugural Devon wide QSG was held on 11 November 2019, chaired by NHSE Director of Nursing & Professional Practice. A number of key presentations were provided to support the group's initial discussions. (Principles and Functions of a QSG; Children and Young People Services; Mortality). Local QSG's in each of our localities will triangulate information and intelligence to safeguard the quality of care locally and will provide key links into the Devon QSG.. The local QSG should ensure that action is taken to mitigate risks, resolve issues locally where possible and drive improvement in quality in an aligned and coordinated way. Issues deemed 'system' risks or areas of notable quality or best practice will report into the Devon QSG. Additionally, as Devon moves towards an Integrated Care System it will be essential to demonstrate that we have systems in place that consider the quality, safety & experience of care and any risks, as one element of the overall quality framework.

- **Northern Devon Healthcare NHS Trust Stocktake**
  (NDHT) is commissioned by the CCG to provide a range of secondary and integrated community services across Devon. Over the last two years actions have been put in place to support the Trust with improvements following recommendations by the commissioner and regulator. QAC received a report outlining improvements in quality seen by the CCG, with recognition of the expected time taken to embed improvements.

- **National and Local Safety Standards update**
  A Devonwide summary on the adoption of National Safety Standards for Invasive Procedures (NatSSIPs) and the use of Local Safety Standards for Invasive Procedures (LocSSIPs) in the four acute hospitals in Devon was summarised, with next steps identified to include sharing best practice and information across the STP.

- **QEIA ToR (AOB)**
  QAC received a copy of the very recently revised ToR that are going to the January QEIA Panel, and requested that these form part of the assurance paper for the February QAC meeting.

Reports received and noted

- As above, and papers for Information:
- Enhanced Health in Care Homes (EHCH)
- Notes of Joint Clinical Effectiveness Group

Risk Register Review (changes and areas of concern)

- QAC received a report that effective risk management processes are in place to identify, assess, manage and mitigate risk, informing of any changes since the last QAC meeting of 12 December 2019.
- QAC noted that the risk data had been extracted on 18 December 2019, with currently 19 risks aligned to QAC. Of those risks, four risks are categorised in the very high category, which QAC considered each of.
- QAC agreed that they would need to consider risk 109 prior to agreeing the removal of risk 89.
- QAC requested that risk 70 would not yet be removed from the corporate risk register until it has been confirmed that the impact of harm has been quantified through evidence based on monitoring and assurance.

Committee Decisions

- See risk section.

Recommendations for Governing Body

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

Recommendations for other Committees

- None

Terms of Reference (ToR) or other committee effectiveness issues
• QAC noted that no amendments are required to enable the Committee to approve policies as this power has been granted by Governing Body. A review of the ToR for QAC will take place after the development session in February 2020.

Management of Conflict of interests:

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

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

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GOVERNING BODY

Report title: Quality and Performance report				
Date of committee: **Date report produced: 17/01/2020**				
Author (s) Name and Title: **Sonja Manton – Director of Commissioning** **Lorraine Webber – Interim Director of Nursing & Caldicott Guardian** **Kelvin Grabham: Associate Director of Business Intelligence** **Karen Helliwell: Senior Information Specialist**		**Name and Title:** **Sonja Manton – Director of Commissioning** **Lorraine Webber – Interim Director of Nursing & Caldicott Guardian** **Contact Details:** **Report Approved by:** **Sonja Manton – Director of Commissioning** **Lorraine Webber – Interim Director of Nursing & Caldicott Guardian** **Date 20/01/2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
For information and assurance				

Executive Summary:

This report provides the latest information on key quality and performance indicators including those contained in the NHS Constitution. The report includes as an appendix the Improvement and Assessment Framework (IAF) indicators for the latest quarter.

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

Committees that have previously discussed/agreed the report and outcomes:
None
Key recommendations and actions requested:
For information and assurance
Impact on Strategic Objectives
We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:

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

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

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

Governing Body – Quality & Performance Report

January 2020

Summary

Performance summary

As agreed, there remains a continued focus on the 3 key areas of improvement: the number of people waiting over 52 weeks, diagnostic waiting times (which should also have a positive impact on cancer waiting times) and waiting times in A&E.

Referral to treatment times

Performance against the 18 week standard was 78.2% against a trajectory of 81.4%, a deterioration of 0.3% since last month. There were 282 people waiting over 52 weeks against a trajectory of 66, a slight improvement since last month (308), with reductions at RD&E and TSD. RD&E continue to have the most breaches at 143, with UHP at 105, TSD at 69 and NDHT at 11. The specialties with the majority of breaches are orthopaedics, neurosurgery (at UHP), general surgery and cardiology.

Current system actions being taken are as follows:

- Awaiting national feedback on the application of the Devon Standard Operating Procedure for Patient choice.
- Management of a Devon-wide Patient Treatment List (PTL) for all patients waiting over 52 weeks is in operation and will be reviewed.
- Additional activity has been secured at Care UK and Newhall, which will support the reduction of the Plymouth waiting list.

All providers are expecting to have no patients waiting over 52 weeks (excluding patient choice and neurosurgery) by the end of March 2020 except for RDE, who predict 38 patients still waiting over 52 weeks.

Diagnostic waiting times

In November performance against the 6 week standard was 12.7% against a trajectory of 4.6%, an improvement from 13.4% last month. Two of the four trusts saw reduced breach rates: TSD (down from 10.0% to 6.4%) and RD&E (a reduction from 22.8% to 21.9%). UHP rose slightly to 11.6% and NDHT increased to 10.2%. The majority of breaches continue to be for imaging (CT/ MRI) and endoscopy where capacity remains challenged.

Current system actions being taken are as follows:

- Recent commissioning policy decisions have been communicated to providers which will support demand management.
- Additional mobile capacity has been secured at several locations across Devon.
- The CCG are working with providers to contract additional capacity at a Devon-wide level in the future.

All providers all expecting to meet their trajectories by the end of March 2020 assuming additional national monies are secured.

A&E waiting times

In December performance against the 4hr standard was 82.5% against a trajectory of 90.3% (excluding UHP), slightly lower than the England average of 83.3%. RD&E saw performance deteriorate from 86.2% to 84.7% but NDHT improved from 82.8% to 84.9% whilst TSD improved slightly from 77.3% to 77.9% but remained comparatively low. None of the providers are meeting their improvement trajectory.

Providers continue to report increases in length of stay and bed occupancy, which are in the main related to the increased acuity of patients who are admitted. This has a detrimental effect on 4 hour performance as many of the patients waiting over 4 hours in A&E are waiting to be admitted to beds. Staffing, particularly nursing and in key specialties, continues to be reported as a key issue across all providers.

Current system actions being taken are as follows:

- Devon-wide Weekly Operational Look Forward calls are in place, which inform of any risks for the week coming and any system support required.
- Providers continue to plan workforce accordingly for ‘busy’ periods and have been relatively well staffed across the board.
- In the South a new framework is in place which will give early indication of concerns for performance and will trigger a system call. This will be reviewed after the first month to determine efficacy and impact.
- In the West daily GOLD calls are in place which are driving up complex discharge numbers. Demand management schemes are also starting to bed in and will be monitored through the AEDB.
- In the East patient demand is being reviewed for alternative places for patients to present.

The Patient Safety and Quality assessment against the main constitutional standards is summarised below.

The Patient Safety & Quality team (PSQ) uses the quality assurance framework as a surveillance tool under the key domains of effectiveness of care, people's experience of care and the safety of care provided. A range of quantitative and qualitative sources is used to support the assurance process and an 'enhanced quality surveillance tool' which formalises actions where quality risk levels trigger as high, has been implemented.

Planned Care Overview

Varied performance across planned care has the potential to adversely impact on quality, safety and patient experience. In order to seek assurance, the CCG continue to receive information from providers that patients are not negatively impacted upon when they experience long waits.

An evaluation of evidence in relation to harm experienced due to long waits for diagnostics in the last 12 months was presented at December's Quality Assurance Committee. The purpose of this paper was to describe levels of assurance around quality of care, specifically for patients waiting for a diagnostic procedure or diagnostic reporting that impacts on their diagnosis and treatment options. Whilst the number of serious incidents (SI) that occur are few, some involve many patients. However, despite there being little evidence of physical harm as a direct result of delays, the report described potential poor patient experience. With the acknowledgment that classification of the delay (the reason) is challenging to collate for this purpose, there is evidence that IT and human error contribute significantly to delays in many cases, rather than capacity challenges.

Care Quality Commission (CQC)

The Care Quality Commission (CQC) are the independent regulator of health and adult social care services in England. Their role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. All health and social care services will be inspected by the CQC and will be rated as: outstanding, good, requires improvement or inadequate. A number of Devon NHS provider organisations have had inspection reports published recently:

- **Livewell Southwest (LWSW):** areas inspected were community health inpatient services, community end of life care, child and adolescent mental health wards, older people mental health inpatient and community mental health services for adults of working age. The CQC rated all five of the key questions 'are services safe, effective, caring, responsive and well-led' as good. The report states that staff in the organisation had worked hard to address concerns that had been previously raised in the last inspection. Two services (community end of life care and child and adolescent mental health wards) that were previously rated as requires improvement at the last inspection were now rated as good. LWSW were awarded an overall rating of 'Good'.

- **University Hospitals Plymouth NHS Trust (UHP):** Four core services were inspected Maternity, Medical care, Diagnostic imaging and Surgery, The CQC rated safe, effective, responsive and well-led as requires improvement with a number of improvement actions being required. Caring was rated as outstanding. The CQC overall rating of the trust stays the same and remains rated as 'requires improvement.

- **Devon Partnership Trust (DPT):** Four core services were inspected. Wards for older people with mental health problems were rated as outstanding. Community mental health services for adults

were rated as inadequate as the inspectors felt that the trust did not have clear oversight of the large number of people on the waiting list and were not safely monitoring these patients or responding to changing and increased levels of risk.. DPT overall were rated as 'Good'.

The CCG monitors all providers CQC action plans through the quality assurance processes.

Primary Care Overview

Following the CQC temporary suspension at Barton Surgery, Plymstock from Monday 28 October 2019, the contract holder for the practice took the decision to cease providing GP services at Barton Surgery with immediate effect. The CCG has been working closely with the practice and local providers to ensure that all patients are allocated to an alternative practice in order that they have ongoing access to a full range of GP services and care. Patients have been informed that they have been allocated to a new provider. A number of reviews have been undertaken in the immediate period following the suspension, including a comprehensive notes review and a Quality Equality Impact Assessment (QEIA). A high level and early review of lessons learnt has been undertaken and will be presented to the Primary Care Committee and the Quality Assurance Committee in January 2020.

Urgent Care Overview

Long waits within the Emergency Departments have been reported in the last month. This includes 12-hour breaches for patients attending with escalation of their mental health. Devon Partnership Trust are leading a system working group to seek solutions and will report through the Devon A&E Delivery Board. The CCG continues to review all 12-hour breaches reported to ensure that providers have effective actions in place to minimize safety risks to patients during the period of long waits. The CCG has undertaken a series of quality reviews within all ED's: analysis has been undertaken and was reported to the Quality Assurance Committee in December and will be presented to the Devon A&E Delivery Board in the new year.

The 111 system is under significant pressure, with a higher than desired level of calls being abandoned by patients not being answered in a timely way. The CCG is working with Devon Doctors to improve the quality and performance of call answering, and a planned programme of urgent updates to the system is in place. Consideration of a different approach to call handling is also underway, and this should rapidly reduce the numbers of patients waiting to be answered once in place.

Mortality Overview

Acute Trusts across Devon have ongoing concerns about their position in relation to mortality rates when computed using national indictors: Hospital Standardised Mortality Ratio and Summary Hospital Level Indicator (HSMR, SHMI). NHS England (NHSE) have also required additional information about Devon mortality rates. This was discussed at the Devon Quality Surveillance Group (QSG) on 11th December 2019. System Medical Directors and other partners agreed to pool their resources into a single mortality working group to address issues and seek system solutions. Terms of reference for this system wide group will reflect the governance and reporting process through the Devon QSG. In addition the CCG reviews trust mortality as part of the quality assurance framework and links with individual provider mortality groups to provide assurance that reviews are robustly identified, investigated and learnt from. A paper detailing the current position for each trust will be presented to the CCG Executive and Senior Leadership team in January.

Influenza Overview

The supply of influenza (flu) vaccine is now available after early delays to vaccines for children and adults under 65. This delay has resulted in a reduction in vaccination rates in these patient groups, with uptake among 2- and 3-year olds significantly lower than previous years. A national and regional communications strategy is in place to improve uptake.
The national flu team have confirmed that the flu season is now under way. Early indications are that the vaccine available is well matched to the circulating strain of flu.
Access to out of hours prophylaxis in a community outbreak situation has been strengthened with some community pharmacists now commissioned to supply and administer prophylaxis at times when the current out of hours provider may lack capacity.

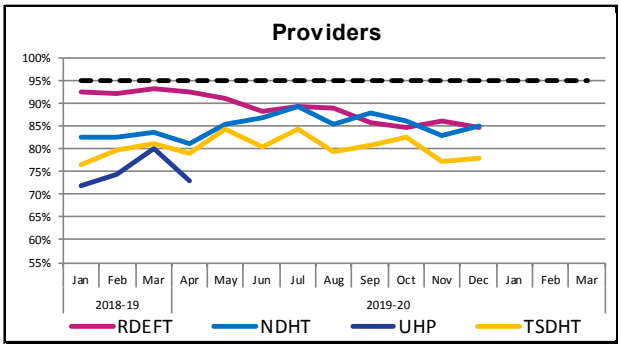
NHS Constitution Performance

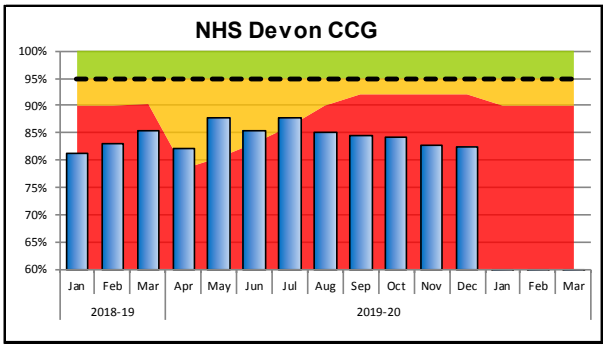
A&E Performance - Percentage of patients waiting less than 4 hours.

All types (including MIU and WiC)

Trust	Trajectory	December	2019/20
RDEFT	91%	84.7%	88.0%
NDHT	84%	84.9%	85.6%
UHP	91%	N/A	N/A
TSDFT	92%	77.9%	80.7%

CCG	Trajectory	December	2019/20
NHS Devon	83%	82.5%	84.7%
ENGLAND		83.3%	86.5%

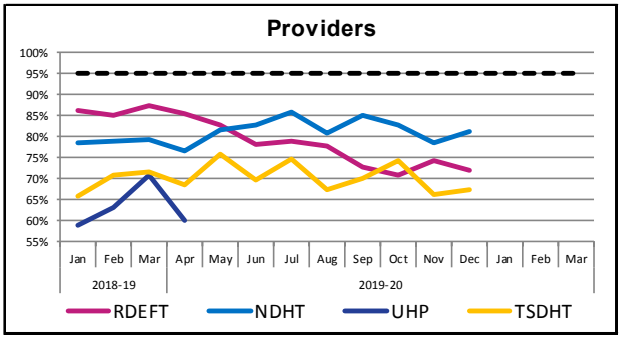


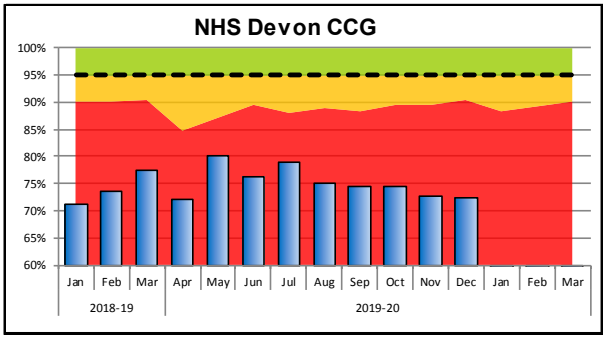


Type 1 A&E only

Trust	Trajectory	December	2019/20
RDEFT	91%	71.9%	77.0%
NDHT	84%	81.4%	81.8%
UHP	91%	N/A	N/A
TSDFT	92%	67.4%	70.5%

CCG	Trajectory	December	2019/20
NHS Devon	83%	72.3%	75.1%
ENGLAND		74.6%	79.2%





Performance Commentary

Performance fell against the A&E 4-hour target in December with the STP 'all types' position at 82.5%, down from 82.8% in November, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. NDHT increased from 82.8% to 84.9% but RD&E fell from 86.2% to 84.7% and TSD remained low, moving from 77.3% to 77.9%.

Quality Commentary and Improvement Actions

The Devon system has continued to experience increased demand impacts within the urgent and emergency care pathways. The CCG is therefore continuing with additional quality reviews including a rolling programme of observational audits which are being undertaken across all localities. Information around patient experience, safety and effectiveness of care from this additional surveillance is shared with the providers and informs local system escalation discussions. Analysis of themes from all ED quality reviews has been completed and presented to the Quality Assurance Committee. This will also be shared with the Devon A&E Delivery Board in the New Year.

Long waits within the Emergency Departments have been reported in the last month. This includes 12-hour breaches for patients attending with escalation of their mental health. Devon Partnership Trust

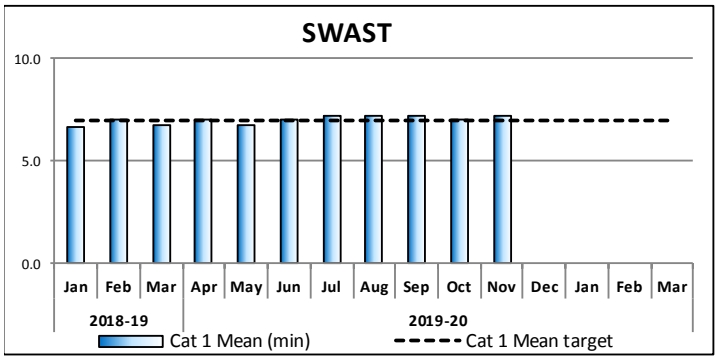
are leading a system working group to seek solutions and will report through the Devon A&E Delivery Board. The CCG continues to review all 12-hour breaches reported to ensure that providers have effective actions in place to minimize safety risks to patients during the period of long waits.

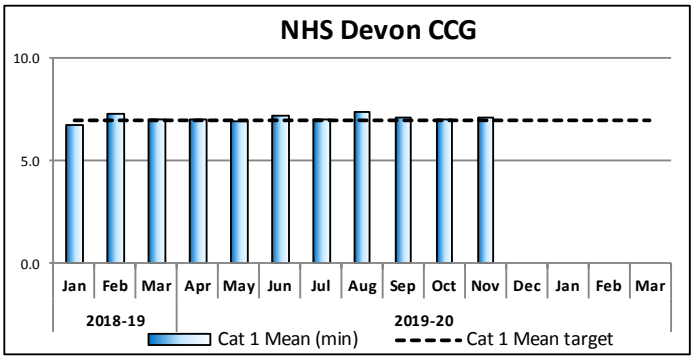
Time lost through handover delays at each ED continue to be monitored closely as these impact on risk to patient safety across the urgent and emergency care pathway. Hospital Ambulance Liaison Officers (HALO's) have been introduced into the Western and South areas to support improvement in timeliness of handover.

Minor injury services (MIU's) that are temporarily closed (Tavistock) or those operating within reduced hours as a result of staffing challenges will have further Quality, Equality Impact Assessments (QEIAs) undertaken and reviewed through the Devon QEIA panel. Communications from the provider of Tavistock MIU service have been updated to reflect the extension of closure until the end January 2020 and workforce remodelling is underway with the aim of addressing current staff shortages and considering service resilience and sustainability for the future.

SWAST Cat 1 Mean response time

Trust	Target	November	2019/20
NHS Devon	7.00	7.10	7.1
SWAST	8.00	7.20	6.9





Performance Commentary

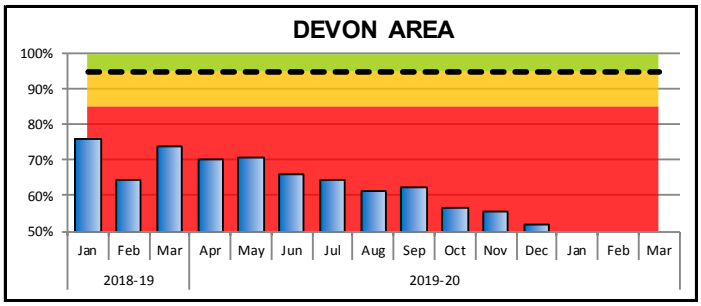
At STP level the 7-minute response time performance was on target in November at 7.1

Quality Commentary and Improvement Actions

SWASFT have increased their risk score from 20 to 25 based on the increasing number of patients waiting for an ambulance and the potential impact these delays may have on patient safety and reported harm in other parts of their footprint (no harm reported in Devon). SWASFT have to date been unable to provide CCG level data in relation to the risk and work continues to obtain this information. The SWASFT Executive review the risk weekly and it is reported through the SWASFT Quality Assurance Group chaired by Dorset CCG as coordinating commissioner where it is considered as part of a package of quality indicators.

NHS 111 answering calls within 60 Seconds

Trust	Target	December	2019/20
DEVON	95%	52.0%	62.3%
ENGLAND	95%	65.6%	79.6%



Performance Commentary

The proportion of calls answered within 60 seconds fell from 55.3% in November to 52.0% in December. Performance remains well below the target of 95%.

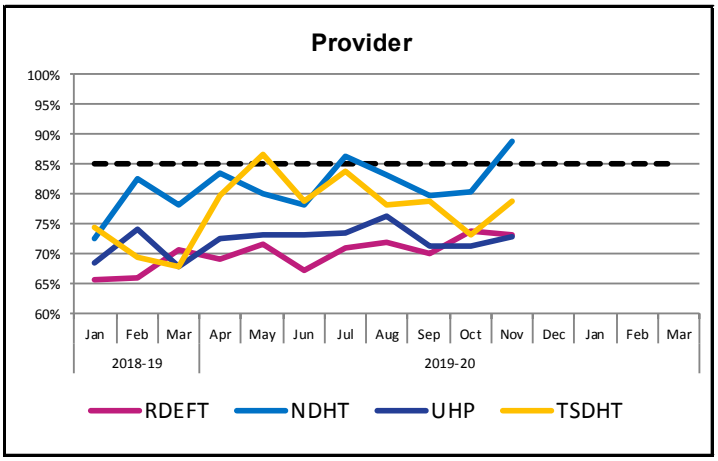
Quality Commentary and Improvement Actions

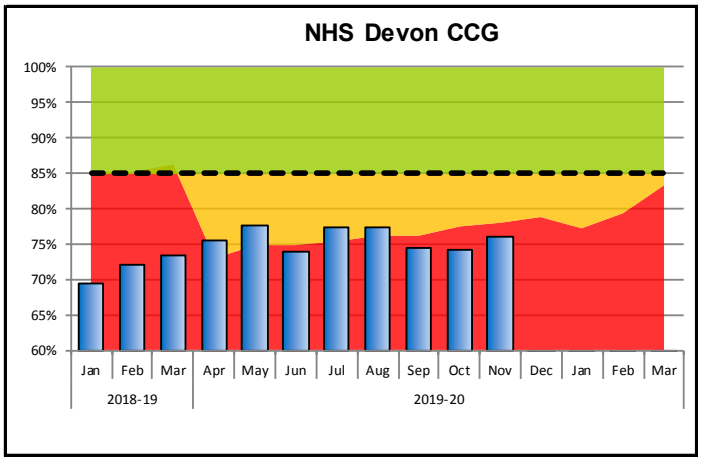
The 111 system is under significant pressure, with a higher than desired level of calls being abandoned by callers who do not receive a timely response. The CCG is working with Devon Doctors to improve the quality and performance of call answering and a planned programme of urgent updates to the call triage system is in place. Consideration of a different approach to call handling is also underway, and this should rapidly reduce the numbers of patients waiting to be answered once it is in place. The CCG quality assurance process continues to review intelligence sources for any adverse impact on patient care or experience as a result of delays in call answering.

Cancer 62 day Urgent Referral

Trust	Trajectory	November	2019/20
RDEFT	78.0%	73.3%	71.1%
NDHT	85.4%	89.0%	82.9%
UHP	69.7%	73.0%	73.0%
TSDFT	85.1%	78.8%	79.8%

CCG	Trajectory	November	2019/20
NHS Devon	78%	75.9%	75.8%
ENGLAND	85%	77.1%	77.1%





Performance Commentary

There was a slight improvement in performance in November with the STP position increasing from 74.2% to 75.9%. NDHT were the only provider to achieve the 85% target at 89.0% but there were improvements at TSD (rising from 73.1% to 78.8%) and UHP (increasing from 71.3% to 73.0%). However, RD&E fell marginally from 73.7% to 73.3%.

RD&E, NDHT and UHP all saw small rises in the backlog of over 62 day waits.

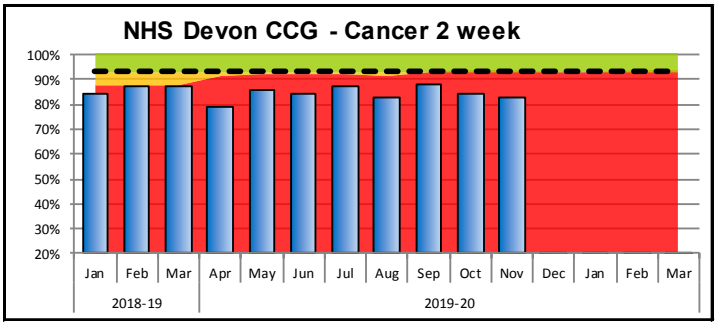
Quality Commentary and Improvement Actions

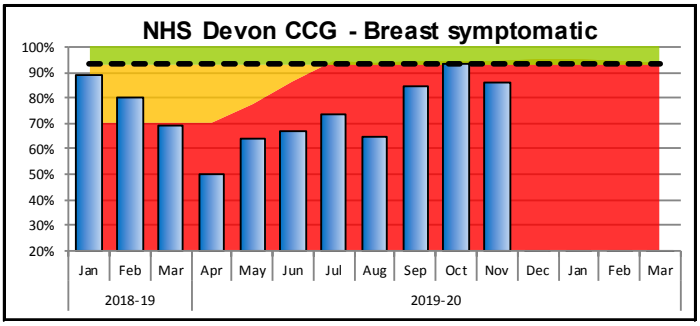
The CCG's strategic plan clearly sets out key areas of work that aim to provide sustainable achievement of the 62-day standard, leading to improved safety and experience for patients. Each provider's improvement plan is overseen by the CCG. There is growing evidence within the system of improved collaboration between providers, as well as new models of care to improve services for patients.

If extended waits are experienced providers have given assurance on the mechanisms by which they maintain patient safety through clinical triage processes, ensuring long waiting patients on cancer pathways are regularly reviewed and communicated with to ensure they remain safe.

Cancer Targets (November-2019)

Target	Measure	NHS Devon	RDEFT	NDHT	UHP	TSDFT
93%	2 week urgent	82.6%	72.1%	90.2%	95.5%	77.9%
93%	2 week breast	86.3%	21.1%	80.0%	87.9%	100.0%
90%	62 day screening	82.2%	85.0%	100.0%	72.2%	85.7%
85%	62 day consultant	80.0%	87.6%	74.5%	60.7%	90.0%
96%	31 day first	95.8%	94.2%	98.9%	94.5%	98.1%
94%	31 day surgery	94.1%	93.8%	91.7%	93.6%	95.0%
98%	31 day drugs	99.7%	100.0%	100.0%	99.3%	100.0%
94%	31 day radiotherapy	96.9%	99.3%	100.0%	90.9%	95.9%





Performance Commentary

Overall performance against the cancer standards remained comparatively good at NDHT and TSDFT and improved at RD&E in November, although is more mixed at UHP who achieved only 2 of the 8 targets.

Performance against the main 2ww standard fell from 84.4% to 82.6% with RD&E dropping to 72.1% and NDHT falling below target to 90.2%. TSD improved from 68.2% to 77.9% and UHP maintained good performance at 95.5%.

Breast symptomatic performance was also below the 93% target at 86.3%, mainly affected by RD&E falling from 100% in October to 21.1% in November. TSD achieved 100% but NDHT fell below target at 80.0% and UHP decreased to 87.9%.

Quality Commentary and Improvement Actions

All providers acknowledge patient experience within their assessments of harm if delays are experienced. Cancer specific action plans are in place for each provider. The aim of the action plans is to set out clear actions to move the Trusts to sustainable achievement of the cancer standards, improving experience for patients requiring cancer care across Devon. These plans now form part of a robust monitoring process supported by NHSI colleagues.

RTT Incomplete Waits

RTT Percentage seen within 18 weeks

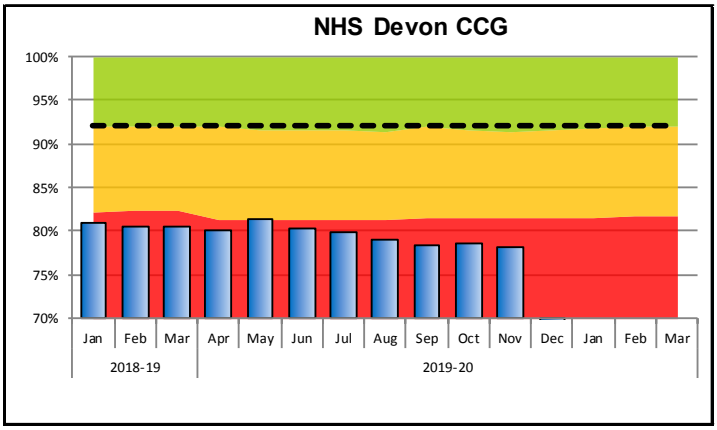
Trust	Trajectory	November	2019/20
RDEFT	82.6%	79.1%	80.3%
NDHT	79.1%	75.6%	78.7%
UHP	77.7%	76.1%	76.6%
TSDFT	81.0%	80.0%	80.8%

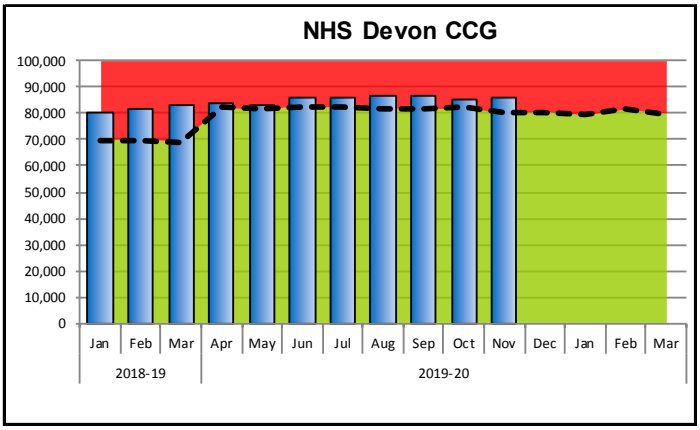
CCG	Trajectory	November	2019/20
NHS Devon	81.2%	78.2%	79.5%
ENGLAND	92.0%	84.7%	85.7%

RTT incomplete waits volume

Trust	Trajectory	November
RDEFT	33,628	34,207
NDHT	10,960	12,086
UHP	27,927	29,934
TSDFT	18,213	20,056

CCG	Trajectory	November
NHS Devon	79,922	85,847





Performance Commentary

The STP level RTT position fell in November from 78.5% to 78.2%. UHP performance fell from 76.5% to 76.1%, RD&E decreased from 79.6% to 79.1% and NDHT dropped from 76.7% to 75.6%. However, TSD increased very slightly from 79.9% to 80.0%. All providers remain under their planned trajectories.

The incomplete waiting list rose by around 350 patients at STP level and is 6,000 (or 7%) above plan, At provider level RD&E, UHP and TSD saw reductions but there was a rise of around 400 at NDHT. All providers are higher than plan (NDHT and TSD by 10%, UHP by 7% and RD&E by 2%).

Providers continue to monitor patients experiencing long waits, and this includes considering the patient experience. Where harm reviews have identified adverse patient impacts providers are reporting and investigating incidents to establish if this was due to the waiting time. The CCG review the incidents to seek assurance that providers are investigating robustly and learning from incidents to drive improvements for patients. This includes reducing time delays as well as improving processes for checking for harm if delays are experienced.

The Devon Referral Support Service (DRSS) continues to work closely with providers and patients, to ensure long waits are managed and patients have a positive experience.

RTT Incomplete Pathways long waiters

40-52 week waits

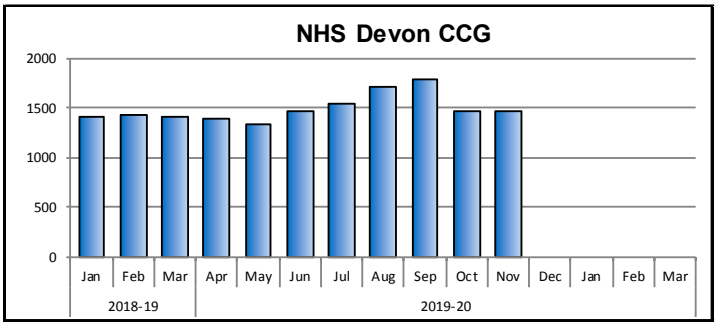
Trust	November	2019/20
RDEFT	574	4734
NDHT	143	1077
UHP	645	5688
TSDFT	315	2723

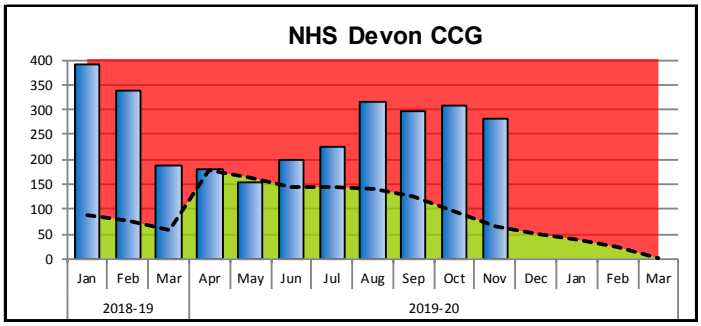
CCG	November	2019/20
NHS Devon	1469	12156

Over 52 week waits

Trust	Trajectory	November	2019/20
RDEFT	0	143	895
NDHT	0	11	73
UHP	25	105	676
TSDFT	47	69	639

CCG	Trajectory	November	2019/20
NHS Devon	66	282	1960





Performance Commentary

Over 52 week waits fell in November from 308 to 282. RD&E continue to have the highest number of breaches, although they fell from 159 to 143. UHP saw an increase from 98 breaches to 105 but TSD fell from 79 to 69. NDHT continue to have a relatively low level of breaches but increased from 9 to 11. All providers are above trajectory.

Quality Commentary and Improvement Actions

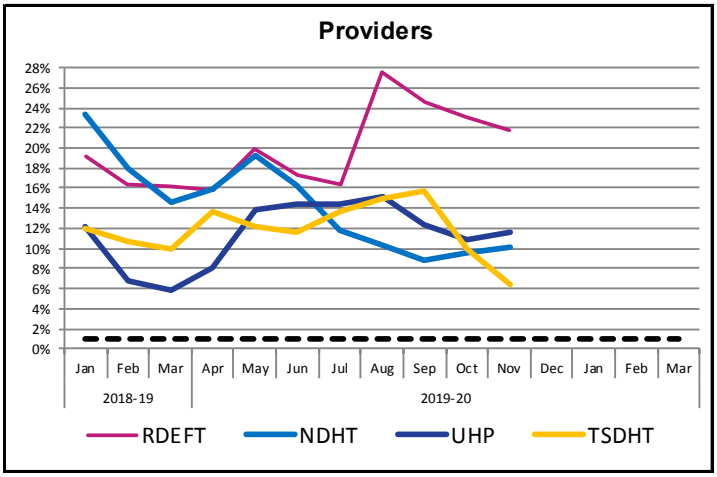
Elements of planned care work continue to be outsourced to the independent sector, with the aim of improving choice and experience and reducing potential risk to patients from a long wait. The CCG continues to seek assurance that provider Trusts are undertaking surveillance to ensure quality is maintained when outsourcing service provision.

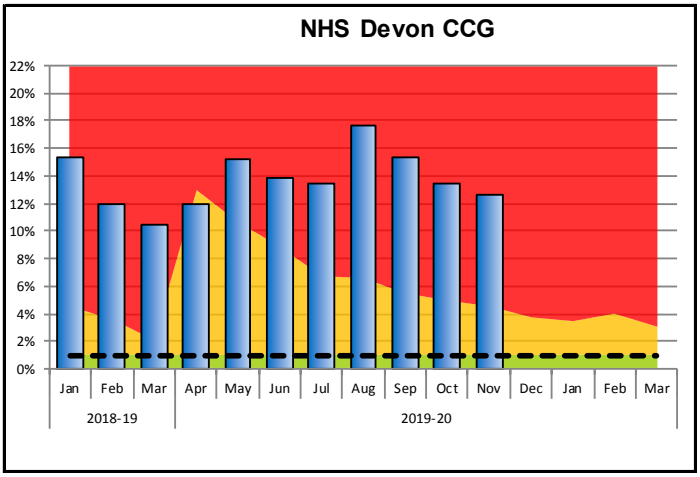
In addition, the Devon wide system program of work for referral to treatment (RTT) improvements is being overseen by DRSS but implemented by providers. This includes a '52-week team' who are contacting all patients to offer alternatives for treatment locations.

Diagnostic 6 week wait

Trust	Trajectory	November	2019/20
RDEFT	1.9%	21.9%	20.9%
NDHT	9.9%	10.2%	13.0%
UHP	3.3%	11.6%	12.7%
TSDFT	7.8%	6.4%	12.4%

CCG	Trajectory	November	2019/20
NHS Devon	4.6%	12.7%	14.2%
ENGLAND	1.0%	3.1%	3.7%





Performance Commentary

The STP position improved again in November with the 6-week breach rate falling from 13.4% to 12.7%. There were further reductions in breaches at RD&E (22.8% to 21.9%) but slight increases at both NDHT (9.6% to 10.2%) and UHP (10.9% to 11.6%). Out of area breaches fell from 8.5% to 6.3%.

RD&E and UHP are significantly above improvement trajectories, with NDHT moving 0.3% above plan in November. The majority of breaches continue to be for imaging and endoscopy.

Quality Commentary and Improvement Actions

To improve waiting times for patients, all acute Trusts have worked together with the CCG to increase capacity. This includes short to medium term measures, but also planning long term to ensure diagnostic pathways are delivered effectively for patients, but in a sustainable way.

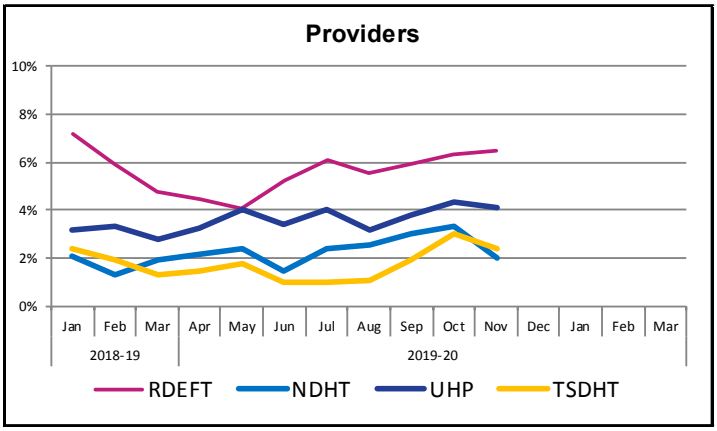
Serious incidents involving diagnostic delays are reported to the CCG through the National Incident Reporting process and full root cause analysis investigations are undertaken. Patient experiences of waiting for diagnostic tests is considered within all Patient Advice & Liaison (PAL's) enquiries and through formal complaints.

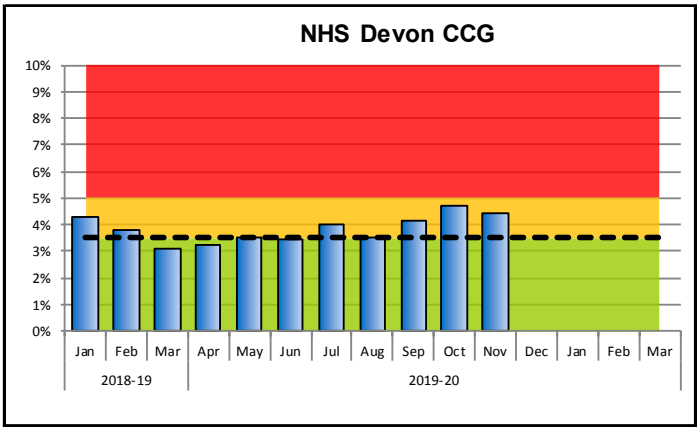
An evaluation of evidence in relation to harm experienced due to long waits for diagnostics was presented at December's Quality Assurance Committee. The purpose of this paper was to describe levels of assurance around quality of care, specifically for patients waiting for a diagnostic procedure or diagnostic reporting that impacts on their diagnosis and treatment options.

Acute Delayed Transfers of care

Trust	Target	November	2019/20
RDEFT	3.50%	6.5%	5.2%
NDHT	3.50%	2.0%	2.3%
UHP	3.50%	4.1%	3.6%
TSDFT	3.50%	2.4%	1.4%

CCG	Target	November	2019/20
NHS Devon	3.50%	4.44%	3.6%





Performance Commentary

In November acute delayed transfers of care (DTOC) fell at TSD, NDHT and UHP but rose slightly at RD&E. The DTOC rate remains low at NDHT and TSD but is slightly above the 3.5% target at UHP at 4.1%. RD&E delays increased from 6.3% to 6.5%.

Quality Commentary and Improvement Actions

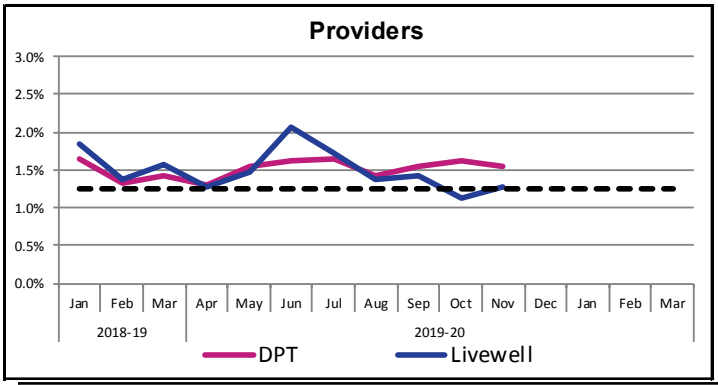
Progress against performance and quality actions continues to be reviewed through the locality A&E Delivery Boards, with reporting and oversight through the Devon Urgent Care Board.

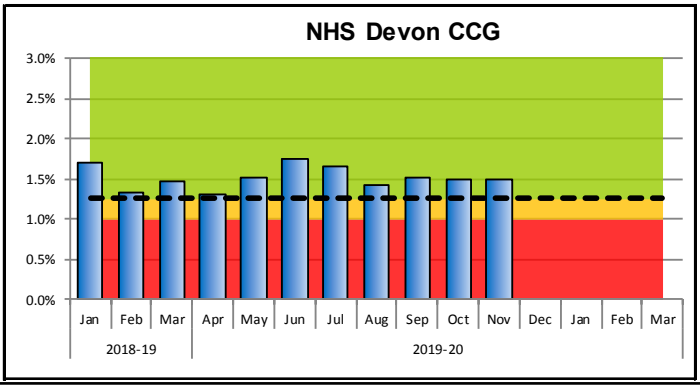
Impact of delayed transfers of care can be seen across the urgent care pathways and the CCG has sight of the position through receipt of the daily situation reports from providers. The patient and system impact of delayed transfers remains a key element of escalation discussions. Partners from across the health and care system participate in escalation discussions to ensure oversight and resolution to challenges in accessing services such as rapid response or domiciliary care that may be delaying timely discharge from hospital.

IAPT Monthly Access rate

Trust	Target	November	2019/20
DPT	1.25%	1.6%	12.3%
LIVEWELL	1.25%	1.28%	11.72%

CCG	Target	November	2019/20
NHS Devon	1.25%	1.5%	12.1%





Performance Commentary

The STP achieved the IAPT access rate indicator in November. with Livewell at 1.28% and DPT at 1.6%.

Quality Commentary and Improvement Actions

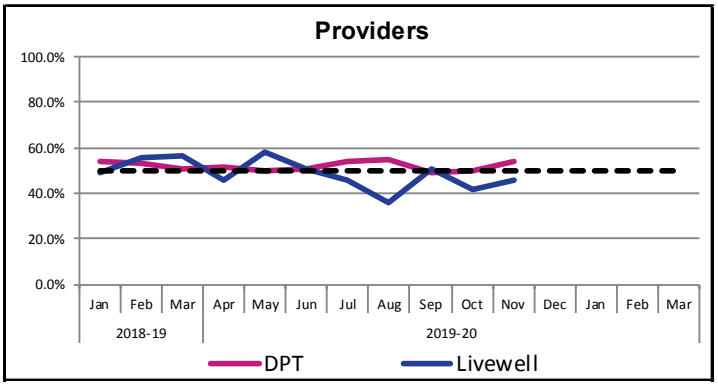
There remains evidence of variance across Devon in accessing some therapy services, and this potentially compromises patient quality and experience. This may also adversely impact on carers and families and is monitored through the CCG quality monitoring processes. Through the Mental Health Investment Standard, local funding for mental health (excluding learning disabilities and dementia), will ensure sufficiency of staff with regards to expansion and replacement of therapists.

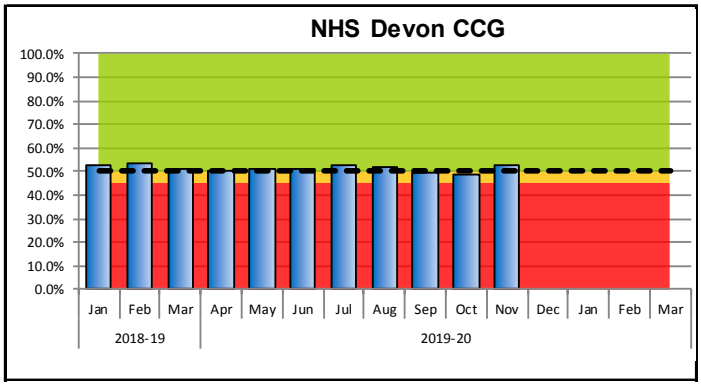
The CCG Quality Assurance Committee has received assurances in relation to IAPT access rates and a further update is due in March 2020.

IAPT Recovery rate

Trust	Target	November	2019/20
DPT	50%	54.0%	51.8%
LIVEWELL	50%	45.7%	46.1%

CCG	Target	November	2019/20
NHS Devon	50%	52.7%	50.9%





Performance Commentary

The STP achieved the 50% target in November, with DPT performance improving back above target at 54% but Livewell underachieving at 45.7%.

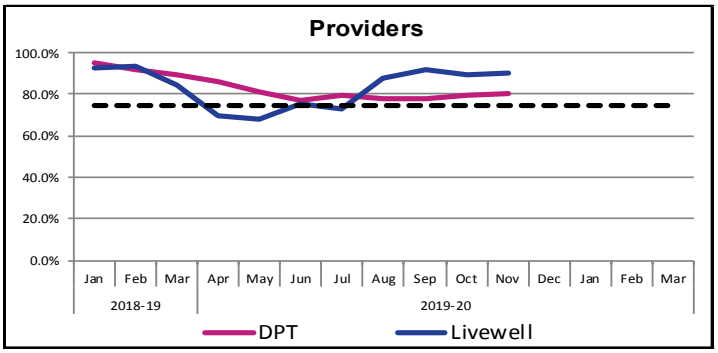
Quality Commentary and Improvement Actions

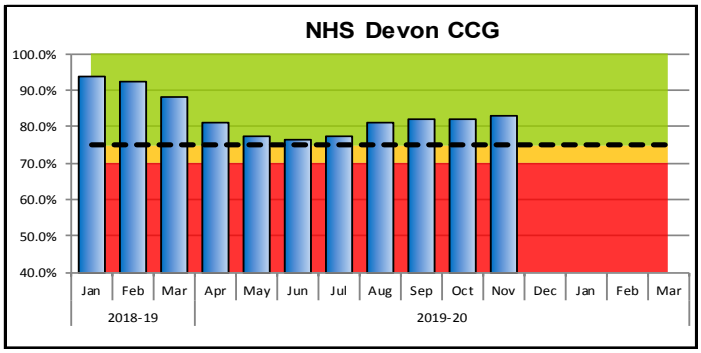
The CCG continues to review all information from provider meetings and other sources to inform the range of indicators within the quality assurance process.

IAPT waiting 6 weeks

Trust	Target	November	2019/20
DPT	75%	80.1%	80.0%
LIVEWELL	75%	90.2%	80.1%

CCG	Target	November	2019/20
NHS Devon	75%	82.8%	80.1%





Performance Commentary

Both DPT and Livewell achieved the target in November.

Quality Commentary and Improvement Actions

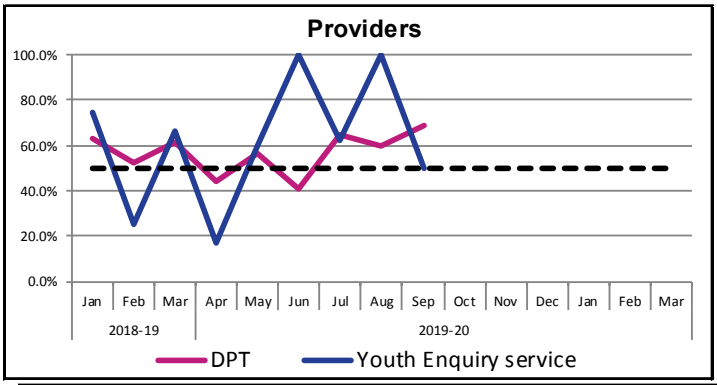
Quality assurance continues through the quality assurance framework process and the CCG Quality Assurance Committee have received assurance in relation to the IAPT recovery rate.

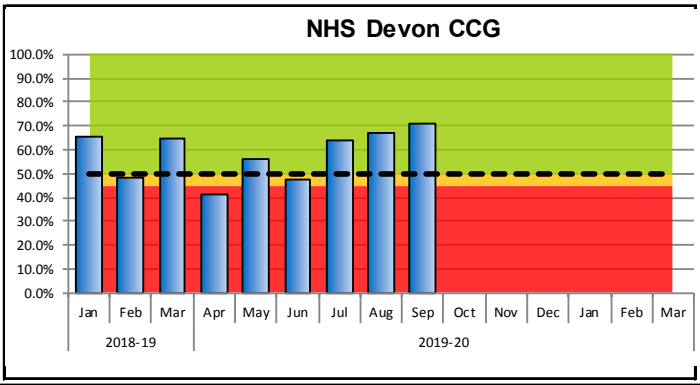
The CCG is currently reviewing challenges raised by Primary Care for those patients who may not be eligible for Community Mental Health Services but present as too complex for depression and anxiety services. Livewell Southwest (LWSW) are undertaking a review of all patients that were considered not eligible for referral to their Community Mental Health Teams (CMHT). The review will focus on where the patient was alternatively referred to, whether they attended any appointments offered and what their outcomes were. This will include patients signposted to other agencies and self-help options. This review will be reported into LWSW board in January 2020. The CCG will work closely with LWSW during this quality review.

Mental Health Early Intervention

Trust	Target	September	2019/20
DPT	50%	69.2%	55.3%
THE ZONE	50%	50.0%	56.7%

CCG	Target	September	2019/20
NHS Devon	50%	100.0%	61.6%
ENGLAND	50%	76.7%	75.1%





Performance Commentary

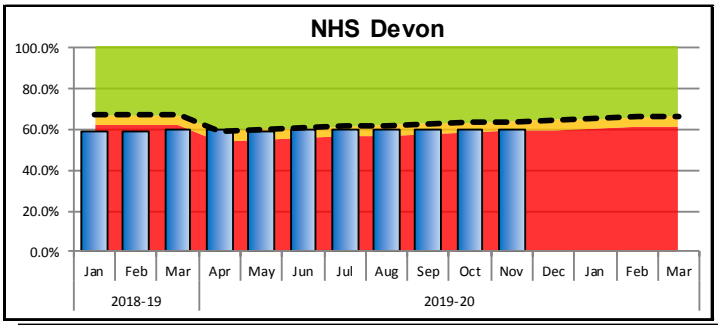
This is a two-part indicator for patients with suspected first episode psychosis or at risk mental state on a completed pathway receiving NICE-recommended care package and allocated to and engaged with an EIP care co-ordinator. Performance improved in September to 70.6%, above target with the Youth Enquiry Service (The Zone) at 50% and DPT at 69%.

Quality Commentary and Improvement Actions

Providers have continued to demonstrate the positive impact of early intervention services however, challenges in achieving timely access to services for some patients continues. In order to understand the potential quality and experience impacts for waiting patients the CCG is undertaking further reviews and the outcomes of these will be reported through the CCG Quality Assurance Committee. These aim to identify any potential gaps where patients may be awaiting assessment or allocation of a community mental health care co-ordinator or where they may be deemed too complex for other services or signposting.

Dementia Diagnosis Rate

CCG	Trajectory	November	2019/20
NHS Devon	64.0%	59.8%	59.7%
ENGLAND	67.0%	68.2%	68.5%



Performance Commentary

STP level performance remained static in November and there has been little change at CCG level over the past year. Nationally performance has been mapped to Local Authority areas which is showing that the lowest rates in Devon are seen in South Hams (41.8%), Mid Devon (49%) and Plymouth (55%). Conversely Exeter is at 71.4%, Torbay 61.6 and East Devon at 64.4%.

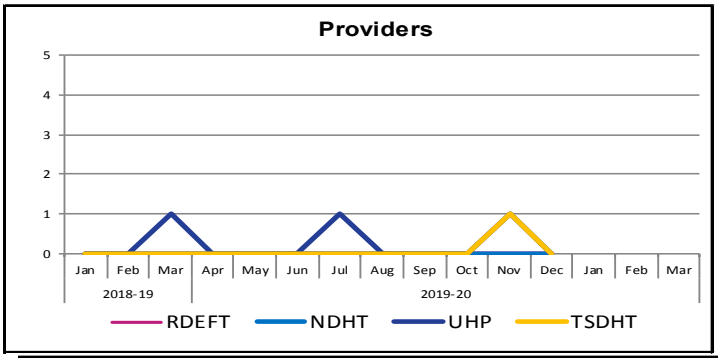
Quality Commentary and Improvement Actions

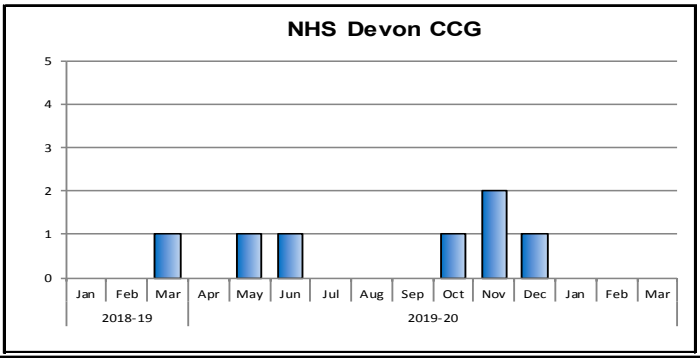
Devon Partnership Trust and Livewell Southwest continue to make improvements in the diagnosis rate. The CCG continues to work with primary care to ask for their support to ensure the correct coding has been used and that patients are identified and referred into these services.

MRSA breaches

Trust	Target	December	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	0	2
TSDFT	0	0	1

CCG	Target	December	2019/20
NHS Devon	0	1	6





Performance Commentary

There were two reported cases of MRSA in November at STP providers and one out of area case in December.

Quality Commentary and Improvement Actions

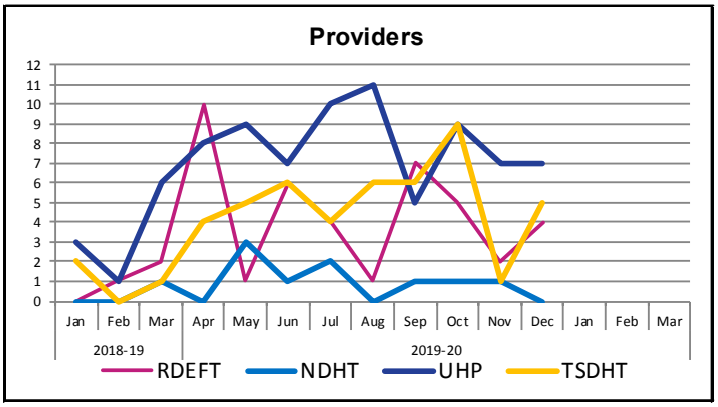
In August there was an outbreak of MRSA colonisation within a ward containing vulnerable patients in UHP. This colonisation did not lead to any cases of MRSA infection.

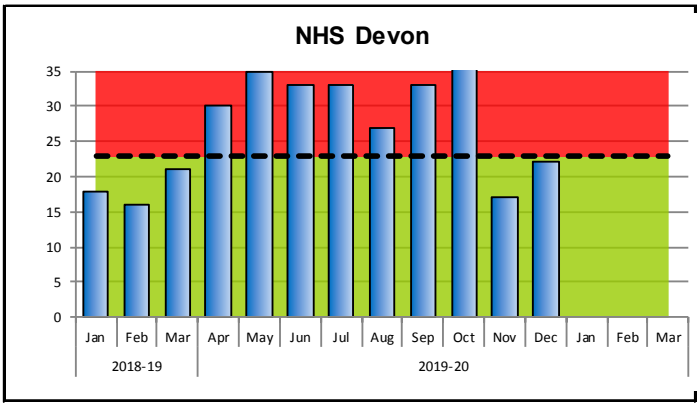
The case in July was a patient from Cornwall, leading to the discrepancy observed above. The October case was community-acquired and therefore does not count towards any of the acute Trust totals. There were two unrelated hospital-acquired cases in late November, one from Plymouth and one from Torbay. Both are under investigation by the apportioned Trust and will be reviewed by the CCG once investigations are complete.

C-Diff breaches

Trust	Target	December	2019/20
RDEFT	<31	4	40
NDHT	<9	0	9
UHP	<63	7	73
TSDFT	<36	5	46

CCG	Target	December	2019/20
DEVON STP	<274	22	269





Performance Commentary

There were 16 C-Diff cases acquired within the acute providers and 22 across the STP in December.

Quality Commentary and Improvement Actions

There has been a significant increase in *C difficile* cases across all providers since April 2019. This is due to changes in reporting requirements (see below), with all areas well above trajectory. The national view is that the trajectories are likely to be incorrect, as they rely on an estimate of activity rather than actual previous activity. This estimate was necessary due to the 2019/20 changes to the C difficile reporting algorithm:

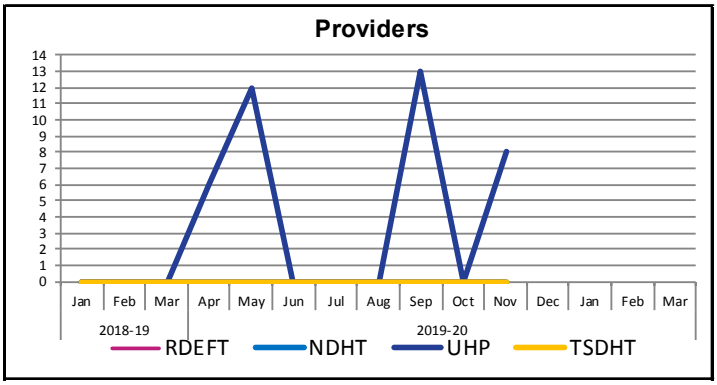
- adding a prior healthcare exposure element for community onset cases
- reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

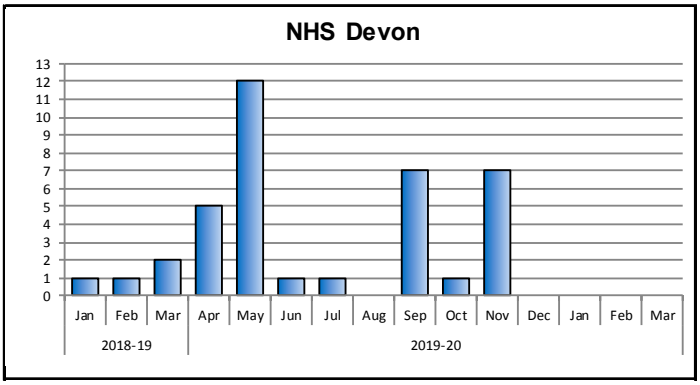
All providers have now reached or exceeded the national targets. Community-onset healthcare-associated cases have contributed significantly to the increase in reported cases, comprising approximately one in three cases. The CCG has invested in a community infection management service including a system lead role for Infection, Prevention and Control (IPC); this service will support future work across community and primary care.

Mixed Sex accommodation breaches

Trust	Target	November	2019/20
RDEFT	0	0	0
NDHT	0	0	0
UHP	0	8	39
TSDFT	0	0	0

CCG	Target	November	2019/20
NHS Devon	0	7	34





Performance Commentary

There were 8 breaches at UHP in November.

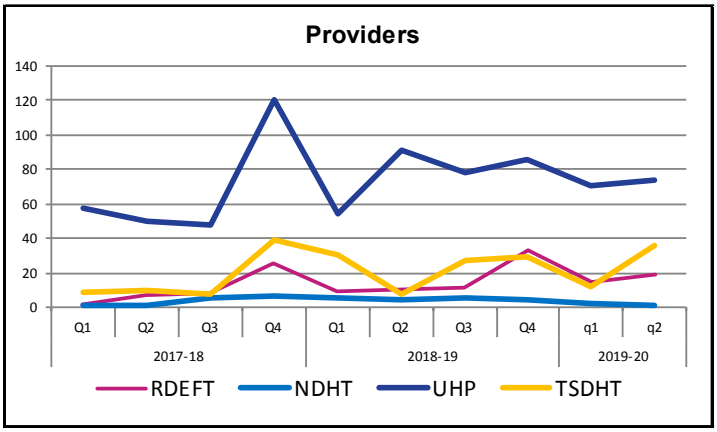
Quality Commentary and Improvement Actions

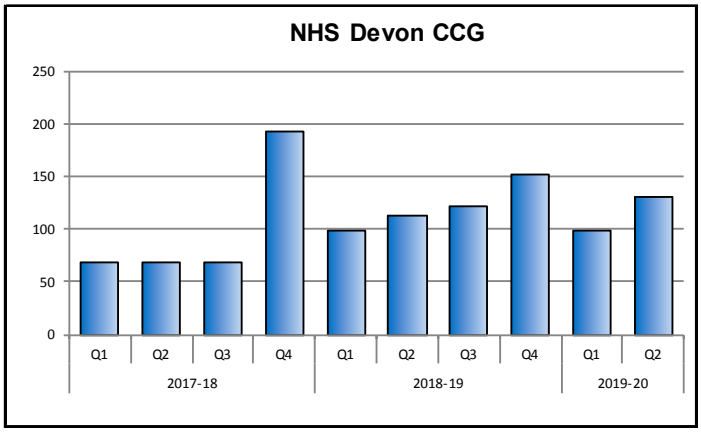
The CCG will continue to seek assurance from the provider organisations that any MSA breaches reported are clinically justifiable.

Cancelled operations not treated with 28 days of cancellation

Trust	Target	Q2	2019/20
RDEFT	0	19	34
NDHT	0	1	3
UHP	0	74	144
TSDFT	0	36	48

CCG	Target	Q2	2019/20
NHS Devon	0	130	229





Performance Commentary

There is a zero breach tolerance for last minute cancelled operations not treated within 28 days of cancellation. Quarter two showed a slight increase from quarter one with rises at all providers except NDHT.

Quality Commentary and Improvement Actions

Providers have developed improved systems and processes, however, there continues to be evidence of information from providers in relation to quality impacts, including experience, for patients who experience cancelled operations and a further delay of 28 days or more. There are processes in place to ensure that patients are appropriately re-booked for their operations.

Various complexities are acknowledged for specific complex surgical operations (including availability of ITU beds across the system), therefore additional assurance continues to be sought through the locality planned care forums and the system planned care forum. This includes reviewing provider processes to ensure collaborative work with partner organisations, planning and on-going communication with patients. In addition, specific key lines of enquiry are undertaken with providers during escalation periods and when it is recognised that cancellation figures are increased. These aim to provide assurance that the patient receives care in the most appropriate setting and within the quickest time frame.

NHS Devon CCG

Summary

Indicator	Domain	Area	Period	England value	Target	Rate	15N: NHS Devon CCG Rank	Change
104a: Injuries from falls in people aged 65 and over	Preventing ill health and reducing inequalities	Falls	19-20 Q2	1763		1563	(51/191)	↓
105b: Personal health budgets	New Service Models	Personalisation and patient choice	19-20 Q1	80		512	(2/191)	
107a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	Preventing ill health and reducing inequalities	Antimicrobial resistance	2019 06	0.940	0.965	0.950	(87/191)	↓
107b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Preventing ill health and reducing inequalities	Antimicrobial resistance	2019 06	8.63%	10%	9.67%	(138/191)	↓
108a: The proportion of carers with a long term condition who feel supported to manage their condition	Quality of care and outcomes	People with long term conditions and complex needs	2019	57.3%	100%	59.7%	(53/191)	
109a: Reducing the rate of low priority prescribing	Finance and use of resources	Finance and use of resources	19-20 Q1			Amber		
121a: Provision of high quality care: hospital	Quality of care and outcomes	General	19-20 Q1				(190/189)	
121b: Provision of high quality care: primary medical services	Quality of care and outcomes	General	19-20 Q1				(190/189)	
122d: Cancer patient experience	Quality of care and outcomes	Cancer services	2018			8.9	(60/191)	↓
123a: Improving Access to Psychological Therapies – recovery	Quality of care and outcomes	Mental health	19-20 Q1	52.2%	50%	45.83%	(176/191)	↑
123b: Improving Access to Psychological Therapies – access	Quality of care and outcomes	Mental health	19-20 Q1	4.68%		4.35%	(130/191)	↓
123c: People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Quality of care and outcomes	Mental health	2019 07	84.8%	56%	77.12%	(156/191)	↑
123f: Mental health out of area placements	Quality of care and outcomes	Mental health	2019 06	156		845	(190/191)	↑
123g: Proportion of people on GP severe mental illness register receiving physical health checks	Quality of care and outcomes	Mental Health	19-20 Q1	29.5%	60%	24.4%	(114/178)	
123i: Delivery of the mental health investment standard	Finance and use of resources	Finance and use of resources	19-20 Q1			Green		
123j: Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI)	Quality of care and outcomes	Mental Health	2019 05			91.74%	(10/191)	↑
125d: Maternal smoking at delivery	Quality of care and outcomes	Smoking	19-20 Q1	10.4%	6%	12.41%	(121/191)	
126a: Estimated diagnosis rate for people with dementia	Quality of care and outcomes	People with long term conditions and complex needs	2019 06	68.5%	67%	60.04%	(178/191)	↑
127b: Emergency admissions for urgent care sensitive conditions	New Service Models	Integrated primary care and community health services	19-20 Q2	2125		1864	(43/191)	↓
127a: Delayed transfers of care per 100,000 population	New Service Models	Acute emergency care and transfers of care	2019 08	10.9		12.3	(132/191)	↓
128b: Patient experience of GP services	New Service Models	Integrated primary care and community health services	2019	82.9%		87.62%	(17/191)	
128d: Primary care workforce	Leadership and workforce	Leadership and workforce	2019 03	1.06		1.23	(28/191)	↑
129b: Overall size of the waiting list	Quality of care and outcomes	Planned care	2019 08	4407974		86789	(190/191)	↑
129c: Patients waiting over 52 weeks for treatment	Quality of care and outcomes	Planned care	2019 08	1233		316	(191/191)	↑
131a: Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	New Service Models	Integrated primary care and community health services	19-20 Q1	6.54%	15%	0.00%	(1/191)	+
133a: Percentage of patients waiting 6 weeks or more for a diagnostic test	Quality of care and outcomes	Planned care	2019 08	4.31%	1%	17.63%	(189/191)	↑
134a: Evidence based interventions	Quality of care and outcomes	General	19-20 Q1			Red		
141b: In-year financial performance	Finance and use of resources	Finance and use of resources	19-20 Q1			Red		
144a: Utilisation of the NHS e-referral service to enable choice at first routine elective referral	New Service Models	Personalisation and patient choice	2019 07	99.8%	100%	98.91%	(187/191)	↓
145a: Expenditure in areas with identified scope for improvement	Finance and use of resources	Finance and use of resources	19-20 Q1			Red		
162a: Probity and corporate governance	Leadership and workforce	Leadership and workforce	19-20 Q1					
165a: Quality of CCG leadership	Leadership and workforce	Leadership and workforce	19-20 Q1			Amber		
166a: Compliance with statutory guidance on patient and public participation in commissioning health and care	Leadership and workforce	Leadership and workforce	2018					

Direction of change arrows
↑ Increase
↓ Decrease
\+ Equal
✕ No data

Banding
Highest performing quart
Interquartile range
Lowest performing quarti
n/app

Indicators with a target
Pass
Fail
n/app

RateText
Null
Green
Amber
Red

Colour of change arrows
Improvement
Deterioration
No change
n/app

Appendix B. Key performance indicators – NHS Devon CCG

FIGURES FOR NHS DEVON CCG

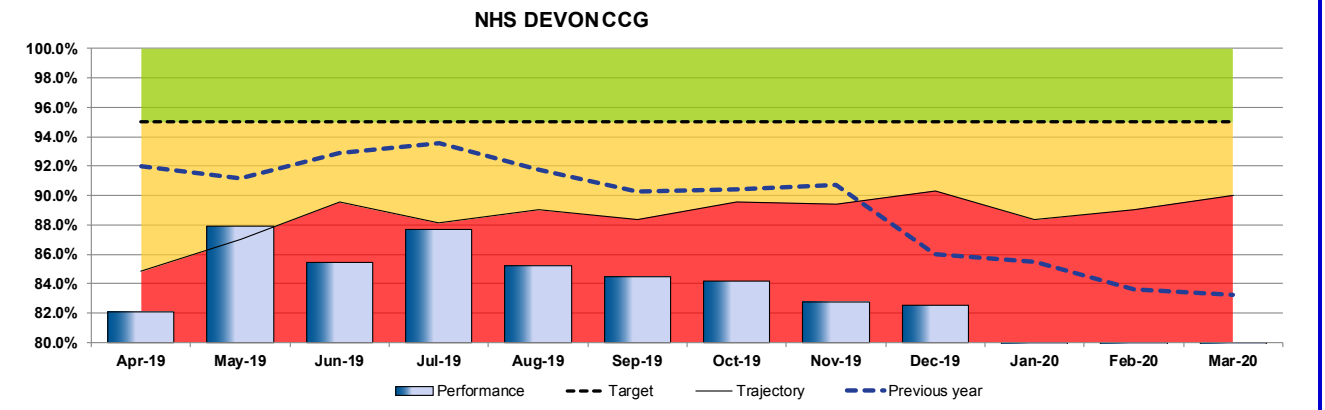
PERFORMANCE MEASURES

INDICATOR	TARGET	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2019/20 YTD
Referral to treatment - percentage seen within 18 weeks - Incomplete pathways	>=92%	80.9%	80.6%	80.5%	80.1%	81.3%	80.4%	79.8%	79.0%	78.4%	78.5%	78.2%					80.6%	79.1%	78.3%		79.5%
Referral to treatment - Number seen over 52 weeks - Incomplete pathways	0	391	339	188	179	153	199	225	316	298	308	282					531	839	590		1960
Diagnostics - percentage patients waiting over 6 weeks - 15 key tests	<=1%	15.3%	11.9%	10.5%	12.0%	15.2%	13.9%	13.4%	17.6%	15.3%	13.4%	12.7%					13.7%	15.4%	13.1%		14.2%
Cancer - percentage seen within 2 weeks - urgent referral to first seen	>=93%	84.4%	87.6%	87.1%	78.8%	85.9%	84.3%	87.3%	83.0%	88.2%	84.4%	82.6%					83%	86.1%	83.5%		84.3%
Breast symptomatic- percentage seen within 2 weeks	>=93%	89.1%	80.0%	69.0%	50.2%	64.3%	66.8%	73.5%	64.8%	84.8%	93.5%	86.3%					60%	74.2%	90.2%		71.7%
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment	>=85%	69.3%	72.1%	73.5%	75.4%	77.7%	73.9%	77.3%	77.4%	74.5%	74.2%	75.9%					76%	76.4%	75.0%		75.8%
Cancer - percentage treated within 62 days - referral from NHS Cancer Screening Programme	>=90%	90.7%	92.1%	86.7%	95.6%	89.2%	87.2%	90.7%	86.0%	90.2%	77.4%	82.2%					91%	89.2%	79.6%		87.3%
Cancer - percentage treated within 62 days - consultant upgrade	>=85%	87.0%	82.6%	85.5%	76.5%	81.1%	83.0%	89.8%	86.0%	73.7%	75.0%	80.0%					80%	83.8%	77.2%		80.8%
Cancer - percentage treated within 31 days - decision to treat to first definitive treatment	>=96%	94.5%	93.1%	93.2%	92.8%	95.7%	94.5%	95.7%	94.9%	95.7%	94.7%	95.8%					94%	95.5%	95.2%		95.0%
Cancer - percentage receiving subsequent treatment within 31 days - surgery	>=94%	88.5%	87.9%	88.4%	93.0%	92.0%	93.7%	96.0%	94.6%	86.0%	87.9%	94.1%					93%	92.1%	91.0%		92.1%
Cancer - percentage receiving subsequent treatment within 31 days - drug	>=98%	99.7%	99.7%	99.7%	99.3%	99.4%	99.7%	99.7%	99.7%	100.0%	100.0%	99.7%					99%	99.8%	99.9%		99.7%
Cancer - percentage receiving subsequent treatment within 31 days - radiotherapy	>=94%	92.9%	93.7%	91.2%	92.8%	90.2%	91.8%	96.0%	96.3%	94.5%	96.1%	96.9%					92%	95.6%	96.6%		94.4%
Accident and Emergency - percentage attendances seen within 4 hours (Acute)	>=95%	71.3%	73.7%	77.4%	72.0%	80.3%	76.3%	79.0%	74.9%	74.6%	74.5%	72.5%	72.3%				76%	76.2%	73.2%		75.1%
Accident and Emergency - percentage attendances seen within 4 hours (Acute & Community)	>=95%	81.3%	82.9%	85.4%	82.1%	87.9%	85.4%	87.7%	85.2%	84.5%	84.2%	82.8%	82.5%				85%	85.8%	83.2%		84.7%
Ambulance Category 1 Mean response Duration (min)	7	6.8	7.3	7.0	7.0	6.9	7.2	7.0	7.4	7.1	7.0	7.1					7.0	7.2	7.1		7.1
Ambulance Category 1 90th response Duration (min)	15	12.0	13.1	12.3	13.1	12.5	13.5	12.7	13.7	13.2	12.7	13.4					13.0	13.2	13.1		13.1
Ambulance Category 2 Mean response Duration (min)	18	28.5	28.3	27.3	26.0	26.1	26.3	26.8	26.3	25.5	25.5	25.7					26.1	26.2	25.6		26.0
Ambulance Category 2 90th response Duration (min)	40	58.7	59.5	56.0	53.7	54.3	54.6	56.0	54.6	52.2	52.9	54.0					54.2	54.3	53.0		54.0
Ambulance Category 3 90th response Duration (min)	120	169.7	161.3	156.5	162.4	155.1	158.4	163.4	162.1	167.1	152.9	148.6					158.6	164.2	156.2		158.8
Ambulance Category 4 90th response Duration (min)	180	220.2	214.4	200.1	196.4	186.4	197.0	207.5	197.9	165.2	156.0	175.3					193.3	190.2	165.5		185.2
Cancelled Operations - Number of patients not treated within 28 days of cancellation	0			152			99										99				99
IAPT Percentage of people entering treatment against the level of need in the general population (Monthly Access rate)	1.25%	2%	1%	1%	1.3%	1.5%	2%	2%	1%	2%	1%	1%					4.6%	1.5%	1.5%		12.1%
IAPT recovery rate - percentage of people who are moving to recovery	50%	53.0%	53.7%	51.4%	50.7%	50.9%	50.7%	52.5%	52.0%	49.1%	48.6%	52.7%					50.8%	51.2%	50.7%		50.9%
IAPT - started treatment with 6 weeks of referral	75%	94.0%	92.3%	88.0%	81.3%	77.6%	76.5%	77.6%	81.0%	82.3%	81.9%	82.8%					78.4%	80.2%	82.4%		80.1%
Mental Health - Percentage of people on CPA who were followed up with in 7 days of discharge	95%	97.7%	87.0%	97.9%	91.1%	98.3%	89.8%	93.8%	91.8%	100.0%	98.1%	90.0%					93.5%	95.1%	94.2%		94.3%
Mental Health - Percentage of patients who have had a CPA review within the past 12 months	95%	93.7%	93.4%	93.5%	91.4%	89.0%	86.8%	90.4%	92.1%	90.3%	89.7%	87.7%					89.0%	90.9%	88.7%		89.7%
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50%	65.2%	48.1%	64.7%	40.9%	56.0%	47.4%	64.0%	66.7%	70.6%							48.5%	66.7%	100.0%		61.6%
Dementia diagnosis rate	62%	59.1%	58.9%	59.6%	59.5%	59.3%	60.0%	59.6%	59.8%	59.9%	59.8%	59.8%					59.6%	59.8%	59.8%		59.7%
MRSA bacteraemia - number of hospital infections	0	0	0	1	0	1	1	0	0	0	1	2	1				2	1	4		6
Clostridium difficile - number of hospital infections	316	18	16	21	30	35	33	33	27	33	39	17	22				98	99	78		269
Mixed sex accommodation (MSA) - number of hospital breaches	0	1	1	2	5	12	1	1	0	7	1	7					34	8	8		34
Delayed transfers of care - patient delays as a percentage of occupied beds (Acute only)	3.5%	4.3%	3.8%	3.1%	3.3%	3.5%	3.4%	4.0%	3.5%	4.1%	4.7%	4.4%					3.4%	3.9%	4.6%		3.6%
Delayed transfers of care (all) - Percentage of delays per Occupied bed	3.5%	5.3%	4.9%	3.9%	4.2%	4.7%	4.6%	5.3%	5.2%	5.3%	5.9%	5.3%					4.5%	5.2%	5.2%		4.9%

4 hour waits A&E &MIU

NHS Devon CCG

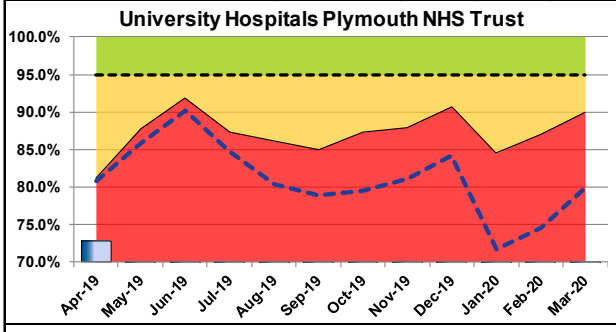
STP footprint	National target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Performance	>95%	82.1%	87.9%	85.4%	87.7%	85.2%	84.5%	84.2%	82.8%	82.5%			
Trajectory		84.8%	87.0%	89.5%	88.1%	89.0%	88.4%	89.6%	89.4%	90.3%	88.3%	89.1%	90.0%
NHS England		85.1%	88.0%	87.7%	87.8%	87.6%	86.8%	85.3%	83.3%	81.8%			

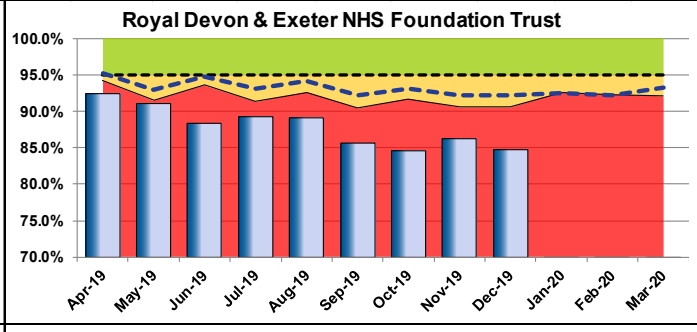


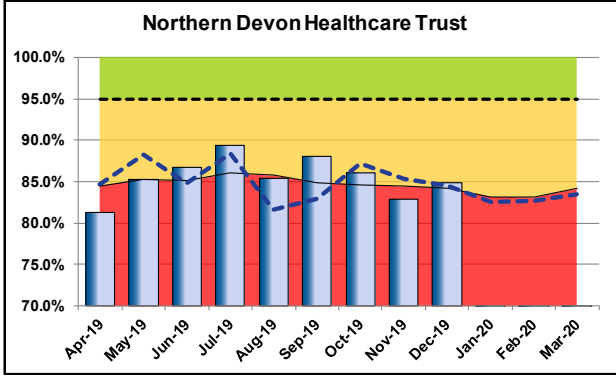
Comment:
Performance fell against the A&E 4-hour target in December with the STP 'all types' position at 82.5%, down from 82.8% in November, although this does not include UHP who are not submitting validated data during the period when they are part of the national trial of new A&E measures. NDHT increased from 82.8% to 84.9% but RD&E fell from 86.2% to 84.7% and TSD remained low, moving from 77.3% to 77.9%.

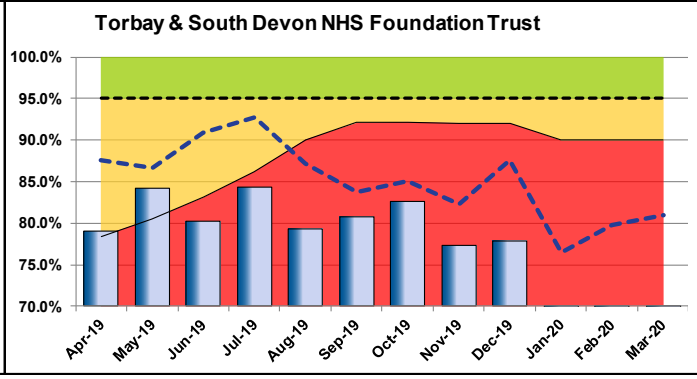
Provider level

Provider		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
UHP	Actual	72.8%											
	Trajectory	81.1%	87.8%	91.9%	87.4%	86.1%	85.0%	87.3%	88.0%	90.7%	84.5%	87.1%	90.0%
RDEFT	Actual	92.4%	91.1%	88.3%	89.3%	89.0%	85.7%	84.5%	86.2%	84.7%			
	Trajectory	94.2%	91.5%	93.6%	91.3%	92.6%	90.4%	91.7%	90.6%	90.6%	92.6%	92.3%	92.1%
NDHT	Actual	81.3%	85.2%	86.8%	89.4%	85.4%	88.0%	86.1%	82.8%	84.9%			
	Trajectory	84.5%	85.2%	85.1%	86.0%	85.8%	84.9%	84.6%	84.4%	84.2%	83.2%	83.1%	84.2%
TSDFT	Actual	79.1%	84.2%	80.3%	84.3%	79.3%	80.7%	82.7%	77.3%	77.9%			
	Trajectory	78.4%	80.5%	83.1%	86.2%	90.1%	92.1%	92.2%	92.0%	92.0%	90.0%	90.0%	90.0%





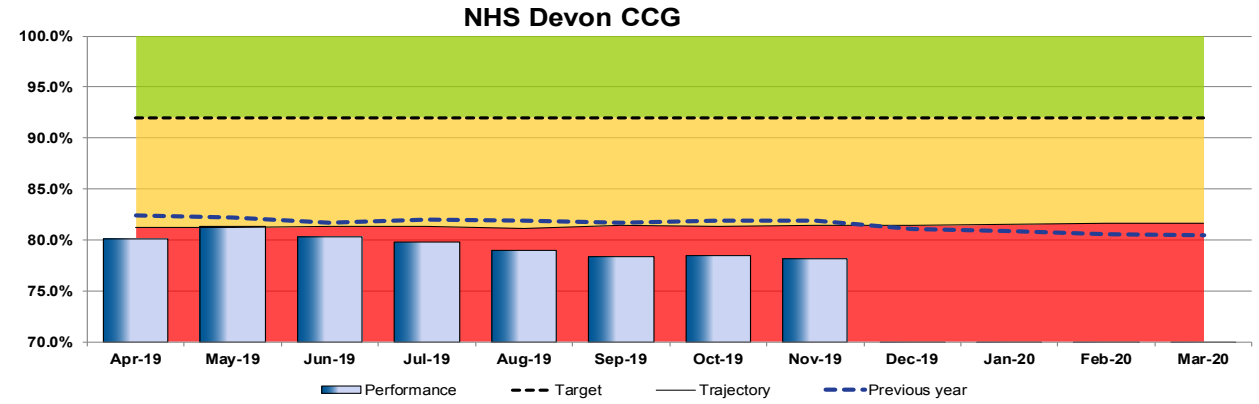




18-week RTT (incomplete pathway)

NHS Devon CCG

NHS Devon CCG	National target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Performance	>92%	80.1%	81.3%	80.4%	79.8%	79.0%	78.4%	78.5%	78.2%				
Trajectory		81.2%	81.2%	81.3%	81.3%	81.2%	81.4%	81.4%	81.4%	81.4%	81.5%	81.7%	81.7%
NHS England		86.5%	86.9%	86.3%	85.8%	85.0%	84.8%	84.7%					
RTT total waiting list	78,364	83,546	83,041	85,931	85,991	86,788	86,517	85,497	85,847				
Trajectory		82,086	81,536	82,603	82,054	81,730	81,454	82,036	79,922	80,442	79,389	81,351	79,872



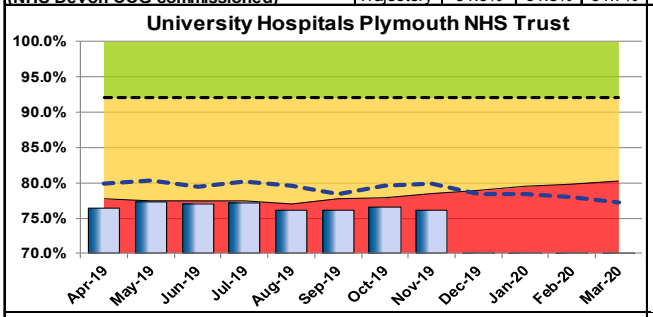
The STP level RTT position fell in November from 78.5% to 78.2%. UHP performance fell from 76.5% to 76.1%, RD&E decreased from 79.6% to 79.1% and NDHT dropped from 76.7% to 75.6%. However, TSD increased very slightly from 79.9% to 80.0%. All providers remain under their planned trajectories. The incomplete waiting list rose by around 350 patients at STP level and is 6,000 (or 7%) above plan, At provider level RD&E, UHP and TSD saw reductions but there was a rise of around 400 at NDHT. All providers are higher than plan (NDHT and TSD by 10%, UHP by 7% and RD&E by 2%).

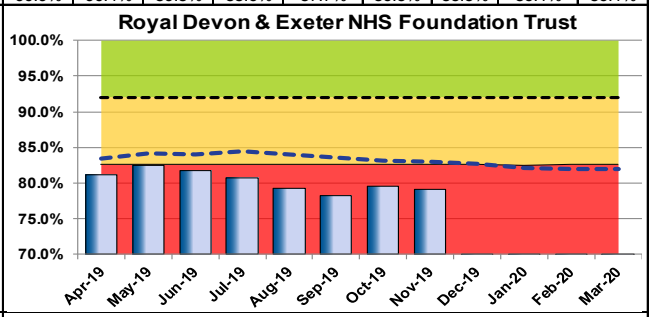
Over 52 week waits fell in November from 308 to 282. RD&E continue to have the highest number of breaches, although they fell from 159 to 143. UHP saw an increase from 98 breaches to 105 but TSD fell from 79 to 69. NDHT continue to have a relatively low level of breaches but increased from 9 to 11. All providers are above trajectory.

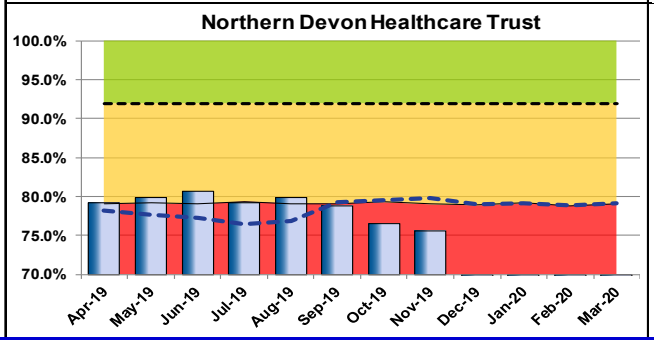
18-week RTT (incomplete pathway).....continued

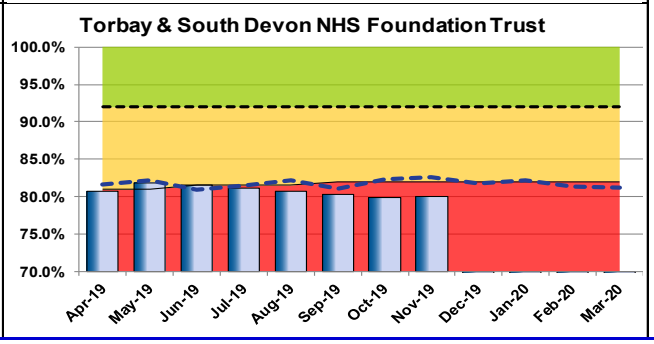
Provider level

Provider		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
UHP	Actual	76.4%	77.3%	77.0%	77.2%	76.2%	76.2%	76.5%	76.1%				
	Trajectory	77.7%	77.5%	77.5%	77.4%	77.0%	77.8%	77.9%	78.5%	78.9%	79.5%	79.9%	80.3%
	Waiting list	28,195	28,611	28,899	29,702	30,115	29,618	30,283	29,934				
	Trajectory	28,351	28,476	28,496	28,533	28,730	28,354	28,277	27,927	27,703	27,404	27,312	27,217
RDEFT	Actual	81.1%	82.4%	81.7%	80.7%	79.3%	78.3%	79.5%	79.1%				
	Trajectory	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%	82.6%
	Waiting list	33,619	35,690	36,355	35,697	36,453	35,901	34,721	34,207				
	Trajectory	34,555	33,783	34,857	34,374	33,707	33,992	35,016	33,628	34,374	33,457	35,712	34,293
NDHT	Actual	79.3%	79.9%	80.7%	79.2%	79.9%	78.8%	76.5%	75.6%				
	Trajectory	79.1%	79.2%	79.1%	79.4%	79.1%	79.1%	79.3%	79.1%	78.9%	79.1%	78.9%	79.1%
	Waiting list	11,385	11,403	11,429	11,641	11,709	11,836	11,696	12,086				
	Trajectory	11,797	11,665	11,564	11,396	11,313	11,194	11,044	10,960	10,863	10,709	10,626	10,479
TSDFT	Actual	80.7%	81.9%	81.5%	81.1%	80.7%	80.4%	79.9%	80.0%				
	Trajectory	81.0%	81.0%	81.5%	81.5%	81.5%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%
	Waiting list	19,016	19,534	19,636	19,939	19,899	20,281	20,668	20,056				
	Trajectory	18,567	18,548	18,416	18,398	18,379	18,249	18,231	18,213	18,194	18,176	18,158	18,140
Other providers (NHS Devon CCG commissioned)	Actual	81.7%	82.5%	82.0%	81.6%	81.2%	80.8%	80.2%	80.5%				
	Trajectory	91.6%	91.8%	91.7%	90.9%	90.4%	89.8%	88.6%	87.7%	86.3%	85.3%	86.1%	86.1%





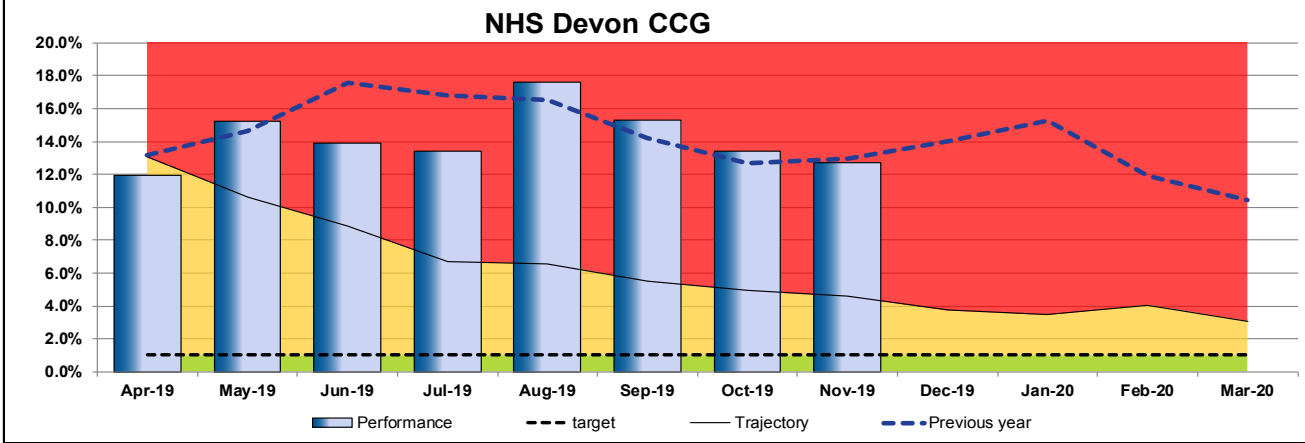




6 Week Diagnostics

NHS Devon CCG

NHS Devon CCG	National target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Performance	>1%	12.0%	15.2%	13.9%	13.4%	17.6%	15.3%	13.4%	12.7%				
Trajectory		13.0%	10.6%	8.9%	6.7%	6.6%	5.5%	4.9%	4.6%	3.7%	3.5%	4.0%	3.1%
NHS England		3.6%	4.1%	3.8%	3.5%	4.3%	3.8%	3.1%					



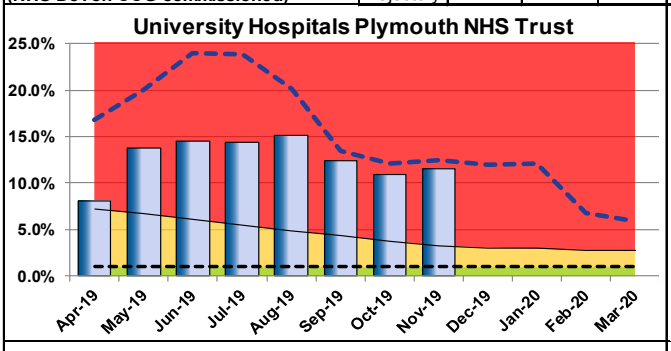
The STP position improved again in November with the 6-week breach rate falling from 13.4% to 12.7%. There were further reductions in breaches at RD&E (22.8% to 21.9%) but slight increases at both NDHT (9.6% to 10.2%) and UHP (10.9% to 11.6%). Out of area breaches fell from 8.5% to 6.3%.

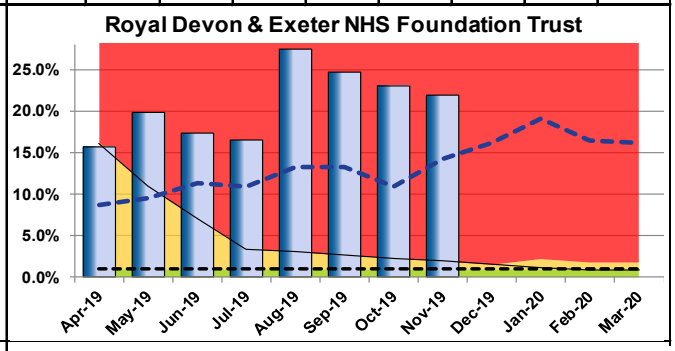
RD&E and UHP are significantly above improvement trajectories, with NDHT moving 0.3% above plan in November. The majority of breaches continue to be for imaging and endoscopy.

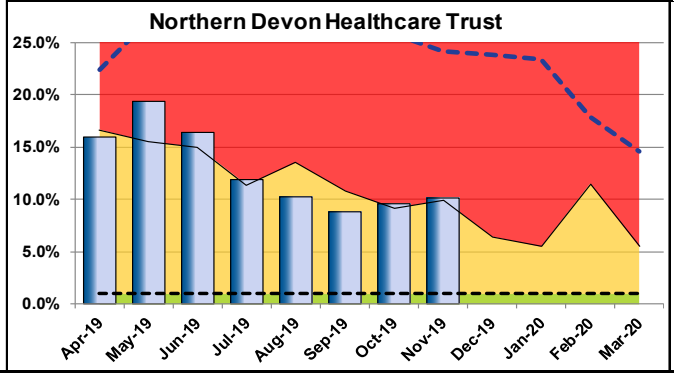
6 Week Diagnostics……continued

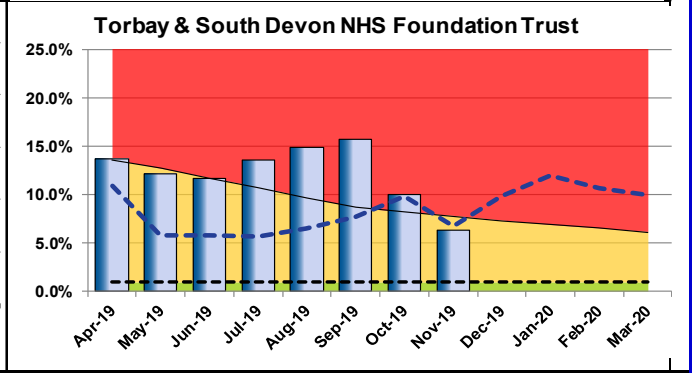
Provider level

Provider		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
UHP	Actual	8.1%	13.8%	14.5%	14.4%	15.2%	12.4%	10.9%	11.6%				
	Trajectory	7.2%	6.7%	6.1%	5.4%	4.9%	4.4%	3.8%	3.3%	3.0%	3.0%	2.8%	2.7%
RDEFT	Actual	15.7%	19.9%	17.3%	16.4%	27.5%	24.6%	23.1%	21.9%				
	Trajectory	16.1%	11.0%	7.1%	3.4%	3.0%	2.7%	2.3%	1.9%	1.6%	1.2%	0.9%	0.8%
NDHT	Actual	15.9%	19.3%	16.3%	11.8%	10.2%	8.8%	9.6%	10.2%				
	Trajectory	16.6%	15.5%	15.0%	11.4%	13.5%	10.8%	9.1%	9.9%	6.4%	5.5%	11.5%	5.5%
TSDFT	Actual	13.7%	12.1%	11.7%	13.7%	14.9%	15.7%	10.0%	6.4%				
	Trajectory	13.7%	12.7%	11.8%	10.8%	9.7%	8.7%	8.3%	7.8%	7.3%	6.9%	6.5%	6.2%
Other providers (NHS Devon CCG commissioned)	Actual	11.7%	10.7%	9.8%	11.0%	12.9%	12.3%	8.5%	6.3%				
	Trajectory												





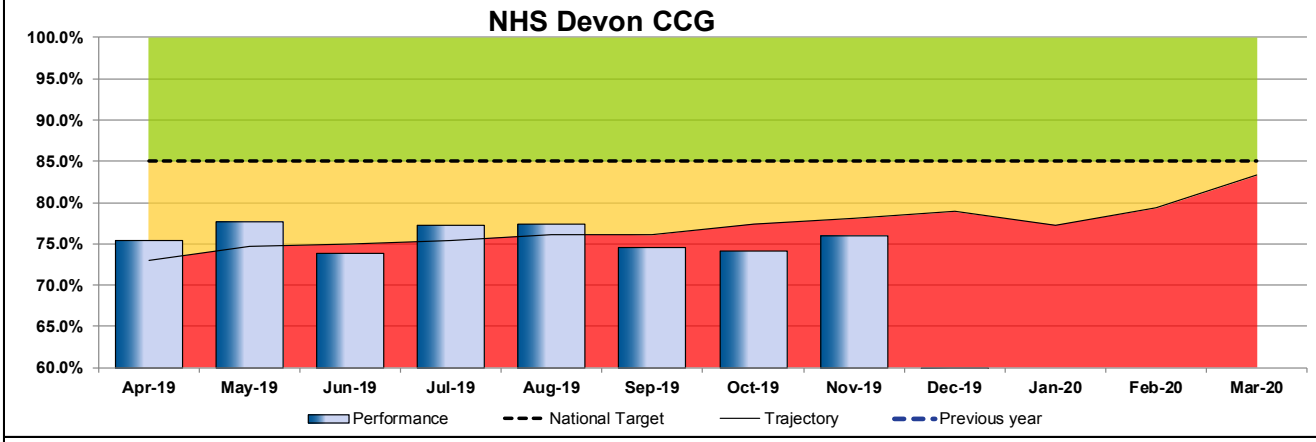




62 day standard Cancer waits

NHS Devon CCG

NHS Devon CCG	National target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Performance	>85%	75.4%	77.7%	73.9%	77.3%	77.4%	74.5%	74.2%	75.9%				
Trajectory		73.0%	74.7%	74.9%	75.4%	76.1%	76.1%	77.4%	78.1%	78.9%	77.3%	79.3%	83.3%
NHS England		79.4%	77.5%	76.7%	77.6%	78.5%	76.9%	77.1%					



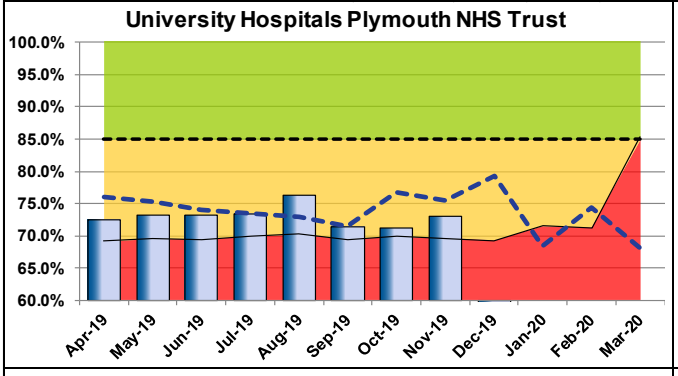
There was a slight increase in performance in November with the STP position increasing from 74.2% to 75.9%. NDHT were the only provider to achieve the 85% target at 89.0% but there were improvements at TSD (rising from 73.1% to 78.8%) and UHP (increasing from 71.3% to 73.0%). However, RD&E fell marginally from 73.7% to 73.3%.

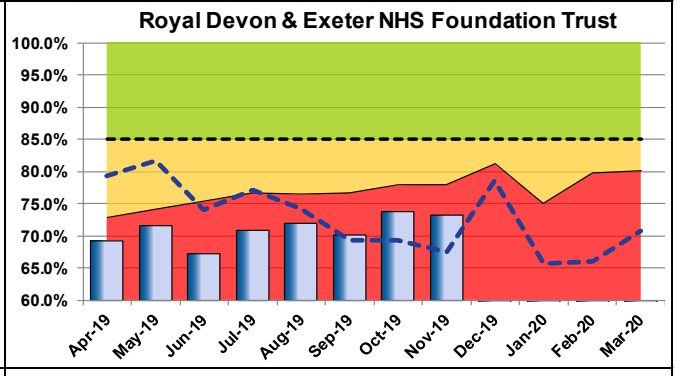
RD&E, NDHT and UHP all saw small rises in the backlog of over 62 day waits.

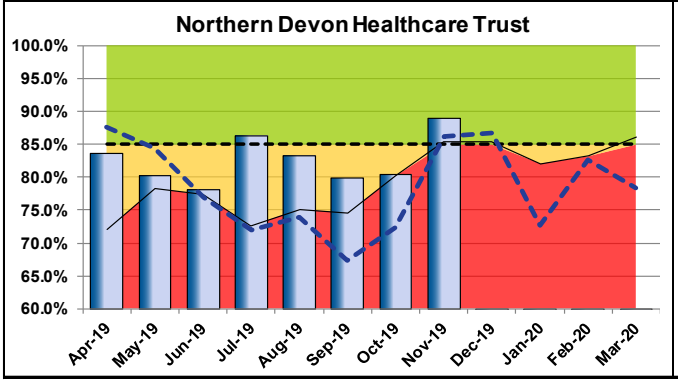
62 day standard Cancer waits……continued

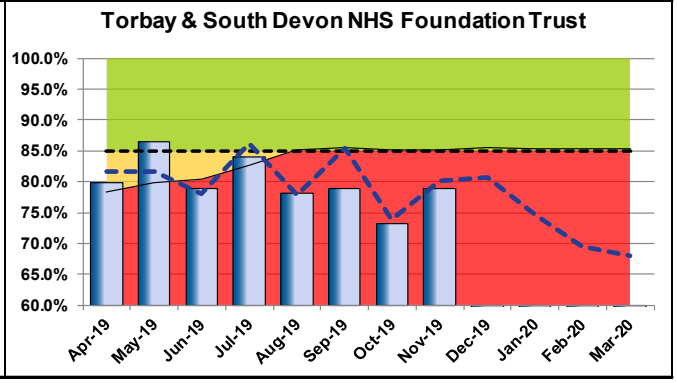
Provider level

Provider		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
UHP	Actual	72.6%	73.2%	73.2%	73.4%	76.2%	71.4%	71.3%	73.0%				
	Trajectory	69.2%	69.6%	69.4%	69.9%	70.2%	69.5%	70.0%	69.7%	69.2%	71.5%	71.3%	85.4%
RDEFT	Actual	69.3%	71.6%	67.2%	70.9%	72.1%	70.1%	73.7%	73.3%				
	Trajectory	72.8%	74.2%	75.4%	76.8%	76.5%	76.7%	77.9%	78.0%	81.2%	75.1%	79.8%	80.2%
NDHT	Actual	83.6%	80.2%	78.1%	86.3%	83.2%	79.8%	80.4%	89.0%				
	Trajectory	72.0%	78.3%	77.3%	72.6%	75.1%	74.6%	80.2%	85.4%	85.3%	82.1%	83.2%	86.1%
TSDFT	Actual	79.9%	86.5%	78.8%	84.0%	78.2%	78.9%	73.1%	78.8%				
	Trajectory	78.3%	79.8%	80.4%	82.8%	85.1%	85.5%	85.1%	85.1%	85.5%	85.3%	85.3%	85.3%









NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Audit Committee

Date of Governing Body: 30th January 2020

Dates of Committees covered in this report: 8th January 2020

(Minutes of this meeting are not yet available)

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

Contact Details: nick.ball1@nhs.net

Reports discussed and assurances received

- The Director of Commissioning (Western) was invited to attend to discuss responsible areas of risk. The Audit Committee felt assured by the responses and welcomed continued Executive attendance at future meetings by invitation of the Audit Chair.

Reports received and noted

- Annual Report and Accounts Timeline - The Audit Committee received and noted the report. NHS Devon CCG are required to produce its annual report and accounts (ARA) 2019-20 for NHS England and associated auditors. This year the national guidance for content has been updated by the Department of Health and organisations have been asked to fulfil this content within nationally set deadlines. This report forms part of good governance to assure the committee that the ARA 2019-20 for NHS Devon CCG is being developed within the nationally proposed deadlines and within Department of Health financial manual editorial guidance.

- Policy Status – The report was presented to provide the Audit Committee assurance and oversight of the policy status for NHS Devon CCG. Clinical Commissioning Groups (CCGs) have a duty to spend public money wisely and deliver quality and safe care. As part of good governance and to effectively support this, NHS Devon CCG needs to ensure that there are appropriate policies and guidance in place to enable staff to undertake their roles professionally and safely in line with national and/or local guidance.

- Risk Scoring - The Audit Committee requested at the meeting held on the 13th November 2019 to receive a paper to provide assurance that the process followed within Devon CCG provides consistency of risk scoring. To aid the risk owners and risk coordinators a 12 steps to risk management document has been produced which provides quick links to the policy.

- Losses and Special Payments – Clinical Commissioning Groups (CCG) are required to report any potential losses or special payments to the Audit Committee. The only item on the losses and special payment register, year to date, is an ex-gratia payment for £8,000 which was clarified at committee by the Chief Finance Officer (Western) and was in relation to supporting patient care.

- Internal Audit Update Report – The January 2020 Internal Audit Update Report summarises the work of ASW Assurance since the previous Audit Committee meeting in November 2019, for the Audit Committee's information and assurance. The Audit Committee was asked to consider the updates provided for the eight recommendations remaining open and approve the requested extensions to deadlines

- External Audit Progress report – the paper provides the Audit Committee with a report on progress in delivering Grant Thornton's responsibilities as the CCG's external auditors. The paper also included a summary of emerging national issues and developments that may be relevant to the Clinical Commissioning Group. The report included a number of challenge questions in respect of emerging issues which the Committee were asked to consider.

  The contents of the Progress Report were noted and there were no items for escalation to the GB.

- External Audit report on the MHIS Compliance Statement for NHS Devon - the report summarised the results of External Audit's independent reporting accountant's assurance engagement on the CCG's MHIS Compliance Statement in line with the terms of engagement set out in External Audit's engagement letter dated 16 July 2019.

  The contents of the MHIS Compliance Statement were noted and there were no items for escalation to the GB.

- Review Counter Fraud Progress report - the report provided an update for the CCGs in respect of counter fraud activity and to provide a briefing on national developments and areas of interest in relation to counter fraud.

Risk Register Review (changes and areas of concern)

This was not discussed at this meeting.

Committee Decisions

The Audit Committee:

- **Noted the Annual Report and Accounts Timeline report**
- **Noted the Policy Status report**
- **Noted the Risk Scoring report**
- **Noted the Losses and special payments report**
- **Noted the Internal Audit update report**
- **Noted the External Audit progress report and MHIS Compliance Statement for NHS NEW Devon CCG**

Recommendations for Governing Body

NA

Recommendations for other Committees
NA
Terms of Reference or other committee effectiveness issues
NA

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: Environmental Policy				
Date of committee: 30 January 2019 **Date report produced: 14 January 2020**				
Author (s) Name and Title: **Ginny Snaith, Board Secretary** **Theresa Farris Risk and Governance Manager** **Contact Details: theresa.farris@nhs.net**		**Supporting Executive:** **Simon Tapley, Accountable Officer** **Report Approved by:** **Ginny Snaith, Board Secretary - 15/01/2020**		
Public or Private (Governing Body only):	**Public**	✓	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This policy aims to set out our plans and responsibilities for identifying and addressing our environmental issues and provide a policy framework for identifying the activities which affect the environment surrounding us, our environmental objectives and our defined and measurable environmental targets.

The policy sets out our commitment to maintaining and improving the economic and social wellbeing of our staff and the health of the population by contributing towards sustainability throughout the organisation. The CCG will do all that is reasonably practicable to ensure that all staff work together to reduce corporate impacts and staff will work with providers, suppliers and the local community positively to enable the CCG to comply with statutory regulations and other guidance relating to energy, the environment and sustainability.

The priority focus for the CCG will cover the following areas:

- Travel
- Facilities Management
- Procurement
- Community Engagement
- Promoting sustainable development in Primary Care
- Workforce
- Models of care
- Corporate and Governance

The CCG is a member of the Devon Climate Emergency Response Group and has been approached to add our signature to the Devon Climate Declaration **here** and declare a climate emergency. Other signatories to this declaration can be found **here** and includes Devon County Council and District Councils.

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

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

Executive Team

Key recommendations and actions requested:

The Governing Body are asked to:

1. **Approve the Environmental Policy**
2. **Agree to NHS Devon CCG declaring a climate emergency**
3. **Agree to NHS Devon Clinical Commissioning Group signing the Devon Climate Declaration**
4. **Approve the use of the action plan to monitor delivery of the environmental policy**

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:

https://www.devonclimateemergency.org.uk/

https://www.devonclimateemergency.org.uk/devon-climate-declaration/

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.

NHS
Devon
Clinical Commissioning Group

Environmental Policy

NHS Devon Clinical Commissioning Group

Owner(s): Ginny Snaith, Board Secretary Theresa Farris Risk and Governance Manager	**Directorate Contact Details:** d-CCG.governance@nhs.net	
Approved by: Governing Body	**Date of formal approval**	**Review Date:** February 2021
Date Issued: *		**Version** V2.1
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		
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	Ensure compliance with legal and statutory obligations	No
Engagement and Consultation		No
Risk		No

All policies are held centrally by Governance: d-ccg.governance@nhs.net

Document Change History:			
Version	**Date**	**Action (amended/ approved)**	**Summary of Changes**
V1	2017	Draft Policy	Reviewed and agreed with Executives
v2	December 2019	amended	
V2.1	December 2019	Review	Reviewed by Board Secretary
V2.1	January 2020	Review and approve	Reviewed and approved by Executive Team

Equality, diversity and inclusion statement

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

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

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

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

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Environmental Policy

1. Introduction

Devon Clinical Commissioning Group (the CCG) recognises that in commissioning healthcare services, its activities may impact on the environment and it is essential that where possible these impacts are minimised. The CCG recognises that we should lead by example, as such we are committed to reducing the environmental impact of our activities. We expect a commitment to the same principles from our providers and suppliers.

This policy aims to set out our plans and responsibilities for identifying and addressing our environmental impact and provide a policy framework for identifying the activities which affect the environment surrounding us, our environmental objectives and our defined and measurable environmental targets.

This policy sets out our commitment to maintaining and improving the economic and social wellbeing of our staff and the health of the population by contributing towards sustainability throughout the organisation. The CCG will do all that is reasonably practicable to ensure that all staff work together to reduce corporate impacts and staff will work with providers, suppliers and the local community positively to enable the CCG to comply with statutory regulations and other guidance relating to energy, the environment and sustainability. *(Appendix 1– Register of Legal Requirements)*

We should be prepared to lead by example in promoting a sensitive, considered attitude to the environment. Good practice in environmental management makes sound business sense.

A key element of our environmental policy is embedding a strong environmental and sustainability culture throughout the CCG. All employees, contractors, sub-contractors and anyone working for the CCG in an unpaid or temporary capacity are included within the scope of this policy.

When considering environmental and sustainability issues we will be mindful of any differential impact there may be on people with a protected characteristic, as defined by the Equality Act 2010.

The Board Secretary is the environmental champion responsible for implementing this policy within the CCG.

2. Aims

2.1 The overall aim of this policy is to set out how Devon Clinical Commissioning Group will manage and reduce our environmental impact to achieve the following aims:

- To provide a framework for maintaining and improving the economic and social wellbeing of all our staff and contributing towards a sustainable and high-quality working environment
- To pursue and encourage environmental sustainability by:
    - working in partnership with employees, suppliers and customers to encourage their active involvement in environmental issues and in promoting environmental sustainability.
    - regularly assessing the environmental impact resulting from business operations and remaining fully informed of recognised best practices.
- To achieve good environmental standards in all activities including:
    - the reduction, re-use, recycling and disposal of waste.
    - making economic use of energy, water and transport to minimise waste
- To meet our legal obligations

2.2 The Environmental Policy and supporting plans will be communicated to all employees and suppliers and will be available on our website and available to customers, the public and other stakeholders to view.

2.3 The performance of the Environmental Policy will be reported on a regular basis to our Audit Committee which in turn reports to the CCG's Governing Body. In this way the organisation will demonstrate that it is doing what is reasonably practicable to manage environmental issues, discharge its statutory duties and meet its corporate objectives.

2.4 The appropriateness of the Environmental Policy will be continually reviewed in the light of both legal and national requirements and the requirements of the organisation.

3. Objectives

3.1 The CCG is committed to embedding sustainability into behaviours by staff and other partners by encouraging increased awareness and promoting behavioural change. By, concentrating on reduction of paper, increased recycling, sustainable travel and energy and carbon reduction.

3.2 The CCG has set the following objectives:

- Reduce the negative environmental impact of the organisation
- Increase staff and community awareness to enable them to reduce, reuse, recycle both at work and home
- Ensure our role as commissioners encompasses the principles of environmental awareness and compliance

4 Organisational Responsibilities

This section outlines the organisational responsibilities for environmental management within the CCG

4.1 All Employees

All employees, contractors, sub-contractors and anyone working for the CCG in an unpaid or temporary capacity are included within the scope of this policy and are responsible for:

- regularly assessing the environmental impact resulting from their role in delivering business operations
- being aware of and adhering to recycling arrangements
- taking responsibility for their own work area and supporting the reduction of environmentally harmful activities such as travel, use of electricity, document printing, etc

4.2 Accountable Officer

The Accountable Officer has overall responsibility for ensuring that adequate environmental arrangements are in place.

4.3 Board Secretary

The Board Secretary has the delegated responsibility for the implementation of this policy and ensuring the Governing Body is kept fully informed on environmental issues that arise as and when appropriate. This will include:

- The development and implementation of an Environmental Action Plan
- Co-ordinating with the executive and senior management to identify issues which affect the environment
- Reporting progress against agreed targets and objectives
- Working with key staff across the organisation who have lead responsibility on business activities which impact on environmental and sustainability issues across the organisation for example, IT printing and procurement liaison with suppliers

4.4 Executive Team

Executive team have delegated responsibility from the Accountable Officer to ensure this policy and associated procedures, protocols, guidance and management systems are fully understood, applied and resourced within their areas of responsibility. They should also provide leadership by example and proactively promote responsible attitudes towards environmental issues by:

- Embedding the environmental and sustainability culture as well as pro environmental behaviour
- Implementation of the environmental policy and standards
- Regularly assessing the environmental impact resulting from delivering business operations
- Raising awareness and promoting active involvement in environmental issues

- Achieving good environmental standards in all activities including the reduction, re-use, recycling and disposal of waste.
- Making economic use of energy, water and transport to minimise waste in all aspects of the business function.
- Identifying key staff who have lead responsibility on business activities which impact on environmental and sustainability issues across the organisation for example, IT printing and procurement to seek information from relevant suppliers about the environmental effects of products and services that they supply.

4.5 Senior Managers

Senior Managers will support the continual improvement of the organisational environmental impact and pursue and encourage environmental sustainability within their area of responsibility

4.6 Line Managers

Line Managers should ensure that all employees who report to them have an awareness of the environmental policy and maintain an awareness of the environmental and sustainability issues within their teams.

4.7 Environmental Working Group

This group will be established to provide a forum for staff and managers to identify how environmental management can be improved and establish monitoring mechanisms.

Each site will have a site champion(s) who will represent their site on the environment working group.

5. Arrangements for Environmental Management

This section contains the detail on what we are going to do in practice to achieve the objectives set out in our Environmental Policy.

We accept that not only do we have a responsibility to identify the aspects which affect the environment but also to comply with all applicable environmental laws and other requirements. *(Appendix 1 – Register of Legal Requirements).*

5.1 Understanding the environmental aspects and impacts

Understanding the environmental aspect and impact of our CCG is key to the successful implementation of our environmental policy

Three key areas for office-based services to take account of are:

- minimising waste
- recycling
- energy consumption

5.2 Environmental Action Plan

An Environmental Action Plan will be produced on completion of the following steps:

1. Identification of the activities e.g. Travel, purchasing, office working including use of technology
2. The identification of issues which affect the environment (ASPECTS) e.g. Incorrect or inefficient disposal of waste/surplus items, inefficient use of fuel, unnecessary purchases, unnecessary facilities costs,
3. The identification of the effects they have on the environment (IMPACTS) e.g. Air pollution, unnecessary use of landfill, depletion of natural resources, inefficient use of space
4. Assessing for 'significance' within our work environment i.e. their potential impact on the environment
5. Changing of attitudes towards the environmental issues by tackling the three barriers to pro environmental behaviour, individuality, responsibility and practicality. By tackling the three barriers, attitudes will improve, intentions will change and subsequently so will individual behaviours of all with responsibility.

5.3 Risk Assessments

Risk assessments will be conducted to identify sources of potential environmental harm.

Corrective actions identified will be operationally managed by an issue log and if considered significant added to the Corporate Risk Register in line with the CCG's Risk Management Framework Policy

5.4 Communication and Information

Relevant information will be displayed in appropriate locations within our premises for example, in kitchens.

6. Action plan

6.1 The priority focus for action by the CCG will cover the following areas as detailed in our action plan appendix 2:

- Travel
- Facilities Management
- Procurement
- Community Engagement
- Promoting sustainable development in Primary Care
- Workforce
- Models of care
- Corporate and Governance

6.2 We will link our actions to the objectives as stated in section 3.2

Objectives	Action plan	Outcomes
Reduce the negative environmental impact of the organisation	Travel Corporate Governance Facilities management	Reduced carbon emissions
Increase staff and community awareness to enable them to reduce, reuse, recycle both at work and home	Workforce Community engagement	Awareness of their active involvement in environmental issues and in promoting environmental sustainability.
Ensure our role as commissioners encompasses the principles of environmental awareness and compliance	Procurement Promoting sustainable development in Primary Care Models of Care	Sustainability in procurement policies and embedded sustainability targets within performance management with providers Improved medicines management and prescribing practice to reduce inefficient or wasteful use of pharmaceuticals

5.3 The CCG will sign up to the Devon Climate Declaration https://www.devonclimateemergency.org.uk/devon-climate-declaration/ detailed in appendix 3

7. Performance Evaluation and Monitoring

The CCG will use Key Performance Indicators (KPIs) to monitor and assess the effectiveness of this Environmental Policy. This will be managed by the Board Secretary and Environmental Working Group reporting to the executive team, Audit Committee and Governing Body.

The CCG will review the 'life cycle' financial costs for example, energy savings, waste management, fuel and travel expenses.

7.1 Compliance

The Environmental Policy will be reviewed, and internal audits scheduled as appropriate and recommendations addressed.

Appendix 1

LEGAL REQUIREMENTS

The CCG accepts that not only does it have a responsibility to identify its environmental aspects, it also is required to comply with all applicable environmental legislation.

Environmental Legislation	Duty Imposed
Environmental	
Environmental Civil Sanctions (England) Order 2010	Supplement existing enforcement powers of the Environment Agency.
Environmental Protection Act 1990 (the overarching / umbrella act for environmental laws and regulations) Environment Act 1995 (enforcement, Environment Agency, functions, duties and powers)	The legislation covers a wide range of subjects, many of which are covered by supplementary legislation, with the main areas being: • Maintenance of premises • Control over disposal of wastes • Smoke, fumes or gasses emitted • Dust, steam, smell or other effluvia • Accumulation or deposit • Noise for premises • Noise caused by a vehicle, machinery, or equipment in a street
Environmental Protection (Duty of Care) Regulations 1991, SI 2839 Environmental Protection (Duty of Care) (England) (Amendment) Regulations 2003, SI 63	
The Air Quality (England) Regulations 2000	The regulations impose a duty to ensure that pollutants do not enter the air.
Waste - General	
Controlled Waste Regulations 1992, SI 588 Controlled Waste (Amendment) Regulations 1993, SI 566	The Regulations define controlled waste for the purposes of the Environmental Protection Act Part 2, which introduced three categories of controlled waste: household; industrial; and commercial.
Waste Management Regulations 1996, SI 634	The legislation controls the declaration, classification, controls and disposal of waste, general waste and electronic equipment.
Waste (England and Wales) Regulation 2011 (as amended)	Imposes duties regarding the improvement and use of waste as a resource.
Controlled Waste regulations England and Wales 2012.	Classifies waste as household waste or industrial waste for the purposes of part two of the Environmental Act 1990.

Landfill (England and Wales) Regulations 2002, SI 1559	Mainly applies to landfill sites. Imposes restrictions on the type of waste that can be disposed of at landfill sites. The sites must be registered and accept only certain types of waste to avoid additional contamination.
The Control of Pollution (Oil Storage) (England) Regulations 2001 (SI 2001/2954)	To adequately control oil storage
Electrical and Batteries	
WEEE Regulations 2013	Dispose of electronic and electrical equipment containing certain substances by a licensed waste contractor taking account of recovery and recycling opportunities
The Waste Batteries and Accumulators Regulations 2009	The regulations affect any business that uses produces, supplies, or disposes of batteries, as well as any business that manufactures or designs battery-powered products. Business users will be: • encouraged to separate their waste batteries to help treatment and recycling • informed about collection and recycling schemes available.
Water	
Water Industry Act 1991	Part 3 of the act deals with water supply and requires occupants of a premises to ensure that their fittings do not allow the mains water to be contaminated or wasted. Part 4 prohibits deals with sewerage services and standards for connection. Prohibits the disposal of dangerous substances or anything that may interfere with the free flow of treatment. Part 5 of the act deals with trade effluent.
Water Industry Act 1999	It is an offence for an owner or occupier of premises, either through intent or negligence, to allow a water supply fitting to be in a state of disrepair so as to cause the wasting, misuse or contamination of water. All those who use a supply of water must ensure that water is not wasted and that internal fittings are in a good state of repair
The Water Supply (Water Fittings) Regulations 1999	Set legal requirements for the design, installation, operation and maintenance of plumbing systems, water fittings and water-using appliances.
The Groundwater (England and Wales) Regulations 2009	To regulate trade effluent discharges to public sewers
Water Resources Act 1991 (Amendment) (England and Wales) Regulations 2009 SI 3104	Not neither to contaminate surface or foul drain water nor to wilfully waste water resources.

NHS Devon Clinical Commissioning Group
Environmental Policy Action Plan

Devon Clinical Commissioning Group (the CCG) recognises that in commissioning healthcare services, its activities may impact on the environment and it is essential that where possible these impacts are minimised. The CCG recognises that we should lead by example, as such we are committed to reducing the environmental impact of our activities. We will expect a commitment to the same principles from our providers and suppliers.

NHS Devon CCG will:

Aim	Actions	Expected outcomes	Executive Lead	Team Lead	Deadline/ progress
Travel	Reduce the level of carbon emissions from car usage by reviewing and promoting the use of technology that removes the need for travel. Explore the possibility of a new scheme for staff to lease or purchase electric cars in conjunction with Sustainability Transformation Partners (STP) partners. Explore the provision of electric car charging points at CCG offices Use the expenses system to obtain data Encourage the use of public transport where appropriate and where time allows Order bulk stationery orders to reduce the number of journeys a supplier makes.	Increased use of technology reducing the need to travel e.g. teleconferencing, video conferencing, webinars, e-meetings etc. Reduced car travel – reduction in carbon emissions Patient services are local and reduce car travel or are available using public transport reduced carbon emissions Monthly ordering reduced from weekly	Board Secretary		
Facilities Management	Promote energy conservation throughout the organisation Complete an annual review of energy usage at all CCGs offices, with the support of landlords	Reduce energy usage To establish a baseline to monitor progress of reduction of usage	Board Secretary		

Procurement	Providers must demonstrate that they are meeting their obligations under a contract, the provider must take all reasonable steps to minimise its adverse impact on the environment. The provider must demonstrate how it will make progress on social, economic and environmental aspects of sustainable development for the benefit of public health, including in its performance on climate change adaptation and mitigation, air pollution, minimising wastes and minimising use of plastics, and must provide an annual summary of that progress to the Co-ordinating Commissioner. Assess business/commissioning cases for new schemes against sustainability criteria Ensure that commissioning of local healthcare services are considered when procuring new services	Commissioning of health services which are environmentally, socially and economically sustainable. Joint commissioning of integrated services to achieve high quality sustainable services. Sustainability remains a key priority for the CCG and a way to achieve this is always considered. Patient services are local to reduce car travel or are available using public transport.	Chief Finance Officer		
Community Engagement	Proactively involve patients and the public in planning and decision making Work with key stakeholders to ensure local priorities and decisions support improved health and sustainability Continue to seek innovative ideas from the public and other partners and stakeholders as to how sustainability can be improved	Engagement and input from patients and service users will mean the right services are commissioned in the right place Increased sustainability of services Ensures sustainability is a key priority for the CCG	Director of communications and HR		
Promoting sustainable development in Primary Care	Promote Primary Care sustainable development via Primary Care strategies Encourage and support practices to promote active travel with practice staff and patients Improve medicines management and prescribing practice to reduce inefficient or wasteful use of pharmaceuticals	Increase in practice sustainability initiatives being implemented Reduction in carbon emissions and increase in staff and patient's health and wellbeing	Director of Commissioning (Western)		

Workforce	The CCG will ensure that the policies its staff follow has a positive impact on sustainability in the workplace, the community they serve and in their home environment. Reuse, reduce recycle Participate in national sustainability campaigns (Sustainability Day, Climate Change Week, Green Office Week, Energy Saving Week) Delivery of training to staff via online platforms whenever possible Encourage staff to provide suggestions and ideas on how sustainability can be improved in all areas across the organisations Development and implementation of health and wellbeing initiatives for staff and include sustainability covered by induction.	Increased staff awareness and reduction in energy usage, resources and waste Reduce travel Improved health and wellbeing of staff will have a positive impact on productivity and staff retention Raise awareness and importance of sustainability amongst staff and increase involvement from staff around sustainability.	Director of communications and HR		
Models of care	To continue to work to reduce secondary care admissions with more services being delivered close to home in primary or community settings To continue to focus on prevention and early intervention measures to ensure that our populations stay as healthy as possible for as long as possible and are cared for within the community if required	Consider sustainability principles when deciding what is right for patients and clients Consider the use of local services and an increase in technology to reduce car travel for patients, reducing carbon emissions. To take account of the environmental and social impacts of service modelsto support the development and delivery of more integrated and sustainable models of care in the future.	Directors of Commissioning		
Corporate and Governance	The CCG is committed to complying with all relevant UK environmental legislation and will embed sustainability in its operations and monitor performance accordingly. Ensure the CCGs embed sustainability into all policies and procedures and that accountability is clear	Sustainability will remain a priority for the CCGs Increased staff awareness and move towards sustainability becoming business as usual A robust plan to ensure we are well placed to deal with changes	Board Secretary		

	Ensure sustainability development is referenced in the CCGs vision and Corporate Objectives The CCG will sign up to the Devon climate declaration https://www.devonclimateemergency.org.uk/devon-climate-declaration/	The CCG will declare a climate emergency			

Appendix 3

Devon Climate Declaration

The Declaration (https://www.devonclimateemergency.org.uk/devon-climate-declaration/)

1. This Declaration has been prepared by a consortium of public, private and voluntary organisations collaborating through a Devon Climate Emergency Response Group. It sets out an ambition to tackle climate change that covers all of Devon, including those people who live, work in and visit our county, and those businesses who are based or operate here.

2 We are aware of the significant implications of climate change for Devon's communities; it is already affecting our environment, infrastructure, economy and health & wellbeing. If not addressed, the impact on future generations will be profound and the ability to meet the United Nation's Sustainable Development Goals will be severely compromised.

3 We understand that the Intergovernmental Panel on Climate Change (IPCC) has advised that carbon emissions must reduce globally by at least 45% by 2030 from 2010 levels and reach net-zero by 2050 if we are to avoid the worst effects of climate change by keeping warming below 1.5 degrees.

4. We will lead in the global response to climate change through our collective action, innovation and influence.

5. Individually, we will review (within 6 months) our plans to reduce our organisation's carbon emissions to meet or exceed these targets, including ensuring the people we do business with are doing the same. We will publicly report our carbon emissions annually in accessible formats.

6. In collaboration, we will engage Devon's residents, businesses and visitors to develop and implement a plan to facilitate the reduction of Devon's production and consumption emissions to meet IPCC recommendations at the latest. We will openly report progress on its delivery. We know this transformational change will be challenging and will include:
•Deploying more renewable, decentralised and smart energy systems

- Retrofitting energy-efficiency measures into our existing buildings
- Constructing zero-carbon new buildings
- Travelling less and using improved walking, cycling and public transport infrastructure more often, and using electric and hydrogen vehicles
- Changing our consumption to use less, re-use more and choose low-carbon options
- Challenging all economic sectors to review their practices and the values of those they do business with
- Divesting from fossil fuels
- Changing our dietary patterns and reducing food waste

- Changing agricultural practices to reduce emissions associated with farming operations, manage soils sustainably and replenish soil carbon
- Encouraging carbon storage such as through tree planting, the use of wood in construction and peatland restoration
- Empowering the people of Devon with the knowledge and skills to act collectively.

7.Additionally, we will work to understand the near-term and future risks of climate change for Devon to plan for how our infrastructure, public services and communities will have to adapt for a 1.5-degree warmer world.

8.Local organisations and communities cannot do this alone as the national government plays a key role in many of the policy areas that are vital to reducing emissions and adapting to climate change. We call on the government to prioritise decarbonisation and adaptation within decision making and work with us by using its powers to provide the resources and funding necessary to accelerate the transition to a low-carbon and resilient economy and society.

9.We challenge every organisation, business, community and individual to do the same.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Establishment of an Ambulance Joint Commissioning Committee				
Author (s) Name and Title: **Clare Doble, Head of Governance** **Contact Details: clare.doble@nhs.net**		**Supporting Executive: Ginny Snaith** **Name and Title:** **Contact Details: g.snaith@nhs.net** **Report Approved by:** **Name and Title: As above** **Date 27 December 2019**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

1.1 Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) Clinical Commissioning Groups (CCGs) have responsibility for ambulance commissioning.

1.2 Recent reviews[1] have highlighted variations in the effectiveness and efficiency of commissioning of ambulance services and emphasised the need for new, collaborative arrangements that integrate 999 (emergency) ambulance services with wider urgent and emergency care (UEC) ambulance services.

1.3 In October 2018 NHS England published a new commissioning framework for ambulance services to support system leaders to work in a more collaborative way when commissioning ambulance services, especially across the wider urgent and emergency care system.[2]

1.4 During 2018/19 Dorset CCG, acting in its capacity as commissioning coordinator for ambulance services in the south west, undertook a review of ambulance commissioning arrangements using the self-assessment tool within the NHS England framework. This review led to the co-design of a new collaborative commissioning model involving all CCGs across the region.

[1] These include the National Audit Office Review of Ambulance Services, the Carter Review and the Ambulance Response Programme Spring Review.
[2] Commissioning Framework: A Framework for the Commissioning of Ambulance Services, NHS England Central Ambulance Team

1.5 The CCGs covered by these joint commissioning arrangements (the Commissioners) are as follows:

1.6 Bath and North East Somerset CCG;
Bristol, North Somerset and South Gloucestershire CCG;
Devon CCG;
Dorset CCG;
Gloucestershire CCG;
Kernow CCG;
Somerset CCG;
Swindon CCG; and
Wiltshire CCG.

1.7 The Governing Body is now asked to agree the formation of the new collaborative commissioning arrangements, including:

- the establishment of an ambulance joint commissioning committee (AJCC) to jointly commission emergency ambulance services across the south west and to manage the commissioning contract with the provider of emergency ambulance services;

- the delegation of functions to the AJCC as set out in the enclosed Delegation; and the AJCC terms of reference (ToR), which will govern the operation of the AJCC.

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:

Shadow Ambulance Joint Commissioning Committee

Key recommendations and actions requested:

The Governing Body is asked to:

1. AGREE to jointly exercise the CCG's commissioning functions in relation to emergency ambulance services (pursuant to section 14Z3(2)(b) of the NHS Act) and to establish the Ambulance Joint Commissioning Committee (AJCC) for this purpose (pursuant to section 14Z3(2)(b) of the NHS Act).

2. AGREE the delegation of functions to the AJCC as set out in the enclosed AJCC Delegation.

3. AGREE the terms of reference for the AJCC as set out in the enclosed AJCC Terms of Reference (ToR).

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
Appendix 1 - Terms of reference of the AJCC which will govern the operation of the AJCC Appendix 2 - Delegation of functions to the AJCC NHS Devon CCG Constitution section 5.12 *'joint commissioning arrangements'* NHS Devon Scheme of reservation and delegation
Does this report have implications in any of the areas highlighted below?

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

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

Report Title: Establishment of an Ambulance Joint Commissioning Committee

1. Introduction

1.1 Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) Clinical Commissioning Groups (CCGs) have responsibility for ambulance commissioning.

1.2 Recent reviews[3] have highlighted variations in the effectiveness and efficiency of commissioning of ambulance services and emphasised the need for new, collaborative arrangements that integrate 999 (emergency) ambulance services with wider urgent and emergency care (UEC) ambulance services.

1.3 In October 2018 NHS England published a new commissioning framework for ambulance services to support system leaders to work in a more collaborative way when commissioning ambulance services, especially across the wider urgent and emergency care system.[4]

1.4 During 2018/19 Dorset CCG, acting in its capacity as commissioning coordinator for ambulance services in the south west, undertook a review of ambulance commissioning arrangements using the self-assessment tool within the NHS England framework. This review led to the co-design of a new collaborative commissioning model involving all CCGs across the region.

1.5 The CCGs covered by these joint commissioning arrangements (the Commissioners) are as follows:

1.6 Bath and North East Somerset CCG;
Bristol, North Somerset and South Gloucestershire CCG;
Devon CCG;
Dorset CCG;
Gloucestershire CCG;
Kernow CCG;
Somerset CCG;
Swindon CCG; and
Wiltshire CCG.

1.7 The Governing Body is now asked to agree the formation of the new collaborative commissioning arrangements, including:

- the establishment of an ambulance joint commissioning committee (AJCC) to jointly commission emergency ambulance services across the south west and to manage the commissioning contract with the provider of emergency ambulance services;

- the delegation of functions to the AJCC as set out in the enclosed Delegation; and the AJCC terms of reference (ToR), which will govern the operation of the AJCC.

[3] These include the National Audit Office Review of Ambulance Services, the Carter Review and the Ambulance Response Programme Spring Review.
[4] Commissioning Framework: A Framework for the Commissioning of Ambulance Services, NHS England Central Ambulance Team

2. Background to changes in ambulance commissioning

2.1 Through 2017-18 several developments indicated a need to change the collaborative commissioning agreement (CCA) for ambulance commissioning across the south west. The key changes were:

- National Audit Office Review of Ambulance Services, which highlighted variation in provision and commissioning of ambulance services;
- NHS England publication of a national framework for commissioning ambulance services, which introduced a series of competencies and requirements of "good" ambulance commissioning;
- Requirement to have in place a transformation plan for ambulance services in the south west, on order to meet response standards;
- A recognition by all CCGs that the model took too much and there was an opportunity to be more efficient and effective in commissioning.

2.2 A workshop was held in January 2019, to co-design a new model for commissioning ambulance services. The preferred model at the time was for a lead commissioner arrangement, which Dorset CCG (the co-ordinating commissioner) agreed to fulfil. A collaborative commissioning arrangement would still function across all the CCGs, but Dorset would take the lead and have delegated authority for several areas of the contract. Transformation resource would also be available to mitigate growth in demand and support service change to meet response times.

2.3 Devon CCG, together with Kernow, Somerset and Dorset, agreed to the move towards a lead commissioner model with transformation funding. However, not all SW CCGs agreed – which was a requirement - and so a new arrangement needed to be developed. The alternative model put forward was for the ambulance strategic partnership board to become a fully delegated committee, and hereafter to be known as the Ambulance Joint Commissioning Committee (AJCC), with decision making rights and senior attendance (Accountable Officer or Director, as a minimum). CCGs schemes of delegation need to be amended, similar to previous arrangements for specialised commissioning. The model enables closer working with NHSE/I. As part of this change, the Commissioning Support Unit (CSU) would be decommissioned with funds flowing to Dorset to take on the commissioning support role.

The revised model is intended to deliver the following:

Transformation	Using non-recurrent funding from the agreed £1.7 million transformation fund, to fund fixed term posts for the SW.
Provision and analysis of data	New BI report with some analysis, but more may be required at CCG/STP level.
Relationship management	Via refreshed governance framework and visits to CCG/STP meetings, supported as far as possible.
Contract and performance management	As now.
SW strategic planning	Additional input from CCG and STP senior managers needed, or access to non-recurrent funding for fixed term posts. Clinical reference group to lead.
Quality and patient safety	As now, including an assurance function including CQUIN and significant events. Local leads will need to continue to engage with local ambulance lead.

3. AIMS AND BENEFITS OF THE JOINT COMMISSIONING ARRANGEMENTS

3.1 The AJCC aims to secure high quality, patient focused and value for money emergency ambulance services across the whole geography and for all patients served by the provider of ambulances services by fulfilling a strategic commissioning function across the region to ensure that the commissioning of emergency ambulance services is aligned and integrated with the wider urgent and emergency care sector. It builds on and strengthens the existing collaborative arrangements and reflects national policy.

3.2 The Commissioners aim to achieve a number of benefits to improve the quality and cost effectiveness of services to patients and their families, including:

3.3 Facilitating robust stewardship of the provider of emergency ambulance services;

3.4 Improving the Commissioners' ability to hold the provider of emergency ambulance services to account;

3.5 Securing efficiency of effort for Commissioners and for the provider of emergency ambulance services;

3.6 Improving the potency of commissioners; and

3.7 Delivering the benefits of collaborative working, including sharing and dissemination of best practice and promoting innovation.

4. THE AMBULANCE JOINT COMMISSIONING COMMITTEE

4.1 The AJCC shall be established as a committee of the CCG, in accordance with Schedule 1A of the NHS Act.

4.2 The AJCC shall enable the Commissioners to come together to implement the joint commissioning arrangements and to make collective decisions on the delegated functions. Decisions of the AJCC will be binding on members of the AJCC. The role of the AJCC is described in detail in paragraph 9 of the ToR.

4.3 The AJCC shall consist of one representative from each Commissioner who shall be the Chief Officer or Accountable Officer or their nominated deputy, provided that any such deputy shall be of sufficient seniority to support the functioning of the AJCC. The seniority of role is also to ensure appropriate awareness and linkage between the role of the AJCC with emerging integrated care systems.

4.4 Responsibility for chairing the AJCC shall be shared between all Commissioners, although Dorset CCG shall undertake the role of Chair initially to ensure continuity as the new arrangements are implemented and embedded.

4.5 NHS England and NHS Improvement shall be invited to attend the AJCC as non-voting attendees and the AJCC may call additional experts to attend meetings on an ad hoc basis to inform discussions and assist the AJCC to perform its functions.

4.6 Decisions of the AJCC shall be achieved by consensus decision making wherever possible, with voting reserved as a decision making tool of last resort. In the event that consensus cannot be achieved then a decision may be made by the agreement of 5 of the 7 AJCC members.

4.7 The AJCC shall be required to present its minutes to this Governing Body and to the governing bodies of all Commissioners. Representatives shall be responsible for ensuring effective two-way communication between each Commissioner and the AJCC by informing the AJCC of relevant local matters than may impact upon emergency ambulance services and reporting back on decisions taken by the AJCC.

4.8 The CCG may withdraw from the AJCC, and from the joint commissioning arrangements, in accordance with the terms of paragraph 38 of the ToR and upon giving six months' written notice to the other Commissioners.

5. DELEGATION OF FUNCTIONS

5.1 The delegation of commissioning functions to the AJCC shall be as set out in paragraph 2 of the enclosed Delegation and shall take effect from 1 February 2020, providing that the Delegation is agreed by the Governing Body.

5.2 The Governing Body will note that it retains the ability to vary or revoke the Delegated Functions under the terms of paragraphs 12 and 13 respectively of the Delegation.

6. FURTHER ARRANGEMENTS

6.1 Paragraph 33 of the ToR grants the AJCC the power to establish sub-committees and to determine the membership, role and remit of each sub-committee so established. The Commissioners are in the process of developing the sub-committee structure and terms of reference for each AJCC sub-committee. These arrangements will be approved by the AJCC at its first meeting.

6.2 The delegation of functions to any sub-committees shall be set out in the terms of reference for each sub-committee and in the scheme of reservation and delegation for the AJCC, which shall be published in the AJCC Handbook.

6.3 A collaborative commissioning agreement will set out the terms under which the Commissioners will collaborate in assessing the need for ambulance services and jointly procure, enter into and manage the commissioning contract for the duration of its terms. The Commissioners are in the process of finalising the joint commissioning agreement and this will be approved by the AJCC at its first meeting. A draft of the agreement is enclosed with this pack, for information.

5 RECOMMENDATIONS

5.1 The Governing Body is asked to:

1. **AGREE** to jointly exercise the CCG's commissioning functions in relation to emergency ambulance services (pursuant to section 14Z3(2)(b) of the NHS Act) and to establish the Ambulance Joint Commissioning Committee (AJCC) for this purpose (pursuant to section 14Z3(2)(b) of the NHS Act).

2. **AGREE** the delegation of functions to the AJCC as set out in the enclosed AJCC Delegation.

3. **AGREE** the terms of reference for the AJCC as set out in the enclosed AJCC Terms of Reference (ToR).

Ambulance Joint Commissioning Committee (AJCC)

Draft Terms of Reference

Introduction

1 Emergency ambulance services are currently commissioned on a collaborative basis across all nine South West clinical commissioning groups ("CCG"). Each CCG established by NHS England[1] under sections 14B,14C and 14D of the National Health Service Act 2006 (as amended) ("NHS Act") and listed in Appendix 1 to these Terms of Reference ("ToR") has agreed to:

1.1 jointly exercise their commissioning functions in relation to emergency ambulance services, pursuant to section 14Z3(2)(b) of the NHS Act; and

1.2 establish a joint committee, the Ambulance Joint Commissioning Committee ("AJCC"), pursuant to section 14Z3(2A) of the NHS Act. The AJCC will function as a corporate decision-making body for the management and exercise of the commissioning functions delegated to it.

2 The establishment of the AJCC reflects the need to coordinate the commissioning of emergency ambulance services across the region and to integrate 999 (emergency ambulance services) with wider urgent and emergency care. It is consistent with the statutory duties on CCGs under the NHS Act, including the duty to promote integration and the duty to act effectively, efficiently and economically.

3 The CCGs listed in Appendix 1 work as part of wider Integrated Care Systems and each CCG's representative on the AJCC brings to the work of the AJCC an understanding of the work of their ICS and its strategic priorities. Decisions taken on emergency ambulance commissioning by the AJCC will reflect national and local priority objectives, including the NHS Long Term Plan and local implementation plans across the South West region.

4 In particular, the intention is for the AJCC to fulfil a strategic commissioning function across the region, in order to ensure that the commissioning of emergency ambulance services is aligned and integrated with the wider urgent and emergency care sector, consistent with NHS England's Commissioning Framework for Ambulance Services (September 2018). Further information about this is set out below and in the related Collaborative Commissioning Agreement entered into between the CCGs.

Status of the AJCC

5 Arrangements made under section 14Z3 of the NHS Act may be made on such terms and conditions (including terms as to payment) as may be agreed between the parties. The terms that have been agreed are set out below.

6 Joint arrangements made under section 14Z3 of the NHS Act do not affect the liability of each individual CCG for the exercise of its functions.

[1] A full list of CCGs is included in Appendix 1. In the event that any merger takes place between some of the member CCGs, the list in Appendix 1 will be updated accordingly, with the guiding principle throughout being that each individual CCG will be entitled to nominate one appropriately senior individual member to the AJCC and that each representative shall have one vote.

7 The AJCC is established as a committee of each CCG, in accordance with Schedule 1A of the NHS Act and with the specific provisions contained within each CCG's Constitution.

8 The AJCC will commence its operation on 1 February 2020.

Role of the Committee

9 The AJCC has been established in order to enable the members to make collective decisions on the Delegated Functions[2]:

9.1 the commissioning of emergency ambulance services as an integral part of the urgent and emergency care system according to national requirements and standards;

9.2 developing and agreeing a shared vision and understanding of emergency ambulance commissioning, working with colleagues within the urgent and emergency care system to do so and ensuring that the vision supports alignment and integration of services;

9.3 negotiating and agreeing a contract that delivers national performance, clinical and quality standards, incorporating any known challenges and improvement plans into the contract;

9.4 performance managing the contract against agreed standards and key performance indicators, including agreed quality standards, observance of service specifications and monitoring of activity and finance;

9.5 ensuring that the ambulance service is clear on, and has plans to meet, their contractual, performance, quality, transformational and financial objectives and critical infrastructure resilience and interoperability. This includes but is not limited to all decision-making in relation to planned investments by the ambulance service;

9.6 managing the ambulance service's performance against the plans referred to above and being assured of performance;

9.7 supporting and challenging the ambulance service and holding it to account for planning guidance deliverables;

9.8 being assured of the ambulance service's level of emergency preparedness;

9.9 the award and entering into of contracts for the provision of emergency ambulance services and all decision-making in respect of variations to the contact, in accordance with national policy, service user needs and clinical developments;

9.10 all decision-making in respect of financial adjustments or sanctions resulting from provider breach of the contract;

[2] The Delegated Functions are set out in the Delegation, a copy of which is enclosed in the AJCC Governance Handbook.

9.11 all decision making relating to the termination of the contract, or any part of it, in accordance with the terms of that contract;

9.12 if necessary, responding to informal or formal legal challenges brought in connection with the commissioned services;

9.13 ensuring compliance with all relevant statutory duties as they apply to the CCGs including, but not limited to, those relating to equality (under the Equality Act 2010 and specifically including the public sector equality duty under s 149 of that Act); health inequality (section 14T of the NHS Act); patient and public involvement (section 14Z2 of the NHS Act); improvement in quality of services (section 14R of the NHS Act); and integration (section 14Z1 of the NHS Act); and

9.14 such other related commissioning functions as need to be exercised by the AJCC in order to lawfully complete the procurement and contracting process for emergency ambulance services and for managing the services in accordance with the terms of that contract.

10 In discharging its functions, the AJCC will:

10.1 ensure that patient outcomes are at the heart of everything it does;

10.2 provide system leadership and ensure the ambulance service is an integral part of system planning and collaboration;

10.3 work with colleagues to review and revise the agreed collaborative governance arrangements as the wider integrated care landscape develops.

11 In performing its role, the AJCC will exercise its functions in accordance with these ToR and the terms of the delegations made to it by the CCGs. A copy of the delegation is attached at Appendix 2.

Geographical Coverage

12 The AJCC will cover the entire region of South West England covered by the member CCGs as set out in their respective constitutions.

Membership

13 The AJCC shall consist of one representative from each CCG, as nominated by the respective CCG.

14 The CCGs have agreed that the representative should be the Chief Officer or Accountable Officer for each CCG or their nominated deputy, provided that such deputy must be of sufficient seniority (i.e. Executive Director level) to support the functioning of the AJCC. Where deputies are nominated the Chair of the AJCC will approve such nominations before they take effect.

15 Each representative is expected to ensure that matters for consideration and agreement at a meeting of the AJCC have been appropriately discussed by their CCG prior to attending to AJCC meeting.

16 The Chair of the AJCC will be a shared responsibility amongst all CCGs. For the first six months of the AJCC's operation the Chair will be the representative for NHS

Dorset CCG. In line with the review process for the AJCC, this will be reviewed after this initial period and Chairing responsibilities confirmed at that stage by the AJCC.

17 The Chair will have the following roles and responsibilities:

17.1 Be a visible, engaged and active leader, not a figurehead;

17.2 Have sufficient time, experience and the right skills to carry the full responsibilities of the role;

17.3 Ensure that the AJCC supports the delivery of a safe, risk assessed service;

17.4 Create an open, honest and positive culture;

17.5 Follow the specified procedures for decision-making, including in relation to managing actual and potential conflicts of interest;

17.6 Ensure problem resolution;

17.7 Ensure reporting requirements are complied with.

18 At its first meeting, the AJCC will appoint a Deputy Chair, drawn from its membership.

19 The following will be invited to attend the AJCC as non-voting attendees:

19.1 One or more representatives from NHS England and NHS Improvement.

20 The AJCC may call additional experts, such as clinicians, procurement experts and others, to attend meetings on an ad hoc basis to inform discussions and assist it with the exercise of its functions.

21 Secretariat support will be provided to the AJCC by NHS Dorset CCG, with the general expectation being that Chairing responsibilities and secretariat support will be performed by the same member CCG.

22 In addition to managing meetings of the AJCC, the Secretariat shall be responsible for maintaining the AJCC Handbook, which shall include the following:

22.1 the AJCC Delegation;

22.2 the terms of reference for the AJCC and any sub-committees established by the AJCC;

22.3 the AJCC scheme of delegation and reservation;

22.4 the Collaborative Commissioning Agreement;

22.5 any other relevant documents, as determined by the AJCC.

Grounds for Removal from Office

23 Member representatives of the AJCC shall vacate their office if any of the following grounds apply:

21.1 The individual ceases to hold an appropriately senior role within their CCG and/or is otherwise disqualified from holding the role in question;

21.2 An alternative individual is nominated by the CCG member in question;

21.3 The individual fails to attend 3 or more AJCC meetings without prior agreement of the Chair, in which case the member CCG will be asked to nominate an alternative individual and/or the dispute resolution mechanisms set out below will be invoked;

21.4 The individual needs to step down from their role due to illness or other incapacity. In which case an alternative individual will be nominated by the CCG member in question;

21.5 The AJCC agree that continuation as a member representative is not in the interests of the AJCC, in which case the member CCG will be asked to nominate an alternative individual and/or the dispute resolution mechanisms set out below will be invoked.

Meetings and Voting

24 The AJCC will operate in accordance with the following provisions:

24.1 The AJCC shall adopt the standing orders of Dorset CCG insofar as they relate to the:

24.1.1 notice of meetings

24.1.2 handling of meetings

24.1.3 agendas

24.1.4 circulation of papers

24.1.5 conflicts of interest

24.2 The Secretariat will be responsible for giving notices of meetings, taking minutes and circulating these within one week after the meeting;

24.3 Any notice of a meeting will be accompanied by an agenda and supporting papers and will be circulated to each member no later than 7 days prior to the date of the meeting;

24.4 The Chair may agree that the members of the AJCC may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting;

24.5 The Chair may determine that the AJCC needs to meet on an urgent basis, in which case the notice period shall be as specified by the Chair. Urgent meetings may be held virtually;

24.6 Each member of the AJCC shall have one vote. Attendees do not have voting rights. The aim will be for decisions of the AJCC to be achieved by consensus decision-making, with voting reserved as a decision-making step of last resort

and/or where it is helpful to measure the level of support for a proposal. Where consensus cannot be reached, a decision shall be reached by 5 of the 7 members agreeing to approve the decision in question. The Chair shall have a second and deciding vote if necessary. Where agreement cannot be reached in this way, the dispute resolution provisions set out below will be followed;

24.7 Quorum for decision-making shall be 5 out of the 7 representatives, including the Chair;

24.8 Conflicts of interest will be managed in accordance with the policies and procedures of each CCG Member and shall be consistent with the statutory duties contained in the NHS Act and the statutory guidance issued by NHS England (Managing conflicts of interest: revised statutory guidance for CCGs 2017 https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/).

25 Members of the AJCC have a collective responsibility for its operation. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

26 Where confidential information is presented to the AJCC, all members will ensure that they comply with any confidentiality requirements.

27 Decisions of the AJCC shall be binding on each CCG listed in Appendix 1.

Frequency of Meetings

28 For the initial period of its operation, the AJCC will meet bi-monthly, with the frequency being reviewed as part of the 6-month post commencement review.

29 At any stage, the frequency of meeting may be varied to meet operational need, with the Chair determining this as necessary and in accordance with the provisions for meetings as set out above.

Reporting

30 The AJCC will present its minutes to each CCG governing body for information and ensure that appropriate updates are provided to each AJCC sub-committee to enable them to carry out their role.

31 Individual member representatives are responsible for ensuring that they appropriately report-back on decisions made by taken by the AJCC and that the AJCC is informed of relevant local matters that impact on its operation and role.

AJCC sub-committees

32 In order to assist it with performing its role and responsibilities, the AJCC is authorised to establish sub-committees and to determine the membership, role and remit for each sub-committee. Any sub-committee established by the AJCC will report directly to it.

33 The AJCC may decide to delegate decision-making to any of its sub-committees duly established but, unless this is explicitly stated within the terms of reference for the relevant sub-committee, the default will be that no decision-making has been delegated. Where decision-making responsibilities are delegated to a sub-

committee, these will be clearly recorded in the AJCC's scheme of reservation and delegation , which shall be maintained by the Secretariat to the AJCC.

34 Subject to paragraph 33, above, and as a guiding principle only, the AJCC will have overall responsibility for determining the strategy, vision and objectives for matters within its remit, with day-to-day operational matters being managed at sub-committee level or escalated to the AJCC as per the agreed escalation arrangements.

35 Details of any sub-committees established by the AJCC will be set out in the terms of reference for each sub-committee and the scheme of reservation and delegation for the AJCC, all of which shall form part of the AJCC Handbook.

Dispute Resolution

36 As far as possible any disputes relating to the AJCC and its operation will be resolved by the members, with reference to the guiding principles for its operation as set out above.

37 Where it is not possible for a dispute to be resolved in this way, mediation will be provided through the regional NHSE/I offices.

Withdrawal from the AJCC

38 Should this joint commissioning arrangement prove to be unsatisfactory, the governing body of any of the member CCGs can decide to withdraw from the arrangement, but has to give six months' written notice to the other CCG members, with new arrangements starting from the beginning of the next new financial year or as otherwise agreed by the remaining members of the AJCC.

Review

39 The arrangements for the AJCC, including its terms of reference and those of any sub-committee established by it, shall be reviewed after the first 6 months of its establishment and revised as necessary.

40 Thereafter, the ToR will be reviewed annually or more frequently as required.

Date of adoption: 1 February 2020.

Appendix 1 List of CCG members

Bath and North East Somerset CCG

Bristol, North Somerset & South Gloucester CCG

Devon CCG

Dorset CCG

Gloucestershire CCG

Kernow CCG

Somerset CCG

Swindon CCG

Wiltshire CCG

Appendix 2 CCG Delegation

Appendix 3 CCG Standing Orders

Delegation

1 In accordance with its powers under section 14Z3 and 14Z4 of the National Health Service Act 2006 (as amended) ("NHS Act") NHS Devon CCG ("the CCG") has approved the establishment of the Ambulance Joint Commissioning Committee ("AJCC") and has delegated the exercise of the functions specified in this Delegation to the AJCC.

Delegation Functions

2 The following commissioning functions (known as the Delegated Functions) are hereby delegated to the AJCC:

2.1 all commissioning functions associated with the commissioning of emergency ambulance services as an integral part of the urgent and emergency care system according to national requirements and standards;

2.2 developing and agreeing a shared vision and understanding of emergency ambulance commissioning, working with colleagues within the urgent and emergency care system to do so and ensuring that the vision supports alignment and integration of services;

2.3 negotiating and agreeing a contract that delivers national performance, clinical and quality standards, incorporating any known challenges and improvement plans into the contract;

2.4 the award and entering into of contracts for the provision of emergency ambulance services;

2.5 performance managing the contract against agreed standards and key performance indicators, including agreed quality standards, observance of service specifications and monitoring of activity and finance;

2.6 all decision-making in respect of variations to the contract in accordance with national policy, service user needs and clinical developments;

2.7 all decision-making in respect of financial adjustments or sanctions resulting from provider breach of the contract;

2.8 ensuring that the ambulance service is clear on, and has plans to meet, their contractual, performance, quality, transformational and financial objectives and critical infrastructure resilience and interoperability. This includes but is not limited to all decision-making in relation to planned investments by the ambulance service;

2.9 managing the ambulance service's performance against the plans referred to in 2.8 above and being assured of performance;

2.10 supporting and challenging the ambulance service and holding it to account for planning guidance deliverables;

2.11 being assured of the ambulance service's level of emergency preparedness;

2.12 all decision making relating to the termination of the contract, or any part of it, in accordance with the terms of that contract;

2.13 if necessary, responding to informal or formal legal challenges brought in connection with the commissioned services;

2.14 ensuring compliance with all relevant statutory duties as they apply to the CCGs including, but not limited to, those relating to equality (under the Equality Act 2010 and specifically including the public sector equality duty under s 149 of that Act); health inequality (section 14T of the NHS Act); patient and public involvement (section 14Z2 of the NHS Act); improvement in quality of services (section 14R of the NHS Act); and integration (section 14Z1 of the NHS Act); and

2.15 such other related commissioning functions as need to be exercised by the AJCC in order to lawfully complete the procurement and contracting process for emergency ambulance services and for managing and assuring the services in accordance with the terms of that contract.

3 Even though the exercise of the functions passes to the AJCC, the liability for the exercise of any of its functions remains with the CCG.

4 In exercising its delegated functions the AJCC must comply with the statutory duties set out in the NHS Act and/or any directions made by NHS England or by the Secretary of State, and must enable and assist the CCG to meet its corresponding duties.

Commencement

5 This Delegation, and any terms and conditions associated with the Delegation, including the terms of reference for the AJCC take effect from 01 February 2020.

Exercise of delegated authority

6 The AJCC must exercise its delegated functions in accordance with its terms of reference.

7 The decisions of the AJCC shall be binding on the CCG.

Accountability

8 The CCG must continue to comply with its statutory duties, including those relating to finance under sections 223H and 223I of the NHS Act and those relating to equality / inequalities under the Equality Act 2010 and the NHS Act, in particular section 14T.

9 The CCG will comply with the reporting and audit requirements set out in the NHS Act.

10 The CCG may, at its discretion, waive non-compliance with the terms of the Delegation.

11 The CCG may, at its discretion, ratify any decision made by the AJCC that is outside the scope of this Delegation and which it is not authorised to make. Such ratification will take the form of the CCG considering the issue and decision made by the AJCC and then making its own decision. This ratification process will then make the said

decision one which the CCG has made. In any event ratification shall not extend to those actions or decisions that are of themselves not capable of being delegated by the CCG to the AJCC.

Variation, Revocation and Termination

12 The CCG may vary this Delegation at any time, including by revoking the existing Delegation and re-issuing by way of an amended Delegation.

13 This Delegation may be revoked by the CCG on giving six months' written notice to the other CCG members of the AJCC, with new arrangements starting from the beginning of the next new financial year.

Signed by:

Date:

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 30th January 2020

Dates of Committees covered in this report 19th December 2019 & 16th January 2020

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

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

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received for both December 2019 and January 2020 meeting

- **Risk Register Reports**
- **Devon CCG Monthly Finance Report**
- **STP Monthly Finance Report**
- **Governing Body Quality & Performance Report**

Reports received and noted

December 2019 meeting

- **Operational planning**
- **Bi-yearly Contracting update**

January 2020 meeting

- **BCF & Section 75 – Plymouth**
- **2020/2021 Operational Financial Plan**

Risk Register Review (changes and areas of concern)

December 2019 meeting

- **There have been no changes to scores, no risks for closure and no new risks added. Risk 106 was an area of concern.**

January 2020 meeting

- **There were no risks recommended for closure or no new risks.**

Committee Decisions

•
Recommendations for Governing Body
• **None**
Recommendations for other Committees
• **None**
Terms of Reference or other committee effectiveness issues
December 2019 • **The terms of reference are being reviewed.**

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: FINANCIAL PERFORMANCE REPORT				
Date of committee: 30th January 2020 **Date report produced: 21st January 2020**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date:** 21st January 2020		
Public or Private (Governing Body only):	**Public**		**Private**	✓
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

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

The report details the financial position to the 31st December 2019 and provides and assessment of the CCG's risk to delivering its planned deficit of £27m. The CCG is currently forecasting a deficit of £66.5m. The reasons for the adverse movement from plan is described in the following paragraphs.

The planning round for 2019/20 was challenging for the Devon System. The balance between performance, growth in activity and finance proved difficult to square. The Devon System submitted a combined plan that maintained current performance standards within an environment where activity is increasing. The resulting financial impact led to a projected deficit of £115m against a deficit control total of £43m for the Devon System.

Since the initial assessment The Devon System went through an intensive programme, supported by NHSE & I colleagues, to reach a more acceptable position in relation to financial performance against control total. This resulted in an improvement in the gross system deficit from £115m to £70m, a distance of £27m from control total, based on significantly increasing the level of ambition the plan and accelerating the pace of change in the transformation programmes the System is undertaking.

Within the system plan the CCG submitted a Financial Plan for 2019/20 which set out a forecast deficit to 31st March 2020 of £27m. Within this the CCG has a savings target of £81m which includes the £45m anticipated improvement through accelerating transformation programmes as described above. All parties in the system recognise the challenge this represents and developed a risk sharing mechanism between NHS partners to enable all parties to recognise individual contributions to the shared risk of delivery.

Consequently, the delivery of the required savings plan is the main financial risk and challenge to the CCG. A review of the CCG's financial position was undertaken, in conjunction with NHSE, and a decision taken to include £39.5m of unmitigated risks, identified at month 6, to the planned forecast deficit of £27m resulting in an overall forecast deficit position of £66.5m.

The CCG continues to prioritise its work to mitigate the potential impact of any other in year risks and seek to improve on the revised deficit position.

This report sets out the financial performance of the CCG to the end of December 2019 (month 9 management accounts).

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

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

None.

Key recommendations and actions requested:

The Governing Body is asked to consider, review and discuss the month 9 position as at 31st December and the level of risk to delivery of the revised forecast.

Impact on Strategic Objectives

(Delete as applicable)

We will continue to commission safe, effective and accessible services

We will work as a strategic partner in Devon

We will improve the physical and mental health of our population

We will make best use of our resources

Reference to other documents or accompanying papers:

N/A

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

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

NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 9 – 2019/20

Contents

Appendices

1. Executive Summary

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

The report details the financial position to the 31st December 2019 and provides and assessment of the CCG's risk to delivering its planned deficit of £27m. The CCG is currently forecasting a deficit of £66.5m. The reasons for the adverse movement from plan is described in the following paragraphs.

The planning round for 2019/20 was challenging for the Devon System. The balance between performance, growth in activity and finance proved difficult to square. The Devon System submitted a combined plan that maintained current performance standards within an environment where activity is increasing. The resulting financial impact led to a projected deficit of £115m against a deficit control total of £43m for the Devon System.

Since the initial assessment The Devon System went through an intensive programme, supported by NHSE & I colleagues, to reach a more acceptable position in relation to financial performance against control total. This resulted in an improvement in the gross system deficit from £115m to £70m, a distance of £27m from control total, based on significantly increasing the level of ambition the plan and accelerating the pace of change in the transformation programmes the System is undertaking.

Within the system plan the CCG submitted a Financial Plan for 2019/20 which set out a forecast deficit to 31st March 2020 of £27m. Within this the CCG has a savings target of £81m which includes the £45m anticipated improvement through accelerating transformation programmes as described above. All parties in the system recognise the challenge this represents and developed a risk sharing mechanism between NHS partners to enable all parties to recognise individual contributions to the shared risk of delivery.

Consequently, the delivery of the required savings plan is the main financial risk and challenge to the CCG. A review of the CCG's financial position was undertaken, in conjunction with NHSE, and a decision taken to include £39.5m of unmitigated risks, identified at month 6, to the planned forecast deficit of £27m resulting in an overall forecast deficit position of £66.5m.

The CCG continues to prioritise its work to mitigate the potential impact of any other in year risks and seek to improve on the revised deficit position.

Financial Position

This report sets out the financial performance of the CCG to the end of December 2019 (month 9 management accounts).

The CCG's 2019/20 forecast deficit is £66.5m.

	Planned Deficit £'000	Actual Deficit £'000	Variance to plan £'000
Year to date position	20,250	43,764	23,514
Year end forecast	27,000	66,500	39,500

There are several variances at month 9 resulting in a year to date deficit of £43.76m. These are discussed and set out in later sections.

Savings Plan

As set out in section 4, the CCG has a savings plan of £80.9m. The current assessment of deliverability suggests a saving of £41.2m could be delivered leaving a risk of £39.7m against the plan, therefore resulting in under delivery. The under delivery of the savings plan and in particular the system savings target held by the CCG is a major factor in the resulting forecast deficit.

Risk

The unmitigated risk to the delivery of the CCG's plan has been included in the year end forecast deficit position of £66.5m, a movement of £39.5m from the planned forecast deficit of £27m. Actions to improve the financial position, through a set of recovery actions, are being pursued.

There are in year pressures relating to the delivery of the 52-week target, as well as risk relating to the forecast savings through demand management within the RD&E contract, however these risks are currently alleviated by a reassessment of the opening plan risks and mitigations.

STP Plan

The CCG's plans sit within an overall plan for the STP which has a deficit of £68.7m (excluding anticipated Transformation/Sustainability Funding) with a savings plan of £170.6m. The plan is based on an agreed set of block contracts but with a large proportion of the savings predicated on joint working to reduce cost within those contracts through an accelerated transformation programme.
Should the system deliver its planned deficit position providers are expecting to receive £56.4m of Transformation funding resulting in an overall STP deficit position of £12.3m.

As at Month 8 UHP and T&SDFT are reporting adverse forecasts of £22m and £15m respectively. With the consequential loss of Provider Sustainability Funds and the

adverse CCG £39.5m movement in position the STP system is off plan by £90.6m, with additional unmitigated risks totalling £16.2m.

As a consequence of the deteriorating position the system is receiving support through the NHSE/I Intensive Support Team who are working with system partners to better describe the main drivers of the current financial position, and to help build and drive a realistic and deliverable system financial recovery plan.

2. Financial Assurance Dashboard

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

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

- Financial plan
- In Year Financial performance

The detailed areas of assessment that feed into these top-level indicators are shown in tables below.

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

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date in year deficit	20.3	43.8	216.1%	RED
3	Forecast Outturn in year deficit	27.0	66.5	246.3%	RED
4	QIPP - Year To Date Delivery (% achieved)	-46.4	-26.6	57.2%	RED
5	QIPP - Forecast Outturn Delivery	-80.9	-41.2	50.9%	RED
6	Running Costs	25.4	20.9	82.5%	GREEN
7	Risk adjustment to deficit (% of allocation)	0.0	0.0	0.0%	GREEN
8	Cash Position (% drawn down)	75.0%	75.8%	101.1%	RED
9	BPPC (% paid - value)	95%	99.4%	104.6%	GREEN

NO.	INDICATOR	Devon CCG
CCG Additional Indicator		
10	Delivery of plan YTD	RED
11	Delivery of plan FOT	RED

3. Detailed Financial Performance

The financial position to the 31st December 2019 by main service heading is as follows:

FOR THE PERIOD FROM 01 APRIL 2019 TO 31 DECEMBER 2019

Month 09 December	DEVON CLINICAL COMMISSIONING GROUP					
	Year To Date			Current Year Forecast		
	Budget	Actual	Variance Adv / (Fav)	Budget	Forecast	Variance Adv / (Fav)
	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES						
Acute Services	677,308	680,871	3,563	903,054	907,899	4,846
Mental Health Services	152,521	151,615	-905	203,361	202,215	-1,146
Community Health Services	198,788	198,891	103	265,074	265,223	149
Placements	91,074	91,903	829	121,428	122,542	1,113
All Other Healthcare	20,646	40,151	19,505	8,475	42,392	33,918
Primary Care Services						
Prescribing	145,505	146,838	1,333	194,007	196,117	2,110
Other Primary Care	154,305	154,305	-0	212,179	212,180	0
Primary Care Subtotal	299,810	301,143	1,333	406,186	408,296	2,110
Subtotal	1,440,146	1,464,575	24,428	1,907,578	1,948,568	40,990
CORPORATE						
Running Costs	16,823	15,909	-914	22,433	20,944	-1,489
TOTAL COMMISSIONED SERVICES	1,456,969	1,480,483	23,514	1,930,011	1,969,511	39,500
CCG Control Total	1,436,719	1,456,969	20,250	1,903,011	1,930,011	27,000
2019/20 Surplus/Deficit			43,764			66,500

There are a number of YTD variances to report at Month 9 including an overspend in Acute Services which relates mainly to a £3.24m overspend in Independent Sector costs, due to outsourcing treatments, as well as a £0.58m overspend with Taunton and Somerset Foundation Trust. Also, there is a YTD overspend in Placements of £0.83m due to a couple of new clients who have significant needs.

Prescribing is overspending with a YTD overspend of £1.33m and the most significant variance in month 9 is within the category All Other Healthcare, where the under delivery in the system savings target is playing through.

The YTD overspend has arisen as there is an expectation that the QIPP savings planned for will not be realised resulting in an overall YTD deficit of £43.76m. This is discussed and set out in later sections.

When set against our available in year revenue resources of £1,903m for Devon CCG the forecast outturn (FOT) results in an overspend of £66.5m. This is due to the expected overspends in Acute Services, Placements and Prescribing as well as the likely shortfall in QIPP savings.

The detailed expenditure, contract monitoring information and an analysis of potential risks and mitigations is set out in the remainder of this report.

3.1 Acute Services

Risk Share Application – Demand and Activity Management

As part of 2019/20 planning the Devon System set an ambition to achieve demand and activity management savings of £25m, with a risk share agreed to support the delivery of this ambition. The intention was firstly to reduce the (up to £15m) growth funded in contract, varying it back out of contract on the basis on which it was funded. The next £10m will be delivered by a combination of demand management and specific schemes/initiatives. Should this £10m not be achieved the risk share agreement requires organisations to manage an element of this risk in their position based on a 70:30 split between the CCG and the four acute providers.

The measurement of the activity and assumptions underpinning the risk sharing arrangement have been refined and agreed by the system directors of finance the application of which showed an underutilisation of growth in the first quarter of £3.3m.

The same process is currently being applied to quarter two with a view to establishing the forecast delivery of the savings target.

The sections below show the Month 8 position against total contract plans. The CCG continues to work closely with providers to ensure a joint understanding of activity variances.

RD&E Activity Summary – Month 8

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	6,550	6,249	-301	-5%	21,454	20,902	-551	-3%
Day Case	29,802	28,705	-1,097	-4%	22,805	22,416	-389	-2%
Non-Elective	31,502	30,617	-885	-3%	60,473	57,379	-3,094	-5%
A&E	59,131	59,211	80	0%	8,058	8,385	327	4%
New Outpatients	87,247	94,577	7,330	8%	11,726	11,896	170	1%
Follow-up Outpatients	147,817	147,892	75	0%	10,299	10,174	-126	-1%
Outpatient Procedures	69,221	66,837	-2,384	-3%	11,944	11,896	-48	0%
Drugs & Devices					10,720	9,817	-903	-8%
CQUIN					2,093	2,062	-32	-2%
Other					20,451	21,624	1,173	6%
Total					**180,023**	**176,551**	**-3,473**	**-2%**

The RDE Acute contract value has been agreed at £268,9m, at Month 8 there is a £3,473k underspend against plan.

The Elective & Day Case activity is 2.1% below plan equating to an underspend of £940k. The main contributing specialty continues to be Trauma & Orthopaedics with a £727k underspend (10% down on activity). In addition, Urology is under performing by 11% which is an underspend of £284k.

The Non-Elective activity is 5% below plan equating to an underspend of £3,094k. The main contributing specialties that are underspending are Paediatrics (£672k), General Medicine (£812k) and Trauma & Orthopaedics (£507k.)

The A&E activity is 80 attendances above plan with a corresponding case mix driven overspend of £327k.

Outpatient attendances are marginally over plan with a corresponding overspend of £44k. The main overspending specialties continue to be General Surgery and Clinical Physiology (with overspends of £236k & £157k respectively) this is reduced by Ophthalmology with an underspend of £360k.

Outpatient Procedures are on plan, Drugs and Devices are £903k below plan. The group of drugs Cytokine Inhibitors are the main area driver of this position with an underspend of £759k (this is within the specialties of Gastroenterology, Rheumatology and Dermatology).

CQUIN is being reported as being under plan by £32k.

NDHT Activity Summary – Month 8

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	2,173	2,221	48	2%	6,168	5,122	-1,046	-17%
Day Case	12,517	13,293	776	6%	6,671	7,167	495	7%
Non-Elective	12,587	13,842	1,255	10%	26,317	28,211	1,894	7%
A&E	29,378	29,768	390	1%	3,743	3,767	24	1%
New Outpatients	27,230	28,616	1,386	5%	4,561	4,537	-24	-1%
Follow-up Outpatients	59,767	59,237	-530	-1%	4,939	4,913	-26	-1%
Outpatient Procedures	23,580	26,704	3,124	13%	2,993	3,356	362	12%
Drugs & Devices					4,075	4,001	-74	-2%
CQUIN					935	956	21	2%
Other					37,291	38,912	1,621	4%
Total					**97,694**	**100,941**	**3,248**	**3%**

The NDHT acute and community contract value has been agreed at £145.8m, at Month 8 there is an overspend of £3.24m. Uncoded activity remains an issue, however average £ per speciality rather than Point of Delivery has been applied to uncoded activity, which should represent a more realistic financial value.

Elective and Day Case activity is 6% above plan but has an underspend of -£551k. Colorectal Surgery overall is showing +160, £-491k, the move from Inpatient Elective to Daycase in year has contributed to these variances. Trauma & Orthopaedics is showing an underspend of £660k but pressure remains in General Surgery and Gastroenterology.

Non-Elective activity is 10% over plan but is 7% over plan financially the main speciality driving this over performance to plan is General Medicine however there is a stroke budget transfer which will reduce this over spend by £660k.
A&E activity is 1% above plan and has a small overspend of £24k.

New Out Patient activity is showing a 5% overperformance against plan mainly driven by Clinical Physiology with over performance of £165k year to date,

Clinical Physiology is the main driver within OP Procedures, overperforming against plan by 278k.

UHP Activity Summary – Month 8

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	4,405	4,010	-395	-9%	14,964	13,162	-1,802	-12%
Day Case	22,082	23,586	1,504	7%	16,261	16,293	32	0%
Non-Elective	27,683	25,877	-1,806	-7%	56,162	54,482	-1,680	-3%
A&E	87,139	81,190	-5,949	-7%	11,197	10,509	-688	-6%
New Outpatients	51,965	51,705	-260	-1%	7,793	7,804	11	0%
Follow-up Outpatients	113,058	108,788	-4,270	-4%	9,089	8,630	-459	-5%
Outpatient Procedures	48,404	53,335	4,931	10%	7,566	7,941	375	5%
Drugs & Devices					10,453	9,910	-543	-5%
CQUIN					1,708	1,671	-38	-2%
Other					13,617	14,828	1,211	9%
Total					**148,811**	**145,229**	**-3,582**	**-2%**

The UHP contract at Month 8 is showing an underperformance of £3.6m.

Elective Care; 5.7% behind the financial plan and 4.2% ahead of the activity plan. The underperformance increased by £0.4m in month 8. The difference between the volume and value variances is due to a different casemix of patients being treated than was expected with overperformance in lower cost specialities such as Endoscopy (£625k), Clinical Oncology (£178k) and ENT (153k), with underperformance in higher cost specialities such as Orthopaedics (£1,927k), Cardiology (£311k) and Neurosurgery (£192k).

Non-Elective; activity is below plan by 6.5% equating 3% financially with an underperformance worth £1.7m.

Accident and Emergency; is below plan by 2.5% or 1,409 attendances whilst MIU is behind plan by 15.3% or 4,113 attendances. Previously the performance for A&E and MIU has been combined but is now split to give a clearer picture of performance in each service.

Outpatient activity; is exceeding plan by 0.2% whilst the spend is 0.3% less than plan. This variance is driven by UHP seeing more outpatient procedures and non-face to face contacts and fewer follow ups, then had been expected.

Pass-through Drugs and Devices are underspent by 5.2% or £0.5m, which is driven by pass-through drugs underperforming by £0.8m and devices over performing by £0.1m.

TSD Activity Summary – Month 8

	Activity				Cost £000's			
	Plan	Actual	Variance from Plan		Plan	Actual	Variance from Plan	
Inpatient	2,386	2,265	-121	-5%	8,738	8,129	-609	-7%
Day Case	22,113	22,504	391	2%	14,016	13,753	-263	-2%
Non-Elective	20,360	18,880	-1,480	-7%	44,086	42,854	-1,232	-3%
A&E	47,914	47,339	-575	-1%	7,249	7,085	-165	-2%
New Outpatients	51,669	47,957	-3,712	-7%	7,626	7,228	-398	-5%
Follow-up Outpatients	121,818	118,892	-2,926	-2%	9,540	9,349	-191	-2%
Outpatient Procedures	44,030	46,342	2,312	5%	6,647	6,824	178	3%
Drugs & Devices					7,497	7,379	-117	-2%
CQUIN					1,487	1,487	0	0%
Other					22,297	22,869	572	3%
Total					**129,183**	**126,957**	**-2,226**	**-2%**

The TSD contract for activity is below plan and the overall financial under performance is valued at -£2.2m across all acute contract (broadly unchanged from the previous month).

Outpatient Activity; is below plan and the financial underperformance is valued at -£0.4m at full pbr or local price. Follow ups are not materially different from plan but the most significant specialty variances are Vascular Surgery (-£0.12m), Ophthalmology (-£0.09m) and Dermatology (-£0.09m).

Admitted Patient Care; activity is below plan and the financial underperformance is valued at -£1.6m.

There are significant variances in day cases, mainly in Ophthalmology (-£0.2m), Plastic Surgery (-£0.2m) and Gastroenterology (-£0.1m).

Elective inpatients variances occur in Trauma & Orthopaedics (-£0.4m), Vascular Surgery (-£0.2m) and Colorectal Surgery (-£0.2m).

Non-Elective variances occur in General Medicine (-£0.8m), Paediatrics (-£0.4m) and Neonatology (-£0.2m).

Referrals

Below is a summary by provider of the NHS Devon CCG referrals to consultant led clinics for month 8 against 2018/19 YTD

Summary Position

Provider	Referral Source	2019/20	Variance	% Variance
NHS Devon CCG Total	GP/Dental	146,933	2,939	2.0%
	Other	81,870	3,395	4.3%
	Total	**228,803**	**6,334**	**2.8%**
Royal Devon & Exeter	GP/Dental	51,468	-421	-0.8%
	Other	21,292	875	4.3%
	Total	**72,760**	**454**	**0.6%**
University Hospitals Plymouth - **Excludes Trauma & Orthopaedics*	GP/Dental	38,951	2,771	7.7%
	Other	16,180	738	4.8%
	Total	**55,131**	**3,509**	**6.8%**
Torbay & South Devon FT	GP/Dental	29,702	466	1.6%
	Other	29,289	1	0.0%
	Total	**58,991**	**467**	**0.8%**
Northern Devon Heathcare	GP/Dental	15,495	465	3.1%
	Other	8,274	1,301	18.7%
	Total	**23,769**	**1,766**	**8.0%**
Other - **Excludes Trauma & Orthopaedics for Care UK*	GP/Dental	7,780	-510	-6.2%
	Other	2,180	319	17.1%
	Total	**9,960**	**-191**	**-1.9%**
Plymouth Orthopaedic Partnership (POP) - **Trauma & Orthopaedics for UHP and Care UK combined*	GP/Dental	3,537	168	5.0%
	Other	4,655	161	3.6%
	Total	**8,192**	**329**	**4.2%**

The NHS Devon CCG YTD position shows 2.8% growth whilst the rolling 12-month position shows growth of 3.3%.

Since last month the total CCG referral position has reduced by 1.1%

RDE: Month 8 is showing 0.6% growth (454 referrals) a decrease from last month.
Routine referrals have seen a 0.2% growth in referrals YTD whilst 2ww have seen 2.2% growth.
At speciality level the biggest growth includes; Dermatology (7%), General Surgery (14%) and Gastroenterology (13%).

UHP: Month 8 is showing 6.8% growth and the rolling 12-month position is 6.2% growth.
Routine referrals have seen a 3.3% growth YTD, whilst 2ww have seen 16.7% growth.
At specially level the biggest growth includes; Dermatology (20%), Colorectal Surgery (39%), Cardiology (26%) and Urology (19%)

TSDFT: Month 8 is showing 0.8% growth and the rolling 12-month position is 1.6% up.
Routine referrals have seen a 0.3% growth in referrals YTD whilst 2ww have seen 3.2% growth.

At speciality level the biggest growth in volume include; Cardiology (19%), Gastroenterology (23%), and Thoracic Medicine (10%) Despite Trauma & Orthopaedics and Ophthalmology being the two biggest volume specialties for TSDFT, these continue to see the biggest Year on Year declines. T&O saw a -6.4% fall and Ophthalmology -13.1%.

NDHT: Month 8 is currently showing a variance of 8% YTD and the rolling 12-month position is 8.2% up. Routine referrals have seen a 7.8% growth in referrals YTD whilst 2ww referrals have seen growth of 9.3%.
At speciality level the biggest growth in volume include; Colorectal (11%), Trauma and Orthopaedics (12%) and Neurology (49%).

Other providers combined has decreased marginally since last month showing a year to date reduction of -1.9%

3.2 Mental Health Services

The 2019/20 Mental Health budget provides services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and Livewell Southwest with the CAMHs service for Northern, Eastern and Southern localities being provided by Children and Families Health Devon through a contract with Torbay and Southern Devon NHS Foundation Trust.

In 2019/20 the CCG has invested £15m (6.1% increase) in Mental Health Services and will be audited on its overall spending in this area at the end of the year.

At month 9 there is a YTD underspend of £0.227m for IPPs due to LD placements on both Devon & Plymouth Out of Area beds. The position is forecast to be £0.303m underspent at the year end.

Other mental health contracts are showing a YTD underspend of £0.679m, which is a combination of 2018/19 year end accruals and slippage on current year contracts. The position is forecast to be £0.843m underspent at the year end.

3.3 Community Health Services

Community Healthcare Services include contracts with our main providers for community hospital beds and community services as well as children's services, minor injury services and the CCG's investment in the better care fund with our three local authorities. There are no significant variances to report as at M9.

3.4 Placements

Placements is overspent by £1.1m at Month 9 which is a £0.8m improvement on the Month 8 position. The improvement is largely a result of the further mitigating actions taken regarding children with significant needs, higher than anticipated client number drops and prior year improvements. Considerable effort has been applied to improve the overall position in recent months with further mitigating actions being pursued to address the remaining overspend.

There is underlying risk that requires robust financial management. The key remaining risks relate to client number movements and successful delivery of all QIPP savings plans.

The CHC control centre will continue to provide senior oversight to manage the financial position.

3.5 Primary Care Services

Delegated Primary Care Commissioning

On 1st April 2019 Devon CCG took on the formal responsibility for primary care commissioning from NHS England. This means that the CCG is now responsible for a budget of £164m to commission GP services in Devon.

As at month 9 we are forecasting a breakeven position across delegated primary medical care. Although there are small pockets of overspend beginning to emerge, e.g. Other Locums and Retained Doctors, these are being covered by the contingency.

Expenditure plans are put in place as GP Forward View allocations have been received by the CCG.

Primary Care Prescribing

The October data showed a decrease in spend of £0.13m. We now have an estimated year end forecast overspend of £2.11m. The risk of additional CAT M costs, along with the other price concessions and subsequent tariff amounts is assessed to be £0.33m and is included in this forecast.

Due to continued work and some urgent projects taking places in the practices the QIPP Achievement is now forecast at £7.99m which is a vast improvement. The team are currently finalising the plans for next year to continue this.

Other Primary Care Services

Other primary care services include contracts for enhanced GP services, out of hours GP services, home oxygen services and provision for GP IT costs. These are forecast to come in on budget as at M8.

3.6 All Other Healthcare

All Other Healthcare includes contracts for Integrated Urgent Care, hospices, patient transport and other intermediate care services. It also includes reserves and any unallocated savings targets.

The variance reported is due to the use of the reserves, the profiling of the QIPP delivery as well as the shortfall in QIPP savings achieved.

3.7 Running Costs

CCGs are required to manage the running costs (administration costs) of the organisation within an allowance which amounts to £25.4m for the CCG. Running costs are deemed to be those which are not for or related to the purchase of healthcare services (programme costs).

The forecast outturn at month 9 is estimated at £20.9m which would be an underspend of £4.5m when compared to the £25.4m allocation received.

3.8 Resource Allocation

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

	NEW Devon CCG	SD & Torbay CCG	Devon CCG
Planned revenue resources	£'000	£'000	£'000
Final allocation after place based pace of change	1,257,424	433,048	1,690,472
Other funding pace of change	2,191	475	2,666
Total recurrent revenue resources	**1,259,615**	**433,523**	**1,693,138**
Recurrent adjustments			-3,039
Non recurrent adjustments			25,702
Primary care commissioning			161,805
Running costs allocation			25,405
Total revenue resources			**1,903,011**
Total forecast expenditure			1,969,511
Total revised planned overspend 2019/20			(66,500)

4. QIPP/Systems Savings Plan

In order to support the priorities and contractual commitments within the CCG's financial plans for 2019/20, it requires delivery of a series of efficiency improvements and service changes in relation to its existing expenditure.

This can be extended to the ability of the healthcare system in the whole of Devon to live within the resources available to it, with the plan developed for this financial year targeting £166.3m across the Devon system. This is being managed and delivered jointly with the CCG's local system partners as part of the STP foot print.

Work streams to identify efficiency opportunities are in place. The overall programme is managed through its continual focus at the system Programme Delivery Executive Group (PDEG) meetings as well as the respective organisations finance committees and Board/Governing Body.

The management of the system savings programme includes regular assessment of likely delivery, with the shortfall against the plan (unmitigated risk) a continued key focus for the respective organisations to identify further opportunities and apply robust financial management processes to close this gap.

This means that for the CCG, although the total 2019/20 QIPP savings required is £80.9m, the transformational savings plans (i.e. not contractualised) within this amount to £35.0m. All parties in the system recognise the £35.0m challenge and have developed a detailed risk share between NHS partners to enable all parties to recognise individual contributions to the shared risk of delivery.

A summary of the CCG's total QIPP plans and current position is as follows:

QIPP Delivery		Plan	YTD Plan	YTD Actual	YTD Variance	FOT Plan	FOT Actual	FOT Variance
Description	**Service Area**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Demand/activity management and transformation programmes (STP acute providers)	Acute Services	37,000	16,500	3,000	-13,500	37,000	7,000	-30,000
Demand/activity management and transformation programmes (Independent sector providers)	Acute Services	500	375	0	-375	500	0	-500
Reduction in spend on individual patient placements	Placements	1,000	750	730	-20	1,000	1,004	4
Reduction in spend on individual patient placements	Mental Health Services	1,000	750		-750	1,000		-1,000
Joint commissioning	Community Healthcare Services	7,000	5,250	231	-5,019	7,000	1,250	-5,750
Continuing healthcare	Continuing Care Services	5,000	3,750	3,181	-569	5,000	5,106	106
Primary care prescribing	Primary Care Services	8,000	6,000	5,212	-788	8,000	7,991	-9
Allocations/income	Other Programme Services	10,000	4,500	3,400	-1,100	10,000	6,700	-3,300
Further benchmarking opportunities/other flexibilties	Other Programme Services	3,896	2,922	2,922	0	3,896	3,896	0
Non-rec opportunities	Other Programme Services	6,000	4,500	6,753	2,253	6,000	6,753	753
Procurement/Non-healthcare contract/Admin	Other Programme Services	1,500	1,125	1,125	0	1,500	1,500	0
Total QIPP		**80,896**	**46,422**	**26,554**	**-19,868**	**80,896**	**41,200**	**-39,696**

Demand Management/Transformation Programmes

As described at the beginning of section 3.1 the system ambition is to achieve savings as a result of reducing demand and activity within the acute sector as well as delivering transformational changes that allow cost savings to be released.

The system partners have agreed a risk sharing arrangement that underpins the ambition and as at month 9 our assessment of the impact is a forecast saving of £7m.

System partners are developing plans around 7 workstreams to underpin both demand and activity reductions but also to deliver further transformational changes. The workstreams are:

- Planned Care
- Peninsular Clinical Service Strategy
- Mental Health
- Integrated Care Models
- Digital
- Workforce
- Prevention

The financial impact of the schemes within these workstreams will contribute to the £7m forecast with further savings likely to impact in the following financial year.

We have not assumed that demand and activity savings will be seen within our independent sector contracts due to the need to address the number of patients waiting over 52 weeks for treatment.

Individual Patient Placements (IPP)

The emphasis of the IPP QIPP programme is to deliver improvements in service and process. Financial savings are delivered as a result of this focus as opposed to a financially driven approach.

The total net QIPP savings target for 2019/20 is £1.0m. Plans are in place to fully deliver the savings and the latest forecast is to achieve this in full, with a year to date savings of £0.7m.

Joint Commissioning

In previous years the CCG has benefited from the application of funding from Local Authority Grants within the Better Care Funds that were targeted at NHS pressures in non-elective care. Due to priorities within the social care system in 19/20 the level of ambition is likely to fall short of the targeted £7m.

The performance of the Better Care Funds within Devon are regularly monitored and further opportunities to improve on the assessed impact are being explored.

Continuing Healthcare (CHC) QIPP

The total QIPP savings target is £5.0m with a year to date actual savings of £3.2m and the current forecast to achieve £5.1m. The development and pursuit of an in-year recovery plan with a focus on client reviews has helped to achieve this improved position.

Most of the current savings in CHC have been achieved by 'Other cost avoidance measures' such as managing inflationary uplifts, managed reductions in care costs and favourable outcomes on negotiations and financial risks.

Prescribing QIPP

The total QIPP savings target is £8.0m with a year to date actual savings of £5.21m and the current forecast to achieve £7.99m.

The current savings have been achieved in the main by cost containment and prescription reduction as well as savings through the Respiratory, Nutrition and Endocrine prescribing schemes.

Allocations/Income

The system set itself a target to identify income and allocations received in year that could be non-recurrently diverted to support the overall savings programme through slippage of the identified programmes provided this was not detrimental to the quality and performance of services.

Having reviewed the sources of in year funding received to date and projected to be received our assessment of the likely opportunity currently falls short of the £10m target.

The position is reviewed monthly through Deputy Directors of Finance.

Further Benchmarking/Other Flexibilities

We are currently achieving this target and predicting to achieve in full this year through a series of budget reviews that have released contingencies usually applied to manage in year variation at contract level.

This does increase contract risk where they are based on variable activity.

Non-Recurrent Opportunities

We are expecting to achieve this target in full following a review of non-recurrent flexibilities identified at the planning stage. These are primarily savings released form post year end settlements where estimates were used.

Procurement/Non-Healthcare Contracts/Administration

The savings target has been delivered through reductions to running costs.

5. Risks

The assessment of financial risk at month 9 is as follows.

Devon CCG		Month 8	Month 9
Risk	**Description**	**£'000**	**£'000**
Acute Services	Risk relating to the forecast savings through demand management within the RD&E contract	1,000	1,000
Acute Services	Risk of under recovery from providers of the outsourcing cost of delivery the 52 week wait target or its impact on the system risk sharing mechanism.	1,200	1,200
Total Risk		**2,200**	**2,200**
Mitigations	**Description**	**£'000**	**£'000**
Other Programme Services	Initial reassessment of opening plan risks and potential mitigating solutions together with further opportunities.	-2,200	-2,200
Total Mitigations		**-2,200**	**-2,200**
Total unmitigated risk		**0**	**0**

At month 6 the scale of the unmitigated risk was such that when reviewing, with NHSE, the prospect of the CCG delivering its plan for 19/20, it was concluded that the CCG would move the forecast deficit position from £27m to £66.5m, including £39.5m risk identified at that time.

The CCG has developed a set of recovery actions that will impact on QIPP delivery and has taken these actions into account in its ongoing assessment of unmitigated risk.

6. Other Financial Information

6.1 Statement of Financial Position

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

The CCG's position at 31st December 2019 is shown in appendix 1.

6.2 Capital

NHS England have indicated that there is now some capital available to CCGs for business as usual projects. NHS England will access the national requirements and advise the CCG of the allocation in due course.

6.3 Better Payment Practice Code

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

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

	Number	£'000's
Non NHS Creditors - % of bills paid within target	98.38%	99.20%
NHS Creditors - % of bills paid within target	93.55%	99.49%

The target of 95% has not been met for the number of invoices paid within 30 days. This looks to be due to the merger of the two CCGs. Legacy organisations invoices had to be re-scanned, coded and paid via Devon CCG's ledger which resulted in a delay in the process.

6.4 Cash

There are several key cash performance targets that the CCG's are measured against; these are set out in appendix 2.

7 Recommendations

The Governing Body is requested to:

Consider, review and discuss the month 9 year to date performance and the forecast year end position including the current risks around delivery of the CCG's revised forecast.

Appendices

Appendix 1: Statement of Financial Position

AS AT 31 DECEMBER 2019	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	2,179
Intangible Assets	5
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	2,183
CURRENT ASSETS	
Inventories	400
Trade & Other Receivables - NHS	5,573
Trade & Other Receivables - Non NHS	18,647
Other Current Assets	-
Cash & Cash Equivalents	1,602
Non-current Assets held for Sale	-
Total Current Assets	26,222
Total Assets	28,405
CURRENT LIABILITIES	
Trade & Other Payables - NHS	- 31,028
Trade & Other Payables - Non NHS	- 100,256
Other Liabilities	- 1,080
Borrowings / Cash in Transit	- 14,477
Provisions	-
Total Current Liabilities	- 146,842
Total Assets less Current Liabilities	- 118,437
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 95
Total Non Current Liaibilities	-
Total Assets Employed	- 118,532
FINANCED BY TAXPAYERS EQUITY	
General Fund	118,532
Total Taxpayers' Equity	118,532

Appendix 2: Cash

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

Measure	Month 9
CCGs must operate within their Maximum Cash Drawdown (MCD) *The MCD is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,927.327m for Devon CCG the year.*	75.8% of the MCD has been utilised as at month 9 (75.0% is expected based on a straight-line trajectory at month 9).
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £2,427 for December.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

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

Date of Governing Body: 30th January 2020

Dates of Committees covered in this report: 2nd January 2020 plus ratified minutes from 5th December 2019 (Minutes of these committee meetings to be available as an addendum)

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Reports discussed and assurances received:

Members of the Committee discussed the following reports:

Finance Report

Due to the timing of the meeting, the Finance report for month 8 was not presented to Committee., but the Committee were assured that **the prediction was that** slight **over and underspends would balance to ensure break even in the delegated primary care budgets** at year end. A full report will be presented to the next meeting.

Reports received and noted:

Members of the Committee received the following reports for noting:

Digital Accelerator Update – Funding

A discussion took place around the Digital Accelerator Funding. A further update will be provided on how this funding will be used in the February Committee.

Workforce

The committee received an update on the Workforce work that has recently taken place with Dearden's. Further information on the new structure for managing workforce activity, and details of plans for the primary care workforce were requested.

NHSE Dentistry

The Committee received an update from NHSE regarding the latest Dentistry work that is taking place within the South West Region. Staff restructuring has affected progress. Detailed information will be circulated after the meeting. A further update will be provided at the April Primary Care Committee.

Primary Care Contract Management

The Committee received a paper for noting on Primary Care Contract management. and discussed the support that can be put in place for a General Practice prior to arranging Practice Visits.

Risk Register Review (changes and areas of concern)
The Risk Register was reviewed by members. No new risks and no proposed movement, closures or new risks this month**, though it was noted that the Executive were considering closue of risk no 97 and the committee asked that the residual risk (ie sustainability of service beyond current agreement, be considered for possible grading and mitigation.**
Committee Decisions
Teignmouth Medical Practice and Channel View Merger Request and Boundary Review The Committee agreed to the key recommendations for supporting the merger as requested and agreed that the closure of the branch site was acceptable. The Committee agreed and supported the Boundary review of area's 2 and 3. They noted that ceasing to cover Area 1 would leave one practice, with multiple GPs, covering Area 1. The committee support the merger of Teignmouth Medical Practice and Channel View Surgery subject to agreement by the merged practice that they would take on registrations where there was an irretrievable breakdown in the relationship between a patient in Area 1 and the remaining practice, or other circumstance requiring patient allocation. This is likely to be a rare occurrence. **Primary Care Operational Group** The Committee **endorsed** decisions made at Primary Care Operational Group.
Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
None

Management of Conflict of interests:

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

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

NHS
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GOVERNING BODY

Report title: Locality Update Reports				
Date of committee: 30 January 2020 **Date report produced: 21 January 2020**				
Author (s) Name and Title: **Locality Triumvirates**		**Supporting Executive:** **Name and Title: Dr Paul Johnson, Chair** **Contact Details:**		
		Report Approved by: **Name and Title:** Locality Triumvirates **Date 20 January 2020**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of these reports is to provide Governing Body members with an update on key areas of work within its Northern, Eastern, Southern and Western Devon Localities.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
N/A				
Key recommendations and actions requested:				

Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
None

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

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

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

NHS
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Locality update report

Locality:	Northern.
Period covered by update:	November 2019 – January 2020
Locality clinical representative:	John Womersley
Locality executive lead:	Andrew Millward
Locality non-executive representative:	Charlotte Burrows

Key achievements/progress

- **Litchdon Medical Centre** recently underwent a **CQC inspection**. They received an overall rating of **Outstanding** with the domains of Responsive and Well-Led both receiving ratings of Outstanding.

- The Locality held one of its **Primary Care Development Events**. The topics we and our guest speakers covered were PCN End of Life work to be done in the locality; the Farming Community Network: Urinary Tract Infection prevention and management in the elderly: the Dementia Advisory Service: an Obs. and Gynae service update from NDHT: Devon Careers update.

- An initial meeting has been held to discuss next steps in the formation of a **Northern Local Care Partnership**. It is intended to hold the first formal meeting of all stakeholders in the near future so as to establish a leadership team and explore the scope of work to be undertaken by the LCP.

- Our GP **Locality Clinical Advisors** have been working on many local initiatives amongst which are child poverty: suicide prevention: loneliness: homelessness: Exercise on Referral: obesity and a Healthy Weight Forum.

- The Locality held a **GP Members Forum**. Amongst the topics discussed were referral issues to acute providers: Prostate Tracker update: discharge summaries and an update on E-Consult uptake. Referrals to physio, radiology and dermatology by non-GP clinicians produced lively discussion.

- The Locality held a **Public Stakeholder Network** meeting on Dec 10th. The agenda included a Flu Update- Meds optimisation to attend: the purpose of group, its effectiveness and the ToR: a One Northern Devon Update and an update from the CCG Comms team on our Long Term Plan.

  The **Northern A&E Delivery Board** met. Agenda items included One Northern Devon initiatives -High Flow & Flow, UEC Dashboard, Live Life Well. Flu Vac uptake and Local DDoc performance were also discussed. Monitoring of
  1)Winter Emergency Cover Team.
  2) Extended ED GP Service 18:00 to 22:00.
  3) Proactive Care Home Visiting Service.
  4)Community GP (Urgent Visiting).
  5) Acute Flow Portering Support.

- The Locality held a **Stocktake and Rating ICM Workshop**. Ongoing work was mapped across to the STP ICM Programme Delivery Framework. Live Life Well Team Learning, Moorings Mental Health Crisis Café and realising Person Centred Coordinated Care were all incorporated. The Locality set itself objectives around building Placed Based Care and support systems.

- **Practice Visits** to local GP practices continue. No Northern practices are in the top 20 highest referral cohort and almost all practices are below the recorded CCG median referral rate. Month 8 Northern Locality rates for GP practice referrals and for Consultant to Consultant referrals have dropped. This is very creditable and illustrates local clinicians continued commitment to system working.

- Following the announcement of the second tranche of **Winter Revenue Funds**, the locality team worked closely with both NDHT and the PCN lead to return a proposed investment programme, principally focusing on: reducing occupancy levels: improving flow through the hospital: patient safety and dignity: and ambulance handover delays. Schemes that have been put forward include:
  1)Increased community bed capacity
  2)Flow coordinators in ED
  3)Enhanced weekend phlebotomy
  4)Enhanced weekend discharge team
  5)Additional patient transport
  6)Additional weekend consultant physician cover
  7)Increased support for GP practices to manage medication demands

- The **Holsworthy Community Involvement Group (HCIG)**continues to meet regularly and are now preparing a proposal document based on what local people have said about their service needs. During the last 18-months or so, the group has been working with local people to properly understand their needs, gathering evidence from a range of sources – including personal one-to-one interviews and surveys:

In total the HCIG group:

-delivered information leaflets about the project to 16,000 people in the area
-listened to more than 300 people at two “kick off” events in May 2018
-took notice of the feedback from 1155 people directly through online and paper surveys
-spoke face-to-face with 94 people at dedicated focus groups and open events
-attended fortnightly meetings in the where information and evidence were considered
-took on board the findings of the 2016/17 Devon County Council Joint Strategic Needs Assessment
-heard evidence and took advice from a consultant in Public Health
-received information from Northern Devon Healthcare NHS Trust (NDHT) - regarding the implementation plan to re-open the in-patient beds
-received information from local GP surgeries and key health and care stakeholders
-mapped more than 100 community groups, such as local voluntary, charity and statutory services

There are now 2,000 outpatient appointments a month at Holsworthy Community Hospital, compared to 500 in 2017. This includes new services such as those for chronic kidney disease, depression and anxiety and multiple sclerosis.

The group is planning to present the findings at a public meeting in February. The highlighted needs as identified from the quantitative and qualitative surveys are:

- Loneliness and Isolation
- Travel and Transport
- Services in the Home
- Young People
- Carers
- End of Life Care
- Healthier Lifestyles
- Hospital services in Holsworthy

Key priorities for the next three months

- **ICM Group** will focus on implementation and the delivery of high impact changes. These will be:
  H&SC Community Capacity, particularly regarding things like urgent care, mental health etc.
  PCN based MDT Training and Development; similar to the Coastal Model in South Devon.
  Personalised Care plans for people requiring services, their family and carers.
  Data Sharing, specifically regarding the need to understand how to implement, adapt and operate MDTs

Integrated commissioning, regarding the need to build local capability for needs assessment, consultation... across Health & Social Care to encourage potentially more locally appropriate options.

- **Safety and Quality** Team will attend GP Members Forum to discuss important areas of focus as the CCG now commissions some Primary Care Services. There will be a need to liaise closely with CQC inspection processes.

- The Locality is carrying out a review of **Urgent and Emergency Care** provision outside of the Acute Trust A&E department. This includes our Minor Injuries LES. We are working on finalising a Year-round Paramedic visiting service.

- The Locality intends to hold a **Primary Care Development Event** (expected outcomes are to enhance collaborative working and clinical engagement in primary & secondary care: to be aware of the recent changes in clinical practice on the programmed areas: to be updated on service delivery on these areas: to share good practice across primary and secondary care and to network with each other.) We intend to cover PCN QOF prescribing work to be done in the Locality: Pathology Optimisation: Top Tips on Microbiology: Clinical Update on Paediatric Diabetes and an update on the Northern Devon Integrated Diabetes Service.

- **Live Life Well** pilot has received considerable interest from other parts of Devon with teams coming to learn more about this different approach. It seeks to transform ways of system thinking and working to enable a personalised approach to care and support. Having meaningful, understanding conversations with people then allows team members to work across organisational boundaries and beyond traditional system protocols to enact change that will matter to individuals requiring our help.

- We are working with DPT on the implementation of the new **Community Mental Health Framework** to provide an integrated approach across primary care, secondary care and third sector and voluntary services to meet mental health need at the 30-50k population level. . Addressing urgent care needs through Single point of Access and a Rapid Response are top priorities.

Issues of concern or risk

- The Devon CCG Patient Safety & Quality Team undertook a **Provider Stocktake** of NDHT. The CCG has a growing assurance on the quality of care within NDHT through the information described but recognise the need to ensure improvements made by the NDHT and RDEFT teams are embedded and sustained in the longer term within NDHT. The CCG will continue quality surveillance and oversight through the Quality Assurance Framework process and progress against the CQC action plan in order to continue with quality assurances as described.

- Some risks within NDHT have been recognised and assurance has been sought. The risks being monitored are organisational change: the clinical coding mortality and morbidity review process: winter pressures and venous thromboembolism assessment. Partial assurance has now been obtained covering all these areas and is a sign of the ongoing improvements that have taken place since the commencement of clinical and executive support provided by RD&E NHS FT.

- The draft document setting out Year 2 of the national PCN DES has reportedly received significant feedback. Given this there is a risk that practices may disengage from the initiative, leaving the potential for further positive developments around integration and system working somewhat reduced.

- **Workforce challenges** remain a significant risk to delivering safe, effective care; as are the additional challenges presented by our remoteness from other acute care units. This also includes mental health care and the staffing of North Devon inpatient units.

- Out of area **mental health acute bed usage** remains an issue, particularly while some beds remain closed in North Devon. The CCG is working with Devon Partnership Trust to review plans over the winter period which increase system flow and capacity.

Support required from CCG/system or barriers to progress

- The Holsworthy Community Involvement Group has completed its work to develop a set of recommendations based on what it has heard from local people about services available to them. The Locality will require increased support from the CCG Comms and Engagement team to take the findings to a public meeting and then on to relevant stakeholders.

NHS Devon Clinical Commissioning Group

Locality update report

Locality:	Eastern
Period covered by update:	January 20
Locality clinical representative:	Dr Simon J Kerr
Locality executive lead:	John Dowell
Locality non-executive representative:	Glynis Atherton

Key achievements/progress

Eastern commissioning supporting local provider collaboration :

Since last month the key focus in the Eastern locality has been the proposed remodelling of the GP & PCN engagement forums. These forums have now been meeting regularly since 2008 and have mostly been used to convey and receive information to and from members. They are now proposed primarily as GP and ideally PCN clinical director led workshops and will spend time over future months describing the delivery of integrated provision in the eleven PCN neighbourhoods. The" new" GP forums are now meeting in January and papers proposing their change of focus have being prepared and circulated. So far, this idea has been positively received, members are reviewing the terms of references for their forums and more emphasis is being placed on accurate, updated and robust registers of interest being kept.

Clinician to clinician (C2C) focus groups are also being re-arranged and a revised set of principles will support specific work on areas of concern. It is thought cardiology and respiratory pathways could do with some urgent review in the East and concern had specifically been raised by the Eastern collaborative board chair that we should not lose focus on planned care challenges as we so regularly discuss the ICM.

Eastern GP members forums meeting in January 2020.

The three GP forums are initially being used to engage primary care networks across the locality to focus on the operational framework for the integrated care model.

PCN clinical directors are being asked to lead conversations with their cluster service managers and fellow network GPs to develop further a stocktake of implementation and ambition for the ten activities described in the framework. It's hoped these meetings will enable a more comprehensive understanding of ICM delivery across the locality and how the CCG can help to support gaps in progress.

The forums will still be used to convey and receive information from and to members and they will meet again jointly in March to explore the developing population health management programme, how this will relate to each PCN and how CCG stakeholder feedback can better be used to improve the GP member engagement process.

Quality and clinical/financial performance reports were used to feedback details to members and this was I believe much appreciated.
Members have been made aware of the recent PCN DES consultation process and the current renegotiations proposed between NHSE and the GPC.

Clinical Workforce review

Interviews have been underway to recruit further clinical support within the Eastern locality and its hoped to understand the number of sessions per week which have been appointed shortly. Gaps will then be actively recruited to according to perceived gaps in eastern clinical commissioning capability & following the conclusion of the review process.

Key priorities for the next three months

Eastern locality LCP development. The setting out of diarised meetings, stakeholder engagement and the agreement of a calendar workplan.

To develop a more comprehensive mapping of progress against the ICM operational framework for each of Eastern primary care networks. To be able to provide information and input to the STP ICM work programme and to describe gaps in both commissioning and provision at PCN level to which it's hoped the CCG can respond.

To further evolve the 3-level community urgent care model proposed through engagement workshops in the locality and the detail of the service provision proposed at each of these levels. Discussions are ongoing with clinicians at each of the three proposed levels and in several of the communities where this provision will be delivered.

To further support the discussions and development of a collaborative plan for social prescribing to utilise STP prevention monies. Building community conversations on a number of fronts across the locality & to understand the bids which have recently been successful, describing the monitoring of these new services as they start to deliver.

To further consider the need for & to target additional clinical advisory support in the locality following decisions made subsequent to recent GP interviews. Currently we have so little clinical advisory capacity its difficult to effectively support all the various locality workstreams.

To further develop relationships between primary and secondary care clinicians. GP/Consultant “buddy” clinics, clinician to clinician focus on areas of critical performance, cardiology, neurology, orthopaedics, and diagnostics and to link this with PCSS conversations ongoing.

To further understand the STP community estates work & the opportunities provided by community estate in the Eastern locality to enable optimum and most effective implementation of ICM work priorities and this is ongoing.

Issues of concern or risk

ED performance (A+E board risk register). 12hr mental health breaches are an ongoing issue specifically and often caused by a lack of adequate crisis intervention across the locality causing patient flow issues through the hospital.

Provision of domiciliary care (A+E board risk register) specifically, the opportunities to understand how better we can support the various care agencies to recruit and moreover retain their staff contributing to patient flow issues through the hospital.

Delayed transfers of care (A+E board risk register).specifically how we might be able to pilot the relocation of more ward staff to UCR to support the further discharge of the more of the patients regularly on the hospital “green to go list “contributing to patient flow issues through the hospital .

DPT acute bed capacity (A+E board risk register) how can we develop a more comprehensive community mental health offer

Delayed access to diagnostics MRI, CT, endoscopy.

Lack of sufficient clinical advisor capacity in the locality.

Lack of access to pulmonary rehab in the Woodbury/Exmouth/Budleigh area and access only through acute care consultants in Exeter. Inequity and thus often insufficient or no access to this most well evidence-based intervention which

would no doubt significantly impact on patient hospital flow if sorted. …we have made no impact on this this month yet.

Lack of tangible & often patchy connection with community mental health provision. We need much better attendance at LCP and GP forum level.

Continued concern regarding staff fatigue both in primary and secondary care

Lack of a clearly described career pathway for primary care nursing. I note there are 3 meetings planned to support primary care nursing over future weeks.

Support required from CCG/system or barriers to progress

Operational support for the immediate implementation of equitable access to and provision of pulmonary rehabilitation services across all neighbourhoods of the eastern locality. This needs senior commissioner support & clinical advisory support to facilitate the implementation of this by the providers.

Operational support for the review of and implementation of falls prevention services across all neighbourhoods of the eastern locality. This would be a well evidenced based clinical intervention to actively target. Managerial and clinical commissioner challenge should be raised with providers imminently where this is not comprehensively in place going into this winter.

Operational development led by commissioners for the likely key players in the eastern locality care partnership. Facilitated discussion with respect to elements of responsibility noted in recent STP proposed LCP papers and the workability of certain responsibilities such as some CHC, local safeguarding, contract management, workforce and community assets, particularly when this has implication for neighbouring localities. This will need more clinical advisory support within the locality.

Facilitation of far greater visible integration of community mental health provision within community conversations at neighbourhood and place level. This needs the appointment of locality clinical advisory support and the working of this individual with a colleague focussing on mental health at the system level.

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This report must be accompanied by a completed front sheet

Western Locality Update Report

1. Introduction

1.1 This report summarises activities from the past four weeks and key issues and challenges in the Western Locality. The system continues to experience high levels of demand in all sectors

2. Key achievements/progress

2.1 Extensive support, coordination and facilitation of services to ensure patients registered at Barton Surgery (Plymouth) during the period of contract suspension and subsequent contract handback. Practice closed on 31 December and all patients are registered with a new practice.

2.2 Follow up of individuals who expressed an interest in working in the South West at the BMJ and South West jobs fayres in October 2019.

2.3 Hosting of second eConsult event to improve uptake.

2.4 Workshop with stakeholders to review progress in the various areas of implementing the Integrated Care Model according to the new Delivery Framework. Ratings and priorities for implementation will be further developed by the ICM Board in January and a Devon-wide workshop on 6th February.

2.5 Recruitment campaign launched "New to or Returning to Care" to increase community capacity.

2.6 Digital Accelerator project: currently in 4 PCNs with funding secured to roll out across the remaining 4 networks

2.7 Community Pharmacist Consultation Scheme (CPCS) pilot now live between St Neots and a local pharmacy.

2.8 Additional resources for winter have led to further schemes being enhanced for the system over winter and beyond. These include further extension of the care homes LES as well as an opportunistic frailty home visiting scheme as well, both of which have been well received. Additional capacity provided for internal process support for UHP and Livewell and support to demand projects.

2.9 Winter planning actions now in place, challenged system but noting better 'return to usual' after escalation, good discharge processes and levels of DTOCS and Extended LOS. Although projects to prevent and reduce demand have become operational, they have been delayed past the preferred start dates so impact is less than desired. Will see and improvement over next few weeks.

2.10 Pilot scheme of 2WW colo rectal patients being seen in Care UK to improve the performance of endoscopy waiting times commenced. This will have a positive impact on both the diagnostic target and the cancer target at UHP.

2.11 Procurement for the replacement of the Assisted Conception Service in western went live.

2.12 Principles for use of investment as part of movement towards equity for Western System developed, approved by Execs and shared with system partners.

2.13 Smooth closure of Park View surgery on 31 December 2019 following the handing back of their contract.

2.14 Work closely with PCNs to develop MOUs and plans identified by the maturity matrix to

deploy the Primary Care Network Development Funding.

3. Key priorities for the next three months

3.1 Primary Care Networks – MoU and Maturity matrix support in progress to assist development of networks.
3.2 Integrated Care Partnership Procurement.
3.3 Implementation of demand plans through AEDB including maximisation of MIU and AAU pathways.
3.4 Shared work with UHP and Livewell from commissioners to further support interface issues (primary care streaming, UTC, triage, reasons for demand and EOL care).
3.5 Reopening of Tavistock MIU in January and debate commencing with community in relation to developing a sustainable workforce for the future.
3.6 Rolling out high intensity user support for patients attending ED.
3.7 Population health management (Devon-wide and local projects).
3.8 System pharmacy support offer to PCNs – CCG, LSW and UHP Pharmacy leads have met with PCNs to discuss offer. Support and integrated working with individual PCNs to be established.
3.9 Monitor CPCS pilot with rollout to further sites planned.
3.10 Refresh of Integrated Care priorities locally and Devon-wide with planning as part of the Operating Plan regarding actions and outcomes for next year.
3.11 Ensuring the UTC (Cumberland) increases its capacity and capability as planned.
3.12 Progress development of the LCP noting that STP discussions with PCN CDs and local stakeholders yet to take place in January.
3.13 Embed smaller team of CCG Locality Clinical Advisors once CCG Clinical Workforce Review is complete, and refresh priorities for clinical workforce.
3.14 Integrate Western Primary Care Partnership with ICM Board for 3 month trial with the ambition to accelerate PCN involvement.

4. Issues of concern or risk

4.1 Operational Plan delivery to achieve financial efficiencies and performance trajectories.
4.2 52 Week waits (currently above trajectory).
4.3 Diagnostic waits.
4.4 ED performance.
4.5 Workforce capacity – nursing, domiciliary care, pharmacy, voluntary sector.
4.6 Resilience of Plymstock GP practices as a result of Barton Surgery contract handback (contract handed back 31 December 2019)

5. Support required from CCG/system or barrier to progress

5.1 Resolution to information governance issues preventing rollout of population health management (Devon Linked Data Set).

NHS
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Clinical Commissioning Group

Locality update report

Locality:	Southern
Period covered by update:	January 2020
Locality clinical representative:	Dr David Greenwell Dr Matthew Fox
Locality executive lead:	Dr Sonja Manton
Locality non-executive representative:	Judy Hargadon

Key achievements/progress

Integrated Care Model - Health and Wellbeing Centres

- Coastal: Further work on the proposed consultation continues and a number of meetings have taken place with local partners to help develop plans. The project has also been discussed by the CCG's Public Engagement Panel.
- Dartmouth: The first issue of a new update bulletin on the Dartmouth project was published in December. TSDFT also held a public engagement event in December on the new health and wellbeing centre and are collating the feedback.

Integrated Care Model – delivery and governance

- Local ICM Board established, will drive and monitor progress of the implementation of the ICM framework for the Southern locality.
- We are reporting green in terms of our key metric - reducing growth in emergency demand - but work needs to be done to evidence how much of that is attributable to the ICM.

TSDFT performance

- The Trust is experiencing a prolonged period of challenged urgent care performance, particularly ED 4-hour target.
- There is increased confidence in achieving the ambition of zero 52week waits in the system. Improved modelling and forecasting have supported the acquisition of targeted central funding to support Orthopaedics, Ophthalmology and General Surgery. This will help to reduce overall long waits in those specialities by increasing capacity aimed at those who have been waiting the longest.

- We are also seeing better than expected performance in diagnostics as a result of funding secured for increased capacity. This will benefit CT and MRI waits across the system and also positively impact on wait times for Echocardiography at RDE.

Urgent and emergency care

- The focus is currently on winter resilience. All escalation beds are now open, and the acute medical assessment unit is open overnight.
- From w/c 13th January, every weekday, Chief Operating Officer at TSDFT and the CCG Director of Commissioning (NES) will review 10 performance indicators. If on two consecutive days 4 or more of the measures are triggered, then there will be an executive level phone call to assess the situation and agree improvement actions required.
- The Silver emergency care reset continues. There has been good engagement, with Trust staff identifying Gold and Silver patients (those prioritised for prompt discharge) each day, to keep a rhythm going to create flow.
- The community urgent care redesign working group met in December, to progress the proposed local model of care, including:
    - Newton Abbot Urgent Treatment Centre
    - Totnes Community Treatment Centre
    - Dawlish Same Day Urgent Care; and
    - to scope a Same Day Urgent Care Service for Torbay.

Quality

- Emergency Department: We continue to work closely with the Trust, including daily quality walkarounds, and can report patient safety measures are in place.

Key priorities for the next three months

ICM

- Devonwide ICM workshop in February to bring together output from December workshops from each locality. This will highlight local and system priorities for action to ensure we are on track with the delivery framework and activity targets.

Urgent and Emergency Care

- Review of the effectiveness of the Hospital Ambulance Liaison Officer (HALO) roles, introduced to reduce ambulance handover delays and help identify suitable alternatives.
- The Southern A&E Delivery Board will monitor the delivery and impact of the winter pressures schemes, including those funded by NHSE and local authorities. The schemes are intended to increase bed capacity, reduce crowding in ED and prevent corridor care, reduce length of stay and prevent ambulance handover

delays. A key focus of this extra funding is to create a surgical assessment unit in the hospital to alleviate the pressure on ED.

- Complete the review of when the Trust has declared OPEL 4 (the highest level of escalation), a request for all Trusts from the Devon A&E Delivery Board. This will then inform local and Devonwide A&E Delivery Board priorities.
- Commissioning leadership to work with Dawlish and Totnes MIU to return to full opening hours after temporary reduction.
- Finalise the proposed model for community urgent care in the south, in readiness for CCG Governing Body review in March.

Issues of concern or risk

- TSDFT Performance and financial position. A&E performance continues to be an issue and heightened governance arrangements remain in place.
- Personal care capacity and resilience remains a concern across Devon. Additional agency capacity has been secured and we are working with our local authority colleagues to secure a viable and sustainable option.
- The short-term change to MIU provision in Dawlish and Totnes is still in place. We continue to ensure actions are underway to deliver expected outcomes.

Support required from CCG/system or barriers to progress

- Likely that TSDFT performance will continue to require exec-level focus and assurance, in partnership with NHSEI.
- Progressing the developments for modernising health and care services in Teignmouth will require additional capacity and resources including at executive level.