Ipswich and East Suffolk
Clinical Commissioning Group

GOVERNING BODY

Agenda Item No.	**14**
Reference No.	**IESCCG 19-31**
Date.	**21 May 2019**

Title	**Governing Body Assurance Framework and Chief Officers Risk Registers**
Lead Chief Officer	Amanda Lyes, Chief Corporate Services Officer
Author(s)	Tony Buckle, Risk Manager
Purpose	To provide the committee with the updated CCG Governing Body Assurance Framework (GBAF) document for May 2019.

Applicable CCG Clinical Priorities:		
1.	To promote self care	
2.	To ensure high quality local services where possible	✓
3.	To improve the health of those most in need	✓
4.	To improve health & educational attainment for children & young people	✓
5.	To improve access to mental health services	✓
6.	To improve outcomes for patients with diabetes to above national averages	✓
7.	To improve care for frail elderly individuals	✓
8.	To allow patients to die with dignity & compassion & to choose their place of death	
9.	To ensure that the CCG operates within agreed budgets	

Action required by the Governing Body:

The Governing Body is requested to review and approve the updated Ipswich & East Suffolk CCG GBAF for May 2019.

1. Background

1.1 Content of the GBAF is reviewed by the Chief Officers Team every month and by the Governing Body, Clinical Scrutiny and Audit Committees at each of their meetings.

2. GBAF - Key Issues

2.1 A new risk has been added reflecting the position of the Out of Hours service. Actions highlighted with a grey background are complete and will be removed from the next version.

2.2 The following amendments have been agreed by COT at their regular review meeting:

Risk No and Owner	Risk description and actions update
ESNEFT 40 Jane Payling	*Financial pressures at our largest provider, ESNEFT present a risk to service delivery and create knock on financial pressures across the IES Alliance.* **Key Control Established amended.** ESNEFT/CCG financial risk working group (FRWG) to be established from start of 19/20 financial year with links to CCG FPC and ICS. **Action 1 amended** - Agree dates for financial risk working group. **All actions have June 2019 target date.**
ESNEFT 38 Jane Webster	*ESNEFT and Ipswich Hospital site are failing 62-day cancer targets.* **Action 1 revised** - Weekly cancer updates received and monthly commissioner, provider, NHSE/I calls in place. **Target date May 2019.**
NSFT 26a Lisa Nobes	*CQC and CCG inspections of NSFT services in Suffolk demonstrate that the service is inadequate leading to a risk of patient harm and poor experience.* **Revised RAG rating increased to 25 (from 20).** **Action 1** - Quality assurance process to review every service line. **Target:** May 2019. **Update May 2019** - reviews are ongoing, planned until end of June. **Action 2** - Recruitment/secondment of NSFT senior leadership posts to drive improvement in NSFT and partnership working arrangements with ELFT. **Update May 2019**- locality director posts currently being appointed to.
NSFT 26b Jane Webster	*Poor performance of mental health services.* **Action 6** - Children's and adults routine assessment waits to recover to 28 days. **Update:** Recovery date still unclear; more work needed with CCG for realistic recovery date. **Action 7** – Lark Ward reopening. Full opening Feb 2019. **Update:** At May 2019, 7 of 10 beds open. **Action 8** - Youth ADHD services. Target is to reduce long waits - Service reviews to scope scale of issues and oversee improvements. **Update:** Trust has advised that trajectory to clear waiting list backlog is Dec 2019: Not accepted by the CCG or SEND Board, Trust reviewing if earlier recovery possible. **Action 9** – new action Long waits with the EWB. **Target:** 2019/20; target of 95% of patients being seen, treated and discharged from EWB within 10 days. **Update**: to agree trajectory by June 2019. **Action 10** – new action. Eating Disorder waiting time. **Target:** compliance with national waiting times standards by April 2019 **Update**: All new staff recruited.
EEAST 32 Ed Garratt	*EEAST is failing performance targets against ambulance response categories, particular concern are delays in the higher acuity Category 1 and 2 calls.* **Action 1** – EEAST have a target workforce/capacity gap that is taking longer to fill than expected – overall EEAST Staff in Post (SIP) is around 2850 vs ISR target of 3033 SIP. This means that Patient Facing Staff Hours (PFSH) are running below funded levels and there are key ongoing actions/ mitigations to ensure a safe service is maintained : • Incidents are monitored through lead team and PQRM on a monthly basis; • Overtime/Private Ambulance Capacity targeted to peak demand shifts; • Productivity and rota redesign work to optimise available resources; • Demand management schemes in place locally; • Handover delays at hospital being managed and monitored weekly
MHRA 28 Lisa Nobes	*Inspection by MHRA in January 2018 identified a number of failures to comply with the guide to Good Manufacturing Practices for blood transfusion. This is the second inspection that identified areas for improvement.* **Action 2** – Re-inspection by MHRA to assess improvement made by Trust. **Target:** July 2019. **Update May 2019** continued monitoring of action plan to assess progress. **Action 4** - new action. Quality improvement visits being planned to NEESPS services. **Target:** July 2019. **Update;** Visits being scheduled.
CHC 35 Lisa Nobes	*There is a backlog in CHC patients with Deprivation of Liberty safeguards (DOLS) in place that require Court of Protection authorisation. This requires significant staffing resource and expertise in the Court of Protection process. This may have financial impact if the individuals or their families contest the restrictions in place.* **Action 2** - Priority cases applications - 4 per month to be in progress/completed – commenced July 2018.

	Target: March 2019. 4 per month being progressed. **Update May 2019 -** controls continue to be implemented.
Cyber 36 Amanda Lyes	*Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e dispensing services etc.* **Minor amendments to Key Controls Established.** **Action 1 –** Delivery of HSCN connections. Revised target date June 2019. **Action 3** - Rollout of threat detection capability (national solution – ATP). Revised target date May 2019.
Brexit 37 Amanda Lyes	*Brexit and the possibility of a 'no deal' exit from the European Union.* **Key Controls Established amended.** Engagement with NHSE full Incident Coordination Centre (new operational date now awaited) who will deal with any fall out from a negotiated or a no deal scenario.
111 Service 39 Jane Webster	*The 111 service is failing the target for calls answered in 60 seconds.* **Risk removed to directorate risk register.**
Out Of Hours Service 40 Jane Webster	**New Risk** *The Out Of Hours service is failing to see patients within the National NHS Pathways timescales leading to patient safety and quality concerns.* **Granular Operational Risks** Clinical risk of patients not being seen in appropriate timescales. Risk of deteriorating patient outcomes and experience due to long waits. Risk of breaching constitutional obligations. Risk of increasing patient harm. Potential impact on increasing demand for other providers. Risk to quality of care and safety of patients that rely on the service, such as Palliative Care Patients. The number of GP staff available for Out Of Hours work is limited within Suffolk and as such there is also reliance on out of area GPs. **Initial RAG rating 16.** **Key Controls Established.** Continued focus on strong contract management. Bi-weekly meetings between Care UK and the Suffolk GP Federation. Bi-Weekly breach reports shared with the CCG. Suffolk GP Federation are currently reviewing and validating the Out Of Hours Service performance with a view to improve. **Assurance of Controls.** Updates from Care UK through regular escalation conference calls. Contractual communication with Provider to ensure all immediate actions are being taken including agency. **Revised RAG rating 16.** **Action 1** - CCG to monitor the implementation of the provider actions. Target date May 2019. **Action 2** - CCG's Quality team is monitoring breach reports. Target date May 2019. **Action 3** - CCG has requested a review of performance on days that have shown significant concerns. Target date May 2019. **Action 4** - CCG has requested confirmation that the current pathways are those commissioned. Target date May 2019. **Action 5** - CCG is monitoring complaints and incidents on a bi-weekly basis. Target date May 2019.

3. Chief Officers Risk Registers

3.1 A brief highlight report on current risks which may cause concern to the CCGs from local Risk Registers is included in a summary table document with this report. These are reviewed on a regular basis by COT and the Risk Forum.

3.2 The Risk Forum reviews all the departmental risk registers each month and they are all up to date. The accompanying risk register summary table is from the Risk Forum meeting of April 2019, there have been some updates since then and they are included.

NHS
Ipswich and East Suffolk
Clinical Commissioning Group

Governing Body Assurance Framework and Action Plan

2019 - 2020

Version Control:

MONTH	VERSION No	REVIEWED BY	SUMMARY OF CHANGES
April 2019	73	COT 1 April 2019 Clinical Scrutiny 23 April 2019	Approved
May 2019	74	COT 13 May 2019 Governing Body 21 May 2019	
June 2019	75		
July 2019	76		
August 2019	77		
September 2019	78		
October 2019	79		
November 2019	80		
December 2019	81		
January 2020	82		
February 2020	83		
March 2020	84		

Governing Body Assurance Framework

Overview

The Governing Body Assurance Framework (GBAF) provides the NHS Ipswich and East Suffolk Clinical Commissioning Group (CCG) with a simple but comprehensive method for the effective and focused management of risk. Through the GBAF the CCG Governing Body gains assurance that risks are being appropriately managed throughout the organisation.

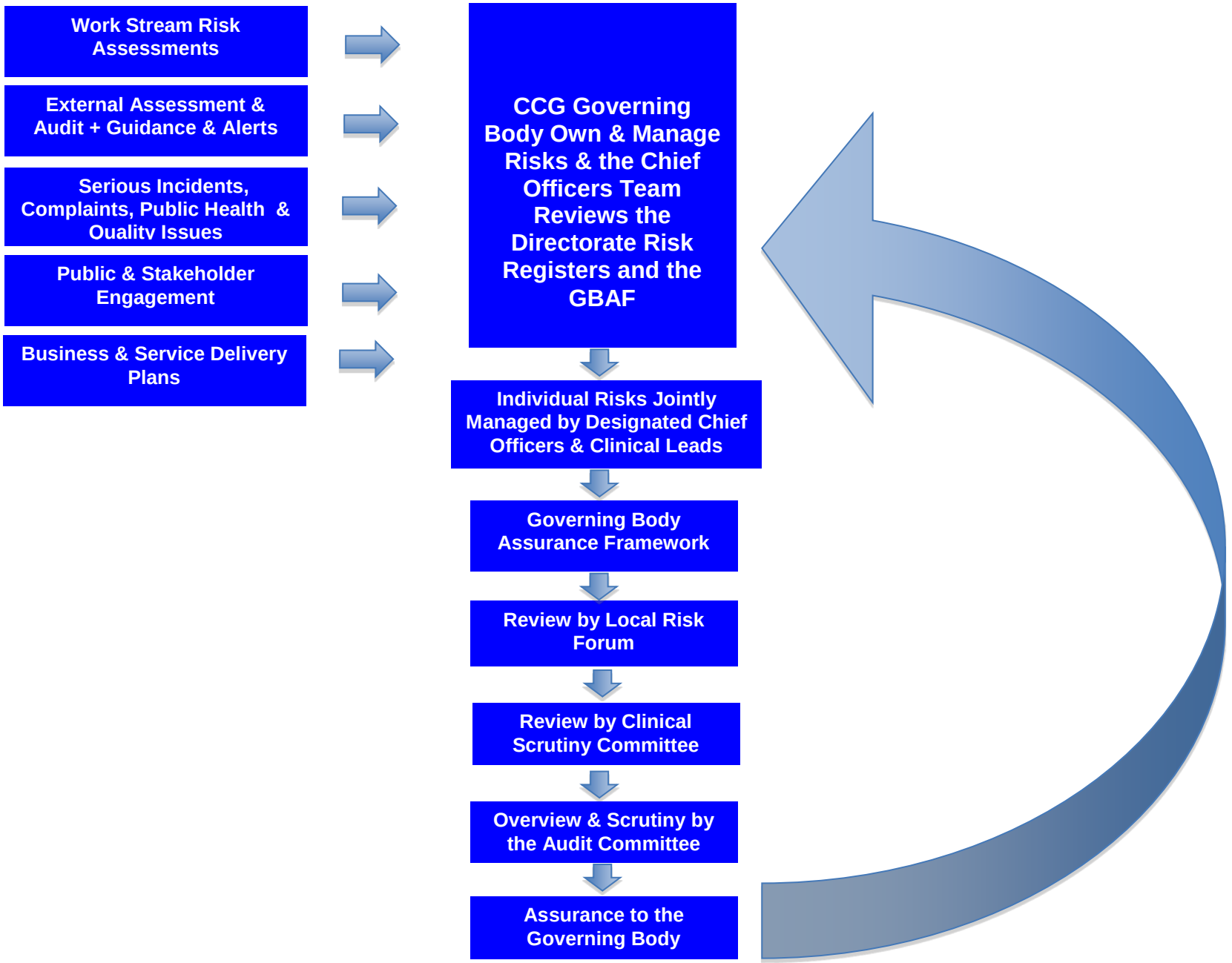
The GBAF identifies which of the organisation's strategic objectives may be at risk because of inadequacies in the operation of controls, or where the CCG has insufficient assurance. At the same time it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the Governing Body to determine how to make the most efficient use of resources and address the issues identified in order to improve the quality and safety of care. The GBAF also brings together all of the evidence required to support the Annual Governance Statement.

The GBAF should be seen as a working document and will be updated regularly by the Chief Officers Team, monitored by the Audit Committee and reported to the Governing Body at each of its meetings. The GBAF is linked to the Risk Register, the content of which is also provided for review by the Chief Officers Team. A flow chart setting out how risks are identified and managed is set out overleaf.

In order to ensure consistency in the risk assessment process, the likelihood and consequences of all risks on the Risk Register are assessed against the former National Patient Safety Agency (NPSA) 5X5 risk matrix and those scoring 15 and above and are of strategic concern migrate to the GBAF and thereby inform the Governing Body agenda. **Once added to the GBAF, a risk should remain in place until its RAG rating has been mitigated to a score of 1-6 when it is considered manageable and therefore no longer a strategic concern.**

The 5X5 risk matrix and subsequent red, amber, green (RAG) score identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action, and determines whether risks are to be accepted on the basis of the colour bandings and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating.

RISKS IDENTIFIED THROUGH:



RAG Score Framework

Likelihood score →	1: Rare	2: Unlikely	3: Possible	4: Likely	5: Almost Certain
Consequence score ↓					
5: Catastrophic	5	10	15	20	25
4: Major	4	8	12	16	20
3: Moderate	3	6	9	12	15
2: Minor	2	4	6	8	10
1: Negligible	1	2	3	4	5

The subsequent red, amber, green (RAG) scores identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action, and determines whether risks are to be accepted on the basis of the colour bandings and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating within the following classifications:

RAG Score	Progress	Risk Assessment	Revising Risk Ratings
CRITICAL (15-25)	• There may be significant gaps in controls to ensure effective management. • Controls are in place but insufficient resources • Controls are in place but external forces may be preventing progress.	• There are insufficient controls in place to address the cause or source of the risk • Controls are considered insubstantial or ineffective • Controls are being implemented but are not yet in place • If this risk were to materialise, the situation could be irrecoverable in terms of the CCGs reputational/financial well-being and or service continuity.	If controls are inadequate then the revised risk rating increases  If controls are uncertain, the revised risk rating stays the same as the original risk rating.  If they are perceived as adequate, then the revised risk rating decreases 
CHALLENGING (8-12)	Progress is being made but there is concern that the objective may not be achieved. Additional controls or management action is being taken to improve the likelihood of success.	There are few controls in place, which are considered substantial and/or effective and address the cause of the risk. The consequences of the risk materialising, though severe, can be managed to some extent via contingency plans.	
MANAGEABLE (1-6)	Progress is being made in accordance with plans. There are no significant concerns.	The risk is considered to be small and there are sufficient controls in place which address or substantially effective the cause of the risk. The consequences of the risk materialising can be managed via contingency plans.	

In order to determine the likely consequence arising from an identified risk and using the 5X5 matrix:

- Define the risk explicitly in terms of the adverse consequence or consequences that might arise

- Use the table below for examples, by risk domains, to determine the **consequence score** relevant to the risk identified

	Consequence score (severity levels) and example of descriptions				
	1	**2**	**3**	**4**	**5**
Risk Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
1. Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
2. Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
3. Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

4. **Statutory duty/ inspections**	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
5. **Adverse publicity/ reputation**	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
6. **Business objectives/ projects**	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
7. **Finance including claims**	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
8. **Service/business interruption**	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
9. **Environmental impact**	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

ESNEFT – Finance. Risk 40 added March 2019.

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
JP/MM	Financial pressures at our largest provider, ESNEFT present a risk to service delivery and create knock on financial pressures across the IES Alliance.	The size of the CIP required to achieve its financial control total resulting from the cost and income profile for ESNEFT is high in absolute and percentage terms. Delivery of the financial control total (which releases additional funding for the trust) may require financial support from the CCGs and/or service reductions. Suffolk and North East Essex ICS has elected to manage financial control totals at alliance level – therefore financial risks at ESNEFT will put the achievement of the alliance control total at risk.	**4 x 5** **20**	ESNEFT/CCG financial risk working group (FRWG) to be established from start of 19/20 financial year with links to CCG FPC and ICS. ESNEFT reinvestment scheme to be established in 2019/20 with funding set aside to support the trust directly or supplement the alliance control total.	Reporting back discussions at AFPC to CCG Executive and CCG FPC. Reinvestment scheme to be monitored quarterly.		**3 x 5** **15**	**3 x 5** **15**	**1.** Agree dates for financial risk working group. **Target date:** June 2019 **Completion date:** **2.** Agree conditions associated with ESNEFT reinvestment fund. **Target date:** June 2019 **Completion date:** **3.** Put in place monitoring mechanisms for reinvestment fund. **Target date:** June 2019 **Completion date:**

ESNEFT – A&E. Risk 27 added September 2016

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
JW/IQ	A&E failing to meet 4-hour standard presenting a potential risk to patient safety and experience. <u>Risk to CCG</u> If IHT fail to meet the 4 hour standard then the CCG would have failed to meet its constitutional performance requirements as stipulated by the Department of Health	• Clinical risk of patients not being seen in appropriate timescales or insufficient beds to accommodate appropriate environments. • Risk of patient experience deterioration due to long waits. • Risk of breaching constitutional obligations. • Risk of needing to be prepared with agreed plan for managing surge in demand for services in Winter	**4 x 4** **16**	• Daily reporting of performance. • Internal escalation process has been re-circulated and updated with short term on the day forward demand planning to anticipate peaks • 111 targets to reduce inappropriate referrals to A+E • A+E referral pathway in place to re-direct appropriate patients to GP+ service. • A&E Board in place • Doctor productivity being recorded manually whilst electronic option is resolved • Assess and address staff shortages in medical and nursing rotas 10 days in advance • Weekly ESNEFT A+E exec meetings to aide ownership	Daily performance information supplied and monitored, regular discussions and monthly formal contract meetings. Formal contract notification to IHT for joint working and review of performance in A+E requirement. Remedial Action Plan is drafted and being worked through this is dove tailed with A+E delivery board. **CCG Priorities** *To ensure high quality local services where possible.* *To improve the health of those most in need* **Integrated performance report area.** **Contractual Performance**	**CHALLENGING**	**4 x 4** **16**	**4 x 4** **16**	**1.** Complete actions from A&E Delivery Board Action Plans: a. Improve streaming options in A&E b. Improve NHS111 call triage and streaming to clinicians c. Improve ambulance triage and streaming to alternative responses d. Improved patient flow within the hospital e. Improved discharge from hospital Actions are monitored monthly by the A&EDB f. Revised plan agreed with ESNEFT for Ipswich site g. Winter Surge and pressure plan agreed and to be monitored through delivery board h. Assurance of staffing challenges within the A&E department being managed **Target:** March 2020 for ESNEFT (combined trajectory) **Completed:**

ESNEFT – Cancer Targets. Risk 38 added December 2018

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
JW/PH	ESNEFT and Ipswich Hospital site are failing 62-day cancer targets. <u>Risk to CCG</u> If ESNEFT fail to meet 62 day target then the CCG would have failed to meet its constitutional performance requirements as stipulated by the Department of Health.	• Clinical risk of patients not being seen in appropriate timescales • Risk of deteriorating patient outcomes and experience due to long waits. • Risk of breaching constitutional obligations. • Risk of increasing patient harm both physically and mentally due to being on Cancer pathway for extended period of time.	**4 x 5** **20**	• Weekly specialty reporting and cancer focused ESNEFT PTL in place • Joint weekly cancer Executive meeting to start November 2018 • New action plans inclusive of new 7 Must Do's in cancer pathways being updated to be reviewed at cancer executive meeting. • NHSE/NHSI/ESNEFT/CCG monthly conference calls focused on Cancer performance. • Additional cancer reporting and information being received by CCG. in advance	Weekly performance information supplied and monitored, regular discussions and weekly exec meetings in place from November 2018. Will allow CCG to be inside decision making process and support improving performance. Additional scrutiny with specific additional cancer meetings from review patient waiting list to cancer board attended and additional reporting being received. Action Plans are being updated to ensure 7 must do's for cancer are incorporated.	**CHALLENGING**	**4 x 4** **16**	**4 x 4** **16**	1. Weekly cancer updates received and monthly commissioner, provider, NHSE/I calls in place 2. 7 must do's in place for all new cancer pathway patients from 1st December 2018. 3. Recovery plan trajectory for compliance against target end of May 2019. **Target:** May 2019 **Completed:**

NSFT – CQC inspection. Risk 26a added July 2015 (Renumbered January 2016)

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LN	CQC and CCG inspections of NSFT services in Suffolk demonstrate that the service is inadequate leading to a risk of patient harm and poor experience. Risk to the CCGs Statutory Duty to ensure patient safety within commissioned services: The Trust inability to demonstrate appropriate safety standards throughout it services present significant patient safety risks to the population of Suffolk.	• Inability to meet performance and clinical quality targets in access to service, care in service and discharge arrangements • Inability to maintain safer staffing levels in accordance with NICE and National Quality Board guidance • Lack of confidence in performance data • Lack of patient safety culture throughout organisation impacting clinical risk assessment, care planning. • Lack of clinical leadership structure throughout organisation	4 x 4 16	Quality assurance process initiated jointly with NSFT to review every service line in NSFT. Monthly meetings to review / challenge quality performance. Quality dashboard. Attendance at monthly stakeholder assurance meetings led by NHS Improvement / CQC. Oversight of quality improvement plans (trust / local) and monthly monitoring of progress. Monitor primary care contract issues and Trust response. New Chair appointed and partnership arrangement agreed with East London Foundation Trust (ELFT). Quality Improvement methodology introduced by Trust and training rolled out. Weekly CCG: NSFT Director meeting to check progress against actions and escalate concerns. Escalation through joint NHSI: CCG oversight meeting.	Improvements to patient safety and experience noted through QA process. Demonstrated improvement against identified contractual key performance indicators evidenced through quality dashboard escalation of issues via Contract Quality Performance Review (CQPR) meetings. Confidence that NSFT have capability and capacity to deliver the required quality improvements. Assurance that actions detailed in the quality improvement plan have been implemented. **CCG Priority** *To improve access to mental health services*	CHALLENGING	5 x 4 20	5 x 5 25	**1**. Quality assurance process to review every service line. **Target:** May 2019 **Completed: Update May 2019** - reviews are ongoing, planned until end of June. Feedback to CCG/NSFT DoNs and agreement on action plan oversight. Feedback to CCGs via Clinical Scrutiny. **2.** Recruitment/secondment of NSFT senior leadership posts to drive improvement in NSFT and partnership working arrangements with ELFT. **Target:** April 2019 **Completed: Update May 2019**- locality director posts currently being appointed to. **3.** Implementation of Suffolk emotional wellbeing and mental health strategy to be commissioned through most capable provider process **Target: March 2020** **Completed:** **Update Feb 2019;** Commissioning process agreed by Governing Bodies.

See following sheet for next risk

NSFT – Performance. Risk 26b added January 2016

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
JW / JH	Poor performance of mental health services Risk to CCG If performance does not improve to the contractual agreed standard then service users will continue to receive an inadequate service and the CCG would have failed in its duty to commission quality safe services	Poor performance against a number of performance indicators, most notably time to assessment. Routine Assessment of children (<18s) and Adults (>18) within 28 days. Long waits within the Emotional Wellbeing Hub (EWB) for patients aged 0-25. Youth ADHD services are reporting exceptionally long waits for assessment / treatment and concerns have been raised by patients/GPs and Community Paediatrician. Treatment of Children with Eating Disorders (urgent cases within 1 week and routine cases within 14 days).	**4 x 4** **16**	• Remedial Action Plans under review for Children's and Adults' Routine Assessment performance indicators • Additional funding agreed for ~~EIP and~~ Eating Disorder Services enabling recruitment of additional staff • CCGs have agreed non recurrent funding for EWB HUB to clear waiting list backlog and recurrent funding for additional HUB staff • ADHD service reviews held, CNO team undertaking review of waiting list focusing on processes for clinical safety/assessment of harm: CCG agreed additional investment for Consultant / Psychologist posts • CNO regularly reviewing progress with CQC action plan via Clinical Quality meetings • Lark ward reopened with limited beds	• Reported to the workstreams, Clinical Executive and Governing Body as appropriate Progress routinely monitored at monthly Quality Contracts & Performance (QCPM) meeting. **CCG Priority** *To improve access to mental health services*	**CHALLENGING**	**4 x 4** **16**	**4 x 4** **16**	**6.** Children's and adults routine assessment waits to recover to 28 days **Target:** October 2019 **Update:** Recovery date still unclear; more work with CCG for realistic recovery date. **Complete:** Monthly monitoring **7.** Lark ward reopening **Target:** Full opening Feb 2019 **Update:** As at May 2019 7 of the 10 beds were open **Completed:** **8.** Youth ADHD services. **Target:** Reduce long waits - Service reviews to scope scale of issues and oversee improvements **Update:** Trust has advised that trajectory to clear waiting list backlog is Dec 2019: Not accepted by the CCG or SEND Board, Trust reviewing if earlier recovery possible. **9.** Long waits with the EWB: **Target:** 2019/20 target of 95% of patients being seen, treated and discharged from EWB within 10 days Update: to agree trajectory by June 2019 **10.** Eating Disorder waiting time **Target:** compliance with national waiting times standards by April 2019 Update: All new staff recruited

EEAST – Performance. Risk 32 added February 2018. Risk is owned by Ipswich and East Suffolk CCG. For note on West Suffolk CCG GBAF

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
IQ/EG	EEAST is failing performance targets against ambulance response categories, particular concern are delays in the higher acuity Category 1 and 2 calls.	<u>Leadership</u> Interim COO recently appointed. <u>Workforce</u> EEAST under performing on recruitment against ISR plan impacting on the level of PFSH available to deploy on the road. <u>Handover delays</u> Arrival of ambulance to handover at ED delays and handover at ED to clear, ready for next call delays.	**5 x 3** **15**	Monthly quality and performance meetings held locally. Monthly quality and performance meetings held regionally. Commissioner attendance at EEAST internal Strategic Efficiency and Capacity review meetings. Review of delay serious incidents. Joint commissioner, EEAST and ESNEFT handover meetings held monthly. NHS 111/IUC enhanced clinical validation of C2, C3 and C4 ambulance dispositions.	Distribution of minutes and actions from sector and regional meetings. Weekly review of performance and handovers. Monthly review of NHS 111/IUC clinical validation performance. Clinical review of serious incidents through newly established SI panel. C1 and C2 performance improvements have been seen. . **CCG Priorities** *To ensure high quality local services where possible.* *To improve the health of those most in need.*	**CHALLENGING**	**3 x 3** **9**	**3 x 3** **9** ⇨	**1. Action** – EEAST have a target workforce/capacity gap that is taking longer to fill than expected – overall EEAST Staff in Post (SIP) is around 2850 vs ISR target of 3033 SIP. This means that Patient Facing Staff Hours (PFSH) are running below funded levels and there are key ongoing actions/ mitigations to ensure a safe service is maintained : • Incidents are monitored through lead team and PQRM on a monthly basis; • Overtime/Private Ambulance Capacity targeted to peak demand shifts; • Productivity and rota redesign work to optimise available resources; • Demand management schemes in place locally; • Handover delays at hospital being managed and monitored weekly

GP Capacity. Risk 24 added January 2015

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
MS and MBW	Significant reduction in the capacity of GP services in Ipswich as a whole and some individual East Suffolk practices, affecting access times for patients, demand for other services and retention of clinical staff	• Clinical risk of patients not being seen in appropriate timescales Risk of patient experience deterioration due to increased waits. • Risk of some practices not being able to function • List closures • Increased prescribing costs • Increased use of A&E	**4 x 4** **16**	• CCG Primary care strategy and support team in daily contact with practices • Ipswich and other locality meetings • Bi-monthly Practice Manager meetings and CCG wide PM meetings • LMC/CCG/Fed meetings • Weekly Clinical Executive meetings • Bi-monthly Governing Body meetings • Establishment of an Ipswich Task Group • Increased practice engagement with the Integrated Neighbourhood Teams • Utilisation of Practices Resilience Fund and £3 per head Transformation Fund and £2.50 fund	**Currently:** Primary care co-commissioning strategy **CCG Priority** *To ensure high quality local services where possible* **Integrated performance report area.** **Clinical Quality and Patient Safety**	**CHALLENGING**	**3 x 4** **12**	**3 x 4** **12**	**1**. On-going daily support with queries **Target**: March 2020 **Completed:** **3.** Transformation Fund investments **Target:** March 2020 **Completed**: **4.** Programmes of work for workforce recruitment agreed and in process of being rolled out **Target:** March 2020 **Completed:** **5.** Two schemes agreed to; increase capacity being worked up, 1 LLTTF and 2, services for a small number of patients who present to services on a regular basis **Target:** March 2020 **Completed**

MHRA – Blood Transfusion. Risk 28 added March 2017

ACCOUNTABLE OFFICER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
LN	Inspection by MHRA in January 2018 identified a number of failures to comply with the guide to Good Manufacturing Practices for blood transfusion. This is the second inspection that identified areas for improvement. <u>Risk to the CCGs</u> Statutory Duty to ensure patient safety within commissioned services: Service failure would present significant patient safety risks to the population of Suffolk.	• Two major failures identified (previous inspection identified critical and major failures). • Clinical governance processes have been identified as requiring improvement. • Staffing capacity and capability is inadequate. • There is a risk that the service may be suspended which would mean that an alternative service provider would have to be found for WSFT to provide: Emergency Department, Maternity, Major Surgery and Intensive Care Services amongst others	**4 x 5** **20**	• WSFT have developed an improvement plan and submitted to MHRA to review. • NEESPs have developed a transformation plan to improve the service. • Monthly Trust / NEESPS updates on progress against plan to CQPRM. • Any incident leading to serious patient safety harm is reviewed by CCG.	MHRA / NHSI review and sign off of proposed actions. Target dates for improvements are met leading to regulatory compliance. Monitoring of patient safety incidents. Weekly staffing reports received. **CCG Priorities** *To ensure high quality local services where possible* *To improve the health of those most in need*	**CHALLENGING**	**3 x 5** **15**	**3 x 5** **15**	1. CCG to monitor the implementation of the provider agreed actions. **Target:** March 2019 **Completed: Update January 2019:** Transformation plan being developed by NEESPS and due to be presented to ESNEFT Board in January. **2.** Re- inspection by MHRA to assess improvement made by Trust **Target:** March 2019 **Completed: Update: May 2019** continued monitoring of action plan to assess progress **3** Acting Chief Contracts Officer and Chief Nurse invited onto strategic NEESPs board to support transformation plan. **4** Quality improvement visits being planned to NEESPS services **Target:** July 2019 **Completed:** Visits being scheduled

SEND – CAMHS. Risk 29 added March 2017

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
LN/IK	If we do not improve access to CAMHS, community paediatric services (ICPS) and health checks in primary care and quality of CYP emotional wellbeing and mental health service consistently, then we will fail to deliver a good service to children and young people with SEND. <u>Risk to the CCGs</u> Statutory Duty to ensure patient safety within commissioned services: If improvements to service access is not made within CAMHs, ICPS and primary care, patient safety may be compromised.	• Delays in accessing ASD/ADHD services. • Delays in accessing speech and language therapy. • Delays in accessing emotional wellbeing and mental health support for children and young people. • Inconsistent quality of health input into EHCPs. • Inadequate access to initial health checks for children in care. • Access to health checks for young people with a learning disability require improvement consistently across Suffolk.	**5 x 4** **20**	• SEND Programme Board (& associated sub-groups) continue to provide strategic leadership and governance overseeing implementation of priority work streams • Programme of transformation for CYP services • Monitoring of access into CYP health services through CQPRMs • QA process to review all NSFT • Primary care QA visits involve LD health check review and support to improve performance	• Joint re-visit (Ofsted/CQC) reviews. • Access information reported to Clinical Scrutiny Committee. • CAMHs operational meeting to be taken forward to track improvements against recommendations from QA visit. **CCG Priorities** *To ensure high quality local services where possible.* *To improve health and educational attainment for children and young people*	**CHALLENGING**	**5 x 4** **20**	**5 x 4** **20**	**1.** SLCN "to be" model to be developed, commissioned and implemented. **Target**: March 2019 **Completed**: **Update March 2019**: SLCN model approved by Governing Bodies. Commissioning arrangements being progressed, recruitment underway **2.** Review of ADHD service and full implementation of recommendations. **Target:** April 2019 **Completed: Update February 2019:** Service review completed. Actions being progressed through ADHD service operational meeting and CQPRM. **3.** QA visit to emotional wellbeing hub identified significant improvements required to EWH service and CAMHs. **Target: June 2019** **Completed: Update March 2019:** Recommendations taken to CCG: NSFT senior leaders meeting, multi-agency action plan developed which will be tracked through CAMHs operational meeting. NSFT trajectory to have managed backlog by end May 2019

CHC – DOLS. Risk 35 added July 2018

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LN/IQ	There is a backlog in CHC patients with Deprivation of Liberty safeguards (DOLS) in place that require Court of Protection authorisation. This requires significant staffing resource and expertise in the Court of Protection process. This may have financial impact if the individuals or their families contest the restrictions in place. Risk to the CCG Statutory duties to Safeguard Individuals will not be met.	Risk to quality of care and safety of patients with DOLS in place within healthcare packages in their own homes - commissioned by CCGs.	**4 x 4** **16**	CHC register of patients requiring Court of Protection applications monitored and reviewed at 6 weekly Health DOLS Meetings. CHC priority list of Court of Protection applications required is regularly reviewed. CHC LD Nurse leads on making urgent applications. CHC Lead preparing paper on resource necessary to mitigate risks and reduce backlog of Court of protection applications required by CCGs. External Advanced MCA and Advanced DOLS training commissioned by MCA/DOLS Lead and provided for CHC staff to upskill staff to make Court of Protection applications.	CHC Register shared and discussed with CCGs MCA/DOLS Lead CHC Priority List shared and discussed at 6 weekly DOLS Meetings chaired by CCGs MCA/DOLS Lead. Priority cases discussed with legal representative from Kennedys Court of protection applications reviewed by legal prior to submission to Court **CCG Priorities** *To ensure high quality local services where possible.* *To improve the health of those most in need*	**CHALLENGING**	**4 x 4** **16**	**4 x 4** **16**	1. Paper detailing resource required to be prepared for presentation to Board by end of August 2018 **Target:** March 2019 **Complete: Update 25/2/19 -** business case improved and recruitment commenced. 26/03/2019 – good response to advert, progressing to interview 2. Priority cases applications- 4 per month to be in progress/completed – commenced July 2018. **Target:** March 2019 **Complete:** 4 per month being progressed. **Update May 2019- controls continue to be implemented.**

Cyber Security. Risk 36 added September 2018

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING - GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
AL/JJ	Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc <u>Risk to the CCGs</u> The CCGs would suffer significant service disruption and potential patient harm and financial loss	▪ National requirements have increased, in respect of the need to achieve cyber essentials + accreditation. ▪ No national funding has been identified specifically for cyber security work to mitigate against the increased risk, and the increased requirements. ▪ No access to systems – would require frontline services to fully enact Business Continuity and Disaster Recovery procedures. ▪ Potential for lack of access to relevant IT skills and insight to develop a recovery plan (dependent on type of attack). ▪ Restoration of services complex, would involve multiple vendors and take a significant period of time	**4 x 5** **20**	*<u>Note</u> - eliminating the risk of a cyber-attack completely is not possible.* Following external cyber assessment (conducted as part of post-Wannacry cyber-attack local review); a number of areas to be addressed to reduce both the risk of an attack and any potential impacts (see actions). **Complete:** External audit **In progress:** Service provider (NEL) undergoing wide scale review of cyber assurance, have achieved cyber essentials accreditation March 2019, and working toward cyber essentials + accreditation in 2019. The CCG has its own domain (green) under NEL and will be working towards achieving cyber essentials accreditation for the CCG also. Internal audit complete. TIAA to review our cyber security processes / controls. ETTF (GP IT Capital) funding has been successful to implement a security monitoring product (DarkTrace) to improve network monitoring. Additional ETTF (GP Capital) funds have been successful to implement a NAC solution, details being worked up with NEL.	External Audit. Internal audit Monthly SLA provider meetings. Monthly service review provider meetings. Bi-monthly Joint Digital and IT Services Board. Audit Committee review. Scrutiny Committee review Governing body – planned Q1 2019.	**CHALLENGING**	**4 x 5** **20**	**4 x 5** **20** 	1. Delivery of HSCN connections. **Target date:** June 2019 **Completion:** 2. Implementation of new HSCN contract with increased capability. **Target date:** Apr – Dec 2019 **Completion:** 3. Rollout of threat detection capability (national solution – ATP). **Target date:** May 2019 **Completion:** 4. Regular communications to users re phishing threats. **Target date:** Ongoing **Completion:** 5. Wide scale review of patching processes and application. **Target date:** Ongoing **Completion:** **Proposed further actions as implementation plans progress:** Procure and rollout new network switching system with NAC (stage 1). Implement new licencing. (Office 2019 and potentially an O365 F1 licencing add on). Procure and rollout identity management system. Rollout W10. Implement end user training programme. Rollout DarkTrace security software.

Brexit. Risk 37 added October 2018

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
AL	Brexit and the possibility of a 'no deal' exit from the European Union Risk to the CCGs The outcome of negotiations may result in a lack of definitive planning for CCGs.	• Continuing lack of clarity about the potential outcome of negotiations & resultant lack of definitive planning guidance. • Inability of providers to deliver contractual obligations with possible shortages of drugs, medical equipment & staff • Financial pressures become more acute after a no deal Brexit, (the Chancellor has already stated that a no deal scenario would necessitate another budget) resulting in direct knock-on effects on waiting times, recovery rates & quality of care. • Additional administrative issues if resident EU citizens no longer qualify for NHS care under existing EU reciprocal healthcare arrangements. • Access to public health contracts • Political instability – possibilities of no deal, a negotiated deal being voted down in Parliament &/or a general election with potential change of government & NHS policy	4 x 4 16	• Reports on preparedness requested from provider organisations • Continued focus on strong financial & contract management • Engagement with STP on the coordinated management of issues arising • Engagement with NHSE full Incident Coordination Centre (new operational date now awaited) who will deal with any fall out from a negotiated or a no deal scenario • DHSC EU Exit Operational Readiness Guidance including Action Card for Commissioners	• Regular monitoring of developments by COT • Engagement with NHSE, STP & providers • Reports to the Governing Body • Engagement with Clinical Executive & GP's • Production of CCG EU Exit Action Log to ensure all Action Card for Commissioner requirements are completed	CHALLENGING	4 x 4 16	4 x 4 16	**4.** Preparedness Reports from Providers **Target date:** 01/06/2019 or 31/10/2019 **Completion date:** Underway **4.** Completion of CCG Brexit Action Log. **Target date:** 01/06/2019 or 31/10/2019 **Completion date:**

111 Service. Risk 39 added January 2019 **Removed to Directorate Risk Register**

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JW/IQ	The 111 service is failing the target for calls answered in 60 seconds. Care UK (Urgent Care Ltd.) predicting a deterioration in performance due to levels of staffing. Poor performance at most challenging time of year although Christmas period was much improved over predicted position.	• Clinical risk of patients not being seen in appropriate timescales • Risk of deteriorating patient outcomes and experience due to long waits. • Risk of breaching constitutional obligations. • Risk of increasing patient harm. • Potential impact on increasing demand for other providers •	**4 x 4** **16**	Late notice of major staffing and performance issue end of November. Critical information was not forthcoming to fully understand issues and recovery plan. This is now being received on weekly basis and formal RAP in place.	• Updates from Care UK through regular escalation conference calls. • Contractual communication with Provider to ensure all immediate actions are being taken including agency and use of clinical advisors front ending calls. • Weekly tracker and updated recovery plan being received	**CHALLENGING**	**4 x 3** **12**	**4 x 3** **12** ⇨	1. Contract Performance Notice issued. Contract management meeting on 7 January 2019. 2. Trajectory and performance actions agreed with timeline of consistent performance by April 2019 3. Weekly updates and trajectory received by Care UK to assure recruitment and retention remains as per plan. **Target:** April 2019 **Completed:**

Out of Hours Service Risk 40 added May 2019 ***NEW RISK***

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JW/FW	The Out Of Hours service is failing to see patients within the National NHS Pathways timescales leading to patient safety and quality concerns.	• Clinical risk of patients not being seen in appropriate timescales • Risk of deteriorating patient outcomes and experience due to long waits. • Risk of breaching constitutional obligations. • Risk of increasing patient harm. • Potential impact on increasing demand for other providers • Risk to quality of care and safety of patients that rely on the service, such as Palliative Care Patients • The number of GP staff available for Out Of Hours work is limited within Suffolk and as such there is also reliance on out of area G.P.s.	**4 x 4** **16**	Continued focus on strong contract management. Bi-weekly meetings between Care UK and the Suffolk GP Federation. Bi-Weekly breach reports shared with the CCG. Suffolk GP Federation are currently reviewing and validating the Out Of Hours Service performance with a view to improve.	• Updates from Care UK through regular escalation conference calls. • Contractual communication with Provider to ensure all immediate actions are being taken including agency.	**CHALLENGING**		**4 x 4** **16**	1. CCG to monitor the implementation of the provider actions. **Target:** May 2019 **Completed:** 2. CCG's Quality team is monitoring breach reports. **Target:** May 2019 **Completed:** 3. CCG has requested a review of performance on days that have shown significant concerns **Target:** May 2019 **Completed:** 4. CCG has requested confirmation that the current pathways are those commissioned **Target:** May 2019 **Completed:** **5.** CCG is monitoring complaints and incidents on a bi-weekly basis **Target:** May 2019 **Completed**

Departmental Risk Register summary of top risks

Date: April 2019

For: COT and requested committees

Department	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. Corporate Services	Failure to recruitment and retain GPs locally.	Develop schemes with Suffolk GP Fed to attract / retain GPs. International recruitment bid successful / Project Team appointed. Established a GP Support Hub. Successful bid to recruit GP Trainees. Suffolk Locum Services established to support current locum GP's / recruit new GP's. GP5YFV workforce plan to oversee project. STP project group monitor progress on all work streams.	**12**	GP retention plan agreed and being implemented. GP Hub to be launched in January 2019. This will support retention of GPs. Focus on recruiting GP Trainees. GP5YFV Workforce Group established to oversee project and monitor progress. Currently the growth of wider workforce numbers is above trajectory and highlighting new patient services being offered in GP Practices.	31 March 2020	Amanda Lyes
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. COO Ipswich & East and West	Sustainability of robust primary care. Individual practices that are at risk of service failure	Continue to support practices across the CCG area that are encountering difficulties. Continue to work proactively with practices. Encourage and support practices to put in place a decision making structure and project plan.	**12**	IESCCG: Heat map developed and updated on monthly basis. WSCCG: Haverhill continues to have capacity issues, and both practices in the area were now reliant upon locum cover. Clements have moved to a model of care that cap demand.	30 May 2019	David Brown / Lois Wreathall
2. COO Ipswich & East	Potential for harm and service disruption if patient risks are not adequately managed by the SAS service.	Existing controls e.g. police attendance may be revised and supplemented in light of outcome of review.	**12**	New GP identified. Incident review pending Alternative premises options being assessed Participation in area wide procurement	30 May 2019	David Brown

3. COO Ipswich & East	Social Prescribing: Connect for Health - Information Governance.	Patient data and information governance concerns between GP practice, CCG, Citizens Advice Bureau and Suffolk Community Foundation.	**12**	Work progressing well. Working with Emma Cooper, GP DPO, CAB, Jodie Stutely and team. SLA in place, consent form and partnership agreement. Concerns re summary of client records after appointment with Community Advisor. Currently GP practice enter this information but looking at getting System One Unit.	30 May 2019	Louise Hardwick
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. Contracts	The performance of the PTS (patient transport) provider remains significantly below the expectation set out in the contract. Failure to ensure performance is in line with KPI thresholds may result in continued poor patient experience, delayed discharges and missed OP appointments.	Actions identified in detail in the SDIP. Main actions taken to mitigate risk: Use of third party and taxis to back fill vacancy. Provider joining escalation calls twice weekly. Increased reporting from provider to CCG to evidence demand / capacity. Communication with Ops teams at acute trusts to prioritise transport. On-going recruitment to fill vacancy. Bi weekly scrutiny of SDIP delivery.	**12**	Second red to green week / compliance visit scheduled 07/05/19 to scrutinise delivery of SDIP actions and see evidence that actions have been embedded as BAU, and that lessons from complaints / incidents have resulted in action. Report to be written and an assessment made on the evidence of the above and decision on whether a contract notice is required, or a deadline for compliance with contract KPIs.	May 2019	Jane Webster
2. Contracts	Due to internal effects of workforce nationally, Care UK have a reduced number of staff to deliver the 60 second response target for 111.	Regular contract meetings. Weekly reporting against recovery plan.	**9**	Performance notice issued. All actions to support recovery are being closely monitored. Performance for first 2 weeks of April greatly improved but need to ensure sustainability.	May 2019	Jane Webster

	Risk Description / consequences	Current controls / assurance		Actions with status	Completion date	Responsible person
1. Finance	CCG liable if employees / persons acting on its behalf facilitate tax evasion. CCG may be prosecuted and be liable to pay HMRC additional monies.	A review of the Criminal Finances Act 2017 has been completed and will be discussed at the 4th December 2018 Audit Committee meeting.	**15**	A SOP has been put in place around IR35, ensuring that all instances of employment are assessed using HMRC guidance and that assessment is stored. The new Recruitment policy went to Audit Committee in February, now going through other approval processes. The counter-fraud policy has now been updated and approved by Audit Committee, on intranet.	End May 2019	Mark Game
2. Finance	Failure to achieve in year financial balance, secure financial sustainability and deliver optimum service from the financial resources available.	Guaranteed Income Contracts in place with key providers. Clinical Executive and Governing Body review expenditure and significant investments. Project management approach to delivery of QIPP through the PMO.	**10**	Monthly SLA provider meetings. Monthly Financial Performance Committee reporting. Continued push for further QIPP opportunities.	March 2020	Jane Payling
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. Nursing	NEESPS Staff resources within the service are reported to be stretched, compounded by high levels of turnover and difficulties recruiting, which are impacting the ability to deliver a safe service.	1 Monthly quality contract meetings with the provider. 2 More detailed staffing information requested. 3 Work with NHSI to establish key deliverables for the service. 4 Development of key contractual metrics	**10**	Concerns formally escalated at quality contract meeting including staffing levels. March 2019 Update; Workforce updates not received from the provider. MHRA inspection Feb 2019 highlighted that "there was no assurance that sufficient qualified & competent personnel were available to assure a safe service". No significant incidents have been reported associated with staffing issues.	May 2019	Chris Hooper

2. Nursing	STP does not have a clear and measurable delivery plan to achieve the National targets for Continuity of Care within the National Maternity transformation programme.	Dedicated PMO to work with Heads of Midwifery to develop initial plan. PMO linking with Regional PMO to provide assurance on recovery plan. Clinical leadership secured for Sept 2018 to develop vision and delivery plan for Maternity Transformation programme.	**15**	Regular discussion with Regional PMO re recovery and milestones able to achieve. Agreement from regional PMO to deliver high level plan in Sept 2018 with detailed submission in Jan 2019. However, STP will remain under high scrutiny from Region until detailed plan provided.	May 2019	Helen Bowles
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. Transformation	Emotional Wellbeing Hub. Performance of the Suffolk (0-25) emotional well-being hub had recently declined	Recent review of the Hub by the quality team has revealed clinical concerns as well as issues with waiting list. Escalated within NSFT and recovery plan developed	**12**	Hub trajectory and capacity plans submitted to Clinical Exec for approval	Sept 2019	Jo John
2. Transformation	Unable to commission long-term, sustainable under 18s ADHD service for Suffolk - Linked to SEND Action Plan requirements and also priority within the CAMHS Transformation Plan.	Recovery plan progress reviewed at fortnightly steering group.	**16**	Trajectory plan and business case outstanding - for discussion	Sept 2019	Jo John