



**GOVERNING BODY**

<b>Agenda Item No.</b>	<b>13</b>
<b>Reference No.</b>	<b>IESCCG 19-07</b>
<b>Date.</b>	<b>22 January 2019</b>

<b>Title</b>	<b>Governing Body Assurance Framework and Chief Officers Risk Registers</b>	
<b>Lead Chief Officer</b>	Amanda Lyes, Chief Corporate Services Officer	
<b>Author(s)</b>	Tony Buckle, Risk Manager	
<b>Purpose</b>	To provide the committee with the updated CCG Governing Body Assurance Framework (GBAF) document for January 2019.	
<b>Applicable CCG Clinical Priorities:</b>		
<b>1.</b>	To promote self care	
<b>2.</b>	To ensure high quality local services where possible	✓
<b>3.</b>	To improve the health of those most in need	✓
<b>4.</b>	To improve health & educational attainment for children & young people	✓
<b>5.</b>	To improve access to mental health services	✓
<b>6.</b>	To improve outcomes for patients with diabetes to above national averages	✓
<b>7.</b>	To improve care for frail elderly individuals	✓
<b>8.</b>	To allow patients to die with dignity & compassion & to choose their place of death	
<b>9.</b>	To ensure that the CCG operates within agreed budgets	
<b>Action required by the Governing Body:</b>		
The Governing Body is requested to review and approve the updated Ipswich & East Suffolk CCG GBAF for January 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 In November 2018 an internal audit of the GBAFs and risk registers was carried out by TIAA. The overall assessment was 'substantial assurance'.  
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
<p><b>26a</b></p> <p>Lisa Nobes</p>	<p><i>Potential impact of service quality delivered by NSFT.</i></p> <p><b>Action 3</b> - Monthly programme of announced/unannounced QIVs. <b>Update 4 Jan 2019</b>; QIV and service line review scheduled to commence in January. Feedback will be via IPR</p> <p><b>Action 5</b> - Continue partnerships with patients &amp; their carers to understand issues, ideas &amp; progress. <b>Update Jan 4 2019</b>: Public sessions for mental health strategy being held January 2019.</p> <p><b>Action 7</b> - Ensure on-going communications with the public. Update 4 Jan 2019; Public sessions for mental health strategy being held January 2019.</p> <p><b>Action 9</b> – CCG request for involvement in the harm review process that NSFT is implementing. <b>Update</b>; Harm review process being presented at NSFT OAG in January.</p>
<p><b>26b</b></p> <p>Jane Webster</p>	<p><i>Poor performance of mental health services.</i></p> <p><b>Additional Granular Operational Risk.</b></p> <p>Youth ADHD services are reporting exceptionally long waits for assessment / treatment and concerns have been raised by patients/GPs and Community Paediatrician.</p> <p><b>Additional Key Controls Established.</b></p> <p>CCGs have agreed non recurrent funding for EWB HUB to clear waiting list backlog and recurrent funding for additional HUB staff.</p> <p>ADHD service reviews held, CNO team undertaking review of waiting list focusing on processes for clinical safety/assessment of harm.</p> <p><b>Action 6</b> - Children's and adults routine assessment waits to recover to 28 days; Update, Recovery plan agreed &amp; to be monitored monthly through SLA. Update: Performance steadily improving although behind trajectory, April 2019 recovery date does not look realistic.</p> <p><b>Action 8 new action</b> – Youth ADHD services; Target: Service reviews established to scope scale of issues. <b>Update</b>: Agreed set of actions in place to monitor patient safety and improve waiting times and communication with patients/parents; also escalated to CCG / Provider Directors.</p>
<p><b>28</b></p> <p>Lisa Nobes</p>	<p><i>Significant issues identified with the blood transfusion service at West Suffolk Hospital.</i></p> <p><b>Action 1</b> – Monitoring of Sis. <b>Update</b>; January 2018 No related SIs raised by the service.</p> <p><b>Action 3g</b> – Re-inspection due October 2018 – outcomes to be fed back. <b>Update</b>; January 2019 no feedback obtained. <b>Update</b> January 2019. Erroneous information received that a re-inspection would take place in October, Based on previous inspection cycle of January and July a re-inspection is expected soon.</p>
<p><b>30</b></p> <p>Lisa Nobes</p>	<p><i>CCG will not be able to meet its statutory duties to safeguard children and adults in Suffolk if they are not able to recruit to the vacant Designated Doctor posts.</i></p> <p><b>Revised RAG reduced to 8.</b></p> <p>Designated Doctor appointed. Start date 4 March 2019.</p>
<p><b>32</b></p> <p>Ed Garratt</p>	<p><i>EEAST is failing performance targets against ambulance response categories, particular concern are delays in the higher acuity Category 1 and 2 calls.</i></p> <p><b>Action updated;</b></p> <p>New governance / leadership framework due to be agreed by EEAST on 12/12/18; new improvement plan PID shared with CCGs and will be monitored in regional meetings</p> <p>Further update to be given after Risk Summit in late January 2019.</p>
<p><b>33</b></p> <p>Lisa Nobes</p>	<p><i>Currently East of England Ambulance are unable to meet the demand for its services, which may impact on the safety of patients.</i></p> <p><b>Action 7</b> - Establish group to review C2 tail breaches; work ongoing.</p> <p><b>Action 9 amended</b> – Additional capacity has been confirmed and is being monitored closely by lead commissioner.</p> <p><b>Action 10 new action</b> – New Improvement Plan will be monitored through regional monthly</p>

	meetings.
37 Amanda Lyes	<p><i>Brexit and the possibility of a 'no deal' exit from the European Union.</i></p> <p><b>Additional Key Control Established.</b> DH SC EU Exit Operational Readiness Guidance including Action Card for Commissioners.</p> <p><b>Additional Assurance of Controls.</b> Production of CCG EU Exit Action Log to ensure all Action Card for Commissioner requirements are completed.</p> <p><b>Action 3 new action</b> – Update report to Clinical Executive; target date W/C 14 January 2019. <b>Action 4 new action</b> – Report CCG Brexit Lead to NHSE; <b>complete.</b> <b>Action 5</b> – Produce CCG Preparedness Action Log; <b>complete.</b></p>
38 Jane Webster	<p><i>ESNEFT and Ipswich Hospital site are failing 62 day cancer targets.</i></p> <p><b>Action 3 date revised</b> – Recovery plan trajectory for compliance against target end of May 2019.</p>
39 Jane Webster	<p><b>New risk added January 2019.</b> <i>The 111 service is failing the target for calls answered in 60 seconds.</i></p> <p><b>Granular Operational Risks.</b> 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.</p> <p><b>Initial RAG Rating 16.</b> <b>Key Controls Established.</b> Late notice of major staffing and performance issue. Critical information not forthcoming to fully understand issues and recovery plan. Lack of, or timely submission of; A performance recovery trajectory Lack of recruitment, retention strategy A weekly submission including 7 key metrics Exception reports on underperformance supplied and discussed with Provider.</p> <p><b>Assurance of Controls.</b> 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.</p> <p><b>Revised RAG Rating 12.</b> <b>Action 1</b> - Contract Performance Notice issued. Contract management meeting on 7 January 2019; target date March 2019.</p>

### 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 also reviewed by 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 November 2018, 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**

**2018 - 2019**

**Version Control:**

MONTH	VERSION No	REVIEWED BY	SUMMARY OF CHANGES
April 2018	61	COT 16 April 2018 Clinical Scrutiny 24 April 2018	Approved
May 2018	62	COT 14 May 2018 Governing Body 22 May 2018 Audit Committee 5 June 2018	Approved
June 2018	63	COT 4 June 2018 Clinical Scrutiny 26 June 2018	Approved
July 2018	64	COT 9 July 2018 Governing Body 24 July 2018 Audit Committee 31 July 2018	Approved
August 2018	65	COT 6 August 2018 Clinical Scrutiny 28 August 2018	Approved
September 2018	66	COT 3 September 2018 Governing Body 25 September 2018	Approved
October 2018	67	COT 1 October 2018 Clinical Scrutiny 23 October 2018	Approved
November 2018	68	COT 5 November 2018 Governing Body 27 November 2018 Audit Committee 4 December 2018	Approved
December 2018	69	COT 3 December 2018	Approved
January 2019	70	COT 7 January 2019 Governing Body 22 January 2019 Audit Committee 5 February 2019	
February 2019	71		
March 2019	72		

# 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:**

- Work Stream Risk Assessments
- External Assessment & Audit + Guidance & Alerts
- Serious Incidents, Complaints, Public Health & Quality Issues
- Public & Stakeholder Engagement
- Business & Service Delivery Plans



**CCG Governing Body Own & Manage Risks & the Chief Officers Team Reviews the Directorate Risk Registers and the GBAF**



**Individual Risks Jointly Managed by Designated Chief Officers & Clinical Leads**



**Governing Body Assurance Framework**



**Review by Local Risk Forum**



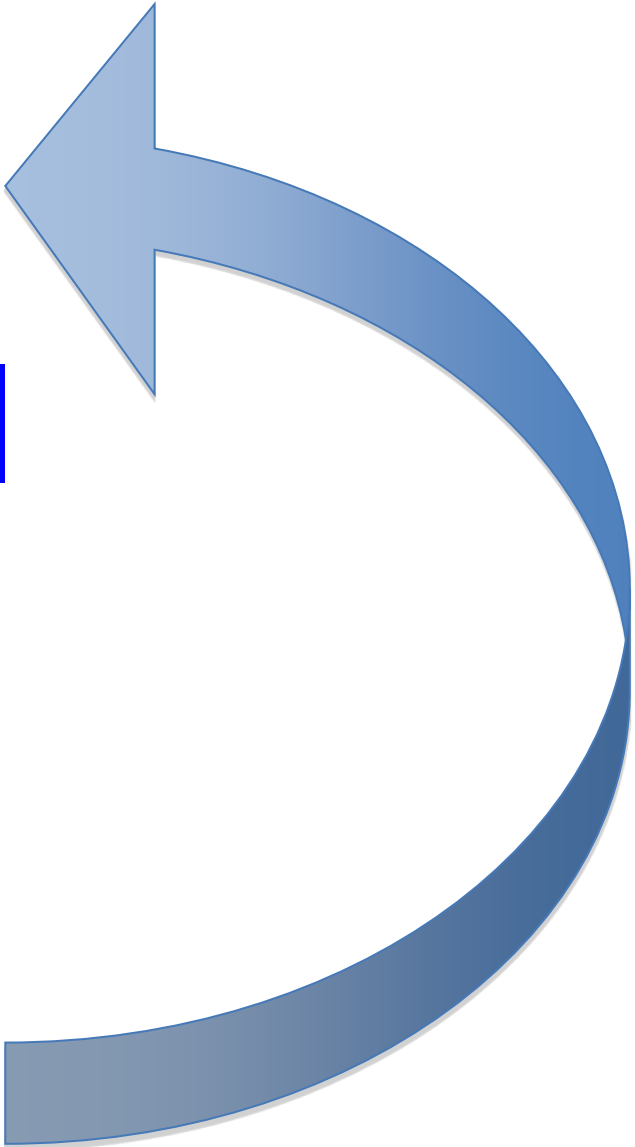
**Review by Clinical Scrutiny Committee**



**Overview & Scrutiny by the Audit Committee**






**Assurance to the Governing Body**



## 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
<b>CRITICAL (15-25)</b>	<ul style="list-style-type: none"> <li>There may be significant gaps in controls to ensure effective management.</li> <li>Controls are in place but insufficient resources</li> <li>Controls are in place but external forces may be preventing progress.</li> </ul>	<ul style="list-style-type: none"> <li>There are insufficient controls in place to address the cause or source of the risk</li> <li>Controls are considered insubstantial or ineffective</li> <li>Controls are being implemented but are not yet in place</li> <li>If this risk were to materialise, the situation could be irrecoverable in terms of the CCGs reputational/financial well-being and or service continuity.</li> </ul>	<p>If controls are inadequate then the revised risk rating increases</p> 
<b>CHALLENGING (8-12)</b>	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.	<p>If controls are uncertain, the revised risk rating stays the same as the original risk rating.</p>  <p>If they are perceived as adequate, then the revised risk rating decreases</p>
<b>MANAGEABLE (1-6)</b>	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
<b>1. Impact on the safety of patients, staff or public (physical/psychological harm)</b>	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
<b>2. Quality/complaints/audit</b>	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
<b>3. Human resources/ organisational development/staffing/ competence</b>	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



<b>4. Statutory duty/ inspections</b>	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation  Reduced performance rating if unresolved	Single breach in statutory duty  Challenging external recommendations/ improvement notice	Enforcement action  Multiple breaches in statutory duty  Improvement notices  Low performance rating  Critical report	Multiple breaches in statutory duty  Prosecution  Complete systems change required  Zero performance rating  Severely critical report
<b>5. Adverse publicity/ reputation</b>	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
<b>6. Business objectives/ projects</b>	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
<b>7. Finance including claims</b>	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
<b>8. Service/business interruption</b>	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
<b>9. Environmental impact</b>	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

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	<ul style="list-style-type: none"> <li>Clinical risk of patients not being seen in appropriate timescales</li> <li>Risk of patient experience deterioration due to increased waits.</li> <li>Risk of some practices not being able to function</li> <li>List closures</li> <li>Increased prescribing costs</li> <li>Increased use of A&amp;E</li> </ul>	4 x 4 16	<ul style="list-style-type: none"> <li>CCG Primary care strategy and support team in daily contact with practices</li> <li>Ipswich and other locality meetings</li> <li>Bi-monthly Practice Manager meetings and CCG wide PM meetings</li> <li>LMC/CCG/Fed meetings</li> <li>Weekly Clinical Executive meetings</li> <li>Bi-monthly Governing Body meetings</li> <li>Establishment of an Ipswich Task Group</li> <li>Secured ETTF funding to evaluate various technologies to improve 'access' and 'efficiency' therefore assisting with capacity management</li> <li>Utilisation of Vulnerable Practices Fund and £3 per head Transformation Fund</li> </ul>	<p><b>Currently:</b> Primary care co-commissioning strategy</p> <p><b>CCG Priority</b> <i>To ensure high quality local services where possible</i></p> <p><b>Integrated performance report area.</b></p> <p><b>Clinical Quality and Patient Safety</b></p>	 <b>CHALLENGING</b>	3 x 4 12	3 x 4 12 	<p>1. On-going daily support with queries <b>Target:</b> March 2019 <b>Completed:</b></p> <p>3. Transformation Fund investments <b>Target:</b> March 2019 <b>Completed:</b></p> <p>4. Programmes of work for workforce recruitment agreed and in process of being rolled out <b>Target:</b> March 2019 <b>Completed:</b></p> <p>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 <b>Target:</b> March 2020 <b>Completed</b></p>



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	<p>Potential impact of service quality delivered by NSFT</p> <p>CQC re-inspection report dated October 2017 gave the Trust an overall rating of "Inadequate" placing the Trust into Special Measures for the second time</p> <p>Following July 2018 inspections of progress against quality improvement plan CQC issued Trust with Section 29a notice.</p> <p><u>Risk to the CCGs Statutory Duty to ensure patient safety within commissioned services:</u> The Trust inability to demonstrate appropriate safety standards throughout its services present significant patient safety risks to the population of Suffolk.</p>	<ul style="list-style-type: none"> <li>Reduction in quality of service and inability to meet performance and clinical quality targets</li> <li>Maintaining safer staffing levels in accordance with NICE &amp; NQB guidance</li> <li>Adverse financial position may impact adversely the quality of care delivered</li> <li>Potential increase in contract issue log referrals</li> <li>Ligatures posing risks to patient safety</li> <li>Seclusion facilities not fit for purpose.</li> <li>Lack of confidence in performance data</li> <li>Failure of Board to demonstrate leadership in patient safety.</li> </ul> <p>July 2018 - CQC found that systems and processes are not operated effectively across the Trust to ensure that the risks to patients are assessed, monitored, mitigated and the quality of healthcare improved in relation to:</p>	4 x 4 16	<ul style="list-style-type: none"> <li>Monthly meetings to review / challenge quality performance</li> <li>Quality dashboard</li> <li>Attendance at monthly stakeholder assurance meetings led by NHS Improvement / CQC</li> <li>Oversight of quality improvement plans (trust / local) and monthly monitoring of progress by quality team and workstream</li> <li>Support for NSFT mock CQC inspections and feedback</li> <li>Announced and Unannounced quality improvement visits</li> <li>Sign off provider CIPs and associated QIAs</li> <li>Monitor primary care contract issues and Trust response</li> <li>Appointment of Improvement Director by NHSI</li> <li>Buddy Trusts identified for the Trust to work with/learn from</li> </ul>	<ul style="list-style-type: none"> <li>Demonstrated improvement against identified contractual key performance indicators evidenced through quality dashboard escalation of issues via SLA meetings</li> <li>Confidence that NSFT have structures in place to deliver the required quality improvements</li> <li>Assurance that actions detailed in the quality improvement plan have been implemented</li> <li>Test that actions detailed in the quality improvement plan have resulted in changes at an operational level</li> <li>To ensure that CIP schemes do not have an adverse impact on quality</li> <li>Timely response to contract issues</li> </ul>	 <b>CHALLENGING</b>	4 x 4 16	4 x 4 16 	<ol style="list-style-type: none"> <li>Regular monitoring of Patient Safety &amp; Quality: Monthly meetings with Provider reviewing comprehensive range of reporting. Undertaking quality visits to services <b>Target:</b> March 2019 <b>Completed:</b> Ongoing - Monthly CQRM continues with key areas for discussion each month. Target date revised to reflect ongoing nature of the action</li> <li>Attendance and challenge at monthly Overview and Assurance Group <b>Target:</b> March 2019 <b>Completed:</b> October 2018 update – DON / DDON continue to attend monthly meetings. Target date revised to reflect ongoing nature of the action</li> <li>Monthly programme of announced/unannounced QIVs <b>Target:</b> March 2019 <b>Completed:</b> Update 4 Jan 2019; QIV and service line review scheduled to commence in January. Feedback will be via IPR.</li> </ol>



		<ul style="list-style-type: none"> <li>- Seclusion environments and seclusion practice</li> <li>- Staffing levels in community services</li> <li>- Access to services in the community and in crisis</li> <li>- Risk Assessment and care planning across the Trust</li> </ul>		<ul style="list-style-type: none"> <li>• Interviews held for new Chief Executive</li> <li>• Deep dive report presented to Clinical Scrutiny</li> </ul>	<p>with effective learning reducing numbers</p> <ul style="list-style-type: none"> <li>• Joint review of plans to act on the areas of concern identified in the Trust mock CQC inspection report.</li> </ul> <p><b>CCG Priority</b> <i>To improve access to mental health services</i></p>				<p>5. Continue partnerships with patients &amp; their carers to understand issues, ideas &amp; progress</p> <p><b>Target:</b> Nov 2018 <b>Completed: Update Jan 4 2019:</b> Public sessions for mental health strategy being held January 2019.</p> <p>7. Ensure on-going communications with the public</p> <p><b>Target:</b> March 2019 <b>Completed:</b> Ongoing - as messages needed working in partnership with NSFT. Public sessions for mental health strategy being held January 2019.</p> <p>8. Outstanding requests / concerns to be escalated formally.</p> <p><b>Target:</b> March 2019 <b>Completed:</b> Update - all quality and patient safety concerns are escalated to the SLA meeting following each CQRM. Target date revised to reflect ongoing nature of the action</p> <p>9. CCG request for involvement in the harm review process that NSFT is implementing</p> <p><b>Target:</b> March 2019 <b>Completed: Update;</b> Harm review process being presented at NSFT OAG in January</p>
--	--	---	--	--	--	--	--	--	---

See following sheet for next risk

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	<p>Poor performance of mental health services</p> <p><u>Risk to CCG</u> 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</p>	<p>Poor performance against a number of performance indicators, most notably time to assessment. Access and Assessment Team (AAT): Routine Assessment of children (&lt;18s) and Adults (&gt;18) within 28 days. Youth ADHD services are reporting exceptionally long waits for assessment / treatment and concerns have been raised by patients/GPs and Community Paediatrician. Treatment of Early Intervention in Psychosis within 14 days, and Treatment of Children with Eating Disorders (urgent cases within 1 week and routine cases within 14 days).</p>	<p><b>4 x 4</b></p> <p><b>16</b></p>	<ul style="list-style-type: none"> <li>Remedial Action Plans agreed for Children's and Adults' Routine Assessment performance indicators</li> <li>Additional funding agreed for EIP and Eating Disorder Services enabling recruitment of additional staff</li> <li>CCGs have agreed non recurrent funding for EWB HUB to clear waiting list backlog and recurrent funding for additional HUB staff</li> <li>ADHD service reviews held, CNO team undertaking review of waiting list focusing on processes for clinical safety/assessment of harm</li> <li>CNO regularly reviewing progress with CQC action plan via Clinical Quality meetings</li> <li>Lark ward reopened with limited beds</li> </ul>	<ul style="list-style-type: none"> <li>Reported to the workstreams, Clinical Executive and Governing Body as appropriate</li> <li>Progress routinely monitored at monthly SLA meetings / clinical quality review meetings</li> </ul> <p><b>CCG Priority</b> <i>To improve access to mental health services</i></p>	<p> <b>CHALLENGING</b></p>	<p><b>4 x 4</b></p> <p><b>16</b></p>	<p><b>4 x 4</b></p> <p><b>16</b></p> <p></p>	<p><b>6.</b> Children's and adults routine assessment waits to recover to 28 days <b>Target:</b> October 2019 <b>Update:</b> Recovery plan agreed &amp; to be monitored monthly through SLA. Update: Performance steadily improving although behind trajectory, April 2019 recovery date does not look realistic <b>Completed:</b> Monthly monitoring</p> <p><b>7.</b> Lark ward reopening <b>Target:</b> Full opening Feb 2019 <b>Update:</b> Partially opened September 2018 <b>Completed:</b> On track</p> <p><b>8.</b> Youth ADHD services. <b>Target:</b> Service reviews established to scope scale of issues <b>Update:</b> Agreed set of actions in place to monitor patient safety and improve waiting times and communication with patients/parents; also escalated to CCG / Provider Directors</p>



See following sheet for next risk

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	<p>A&amp;E failing to meet 4 hour standard presenting a potential risk to patient safety and experience.</p> <p><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</p>	<ul style="list-style-type: none"> <li>Clinical risk of patients not being seen in appropriate timescales or insufficient beds to accommodate appropriate environments.</li> <li>Risk of patient experience deterioration due to long waits.</li> <li>Risk of breaching constitutional obligations.</li> <li>Risk of needing to be prepared with agreed plan for managing surge in demand for services in Winter</li> </ul>	<p>4 x 3 12</p>	<ul style="list-style-type: none"> <li>Daily reporting of performance.</li> <li>Internal escalation process has been re-circulated and updated with short term on the day forward demand planning to anticipate peaks</li> <li>111 targets to reduce inappropriate referrals to A+E</li> <li>A+E referral pathway in place to re-direct appropriate patients to GP+ service.</li> <li>A&amp;E Board in place</li> <li>Doctor productivity being recorded manually whilst electronic option is resolved</li> <li>Assess and address staff shortages in medical and nursing rotas 10 days in advance</li> <li>Weekly ESNEFT A+E exec meetings to aide ownership</li> </ul>	<p>Daily performance information supplied and monitored, regular discussions and monthly formal contract meetings.</p> <p>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.</p> <p><b>CCG Priorities</b> <i>To ensure high quality local services where possible.</i> <i>To improve the health of those most in need</i></p> <p><b>Integrated performance report area.</b> <b>Contractual Performance</b></p>	<p> <b>CHALLENGING</b></p>	<p>4 x 4 16</p>	<p>4 x 4 16</p> <p></p>	<ol style="list-style-type: none"> <li>Complete actions from A&amp;E Delivery Board Action Plans: <ol style="list-style-type: none"> <li>Improve streaming options in A&amp;E</li> <li>Improve NHS111 call triage and streaming to clinicians</li> <li>Improve ambulance triage and streaming to alternative responses</li> <li>Improved patient flow within the hospital</li> <li>Improved discharge from hospital Actions are monitored monthly by the A&amp;EDB</li> <li>Revised plan agreed with ESNEFT for Ipswich site</li> <li>Winter Surge and pressure plan agreed and to be monitored through delivery board</li> <li>Assurance of staffing challenges within the A&amp;E department being managed</li> </ol> </li> </ol> <p><b>Target:</b> March 2019 <b>Completed:</b></p>



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	<p>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</p> <p>Significant issues identified with the blood transfusion service at West Suffolk Hospital (WSH) run by NEESPS during an inspection by the MHRA – January 2017</p> <p><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.</p>	<p>No critical failures identified, two major failures identified (previous inspection identified critical and major failures).</p> <p>Quality governance processes and staffing – adequate numbers, suitably qualified, up to date job descriptions.</p> <ul style="list-style-type: none"> <li>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</li> </ul>	<p><b>4 x 5</b></p> <p><b>20</b></p>	<ul style="list-style-type: none"> <li>Action plan to MHRA who are reviewing</li> <li>Full inspection in six months</li> <li>Trust / TPP improvement plan</li> <li>Monthly Trust / TPP updates on progress against plan to MHRA / NHSI</li> <li>Serious Incident Reporting</li> </ul>	<p>MHRA / NHSI review and sign off of proposed actions</p> <p>Target dates for improvements to made by are met leading to regulatory compliance</p> <p>Review of Serious Incidents to assess if harm has resulted</p> <p>Inspection findings support the assurance provided in the weekly updates of the improvements being made within the service. These have now changed to monthly updates.</p> <p><b>CCG Priorities</b> <i>To ensure high quality local services where possible</i> <i>To improve the health of those most in need</i></p>	<p> <b>CHALLENGING</b></p>	<p><b>3 x 5</b></p> <p><b>15</b></p>	<p><b>3 x 5</b></p> <p><b>15</b></p> <p></p>	1. Monitoring of SI reports
									<p><b>Target:</b> Jan 2019 <b>Completed: Update;</b> January 2019 No related SIs raised by the service.</p>
									<p><b>Target:</b> March 2019 <b>Completed:</b></p>
									<p>3. CCG to monitor the implementation of the provider agreed actions (below). <b>Target:</b> March 2019 <b>Completed: Update 4 Jan 2019;</b> Transformation plan being developed by NEESPS and due to be presented to ESNEFT Board in January.</p> <p><b>g.</b> Re-inspection due October 2018 – outcomes to be fed back <b>Target:</b> October 2018 <b>Completed: Update January 2019.</b> Erroneous information received that a re-inspection would take place in October, Based on previous inspection cycle of January and July a re-inspection is expected soon.</p>



See following sheet for next risk





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 progress SEND priorities, then we will fail to comply with SEND reforms.	<ul style="list-style-type: none"> <li>Requirement to progress the 3 priority work streams to ensure appropriate service is delivered</li> <li>Priority 4 work around transitioning CYP to adult services</li> <li>Priority 3 requirements to deliver a new Speech Language and Communications Needs (SLCN) Model and Neurodevelopmental (NDD) Model.</li> </ul>	<b>5 x 4</b>  <b>20</b>	<ul style="list-style-type: none"> <li>Written statement detailing implementation actions to achieve compliance dated May 2017. Further year of ongoing work to fully implement reforms</li> <li>SEND Programme Board (&amp; associated sub-groups) established to provide strategic leadership and governance overseeing implementation of priority work streams</li> <li>Appointment of SEND programme manager / leads across each organisation to deliver implementation of improvements</li> <li>Appointment of band 7 SEND support worker to operationally deliver SEND reforms</li> <li>Increased time for DCO SEND</li> <li>SEND re-visit to review WSOA</li> </ul>	<p>Written statement signed off by Regulators. Ongoing inspection reviews demonstrating improvements. Milestones to achieve implementation are monitored and rated green. Health milestones are on target to achieve by 2019/2020. Key individuals in each organization leading pathway changes and reforms. Monitoring visit 17 April, positive outcome and feedback from DoE. Self-assessment August 2018.</p> <p><b>CCG Priorities</b>  <i>To ensure high quality local services where possible.</i>  <i>To improve health and educational attainment for children and young people</i></p>	 <b>CHALLENGING</b>	<b>4 x 3</b>  <b>12</b>	<b>4 x 3</b>  <b>12</b> 	<p>1. Scoping of SEND need identified through accurate data collation and analysis from all stakeholder to use NICE guidance Transitioning into Adulthood. Guidance sent to SEND health providers with no response to date.  <b>Target:</b> March 2019  <b>Completed:</b></p> <hr style="border: 2px solid gray;"/> <p>3. Pathways (SLCN, SALT, neuro-developmental and crisis) in place  <b>Target:</b> April 2019  <b>Complete:</b></p> <p><b>November 2018 Update:</b> SLCN 'To Be' Model co-produced and finance and activity aligned, Business Case developed and due for approval at Children Alliance 27/11. NDD 'As Is' Model developed and agreed, 'To Be' in development (co-produced).  <b>4. SEND re-visit:</b> WSOA will be re-visited but actual date not known.  <b>Target:</b> Jan 2019  <b>Complete:</b></p>



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	<p>The CCG will not be able to meet its statutory duties to safeguard children and adults in Suffolk if they are not able to recruit to the vacant Designated Doctor posts.</p> <p><u>Risk to the CCG</u> Statutory safeguarding duties cannot be met.</p>	<p><u>Capacity</u> Designate Doctors post vacant Designate Nurse for looked after children also leading on SEND project</p> <p><u>Governance</u> Leadership for Designated Nurses needs strengthening to ensure direct access to CNO</p> <p><u>Team Relationships</u> Relationship difficulties within the team are distracting from the safeguarding portfolio of work</p> <p>These (shaded areas above) are no longer risks. CNO is Line Managing Safeguarding Teams. Relationships much better</p>	<p>4 x 4</p> <p>16</p>	<p>Increased hours for CiC Designated Nurse.</p> <p>Named professionals are aware to raise any concerns/issues with Designated Nurses that previously would have gone to Designated Doctor. Designated Nurses are able to raise issues with colleagues in other areas where there are Designated Doctors for advice and support.</p> <p>Increased hours for Designate Children's Team</p>	<p>Post advertised and successfully recruited to.</p> <p>Cover arrangements agreed until such time as a permanent appointment is made</p> <p>Changes to line management affected – designate nurses reporting to the Chief Nursing Officer</p> <p>Team relationship are improved greater focus on core work</p> <p><b>CCG Priority</b> <i>To improve the health of those most in need</i></p>	<p>■</p> <p><b>CHALLENGING</b></p>	<p>4 x 4</p> <p>16</p>	<p>2 x 4</p> <p>8</p> <p>↘</p>	<p>5. CCG looking at interim recruitment of medical support – recruitment via BMJ has commenced coupled with letter to Chief Executives and Medical Directors to all acute Trusts <b>Update 4 January 2019;</b> Designated Doctor appointed. Start date 4 March 2109.</p>


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.	<p><u>Leadership</u> EEAST CEO has recently changed which may have short term impact on delivery of agreed ISR and improvements to response times.</p> <p><u>Capacity</u> EEAST under achieving on required number of productive paramedic hours that EEAST can deliver 'on the road'.</p> <p><u>Demand</u> Increase in acuity and volume of calls. Both direct to 999 and through 111 services. This includes rising care home 999 activity.</p> <p><u>Operational Procedures</u> Reduction in productive paramedic hours due to delays in hospital arrival to handover and handover to clear.</p>	5 x 4  20	New interim CEO in place supported by experienced exec team reviewing structures. ISR plan in place, resignation will not significantly impact on agreed milestones. Interim CEO has performance improvement as top priority and seeking to strengthen leadership, governance and engagement. Fortnightly and monthly performance reviews and forecasting updates with Commissioners / Provider. Risk Summit convened in Feb 18 to continue to review performance. Lead Commissioner CEO and EEAST CEO have convened a 'Star Chamber' to hold EEAST Directors to account. Monthly Locality Review focuses on local performance attainment and issues in Suffolk. Adoption of 15 minute maximum handover time and Delivery Board reviews handover performance. 111 enhanced clinical triage for calls triggering an ambulance in place 90% of all C3/C4 calls being clinically validated.	Minutes and actions circulated to attendees of fortnightly / monthly performance review meeting.  EEAST risk summit actions regularly updated with diarised meetings internally and externally to NHSE/NHSI. Next meeting is due January 2019.  Distribution of monthly Locality minutes and agreed actions.  Weekly and monthly distribution of Ambulance turnaround Sitereps  Weekly 111 bench marking reports available from Unify2  <b>CCG Priorities</b> <i>To ensure high quality local services where possible.</i> <i>To improve the health of those most in need</i>	 <b>CHALLENGING</b>	4 x 4  16	4 x 4  16 	<p><b>1. Action</b> - EEAST risk summit identified following actions;</p> <ul style="list-style-type: none"> <li>Adoption of 30 minute maximum handover time.</li> <li>Engagement from EEAST into system escalation calls/ Surge plans/Delivery Boards</li> <li>Introduction of HALO to support ambulance turnaround on targeted poorly performing ED sites.</li> <li>Additional front line capacity is forecast by EEAST over last winter's capacity despite demand falling below 7.4% planned levels of activity.</li> <li>Greater 111/999 integration to manage lower acuity demand together.</li> <li>Strengthen alternative care pathways and work with care homes to reduce 999 reliance.</li> <li>New governance / leadership framework due to be agreed by EEAST on 12/12/18; new improvement plan PID shared with CCGs and will be monitored in regional meetings</li> </ul> <p><b>Target date:</b> Trust not expected to achieve targets until 04/19, with sign off by Regulators and a clear quarterly improvement trajectory</p> <p><b>Ongoing:</b> Update to be given after Risk Summit in late January 2019</p>


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/EG	<p>Currently East of England Ambulance are unable to meet the demand for its services, which may impact on the safety of patients</p> <p><u>Risk to the CCG</u> Statutory Duty to ensure patient safety within commissioned services: The services inability to respond appropriately and in a timely manner would present significant patient safety risks to the population of Suffolk.</p>	High levels of incidents / serious incidents reported end December 2017 through to February 2018. Early analysis, subject to further investigation suggests that high levels of reporting are due to system pressures and resultant delays attending.	<p><b>5 x 4</b></p> <p><b>20</b></p>	<ul style="list-style-type: none"> <li>Contract in place with KPI's focusing on long patient waits (90<sup>th</sup> centile response standards)</li> <li>Monthly Joint CCG Clinical Quality Review meetings</li> <li>Monthly contract &amp; performance meetings</li> <li>Risk Summit Process</li> <li>System wide actions to reduce demand and handover delays – including Care Homes specific</li> </ul> <p>Robust investigation, then review of serious incident investigation reports through enhanced joint localities SI review Panel</p> <p>External oversight of EEAST internal SI processes</p> <p>EEAST weekly reporting of numbers of incidents considered SIs declared</p>	<ul style="list-style-type: none"> <li>Quality reports received monthly</li> <li>Appropriate challenge to reported quality metrics, agreeing actions where improvements required</li> <li>Performance metrics demonstrate that both demand and handover delays are reducing</li> <li>Sample of long C1 waits reviewed in monthly Locality meeting</li> <li>Assurance that incidents have been robustly investigated and that learning shared across system to mitigate against reoccurrence.</li> <li>Assurance that robust effective processes exist</li> <li>Clear Communication of the numbers of SIs being declared</li> </ul> <p><b>CCG Priorities</b> <i>To ensure high quality local services where possible.</i> <i>To improve the health of those most in need</i></p>	<p> <b>CHALLENGING</b></p>	<p><b>4 x 4</b></p> <p><b>16</b></p>	<p><b>4 x 4</b></p> <p><b>16</b></p> <p></p>	<p>4. Joint Localities SI Forum to meet every 2 or 3 months</p> <p><b>Target:</b> March 2019 <b>Completed:</b> Update - Forum met October 2018, will continue to meet at a minimum frequency of quarterly</p> <p>5. Appoint Patient Safety and Quality Lead with sole focus on EEAST <b>Target:</b> October 2018 <b>Completed:</b> Update September 2018 – Appointment made, start date November / December 2018</p> <p>7. Establish group to review C2 tail breaches. <b>Target:</b> November 2018 <b>Completed:</b> Work ongoing</p> <p>8. Patient safety will be assessed following the agreement of the new governance and leadership frameworks by EEAT Board on 12/12/18</p> <p>9. Additional capacity has been confirmed and is being monitored closely by lead commissioner</p> <p>10. New Improvement Plan will be monitored through regional monthly meetings</p>

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/Q	<p>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.</p> <p><b>Risk to the CCG</b> Statutory duties to Safeguard Individuals will not be met.</p>	Risk to quality of care and safety of patients with DOLS in place within healthcare packages in their own homes - commissioned by CCGs.	<p><b>4 x 4</b></p> <p><b>16</b></p>	<p>CHC register of patients requiring Court of Protection applications monitored and reviewed at 6 weekly Health DOLS Meetings</p> <p>CHC priority list of Court of Protection applications required is regularly reviewed</p> <p>CHC LD Nurse leads on making urgent applications</p> <p>CHC Lead preparing paper on resource necessary to mitigate risks and reduce backlog of Court of protection applications required by CCGs.</p> <p>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.</p>	<p>CHC Register shared and discussed with CCGs MCA/DOLS Lead</p> <p>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</p> <p>Court of protection applications reviewed by legal prior to submission to Court</p> <p><b>CCG Priorities</b> <i>To ensure high quality local services where possible.</i> <i>To improve the health of those most in need</i></p>	<p> <b>CHALLENGING</b></p>	<p><b>4 x 4</b></p> <p><b>16</b></p>	<p><b>4 x 4</b></p> <p><b>16</b></p> <p></p>	<p>1. Paper detailing resource required to be prepared for presentation to Board by end of August 2018 <b>Target:</b> Dec 2018 <b>Complete: Update 27<sup>th</sup> November 2018</b> Await outcome of business case</p> <p>2. Priority cases applications- 4 per month to be in progress/completed – commenced July 2018. <b>Target:</b> March 2019 <b>Complete:</b></p>


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	<p>Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc</p> <p><b>Risk to the CCGs</b> The CCGs would suffer significant service disruption and potential patient harm and financial loss</p>	<ul style="list-style-type: none"> <li>National requirements have increased, in respect of the need to achieve cyber essentials + accreditation.</li> <li>No national funding has been identified specifically for cyber security work to mitigate against the increased risk, and the increased requirements.</li> <li>No access to systems – would require frontline services to fully enact Business Continuity and Disaster Recovery procedures.</li> <li>Potential for lack of access to relevant IT skills and insight to develop a recovery plan (dependent on type of attack).</li> <li>Restoration of services complex, would involve multiple vendors and take a significant period of time</li> </ul>	<p><b>4 x 5</b></p> <p><b>20</b></p>	<p><i>Note - eliminating the risk of a cyber-attack completely is not possible.</i></p> <p>Following an external cyber assessment (conducted as part of the post-Wannacry cyber-attack local review), there are a number of areas to be addressed to reduce both the risk of an attack and any potential impacts (see actions).</p> <p><b>Complete:</b> External audit</p> <p><b>In progress:</b> Service provider (NEL) undergoing wide scale review of cyber assurance, and will have achieved cyber essentials accreditation by end October 2018, and cyber essentials + accreditation by end Jan 2019.</p>	<p>External Audit. Internal audit (planned last quarter Jan – Mar 2019).</p> <p>Monthly SLA provider meetings.</p> <p>Monthly service review provider meetings.</p> <p>Bi-monthly Joint Digital and IT Services Board.</p> <p>Audit Committee review.</p> <p>Scrutiny Committee review (planned October).</p>	<p></p> <p><b>CHALLENGING</b></p>	<p><b>4 x 5</b></p> <p><b>20</b></p>	<p><b>4 x 5</b></p> <p><b>20</b></p> <p></p>	<ol style="list-style-type: none"> <li>Delivery of HSCN connections. <b>Target date:</b> March 2019 <b>Completion:</b></li> <li>Implementation of new HSCN contract with increased capability. <b>Target date:</b> Apr – Dec 2019 <b>Completion:</b></li> <li>Rollout of threat detection capability (national solution – ATP). <b>Target date:</b> March 2019 <b>Completion:</b></li> <li>Regular communications to users re phishing threats. <b>Target date:</b> TBD <b>Completion:</b></li> <li>Wide scale review of patching processes and application. <b>Target date:</b> TBD <b>Completion:</b></li> </ol> <p><b>Proposed further actions. As yet local and national funding unidentified – dates to follow if funding becomes available:</b> Procure and rollout new network switching system with NAC (stage 1). Implement new licencing. Procure and rollout identity management system. Rollout W10. Implement end user training programme.</p>

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	<p>Brexit and the possibility of a 'no deal' exit from the European Union</p> <p><u>Risk to the CCGs</u> The outcome of negotiations may result in a lack of definitive planning for CCGs.</p>	<ul style="list-style-type: none"> <li>Continuing lack of clarity about the potential outcome of negotiations &amp; resultant lack of definitive planning guidance.</li> <li>Inability of providers to deliver contractual obligations with possible shortages of drugs, medical equipment &amp; staff</li> <li>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 &amp; quality of care.</li> <li>Additional administrative issues if resident EU citizens no longer qualify for NHS care under existing EU reciprocal healthcare arrangements.</li> <li>Access to public health contracts</li> <li>Political instability – possibilities of no deal, a negotiated deal being voted down in Parliament &amp;/or a general election with potential change of government &amp; NHS policy</li> </ul>	<p><b>4 x 4</b></p> <p><b>16</b></p>	<ul style="list-style-type: none"> <li>Reports on preparedness requested from provider organisations</li> <li>Continued focus on strong financial &amp; contract management</li> <li>Engagement with STP on the coordinated management of issues arising</li> <li>Engagement with NHSE full Incident Coordination Centre from 1st March to 31 May 2019 who will deal with any fall out from a negotiated or a no deal scenario</li> <li>DHSC EU Exit Operational Readiness Guidance including Action Card for Commissioners</li> </ul>	<ul style="list-style-type: none"> <li>Regular monitoring of developments by COT</li> <li>Engagement with NHSE, STP &amp; providers</li> <li>Reports to the Governing Body</li> <li>Engagement with Clinical Executive &amp; GP's</li> <li>Production of CCG EU Exit Action Log to ensure all Action Card for Commissioner requirements are completed</li> </ul>	<p></p> <p><b>CHALLENGING</b></p>	<p><b>4 x 4</b></p> <p><b>16</b></p>	<p><b>4 x 4</b></p> <p><b>16</b></p>	<p>1. Preparedness Reports from Providers <b>Target date:</b> 31/12/2018 <b>Completion date:</b></p> <p>2. Report to Governing Body <b>Target date:</b> 31/01/2019 <b>Completion date:</b></p> <p>3. Update report to Clinical Executive <b>Target date:</b> W/C 14/01/2019 <b>Completion date:</b></p> <p>4. Report CCG Brexit Lead to NHSE <b>Target date:</b> 31/01/2019 <b>Completed:</b> 03/01/2019</p> <p>5. Produce CCG Preparedness Action Log <b>Target date:</b> 31/01/2019 <b>Completed:</b> 03/01/2019</p>

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	<p>ESNEFT and Ipswich Hospital site are failing 62 day cancer targets.</p> <p>Risk to CCG 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. STP cancer transformation monies are also at risk of not being available as not achieving 85% target.</p>	<ul style="list-style-type: none"> <li>Clinical risk of patients not being seen in appropriate timescales</li> <li>Risk of deteriorating patient outcomes and experience due to long waits.</li> <li>Risk of breaching constitutional obligations.</li> <li>Risk of increasing patient harm both physically and mentally due to being on Cancer pathway for extended period of time.</li> </ul>	<p>4 x 5</p> <p>20</p>	<ul style="list-style-type: none"> <li>Weekly specialty reporting and cancer focused ESNEFT PTL in place</li> <li>Joint weekly cancer Executive meeting to start November 2018</li> <li>New action plans inclusive of new 7 Must Do's in cancer pathways being updated to be reviewed at cancer executive meeting.</li> <li>NHSE/NHSI/ESNEFT/CCG monthly conference calls focused on Cancer performance.</li> <li>Additional cancer reporting and information being received by CCG. in advance</li> </ul>	<p>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.</p> <p>Additional scrutiny with specific additional cancer meetings from review patient waiting list to cancer board attended and additional reporting being received.</p> <p>Action Plans are being updated to ensure 7 must do's for cancer are incorporated.</p>	<p>■</p> <p>CHALLENGING</p>	<p>4 x 4</p> <p>16</p>	<p>4 x 4</p> <p>16</p> 	<ol style="list-style-type: none"> <li>Cancer Exec meetings <del>to be</del> in place from November 2018.</li> <li>7 must do's in place for all new cancer pathway patients from 1<sup>st</sup> December 2018.</li> <li>Recovery plan trajectory for compliance against target end of May 2019.</li> </ol> <p>Target: May 2019 Completed:</p>



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	<p>The 111 service is failing the target for calls answered in 60 seconds.</p> <p>Care UK (Urgent Care Ltd.) predicting a deterioration in performance due to levels of staffing.</p> <p>Poor performance at most challenging time of year.</p>	<ul style="list-style-type: none"> <li>Clinical risk of patients not being seen in appropriate timescales</li> <li>Risk of deteriorating patient outcomes and experience due to long waits.</li> <li>Risk of breaching constitutional obligations.</li> <li>Risk of increasing patient harm.</li> <li>Potential impact on increasing demand for other providers</li> </ul>	<p><b>4 x 4</b></p> <p><b>16</b></p>	<p>Late notice of major staffing and performance issue.</p> <p>Critical information not forthcoming to fully understand issues and recovery plan. Lack of, or timely submission of;</p> <ul style="list-style-type: none"> <li>A performance recovery trajectory</li> <li>Lack of recruitment, retention strategy</li> <li>A weekly submission including 7 key metrics</li> </ul> <p>Exception reports on under-performance supplied and discussed with Provider.</p>	<ul style="list-style-type: none"> <li>Updates from Care UK through regular escalation conference calls.</li> <li>Contractual communication with Provider to ensure all immediate actions are being taken including agency, and use of clinical advisors front ending calls.</li> </ul>	<p> <b>CHALLENGING</b></p>		<p><b>4 x 3</b></p> <p><b>12</b></p>	<p>1. Contract Performance Notice issued. Contract management meeting on 7 January 2019.</p>
									<p><b>Target:</b> March 2019 <b>Completed:</b></p>

## Departmental Risk Register summary of top risks

Date: January 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.	<p>Working with Suffolk GP Fed to develop schemes to attract / retain GPs. International recruitment bid successful / Project Team appointed. Successful bid to recruit GP Trainees.</p> <p>Suffolk Locum Services established to support current locum GP's / recruit new GP's.</p> <p>GP5YFV workforce plan to oversee the whole project. PMO structure monitor progress.</p> <p>STP project group monitor progress on all work streams.</p>	12	<p>GP retention plan agreed and in implementation stage.</p> <p>GP Hub to be launched in January 2019. The service will support the retention of GPs. Focus on recruiting GP Trainees.</p> <p>GP5YFV Workforce Group has been established to oversee the project and monitor progress.</p> <p>Develop new clinical models that allow the substitution of GP capacity by other clinical professionals.</p>	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.	<p>Continue to work with Ipswich Primary Care, utilising the funds from the Vulnerable Practices Fund.</p> <p>Continue to work with Ipswich Primary Care, and other practices that are facing resilience issues to explore options and provide support and guidance.</p>	16	<p>IESCCG: Heat map developed and updated monthly. Practices identified for support.</p> <p>Practices supported by CCG staff and where appropriate directed to NHS E resilience funding.</p>	31 March 2019	David Brown / Lois Wreathall

		Continuing to work with Haverhill practices and GP Federation to ensure sustainable primary care in the town.		WSSCCG: Heat map discussed with Chairman weekly. Haverhill continues to have capacity issues; reduction in substantive GPs, and both practices in the area reliant upon locum cover although situation is improving. CCG supporting Lakenheath with capacity issues and Long Melford with GP recruitment issues.		
2. COO Ipswich & East	CCG is entering into an agreement with IBC for abortive costs with a range from £0 to £380k.	Regular meetings with the 2 practices to identify and respond to issues that may cause the project to stall.	16	Outline agreement drafted. Approach agreed by PCCC 27.9.17. Some practices expressing concern re negative equity. Being followed up. Schedule of accommodation to be agreed 26/10/2018	31 March 2019	David Brown
	<b>Risk Description / consequences</b>	<b>Current controls / assurance</b>		<b>Actions with status</b>	<b>Completion date</b>	<b>Responsible person</b>
1. Contracts	Unable to meet Delayed Transfer Of Care (DTCO) trajectory/recovery plan (East). Patients delayed in hospital, beds unavailable to other patients.	Dedicated multi organisation DTCO 'task force' now live - scrutinising every DTCO and working as a system to unblock delays to discharge. Daily monitoring of DTCO activity at patient level. Routine reporting into A&E Delivery Boards.	9	Weekly system wide DTCO MDT meeting at ESNEFT attended by health / social care. Open invitation to domiciliary and care home providers. Daily CHC Conference call held. A Recovery Action Plan is in place	March 2019	Jane Webster
2. Contracts	NHS 111 and GP out of hours unavailable due to provider failure. Immediate consequence for Emergency Departments	Controls to implement - regular service monitoring - CRS status assigned - business continuity plans in place	8	Contract commencing November 1st. Regular contract monitoring meetings in place.	March 2019	Jane Webster

	and subsequent consequence for GP Practices and other services			Service has now been designated a CRS with NHSI, CCG self-insuring against failure, business continuity plan drafted outlining ongoing preparations in case of service failure.		
	<b>Risk Description / consequences</b>	<b>Current controls / assurance</b>		<b>Actions with status</b>	<b>Completion date</b>	<b>Responsible person</b>
<b>1. Finance</b>	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.	<b>15</b>	Appropriate policies to be updated and presented to February 2019 Audit Committee for review and approval. Staff will be briefed on what constitutes an offence, when to ask for help and advice and from whom, and directed to the relevant policies.	February 2019	Mark Game
<b>2. Finance</b>	CCG liable if a person is incorrectly paid outside payroll under IR35. The CCG may be liable to pay HMRC additional monies for the latter.	Human resources and financial accounting staff have been informed of IR35 requirements and are querying before paying invoices.	<b>12</b>	Appropriate policies to be updated and presented to February 2019 Audit Committee for review and approval. SOP will be put in place for IR35, ensuring all instances of employment are assessed using HMRC guidance and that assessment is stored.	February 2019	Mark Game
	<b>Risk Description / consequences</b>	<b>Current controls / assurance</b>		<b>Actions with status</b>	<b>Completion date</b>	<b>Responsible person</b>
<b>1. Nursing</b>	Staff resources within NEESPS service are reported as stretched, compounded by high levels of turnover and difficulties recruiting impacting on ability to deliver a safe service. On-going contract	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	<b>15</b>	Concerns newly raised and have come through 3rd parties. To be formally escalated for action at the next joint quality contract meeting	March 2019	Chris Hooper

	negotiations with Consultants around on-call arrangements, if not resolved will critically compromise the service.					
<b>2. Nursing</b>	Having met Transforming Care trajectories for the past 2 years due to a significant increase in admissions CCG at risk of being over trajectory at year end.	Discharge Planning: Operational planning meetings now weekly (were monthly). Oversight of all discharges by newly formed escalation forum jointly chaired by Senior Managers from the CCG & SCC. Admission Avoidance: Implementation of actions from the independent review focused on 3 themes; community CTR's, ways of working & demographics	<b>12</b>	Action plan to be developed to implement the recommendations of the independent review. Enabling works needed before action plan can be developed	March 2019	Chris Hooper
<b>3. Nursing</b>	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.	<b>15</b>	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.	Jan 2019	Helen Bowles
	<b>Risk Description / consequences</b>	<b>Current controls / assurance</b>		<b>Actions with status</b>	<b>Completion date</b>	<b>Responsible person</b>
<b>1. Transformation</b>	Risk of disconnect between STP and Business as Usual (BAU) agendas. Moving towards STP working, there is a potential for duplication/gaps around local CCG level working.	Communications within the team and across the STP. Regular meetings with STP partners.	<b>9</b>	Discussion of different agendas at SMT and STP specialty meetings. Conversation with NHSE.	Jan 2019	Chief Transformation Officer