Ipswich and East Suffolk
Clinical Commissioning Group

GOVERNING BODY

Agenda Item No.	**14**
Reference No.	**IESCCG 19-46**
Date.	**23 July 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 July 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 July 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 workforce across the system. 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.* **Action 1 complete** – Agree dates for financial risk working group (FRWG). Meeting schedule agreed for 2019/20, first meeting 11/7. **Action 2 amended** – Agree conditions associated with ESNEFT reinvestment fund. To be agreed via FRWG. Target date revised July 2019. **Action 3 amended** – Put in place monitoring mechanisms for reinvestment fund. To be agreed via FRWG. Target date revised July 2019.
ESNEFT 38 Jane Webster	*ESNEFT and Ipswich Hospital site are failing 62-day cancer targets.* **Action 3 amended** – Recovery plan trajectory for compliance against target. Review of action plan suggest compliance July 2019. Target date revised July 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.* **Action 2 update** - Recruitment/secondment of NSFT senior leadership posts to drive improvement in NSFT and partnership working arrangements with ELFT. **Update June 2019**- locality director posts currently appointed to and waiting start dates. **Action 3 update** - Implementation of Suffolk emotional wellbeing and mental health strategy to be commissioned through most capable provider process. **Update June 2019;** Commissioning process agreed by Governing Bodies. Four month rapid improvement programme being led by Alliance partners in LD services, CAMHs, crisis response and community services. High level operational models expected by September 2019.
NSFT 26b Jane Webster	*Poor performance of mental health services.* **This risk has been comprehensively revised.** **Additional Granular Operational Risk.** Care Planning: Poor compliance with range of contractual standards. **Additions and amendments to Key Controls Established.** Additional CCG investment made into service: peer review undertaken with another ED service nationally to identify good practice that could be adopted locally. CCGs have agreed non recurrent funding for EWB HUB to clear waiting list backlog and recurrent funding for additional HUB staff. New contractual standard in 2019/20 of 10 working days total time within Hub agreed. 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. New contractual standard in 2019/20 of 13 weeks from referral to diagnosis. Range of new KPIs set in 2019/20 to give further transparency. **Additional Assurance of Controls.** CAHMS issues also overseen by EWB Hub Board. **Revised RAG Rating increased to 20 (from 16).** **All actions revised.** **Action 1 -** Children's and adult's routine assessment waits to recover to 28 days. Target: October 2019. Update: Recovery date still unclear; working with CCG for realistic recovery date. Issue ongoing. Monthly monitoring. **Action 2 -** Long waits within the EWB Hub. Target: to be determined. Update: meeting held 07.06.2019: Trajectory with regard to the new KPI expected from the Trust by 16.07.2019. Issue ongoing. **Action 3 -** Youth ADHD services. Reduce long waits - Service reviews established to scope scale of issues and oversee improvements. Update: Trust has advised that trajectory to clear waiting list backlog is December 2019: Not accepted by CCG or SEND Board and Trust are reviewing if earlier recovery can be achieved. Trajectory for compliance with new standard to be agreed by end of Q2 as per contractual SDIP. Issues ongoing. **Action 4 -** Eating Disorder waiting time. Compliance with national waiting times standards by April 2019. **Update:** All new staff now recruited. Peer review with Hertfordshire service completed. Meeting to be arranged with Trust to review findings. Issues ongoing.

	Action 5 - Care Planning, compliance with KPIs. Update: Trust sharing detailed plans, identifying specific teams/areas where targeted action required. Issue ongoing.
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 update** - Re - inspection by MHRA to assess improvement made by Trust. Update June 2019, following inspection 2 major issues identified, no critical issues.
SEND 29 Lisa Nobes	*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.* **Action 1 revised** – Review of all NSFT CYP services and full implementation of recommendations. Update June 2019: all reviews complete but CYP mental health services not delivering required improvements. CAMHS rapid improvement programme underway with Alliance partners. **Action 2 revised** – Review of Integrated Community Paediatric Service. Update June 2019: review terms of reference set and steering group established.
CHC DOLS 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.* **Key Controls Established revised.** Every patient has had a desktop review for their health and care needs related to their cognition to understand if they are likely to lack capacity to agree to their care plan. Compared review to the composition of package to understand if it is likely that they will meet the acid test of having their liberty deprived. Spoken to case management teams to understand risk and is starting to assess those patients. CHC register of patients requiring Court of Protection applications monitored and reviewed at regular Health DOLS Meetings. **Additional Assurance of Controls.** Through dedicated case management system, patients frequently discussed and clinical supervision in place. Audit of controls to be completed by internal audit. **Revised RAG Rating reduced to 12 (from 16).** **Action 1 update** – Paper detailing resource required to be prepared for presentation to Board by end of August 2018. **Update June 2019:** CHC DoLs lead has completed desktop reviews and discussed cases with case management teams to understand risk and is starting to assess patients. This has increased the backlog as we now better understand the patient needs and requirements. Due to the better understanding of patients, we now believe that the risk likelihood has decreased. **Action 2 update** – Priority cases applications- 4 per month to be in progress/completed – commenced July 2018. Update June 2019: Internal audit of controls planned for January 2020.
Out of Hours 40 Jane Webster	*The Out Of Hours service is failing to see patients within the National NHS Pathways timescales leading to patient safety and quality concerns.* **Revised RAG Rating reduced to 12 (from 16).** **Actions 1, 2 and 3 complete.** 1. CCG to monitor the implementation of the provider actions. 2. CCG's Quality team is monitoring breach reports. 3. CCG has requested a review of performance on days that have shown significant concerns
Patient Transport Services 41 Jane Webster	*Poor performance of non-emergency patient transport services.* **Action 1 complete** - Formal contract meeting with provider to outline next steps following served CPN. **Action 2 new action** - Recovery plan agreed. Trajectory for compliance. **Target date:** November 2019.
Provider Workforce 42 Amanda Lyes	**New Risk** *Lack of sufficient workforce across the system leading to risks to patient safety, care and services.* **Granular Operational Risks include;** Aging clinical workforce with insufficient younger workforce to replace. Brexit instability affecting overseas workforce. Inability to maintain safer staffing levels in accordance with NICE and National Quality Board guidance. Higher sickness absence of staff due to workload. Risk of patient experience deterioration due to long waits. Risk of breaching constitutional obligations. Primary care risk of some practices not being able to function and list closures. EEAST under performing on recruitment against plan. **Initial RAG Rating 15.** **Key Controls Established.** At system level, a workforce strategy is in place. Interim NHS People Plan released.

	Local Workforce Assurance Boards established. System wide Primary Care Training Hub established. **Assurance of Controls.** IESCCG and WSCCG LWAGs (Local Workforce Assurance Group) reporting to Local Workforce Assurance Board (LWAB). IESCCG and WSCCG Training Hub Advisory Groups (THAG) reporting to the Training Hub Governance Group. **Revised RAG Rating 12.** **Action 1** - LWAB workforce intelligence group to develop system workforce plan with agreed recruitment targets. Target date March 2020. **Action 2** - LWAG, THAG established 2019 to work collaboratively on local recruitment, opportunities to develop new roles, staff training and development. Target date March 2020. **Action 3** - Interim NHS People Plan, which sets national targets to improve recruitment, retention and organisational development across the NHS. Target date March 2020. **Action 4** - Next Generation Project established to provide careers advice and joint recruitments events across Suffolk and NEE. Target date March 2020. **Action 5** - ICS workforce director to be recruited. Target date July 2019. **Action 6** - GP Support Hub for recruitment and retention of GPs. Target date March 2020.

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 July 2019.

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	Approved
June 2019	75	COT 3 June 2019 Clinical Scrutiny 25 June 2019	Approved
July 2019	76	COT 1 July 2019 Governing Body 23 July 2019	
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.

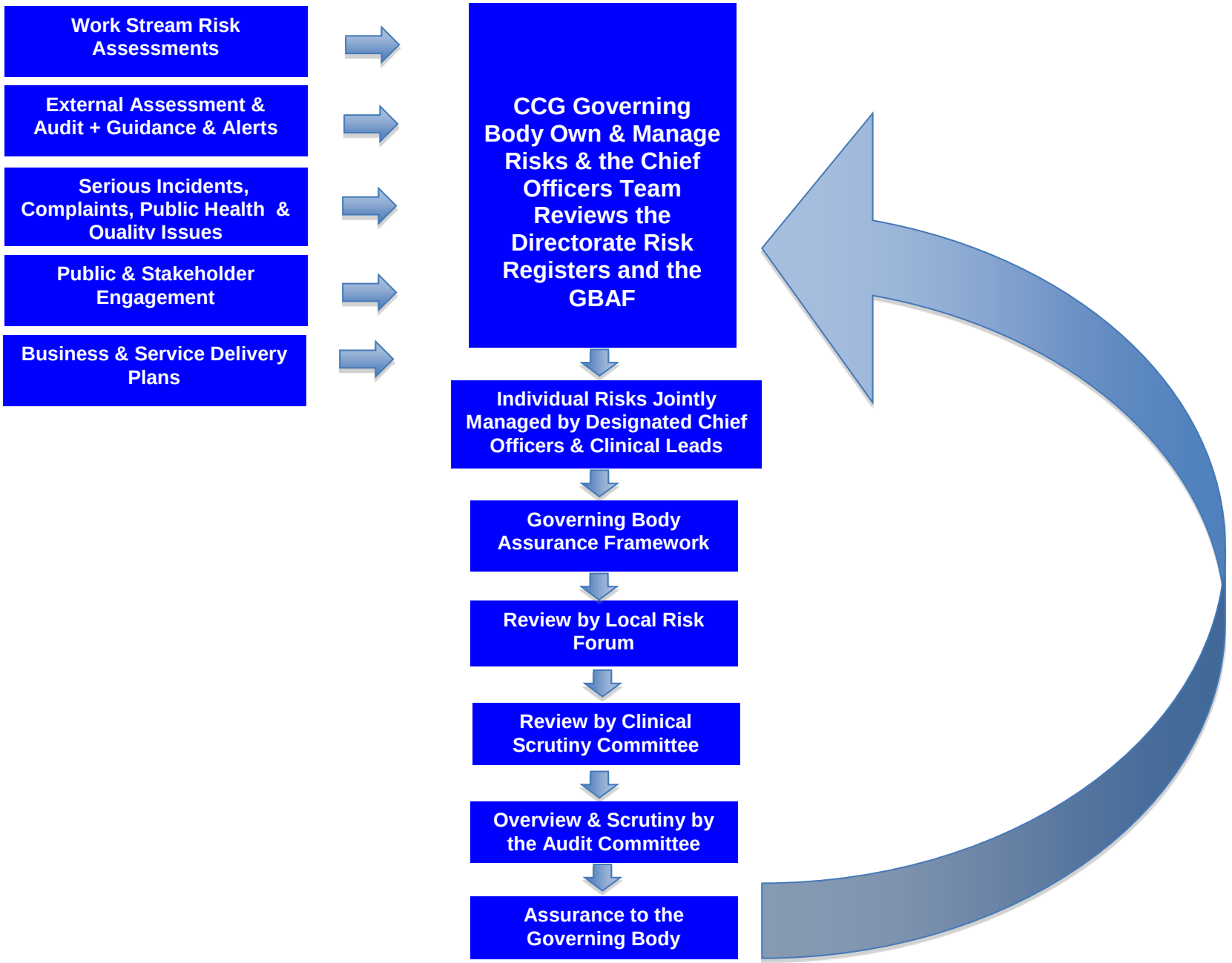
The GBAF identifies which of the organisation's strategic objectives may be at risk because of inadequacies in the operation of controls, or where the CCG has insufficient assurance. At the same time it encompasses the control of risk, provides structured assurances about where risks are being managed 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 Financial Risk Working Group to CCG Executive and CCG FPC. Reinvestment scheme to be monitored quarterly.	**CHALLENGING**	**3 x 5** **15**	**3 x 5** **15**	**1.** Agree dates for financial risk working group. Meeting schedule agreed for 2019/20, first meeting 11/7. **Target date:** June 2019 **Completion date:** June 2019 **2.** Agree conditions associated with ESNEFT reinvestment fund. To be agreed via FRWG **Target date:** July 2019 **Completion date:** **3.** Put in place monitoring mechanisms for reinvestment fund. To be agreed via FRWG **Target date:** July 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. Review of action plan suggest compliance July 2019. **Target:** July 2019 **Completed:**

NSFT – CQC inspection. Risk 26a added July 2015 (Renumbered 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
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 5 25	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 June 2019**- locality director posts currently appointed to and waiting start dates. **3.** Implementation of Suffolk emotional wellbeing and mental health strategy to be commissioned through most capable provider process **Target: March 2020** **Completed:** **Update June 2019;** Commissioning process agreed by Governing Bodies. Four month rapid improvement programme being led by Alliance partners in LD services, CAMHs, crisis response and community services. High level operational models expected by September 2019.

See below 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 <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	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). Care Planning: Poor compliance with range of contractual standards	**4 x 4** **16**	Remedial Action Plans under review for Children's and Adults' Routine Assessment performance indicators. Additional CCG investment made into service: peer review undertaken with another ED service nationally to identify good practice that could be adopted locally. CCGs have agreed non recurrent funding for EWB HUB to clear waiting list backlog and recurrent funding for additional HUB staff. New contractual standard in 2019/20 of 10 working days total time within Hub agreed. 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. New contractual standard in 2019/20 of 13 weeks from referral to diagnosis. CNO regularly reviewing progress with CQC action plan via Clinical Quality meetings. Range of new KPIs set in 2019/20 to give further transparency.	• Reported to the workstreams, Clinical Executive and Governing Body as appropriate. • CAHMS issues also overseen by EWB Hub Board • 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 5** **20**	1 **Children's and adult's routine assessment waits to recover to 28 days.** **Target:** October 2019 **Update:** Recovery date still unclear; working with CCG for realistic recovery date. **Complete**: Issue ongoing. Monthly monitoring. 2 **Long waits within the EWB Hub.** **Target**: to be determined. **Update:** meeting held 07.06.2019: Trajectory with regard to the new KPI expected from the Trust by 16.07.2019. **Complete**: Issue ongoing. 3 **Youth ADHD services**. **Target:** Reduce long waits - Service reviews established to scope scale of issues and oversee improvements. **Update:** Trust has advised that trajectory to clear waiting list backlog is December 2019: Not accepted by CCG or SEND Board and Trust are reviewing if earlier recovery can be achieved. Trajectory for compliance with new standard to be agreed by end of Q2 as per contractual SDIP. **Completed:** issues ongoing. 4 **Eating Disorder waiting time.** **Target:** compliance with national waiting times standards by April 2019 **Update:** All new staff now recruited. Peer review with Hertfordshire service completed. Meeting tba with Trust to review findings. **Complete:** Issues ongoing. 5 **Care Planning, compliance with KPIs.** **Target:** TBA **Update:** Trust sharing detailed plans, identifying specific teams/areas where targeted action required. **Completed:** Issue ongoing.

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 2907 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 has been accelerated • 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: June 2019;** following inspection, 2 major issues identified, no critical issues**.** **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.**Review of all NSFT CYP services and full implementation of recommendations. **Target:** April 2019 **Update June 2019:** all reviews complete but CYP mental health services not delivering required improvements. CAMHS rapid improvement programme underway with Alliance partners. **2.**Review of Integrated Community Paediatric Service **Target: Jan2020** **Update June2019:** review terms of reference set and steering group established.

CHC – DOLS. Risk 35 added July 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
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**	Every patient has had a desktop review for their health and care needs related to their cognition to understand if they are likely to lack capacity to agree to their care plan. Compared review to the composition of package to understand if it is likely that they will meet the acid test of having their liberty deprived. Spoken to case management teams to understand risk and is starting to assess those patients. CHC register of patients requiring Court of Protection applications monitored and reviewed at regular Health DOLS Meetings. 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.	Concerns around 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 as necessary Through dedicated case management system, patients frequently discussed and clinical supervision in place. Court of protection applications reviewed by legal prior to submission to Court Audit of controls to be completed by internal audit. **CCG Priorities** *To ensure high quality local services where possible.* *To improve the health of those most in need*	**CHALLENGING**	**4 x 4** **16**	**3 x 4** **12**	1. Paper detailing resource required to be prepared for presentation to Board by end of August 2018 **Target:** March 2019 **Complete: Update June 2019:** CHC DoLs lead has completed desktop reviews and discussed cases with case management teams to understand risk and is starting to assess patients. This has increased the backlog as we now better understand the patient needs and requirements. Due to the better understanding of patients we now believe that the risk likelihood has decreased. 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 June 2019**: Internal audit of controls planned for January 2020.

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 (done as part of post-Wannacry cyber-attack local review); a number of areas to be addressed to reduce risk of an attack and any potential impacts (see actions). **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. 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. Board level training delivered to IESCCG and WSCCG Board and Lay Members.	External Audit. Internal audit complete 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	**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 <u>Risk to the CCGs</u> 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:**

Out of Hours Service Risk 40 added May 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
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**	**3 x 4** **12**	1. CCG to monitor the implementation of the provider actions. **Target:** May 2019 **Completed:** June 2019 2. CCG's Quality team is monitoring breach reports. **Target:** May 2019 **Completed:** June 2019 3. CCG has requested a review of performance on days that have shown significant concerns **Target:** May 2019 **Completed:** June 2019 4. CCG has requested confirmation that the current pathways are those commissioned **Target:** July 2019 **Completed:** **5.** CCG is monitoring complaints and incidents on a bi-weekly basis **Target:** Ongoing **Completed**

Patient Transport Services Risk 41 added May 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
JW	Poor performance of non-emergency patient transport services. <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.	The performance of the PTS provider remains below the expectation set out in the contract after 1 year. The main reasons identified include: - Insufficient resource - Poor planning resulting in inefficiency - Difficulty recruiting and high attrition rates Failure to deliver a service in line with expectation may result in: - Continued poor patient experience - Delayed discharges from hospital - Missed OP appointments	5 x 4 20	CCG escalation team and Acute Trust operational and patient flow teams increased scrutiny on service. Supportive process of service review and development carried out (Red to Green week) and Service Development and Improvement Plan (SDIP) developed and actions to improve service agreed. New experienced senior local management team at Provider Provider has been asked to provide daily reports on missed appointments due to transport delays to provide view on impact on wider health system	CCG escalation team continue to monitor individual discharge and transfer journeys to reduce to risk of delayed and failed discharges which would result in reduced capacity. Evidence at assurance visit that Provider has implemented some actions on the SDIP, although not to the level to provide significant assurance (see Assurance Visit Paper submitted to CE in June 2019) New experienced management team have only been in post 1-2 weeks. Capacity and demand forward view shared with hospitals and CCG.	 CHALLENGING	4 x 4 16	4 x 4 16	**1.** Formal contract meeting with provider to outline next steps following served CPN. **Target date:** 06/06/2019 **Completion date:** Complete **2.** Recovery plan agreed. Trajectory for compliance **Target date:** November 2019 **Completion date:**

Provider Workforce Risk 42 added July 2019 ***New 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
AL	**Lack of sufficient workforce across the system leading to risks to patient safety, care and services**	The system has ageing clinical workforce with insufficient younger workforce to replace, leading to clinical risk of patients not being seen in appropriate timescales and inability to meet clinical and performance quality targets. Brexit instability affecting overseas workforce. Inability to maintain safer staffing levels in accordance with NICE and National Quality Board guidance. Higher sickness absence of staff due to workload further impact on patient safety, care and services impact on staff retention, losing staff due to increased workload. Risk of patient experience deterioration due to long waits. Risk of breaching constitutional obligations. Primary care risk of some practices not being able to function and list closures. EEAST under performing on recruitment against ISR plan impacting on the level of PFSH available to deploy on the road.	**3 x 5** **15**	At system level, a workforce strategy is in place. • Collaborative working across providers to deliver; • Joint recruitment initiatives, • Career development, portfolio careers, • Joint training (clinical and non-clinical) Interim NHS People Plan released. Local Workforce Assurance Boards established. System wide Primary Care Training Hub established.	IESCCG and WSCCG LWAGs (Local Workforce Assurance Group) reporting to Local Workforce Assurance Board (LWAB). IESCCG and WSCCG Training Hub Advisory Groups (THAG) reporting to the Training Hub Governance Group.	**CHALLENGING**		**3 x 4** **12**	1. LWAB workforce intelligence group to develop system workforce plan with agreed recruitment targets. **Target date:** March 2020 **Completion date:** 2. LWAG, THAG established 2019 to work collaboratively on local recruitment, opportunities to develop new roles, staff training and development. **Target date:** March 2020 **Completion date:** 3. Interim NHS People Plan, which sets national targets to improve recruitment, retention and organisational development across the NHS. **Target date:** March 2020 **Completion date:** 4. Next Generation Project established to provide careers advice and joint recruitments events across Suffolk and NEE. **Target date:** March 2020 **Completion date:** 5. ICS workforce director to be recruited. **Target date:** July 2019 **Completion date:** 6. GP Support Hub for recruitment and retention of GPs. **Target date:** March 2020 **Completion date:**

Departmental Risk Register summary of top risks

Date: June 2019

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.	Range of GP initiatives being delivered across the ICS. GP Support Hub operational for four months. GP Fellowship programme. GP Trainee Skills Programme. Pastoral support for GP Trainees. Coaching offer for GP at all stages. GP Flex programme. Improve data quality on GP.	**12**	Achieved 2018/19 plans agreed for 2019/20. Additional funding secured for GP Support Hub. Part of portfolio career offer for GPs. Support for GP Trainees to transition into employment. Support for all GPs through mentoring and coaching. Flexible contract. Better understanding of workforce and gaps.	31 March 2020	Amanda Lyes
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. COO Ipswich & East and West	Church Farm surgery. Lead GP retiring September 2019, remaining Partner part-time. Therefore significant reduction in clinical staff.	Resilience funding secured from NHSE to provide support.	**15**	Meeting with Practice to discuss options. NHSE has agreed to use resilience money to invite Royal College of General Practitioners to carry out a diagnostic.	31 March 2020	David Brown
2. 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.	31 March 2020	Louise Hardwick

	Risk Description / consequences	Current controls / assurance		Actions with status	Completion date	Responsible person
1. Contracts	18 week RTT performance. Unable to maintain >92% performance target, performance is deteriorating month on month. Target by March 2020 to have same volume of waiting list as at March 2018 also at risk currently ESNEFT Ipswich Site waiting list has grown by 1000 patients a month for the last 3 months.	Elective Care Performance Group not had a chance to impact risk as yet but should do and has been set up to review performance monthly with ADO's, this reports into Elective Care Programme Board. Meeting includes; review of dashboard 12 key metrics, review against trajectory, review of capacity and demand understanding/planning, good 'housekeeping' e.g. closing off cases properly to remove from list.	**12**	Capacity and demand specialty understanding required and needs completed 'big six' due in June. Elective Care Performance Group (ECPG) meetings now set up for year. Performance and waiting list position monitored monthly. Further actions will fall out of ECPG including requirement of new trajectory to be signed off by Elective Care Programme Board	31 July 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 being closely monitored. Care UK have not met the trajectory. Contracts to review performance with a view to the next steps.	30 June 2019	Jane Webster
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. Finance	Staff uncertainty due to organisational change is becoming apparent. Discussion of the required reduction in Administrative Costs does not allay fears of redundancy	Staff are being reassured as far as possible, with restructuring planned to be as smooth as possible.	**12**	Continue to reassure staff and that they are informed as soon as reasonably appropriate of any changes. Run team meeting on planned changes to ensure understanding in place.	End Dec 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	CDI : NHSI HCAI reduction targets per year IESCCG & WSCCG must achieve the nationally set trajectory for year 2019-2020	1. New reporting process implemented March 2019 2. IPC lead attendance at and monitoring through QCPM. 3. IPC lead attends IPR and hospital HICC meetings. 4. Learning shared with Suffolk and NNE HCAI group. 5. Work is required to support RCA completion in Primary Care (information sharing).	**15**	1. Complete 2. Complete BAU 3. Complete BAU 4. Complete BAU 5. Ongoing conversations with linking with CCG primary care team. Note; from April 2019 reporting of CDI cases changes therefore comparison of past data will not be possible.	March 2020	Julia Shields
2. Nursing	E-ZEC unable to provide timely transport. Patients are missing appointments and are not able to get home resulting in high levels of complaints.	1. Working with E-Zec to resolve capacity issues. 2. Analysing patient feedback to look for themes. 3. Monthly monitoring of performance.	**9**	1. A red to green initiative in Feb 2019 identified number of issues. These have been developed into a SDIP which is reviewed fortnightly and also at the Contract meeting each month. Another red-2-green is planned.	June 2019	Rowena Harland
	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	Review of the Hub by the quality team 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 - 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