Ipswich and East Suffolk
Clinical Commissioning Group

GOVERNING BODY

Agenda Item No.	**15**
Reference No.	**IESCCG 19-21**
Date.	**26 March 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 March 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 March 2019.

1. Background

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 financial position of ESNEFT. Some of the risks on the GBAF have been put into groups where there is more than one risk concerning the same provider. The table below is grouped in the same way. The purpose of this is to see how many risks there are for the same provider. 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 – Risks 27, 38 and 40.
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.* **Granular Operational Risks.** 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. **Initial RAG Rating 20.** **Key Controls Established.** Alliance Financial Performance Committee (AFPC) 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. **Assurance of Controls.** Reporting back discussions at AFPC to CCG Executive and CCG FPC. Reinvestment scheme to be monitored quarterly. **Revised RAG Rating 15.** **Action 1** – Agree dates for Alliance FPC. Target date 31 March 2019. **Action 2** – Agree conditions associated with ESNEFT reinvestment fund. Target date 15 April 2019. **Action 3** – Put in place monitoring mechanisms for reinvestment fund. Target date 30 April 2019.
27 Jane Webster	*A&E failing to meet 4 hour standard presenting a potential risk to patient safety and experience.* **Initial risk rating increased to 16 (previously 12).**
	NSFT – Risks 26a and 26b.
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.* **This risk has been comprehensively reviewed with revisions to the Granular Operational Risks, Key Controls Established, Assurance of Controls and Actions.** **Revised risk rating increased to 20 (from 16).** **Action 1** - Quality assurance process to review every service line. **Target:** May 2019. **Update Feb 2019** - service reviews completed in ADHD service; adult inpatient areas; emotional wellbeing hub. Feedback to CCG/NSFT DoNs and agreement on action plan oversight. Feedback to CCGs via Clinical Scrutiny. **Action 2** - Recruitment/secondment of NSFT senior leadership posts to drive improvement in NSFT and partnership working arrangements with ELFT. **Target:** April 2019. **Update Feb 2019** Chair appointed from East London Foundation Trust, Director of Improvement appointed, inpatient clinical lead appointed. **Action 3** - Implementation of Suffolk emotional wellbeing and mental health strategy to be commissioned through most capable provider process. **Target: March 2020. Update Feb 2019;** Commissioning process agreed by Governing Bodies.
26b	*Poor performance of mental health services.*

Jane Webster	**Action 7** – Lark Ward reopening. Full opening Feb 2019. **Update:** Partially opened September 2018. Reported at the QCPM that full opening will be delayed for further 2-3 months. **Action 8** – Youth ADHD services. **Target:** Service reviews established to scope scale of issues and oversee improvements. **Update:** 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. Additional staff are now in place and cohort of patients separately identified on Lorenzo, enabling clear consistent oversight of waiting list size and waiting times.
	MHRA – Risk 28.
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.* **This risk has been comprehensively reviewed with revisions to the Granular Operational Risks, Key Controls Established, Assurance of Controls and Actions.** **Action 1** – CCG to monitor the implementation of the provider agreed actions. **Target:** March 2019. **Update January 2019:** Transformation plan being developed by NEESPS and due to be presented to ESNEFT Board in January. **Action 2** – Re-inspection by MHRA to assess improvement made by Trust. **Target:** March 2019. **Update February 2019.** Inspection carried out 20/21st February. No update yet.
	SEND – Risk 29
29 Lisa Nobes	**Description of strategic risk revised (below).** *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.* **This risk has been comprehensively reviewed with revisions to the Granular Operational Risks, Key Controls Established, Assurance of Controls and Actions.** **Revised risk rating increased to 20 (from 12).** **Action 1** – SLCN "to be" model to be developed, commissioned and implemented. **Target**: March 2019. **Update February 2019**: SLCN model approved by Governing Bodies. Commissioning arrangements being progressed. **Action 2** – Review of ADHD service and full implementation of recommendations. **Target:** April 2019. **Update February 2019:** Service review completed. Actions being progressed through ADHD service operational meeting and CQPRM. **Action 3** – QA visit to emotional wellbeing hub identified significant improvements required to EWH service and CAMHs. **Target: June 2019. Update February 2019:** Recommendations taken to CCG: NSFT senior leaders meeting, multi-agency action plan developed which will be tracked through CAMHs operational meeting.
	Safeguarding – Risk 30.
30 Lisa Nobes	**RISK REMOVED** If the CCG cannot recruit to the Designate Doctor post for SEND/CiC then there could be an impact felt on medical leadership for these programmes of work **Revisions to Granular Operational Risk and Assurance of Controls. One Key Control Established removed.** **Revised risk rating reduced to 6 (from 8).** **Action 5 update** – 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. **Update 24/01/19** Designated Doctor for safeguarding children recruited and commenced on 7th January, 2 Pas a week increasing to 4 Pas on 1st March. Designated Doctor for Child Deaths and Looked After Children remain vacant but recruitment efforts are progressing well.
	DOLS – Risk 35.
35 Lisa Nobes	*There is a backlog in CHC patients with Deprivation of Liberty safeguards (DOLS) in place that require Court of Protection authorisation. This requires significant staffing resource and expertise in the Court of Protection process. This may have financial impact if the individuals or their families contest the restrictions in place.* **Action 1** – Paper detailing resource required to be prepared for presentation to Board by end of August 2018. **Update 25/02/19 –** business case improved and recruitment commenced.
	Cyber Security – Risk 36.
36 Amanda Lyes	*Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e dispensing services etc.* **Additional Key Controls Established.** Service provider (NEL) undergoing wide scale review of cyber assurance, and will have achieved cyber essentials accreditation by end March 2019, and working toward cyber essentials + accreditation in 2019. The CCG has its own domain (green) under NEL and will be working towards achieving cyber essentials accreditation for the CCG also. Internal audit underway by TIAA to review our cyber security processes / controls. Completion mid-March 2019. ETTF (GP IT Capital) funding has been successful to implement a security monitoring product (to be determined) to improve network monitoring.

	Additional ETTF (GP Capital) funds have been successful to implement a NAC solution, details being worked up with NEL.
	111 Service – Risk 39.
39 Jane Webster	*The 111 service is failing the target for calls answered in 60 seconds.* **Action 2 new action** - Trajectory and performance actions agreed with timeline of consistent performance by April 2019. **Target date: April 2019.** **Action 3 new action** - Weekly updates and trajectory received by Care UK to assure recruitment and retention remains as per plan. **Target date: April 2019.**

3. Chief Officers Risk Registers

3.1 A brief highlight report on current risks which may cause concern to the CCGs from local Risk Registers is included in a summary table document with this report. These are reviewed on a regular basis by COT and 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 February 2019, there have been some updates since then and they are included.

NHS
Ipswich and East Suffolk
Clinical Commissioning Group

Governing Body Assurance Framework and Action Plan

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	Approved
February 2019	71	COT 4 February 2019 Clinical Scrutiny 26 February 2019	Approved
March 2019	72	COT 4 March 2019 Governing Body 26 March 2019	

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.

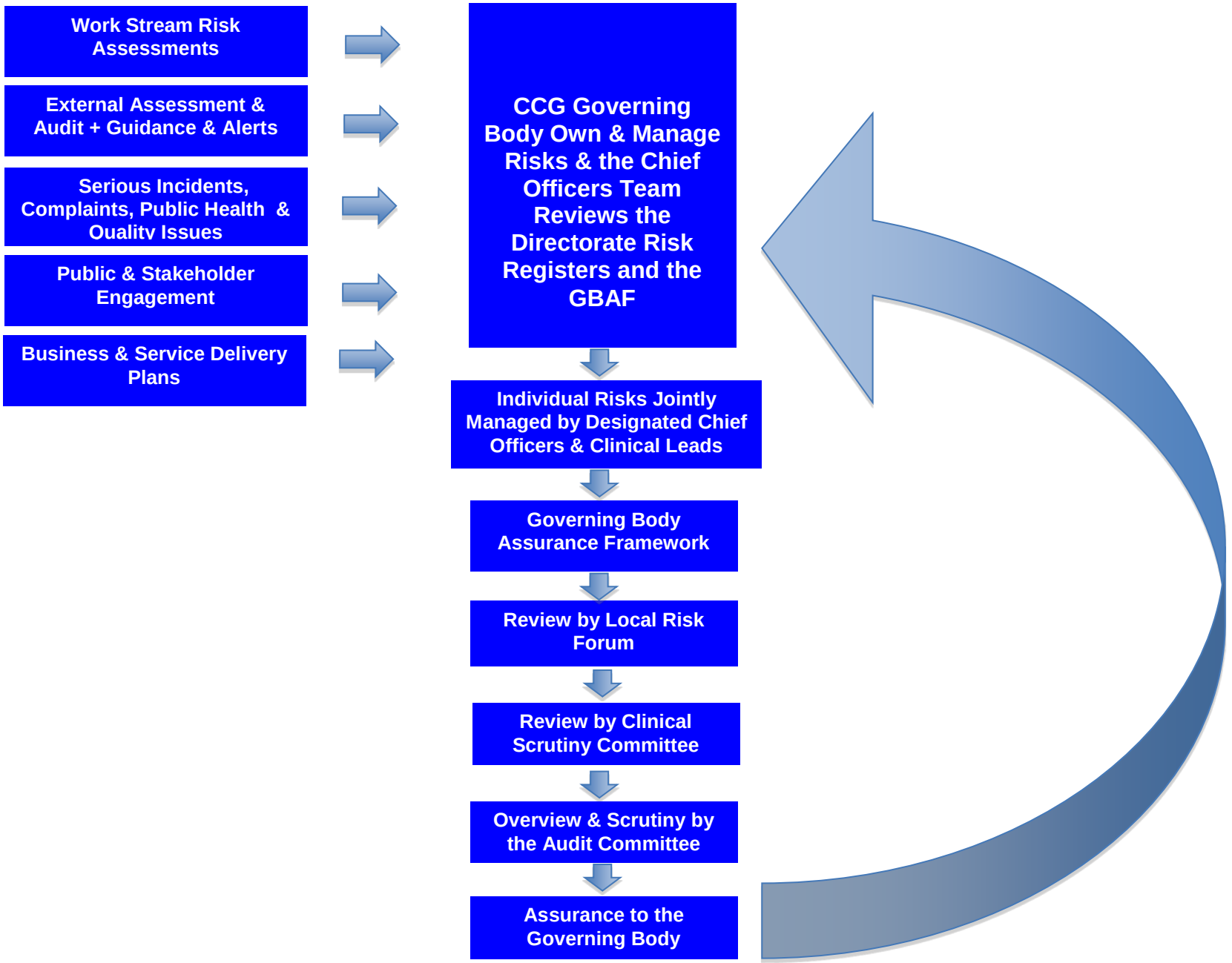
The GBAF identifies which of the organisation's strategic objectives may be at risk because of inadequacies in the operation of controls, or where the CCG has insufficient assurance. At the same time it encompasses the control of risk, provides structured assurances about where risks are being managed 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. ***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
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**	Alliance Financial Performance Committee (AFPC) to be established from start of 19/20 financial year with links to CCG FPC and ICS. ESNEFT reinvestment scheme to be established in 2019/20 with funding set aside to support the trust directly or supplement the alliance control total.	Reporting back discussions at AFPC to CCG Executive and CCG FPC. Reinvestment scheme to be monitored quarterly.			**3 x 5** **15**	**1.** Agree dates for Alliance FPC. **Target date:** 31 March 2019 **Completion date:** **2.** Agree conditions associated with ESNEFT reinvestment fund. **Target date:** 15 April 2019 **Completion date:** **3.** Put in place monitoring mechanisms for reinvestment fund. **Target date:** 30 April 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 2019 **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. STP cancer transformation monies are also at risk of not being available as not achieving 85% target.	• 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. Cancer Exec meetings in place from November 2018. 2. 7 must do's in place for all new cancer pathway patients from 1st December 2018. 3. Recovery plan trajectory for compliance against target end of May 2019. **Target:** May 2019 **Completed:**

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

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**	**4 x 4** **16**	**5 x 4** **20**	**1**. Quality assurance process to review every service line. **Target:** May 2019 **Completed: Update Feb 2019** - service reviews completed in ADHD service; adult inpatient areas; emotional wellbeing hub. 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** 25/2/19 Chair appointed from ELFT, Director of Improvement appointed, inpatient clinical lead appointed. **3.** Implementation of Suffolk emotional wellbeing and mental health strategy to be commissioned through most capable provider process **Target: March 2020** **Completed:** **Update Feb 2019;** Commissioning process agreed by Governing Bodies.

See following sheet for next risk

NSFT – Performance. Risk 26b added January 2016

ACCOUNTABLE OFFICER & GP OWNER	DESCRIPTION OF STRATEGIC RISK	GRANULAR OPERATIONAL RISKS	INITIAL RAG RATING (LIKELIHOOD x CONSEQUENCE)	KEY CONTROLS ESTABLISHED	ASSURANCE OF CONTROLS	RAG RATING OF GAPS IN CONTROLS	RAG RATING LAST MONTH	REVISED RAG RATING	ACTION POINTS & TARGET DATES FOR COMPLETION
JW / JH	Poor performance of mental health services Risk to CCG If performance does not improve to the contractual agreed standard then service users will continue to receive an inadequate service and the CCG would have failed in its duty to commission quality safe services	Poor performance against a number of performance indicators, most notably time to assessment. Access and Assessment Team (AAT): Routine Assessment of children (<18s) and Adults (>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).	4 x 4 16	• Remedial Action Plans agreed for Children's and Adults' Routine Assessment performance indicators • Additional funding agreed for EIP and Eating Disorder Services enabling recruitment of additional staff • CCGs have agreed non recurrent funding for EWB HUB to clear waiting list backlog and recurrent funding for additional HUB staff • ADHD service reviews held, CNO team undertaking review of waiting list focusing on processes for clinical safety/assessment of harm: CCG agreed additional investment for Consultant / Psychologist posts • CNO regularly reviewing progress with CQC action plan via Clinical Quality meetings • Lark ward reopened with limited beds	• Reported to the workstreams, Clinical Executive and Governing Body as appropriate Progress routinely monitored at monthly Quality Contracts & Performance (QCPM) meeting. **CCG Priority** *To improve access to mental health services*	**CHALLENGING**	4 x 4 16	4 x 4 16	**6.** Children's and adults routine assessment waits to recover to 28 days **Target:** October 2019 **Update:** Given clinical risks associated with ADHD waits, NSFT is currently working up a separate recovery trajectory, currently work in progress **Completed:** Monthly monitoring **7.** Lark ward reopening **Target:** Full opening Feb 2019 **Update:** Partially opened September 2018. Reported at the QCPM that full opening will be delayed for further 2-3 months **Completed:** **8.** Youth ADHD services. **Target:** Service reviews established to scope scale of issues and oversee improvements **Update:** 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. Additional staff are now in place and cohort of patients separately identified on Lorenzo, enabling clear consistent oversight of waiting list size and waiting times

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.	Leadership EEAST CEO has recently changed which may have short term impact on delivery of agreed ISR and improvements to response times. Capacity EEAST under achieving on required number of productive paramedic hours that EEAST can deliver 'on the road'. Demand Increase in acuity and volume of calls. Both direct to 999 and through 111 services. This includes rising care home 999 activity. Operational Procedures Reduction in productive paramedic hours due to delays in hospital arrival to handover and handover to clear.	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. **CCG Priorities** *To ensure high quality local services where possible.* *To improve the health of those most in need.*	 **CHALLENGING**	4 x 4 16	4 x 4 16 	1. **Action** - EEAST risk summit identified following actions; • Adoption of 30 minute maximum handover time. • Engagement from EEAST into system escalation calls/ Surge plans/Delivery Boards. • Introduction of HALO to support ambulance turnaround on targeted poorly performing ED sites. • Additional front line capacity is forecast by EEAST over last winter's capacity despite demand falling below 7.4% planned levels of activity. • Greater 111/999 integration to manage lower acuity demand together. • Strengthen alternative care pathways and work with care homes to reduce 999 reliance. • 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. **Target date:** Trust not expected to achieve targets until 04/19, with sign off by Regulators and a clear quarterly improvement trajectory. **Ongoing:** Risk summit held on 21.01.19 have tasked EEAST to provide evidence that their plans are robust and they will be able

									to respond should activity increase in Q4. EEASTs plans have been mapped against activity trajectory and a reducing trend in handover delays. Shift incentives are in place to cover key gaps in the rota. Risk remains around Feb half term week with forecast capacity. Care UK have paused the C2 validation pilot in Suffolk.

EEAST – Patient Safety. Risk 33 added February 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/EG	Currently East of England Ambulance are unable to meet the	High levels of incidents / serious incidents reported end December 2017 through to February 2018. Early	5 x 4 20	• Contract in place with KPI's focusing on long patient waits (90th	• Quality reports received monthly. • Appropriate challenge to reported quality		4 x 4 16	4 x 4 16	**4.** Joint Localities SI Forum to meet every 2 or 3 months.

	demand for its services, which may impact on the safety of patients <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.	analysis, subject to further investigation suggests that high levels of reporting are due to system pressures and resultant delays attending.		centile response standards). • Monthly Joint CCG Clinical Quality Review meetings. • Monthly contract & performance meetings • Risk Summit Process. • System wide actions to reduce demand and handover delays – including Care Homes specific. Robust investigation, then review of serious incident investigation reports through enhanced joint localities SI review Panel. External oversight of EEAST internal SI processes. EEAST weekly reporting of numbers of incidents considered SIs declared.	metrics, agreeing actions where improvements required. • Performance metrics demonstrate that both demand and handover delays are reducing. • Sample of long C1 waits reviewed in monthly Locality meeting. • Assurance that incidents have been robustly investigated and that learning shared across system to mitigate against reoccurrence. • Assurance that robust effective processes exist. • Clear Communication of the numbers of SIs being declared. **CCG Priorities** *To ensure high quality local services where possible.* *To improve the health of those most in need.*	**CHALLENGING**			**Target:** March 2019 **Completed:** January 2019 planned next SI forum. Working with EEAST and locality leads to establish a joint SI review process, which will increase the scrutiny and oversight of Sis. **5.** Appoint Patient Safety and Quality Lead with sole focus on EEAST. **Target:** May 2019 **Completed:** Post holder left after a short time. New internal appointment made to cover post initially until May 2019. **7.** Establish group to review C2 tail breaches. **Target:** March 2019 **Completed:** First meeting planned with commissioners and EEAST on 11th Feb 2019. **8.** Patient safety will be assessed following agreement of new governance and leadership frameworks by EEAST Board on 12.12/2018. Ongoing work with EEAST to review all patient safety indicators. Risk Summit Jan 19 were satisfied with safety. **9.** Additional capacity has been confirmed and is being monitored closely by lead commissioner. Ongoing assurance is being sort from EEAST. During the festive period additional capacity improved performance significantly, the challenge now is make this sustainable. **10.** New Improvement Plan will be monitored through regional monthly meetings. CCG attendance at OPID meetings fortnightly with a focus on reviewing the 12-week improvement plan. Awaiting new assurance/ accountability framework to be shared.

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 2019 **Completed:** **3.** Transformation Fund investments **Target:** March 2019 **Completed**: **4.** Programmes of work for workforce recruitment agreed and in process of being rolled out **Target:** March 2019 **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 February 2019.** Inspection carried out 20/21st February. No update yet.

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**	**4 x 3** **12**	**5 x 4** **20**	**1.** SLCN "to be" model to be developed, commissioned and implemented. **Target**: March 2019 **Completed**: **Update February 2019**: SLCN model approved by Governing Bodies. Commissioning arrangements being progressed. **2.** Review of ADHD service and full implementation of recommendations. **Target:** April 2019 **Completed: Update February 2019:** Service review completed. Actions being progressed through ADHD service operational meeting and CQPRM. **3.** QA visit to emotional wellbeing hub identified significant improvements required to EWH service and CAMHs. **Target: June 2019** **Completed: Update February 2019:** Recommendations taken to CCG: NSFT senior leaders meeting, multi-agency action plan developed which will be tracked through CAMHs operational meeting.

Safeguarding. Risk 30 added September 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	If the CCG cannot recruit to the Designate Doctor post for SEND/CiC then there could be an impact felt on medical leadership for these programmes of work. <u>Risk to the CCG</u> Statutory safeguarding duties cannot be met.	Medical leadership into SEND and CiC programmes of work is which may impact on medical engagement and training.	**4 x 4** **16**	Increased hours for CiC Designated Nurse. 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.	Monitor any concerns raised by team or clinicians relating to lack of medical leadership in CiC/SEND **CCG Priority** *To improve the health of those most in need*	**CHALLENGING**	**2 x 4** **8**	**2 x 3** **6**	**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 **Update 24/01/19** Designated Doctor for safeguarding children recruited and commenced on 7th January, 2 PAs a week increasing to 4 PAs on 1st March. Designated Doctor for Child Deaths and Looked After Children remain vacant but recruitment efforts are progressing well.

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**	CHC register of patients requiring Court of Protection applications monitored and reviewed at 6 weekly Health DOLS Meetings. CHC priority list of Court of Protection applications required is regularly reviewed. CHC LD Nurse leads on making urgent applications. CHC Lead preparing paper on resource necessary to mitigate risks and reduce backlog of Court of protection applications required by CCGs. External Advanced MCA and Advanced DOLS training commissioned by MCA/DOLS Lead and provided for CHC staff to upskill staff to make Court of Protection applications.	CHC Register shared and discussed with CCGs MCA/DOLS Lead CHC Priority List shared and discussed at 6 weekly DOLS Meetings chaired by CCGs MCA/DOLS Lead. Priority cases discussed with legal representative from Kennedys Court of protection applications reviewed by legal prior to submission to Court **CCG Priorities** *To ensure high quality local services where possible.* *To improve the health of those most in need*	**CHALLENGING**	**4 x 4** **16**	**4 x 4** **16**	1. Paper detailing resource required to be prepared for presentation to Board by end of August 2018 **Target:** March 2019 **Complete: Update 25/2/19 -** business case improved and recruitment commenced 2. Priority cases applications- 4 per month to be in progress/completed – commenced July 2018. **Target:** March 2019 **Complete:** 4 per month being progressed.

Cyber Security. Risk 36 added September 2018

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

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 from 1st March to 31 May 2019 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:** 29/03/2019 **Completion date:** Underway **4.** Completion of CCG Brexit Action Log. **Target date:** 29/03/2019 **Completion date:**

111 Service. Risk 39 added January 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
JW/IQ	The 111 service is failing the target for calls answered in 60 seconds. Care UK (Urgent Care Ltd.) predicting a deterioration in performance due to levels of staffing. Poor performance at most challenging time of year although Christmas period was much improved over predicted position.	• Clinical risk of patients not being seen in appropriate timescales • Risk of deteriorating patient outcomes and experience due to long waits. • Risk of breaching constitutional obligations. • Risk of increasing patient harm. • Potential impact on increasing demand for other providers	**4 x 4** **16**	Late notice of major staffing and performance issue end of November. Critical information was not forthcoming to fully understand issues and recovery plan. This is now being received on weekly basis and formal RAP in place.	• Updates from Care UK through regular escalation conference calls. • Contractual communication with Provider to ensure all immediate actions are being taken including agency and use of clinical advisors front ending calls. • Weekly tracker and updated recovery plan being received	**CHALLENGING**	**4 x 3** **12**	**4 x 3** **12** ⇨	1. Contract Performance Notice issued. Contract management meeting on 7 January 2019. 2. Trajectory and performance actions agreed with timeline of consistent performance by April 2019 3. Weekly updates and trajectory received by Care UK to assure recruitment and retention remains as per plan. **Target:** April 2019 **Completed:**

Departmental Risk Register summary of top risks

Date: March 2019

For: COT and requested committees

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

3. COO Ipswich & East	Social Prescribing: Connect for Health - Information Governance.	Patient data and information governance concerns between GP practice, CCG, Citizens Advice Bureau and Suffolk Community Foundation.	**12**	Work is progressing well. Working alongside Emma Cooper, GP DPO, CAB, Jodie Stutely and team. SLA in place, consent form and partnership agreement. Concerns remain regarding summary of client records following appointment with Community Advisor. Currently GP practice to enter this information but looking at purchasing stand alone System One Unit.	31 March 2019	Louise Hardwick
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. Contracts	The NEESP contract ends in March 2019. Need to secure contract from 1 April 2019, which delivers high quality service within financial envelope.	Contract meetings & service improvement meetings in place. Procurement plan also in place, engagement by MDT.	**8**	Contract options considered by Governing Bodies and next steps being taken forward by procurement lead.	April 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.	March 2019	Jane Webster
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. Finance	CCG liable if employees / persons acting on its behalf facilitate tax evasion. CCG may be prosecuted and be liable to pay HMRC additional monies.	A review of the Criminal Finances Act 2017 has been completed and will be discussed at the 4th December 2018 Audit Committee meeting.	**15**	Appropriate policies to be updated and presented to Feb 2019 Audit Committee for review and approval. Staff to be briefed on what is an offence, when to ask for help / advice and from whom, and directed to the relevant policies.	End April 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 2019	Jane Payling
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. Nursing	CDI: NHSI HCAI reduction targets per year. All providers are required to reduce HCAIs year-on-year. Suffolk CCGS are responsible for monitoring compliance via QCPM . The risk is that providers breach CDI targets set . Consequence - patient with bacteraemia / increase in patient stay/increase used of antibiotics/AMR/ increase in patient care costs	1. New reporting process in place across the STP for CDI cases (2018, NHSI guidance). 2. Reporting at QCPM contract meeting/ contract monitoring. 3. IP&C lead attends PIR meetings and HICC /IPC meetings 4. Learning from all RCAs discussed at Suffolk and North East Essex HCAI Network	**15**	Current position ESNEFT reporting shows improvement (notification form/RCA/panel review and closure). WSFT reporting process is good. WSCCG - community onset -trajectory set at 44 current position is 43*. Require RCAs to be completed by GPs/primary care and work with Medicines management team. IP&E CCG are well below trajectory. Small capacity of team. Recruitment underway.	March 2019	Julia Shields
2. Nursing	NEESPS Staff resources within the service are reported to be stretched, compounded by high levels of turnover and difficulties recruiting, which are impacting the ability to deliver a safe service.	1 Monthly quality contract meetings with the provider. 2 More detailed staffing information requested. 3 Work with NHSI to establish key deliverables for the service. 4 Development of key contractual metrics	**10**	Concerns formally escalated for action at quality contract meeting including staffing levels. March 2019 Update; Requested workforce updates not received from the provider. MHRA inspection Feb 2019 highlighted that "there was no assurance that sufficient qualified & competent personnel were available to assure a safe service". No significant incidents have been reported associated with staffing issues.	March 2019	Chris Hooper

3. Nursing	STP does not have a clear and measurable delivery plan to achieve the National targets for Continuity of Care within the National Maternity transformation programme.	Dedicated PMO to work with Heads of Midwifery to develop initial plan. PMO linking with Regional PMO to provide assurance on recovery plan. Clinical leadership secured for Sept 2018 to develop vision and delivery plan for Maternity Transformation programme.	**15**	Regular discussion with Regional PMO re recovery and milestones able to achieve. Agreement from regional PMO to deliver high level plan in Sept 2018 with detailed submission in Jan 2019. However, STP will remain under high scrutiny from Region until detailed plan provided.	March 2019	Helen Bowles
	Risk Description / consequences	**Current controls / assurance**		**Actions with status**	**Completion date**	**Responsible person**
1. Transformation	Emotional Wellbeing Hub. Performance of the Suffolk (0-25) emotional well-being hub had recently declined	Recent review of the Hub by the quality team has revealed clinical concerns as well as issues with waiting list. Escalated within NSFT and recovery plan developed	**12**	Hub trajectory and capacity plans submitted to Clinical Exec for approval	March 2019	Jo John
2. Transformation	Royal college of Ophthalmology reviewed glaucoma services for our patients - Unfavourable report showing patients at risk with some coming to harm. Current incumbent provider for follow up reviews of glaucoma patients is at an end and are requesting a large uplift on contractual value to extend contract	Options being explored to maintain patient safety and to deliver services with an integrated approach	**25**	Urgent meetings taking place with senior staff to look at options to reduce risk to patients	April 2019	Karen Dowsing